COMMITTEE ON INSURANCE

REFERENCE MANUAL

PREPARED BY STAFF OF THE
HOUSE INSURANCE COMMITTEE
JANUARY 2001

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I. ADMINISTRATION

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B. STAFF

Stephen T. Hogge, Staff Director – Since returning to employment with the Florida House of Representatives in 1994, Mr. Hogge has served as Staff Director for the Committees on Tourism & Economic Development (1994); Commerce (1994-96); Financial Services (1996-98); and, most recently, Insurance (1998-Present). Between 1990 and 1994, Mr. Hogge served as Director of Governmental Relations for the Florida Association of Counties and was principally responsibility for environmental and growth management policy issues. Prior to that time, he served as a Staff Attorney/Analyst for the Committees on Transportation and Education K-12. A native of the Commonwealth of Virginia, Mr. Hogge received his juris doctorate from Southern Methodist University School of Law in 1985. Enrolled at George Washington University, Mr. Hogge re-located to Florida in 1979 and received a bachelor of arts degree in International Studies from the University of South Florida.

Bobbye Iseminger, Committee Administrative Assistant – Ms. Iseminger has been with the Legislature for nearly 21 years. She was initially with the Republican Office starting in 1977, then served with the Natural Resources Committee from 1978-1985. After living in Atlanta, Georgia from 1985-88, she returned to Tallahassee and to the Legislature in January 1989 as the Committee Administrative Assistant for the Insurance Committee. She was the Committee Administrative Assistant for the Financial Services Committee from 1996-98 and with the Insurance Committee in 1998.

Meredith Woodrum Snowden, Legislative Analyst – Ms. Snowden has worked for the House of Representatives for over nine years. She began her employment by working in the Clerk's Office from 1991-94, and in the Judiciary Committee from 1994-96. She worked as a Legislative Research Assistant with the Utilities and Communications Committee from 1996-97, as a Legislative Analyst with the Financial Services Committee from 1997-1998, and joined the staff of the Insurance Committee in November 1998 as a Legislative Analyst. Ms. Snowden earned a bachelor of arts degree in English with a minor in communication from Randolph-Macon Woman's College in Lynchburg, Virginia in 1989.

Eric Lloyd, Legislative Attorney – Mr. Lloyd began his employment with the House of Representatives in 1994 with House District 49. He worked in the district office for two and one-half years before returning to his alma mater, Florida State University, to attend law school. While at the Florida State University College of Law, Eric interned twice with the Consumer Affairs Council, working primarily with the Committee on Business Regulation & Consumer Affairs, and also with the Committee on Regulated Services and the Committee on Utilities & Communications. Eric graduated from law school in April 2000 and returned as a full-time employee in July 2000. He was sworn into the Florida Bar in September 2000.

Drew Crawford, Council Intern – Mr. Crawford is in his first year with the House of Representatives and is serving as an Intern with the Council for Competitive Commerce. He splits his time between the Insurance Committee and the Banking Committee. Drew is currently a second year law student at the Florida State University College of Law. Before moving to Tallahassee, he earned his bachelor's degree in Computer Science from Clemson University in Clemson, South Carolina.

C. PRIMARY POLICY JURISDICTION

Primary Policy Jurisdiction, 2000-2002 Biennium

By line of insurance:

Casualty insurance, including:
- Liability insurance
- Malpractice insurance
- Mortgage guaranty insurance
- Motor vehicle insurance
- Workers' compensation insurance

Life insurance (including viatical settlements)
Property insurance
Specialty insurance (e.g., warranty associations)
Surety insurance
Title insurance

By insurance entity:

Insurance companies
Self-insurers (individual and group)
Premium finance companies
Insurance agents
Claims adjusters
Third party administrators
Warranty associations
Reinsurers

By regulatory entity:

Department of Insurance
State Fire Marshal
Treasury
Division of Workers' Compensation (within the Department of Labor)

By regulatory activity:

Insurer licensing
Insurance rate and form regulation
Insurer solvency regulation
Marketing of insurance products
Trade practices
Insurance fraud
Fire prevention

Other:

Implementation of the 1998 Constitutional Revision #8, relating to the Chief Financial Officer

II. OVERSIGHT

A. AGENCY OVERSIGHT

The Committee oversees the administration and operation of all divisions of the Department of Insurance and also the activities of the Division of Workers' Compensation within the Department of Labor and Employment Security.

DEPARTMENT OF INSURANCE

The Treasurer, an elected constitutional officer, is the statutorily-designated head of the Department of Insurance [Department].[1] The Department head is officially named the "Insurance Commissioner and Treasurer." The Treasurer also serves as the State Fire Marshal.

The **Office of the Insurance Consumer Advocate,** an office created by the Legislature, is charged with representing the interest of the public before the Department. The Consumer Advocate is appointed by, and reports to, the Insurance Commissioner. The Consumer Advocate is authorized to recommend actions to the Department, appear in proceedings before the Department or hearing officers, access Department records, examine rate and form filings, hire consultants, and prepare an annual budget request for submission to the Legislature by the Department.

The **Division of State Fire Marshal** is responsible for minimizing the loss of life and property due to fire. The division regulates installation of fire equipment, conducts safety inspections, investigates causes of fires, and provides firefighter training and certification.

The **Division of Treasury** coordinates and directs the keeping of all state funds and securities. It disburses funds upon order of the Comptroller, and invests surplus funds collected by state agencies. The division also administers the state public depository program and the state deferred compensation program, and exercises custodial responsibility for stocks, bonds, and other securities as required by law.

The **Division of Agent and Agency Services** was created in 1990 to regulate the conduct of insurance agents. The division oversees the licensure and appointment of all insurance agents, bail bond agents, title agents, other insurance representatives, and other field and office entities approved to transact insurance in Florida.

The **Division of Insurer Services** generally oversees the operations and conduct of insurers doing business in Florida. This entails review and approval of premium rates, review of the organizational and financial status of insurers, and general oversight of the affairs and field conduct of insurers and

[1] Constitutional Revision 8, approved by Florida voters in November 1998, merges the offices of Treasurer and Comptroller into the office of Chief Financial Officer, effective January 7, 2003.

their agents. In addition, the division regulates and monitors Florida's joint underwriting associations and the title insurance industry.

The **Division of Insurance Consumer Services** is responsible for informing and protecting the insurance-buying public by handling insurance complaints and claim inquiries, developing and distributing insurance buyers' guides, establishing consumer outreach programs, and preparing news releases. In addition to the Tallahassee office, the department operates ten service offices located throughout the state.

The **Division of Insurance Fraud** employs certified law enforcement officers as investigators with the right to make arrests and bear arms. It is empowered to investigate all violations of the Insurance Code and related criminal statutes.

When insurance companies get into serious financial trouble, they are sent to the **Division of Rehabilitation and Liquidation** to be put into Circuit Court receivership. The receivership may attempt to "rehabilitate," that is, correct the financial problem and restore the company to good condition. Or, if the problem cannot be corrected, the receivership may be for purpose of liquidating the company.

The responsibility of the **Division of Legal Services** is to provide legal representation in connection with the performance of the Department's regulatory responsibilities.

The **Division of Risk Management** is responsible for administering the State's property and casualty self-insurance trust funds. The casualty fund provides insurance programs for State employees' workers' compensation coverage, general liability coverage, fleet automobile liability coverage, federal civil rights actions, and court awarded attorney's fees coverage.

DEPARTMENT OF LABOR AND EMPLOYMENT SECURITY

The Department of Labor and Employment Security (DLES) is headed by a Secretary appointed by the Governor and confirmed by the Senate.

The Legislature created the **Division of Workers' Compensation** within the Department of Labor and Employment Security to administer the provisions of Chapter 440, F.S., the Florida Workers' Compensation Act. The division oversees the administration of the workers' compensation laws. The division is funded through assessments against insurers. The proceeds are deposited into the Workers' Compensation Administration Trust Fund.

The division is composed of the following offices and bureaus:

Office of the Director—Provides general management and decision-making authority; coordinates the budgeting, planning, personnel, and legislative activities of the entire division; and oversees a system to administer delivery of services to injured workers.

Bureau of Operations Support—Provides administrative support to all units and field offices. Also responsible for collecting assessments, processing all

cash receipts, investigating and monitoring all insolvency petitions, and regulating self-insured employers.

Bureau of Compliance—Gathers and maintains evidence of coverage on all liable employers and certain exempted parties. This bureau ensures that all licensed carriers comply with established workers' compensation laws and rules.

Bureau of Employee Assistance—Provides general information to the public, investigates and attempts to resolve disputed issues, and assists injured employees in drafting petitions for benefits. Ensures that files for claims are sent to the Judge of Compensation Claims.

Bureau of Information Management—Maintains a comprehensive record management system for all required documents.

Bureau of Monitoring and Audit—Monitors and audits insurer performance of statutory responsibilities.

Bureau of Rehabilitation and Medical Services—Designs and implements schedules for maximum reimbursement for workers' compensation medical care and rehabilitation services and implements procedures for utilization review. Reviews and evaluates claimant requests for training and education, and provides training and/or placement services to qualified employees. By interagency agreement in 2000, the Department of Labor transferred 29 positions to the Agency for Health Care Administration to perform functions related to workers compensation managed care.

Bureau of Research and Education—Designs, develops, and implements research and education programs to provide greater knowledge and understanding of the workers' compensation system.

Employer Services Section—Provides technical assistance, training, and information to the state's employers.

Bureau of Special Disability Trust Fund—Administers the special disability trust fund, determines entitlement to reimbursement, and reimburses employer/carriers for benefits paid.

B. BOARDS AND COMMISSIONS

The committee also monitors the activities of numerous state boards, commissions, and councils. Many of these are constituted as public/private partnerships, and many are purely public bodies. These include the following:

- Deferred Compensation Advisory Council
- Florida (Automobile) Joint Underwriting Association
- Florida Commission on Hurricane Loss Projection Methodology
- Florida Fire Code Advisory Council
- Florida Fire Safety Board
- Florida Hurricane Catastrophe Fund Advisory Council
- Florida Insurance Guaranty Association
- Florida Life and Health Insurance Guaranty Association
- Florida Medical Malpractice Joint Underwriting Association
- Florida Residential Property and Casualty Joint Underwriting Association
- Florida Self-Insurers Guaranty Association
- Florida Surplus Lines Service Office
- Florida Windstorm Underwriting Association
- Florida Workers' Compensation Insurance Guaranty Association
- Florida Workers' Compensation Joint Underwriting Association
- Hurricane Loss Mitigation Program Advisory Council
- Interagency Advisory Council on Loss Prevention
- Office of the Judges of Compensation Claims
- Public Deposits Advisory Committee
- Residual Property Insurance Market Coordinating Council
- Special Disability Trust Fund Privatization Commission
- Workers' Compensation Oversight Board

DEFERRED COMPENSATION ADVISORY COUNCIL

Department: Department of Insurance

Purpose: To provide assistance and recommendations to the Treasurer relating to the State Deferred Compensation Program and the options offered by the program.

Membership: The Deferred Compensation Advisory Council consists of seven members who are employed and appointed by the following:

- the legislative branch, appointed jointly by the House Speaker and the Senate President;
- the judicial branch, appointed by the Chief Justice of the Supreme Court;
- the state university system, appointed by the Chancellor of the State University System;
- the Treasurer, appointed by the Treasurer;
- the Comptroller, appointed by the Comptroller;
- the executive branch, appointed by the Governor; and
- one nonexempt public employee appointed by the Chair of the Public Employees Relations Commission.

Reports: The advisory council is required to make a report of each meeting to the Treasurer.

[1982; s. 112.215, F.S.]

FLORIDA (AUTOMOBILE) JOINT UNDERWRITING ASSOCIATION (FJUA)

Department: N/A

Purpose: FJUA provides auto insurance to any licensed driver who is unable to obtain coverage in the voluntary market. Rates are filed by the FJUA and approved by the Department of Insurance and are intended to be actuarially sound. In the event of a deficit, insurers are assessed on a market share basis based on their auto premium writings in Florida.

At one time, over 500,000 persons were insured with the FJUA; and significant annual assessments against insurers were common. Steady depopulation for approximately the last 12 years has resulted in a population as of December 31, 1999 of about 10,000 policies. The total premium written by the FJUA is less than one percent of the total premium written for automobile insurance in the voluntary market. The FJUA has not experienced a plan deficit resulting in assessments against insurers since 1985.

Certain provisions of the FJUA statutes are designed to assure rate adequacy and to encourage placement in the voluntary market. For example, the FJUA is required to make a rate filing at least once a year, with procedures for actuarial certification as to rate adequacy. The plan may not provide any renewal credits or discounts designed to retain a risk.

Membership: Specified in the FJUA Plan of Operation, as approved by the Department of Insurance.

Reports: No reports are required by statute.

[1973; s. 627.311, 627.351(1), F.S.]

FLORIDA COMMISSION ON HURRICANE LOSS PROJECTION METHODOLOGY

Department: N/A

Purpose: The Legislature created the Florida Commission on Hurricane Loss Projection Methodology to evaluate computer models and other actuarial methodologies for projecting hurricane losses used for ratemaking by insurers. Property insurers are authorized to submit findings from approved models to support rate filings before the Department of Insurance. The commission has approved the following five models for use under its 1999 standards: AIR (Applied Insurance Research); RMS (Risk Management Solutions); EQECAT; E.W. Blanch; and ARA (Applied Research Associates). The commission anticipates that seven models will be submitted by February 28, 2001 for review under the 2000 standards. The commission operates independently of the Department of Insurance and the insurance industry and is housed at the State Board of Administration.

Members: The commission consists of 11 members, including:

- the Insurance Consumer Advocate,
- the Chief Operating Officer of the Florida Hurricane Catastrophe Fund,
- the Executive Director of the Florida Residential Property and Casualty Joint Underwriting Association,
- the Director of the Division of Emergency Management of the Department of Community Affairs,
- the actuary member of the Florida Hurricane Catastrophe Fund, and
- six members appointed by the Insurance Commissioner.

Two of the six members appointed by the Insurance Commissioner include an employee of the Department of Insurance who is an actuary responsible for property insurance rate filings and an actuary employed by a property and casualty insurer in the state. The following four Insurance Commissioner appointees must be full time faculty members of the State University System: an expert in insurer finance who has a background in actuarial science, an expert in statistics who has a background in insurance, an expert in computer system design, and an expert in meteorology specializing in hurricanes.

Reports: No reports are required by statute.

[1995; s. 627.0628, F.S.]

FLORIDA FIRE CODE ADVISORY COUNCIL

Department: Department of Insurance

Purpose: The Florida Fire Code Advisory Council advises and recommends to the State Fire Marshal changes to and interpretations of the uniform firesafety standards adopted under the Florida Fire Prevention Code and those portions of the Florida Fire Prevention Code and the uniform firesafety standards that conflict with building construction standards.

Membership: The council consists of 11 members appointed by the State Fire Marshal, including:

- the State Fire Marshal or his designee;
- an administrative officer from a county or municipal fire department selected from a list submitted by the Florida Fire Chiefs Association;
- a licensed architect selected from a list submitted by the Florida Association/American Institute of Architects;
- a registered engineer with fire protection design experience selected from a list submitted by the Florida Engineering Society;
- an administrative officer from a county or municipal building department selected from a list submitted by the Building Officials Association of Florida;
- a licensed contractor selected from a list submitted by the Florida Home Builders Association;
- a certified firefighter selected from a list submitted by the Florida Professional Firefighters' Association;
- a certified municipal fire inspector selected from a list submitted by the Florida Fire Marshal's Association;
- a member of the general public;
- a member selected from a list submitted by the Department of Education; and
- a member selected from a list submitted by the Chancellor of the State University System.

Reports: No reports are required by statute.

[1975; s. 633.72, F.S.]

FLORIDA FIRE SAFETY BOARD

Department: Department of Insurance

Purpose: The Florida Fire Safety Board provides guidance to the State Fire Marshal on the activities, such as training and educational needs and the scope of current industry practices, of fire equipment dealers and fire protection system contractors licensed by the State Fire Marshal. This board also advises the State Fire Marshal on the appropriateness of fire protection codes and standards.

Membership: The Florida Fire Safety Board consists of seven members appointed by the State Fire Marshal, including:

- the State Fire Marshal or his designee;
- an administrative officer of a municipal or county building department;
- an administrative officer of a municipal or county fire department;
- two licensed fire protection contractors; and

- two licensed fire equipment dealers.

Reports: No reports are required by statute.

[1975; s. 633.511, F.S.]

FLORIDA HURRICANE CATASTROPHE FUND ADVISORY COUNCIL

Department: State Board of Administration

Purpose: The purpose of the advisory council is to make recommendations regarding the operations of the Florida Hurricane Catastrophe Fund.

Membership: The nine-member council is appointed by the State Board of Administration and consists of the following members: an actuary, a meteorologist, an engineer, a representative of insurers, a representative of insurance agents, a representative of reinsurers, and three consumer members who are representative of affected professions and industries.

Reports: No reports are required by statute.

[1993; s. 215.555, F.S.]

FLORIDA INSURANCE GUARANTY ASSOCIATION (FIGA)

Department: N/A
Purpose: The FIGA is a non-profit corporation established pursuant to Chapter 631, Part II. The association provides for payment of claims under property and casualty insurance policies, and liability policies issued by insurers that have become insolvent. The association is divided into three accounts: auto liability, auto physical damage, and all other FIGA-covered insurance. Each account is funded by assessments against insurers writing that type of insurance in the state. The assessments shall not exceed two percent of an insurers net direct written premium.

Membership: All insurers licensed to write any kind of insurance covered by the FIGA are members of the association, which is a condition of their authority. The board of directors is comprised of not less than five or more than nine persons (presently there are nine members). Directors are elected by the member insurers for a four-year term, except that vacancies may be filled for the remaining term.

Reports: No reports are required by statute.

[1970; s. 631.50, F.S., et. seq.]

FLORIDA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION (FLAHIGA)

Department: N/A

Purpose: The FLAHIGA is a non-profit corporation established pursuant to Chapter 631, Part III. The association protects policyholders, insureds, beneficiaries, annuitants, payees and assignees of life insurance policies and annuity contracts against the failure of an insurer to perform its contractual duties due to insolvency. The FLAHIGA guarantees or reinsures life insurance or annuities claims of an insurer that

becomes insolvent. Funding for the FLAHIGA comes from an assessment on its members. The amount of the assessment is based on the amount of premiums received by the insurer for business in Florida. The assessment amount may not exceed one percent of the insurer's total premium in this state.

Membership: All insurers certified to issue life insurance policies, annuity contracts, and health insurance contracts are members of the association, which is a condition of their authority. The board of directors is comprised of not less than five members (presently there are nine members), one of which must be a representative of a domestic insurer. Directors are elected by the member insurers for a three-year term, except that vacancies may be filled for the remaining term by the existing board.

Reports: The FLAHIGA is under the general oversight of the Department of Insurance, and as such, is subject to the applicable reporting laws of Department.

[1979; s. 631.711, F.S., et. seq.]

FLORIDA MEDICAL MALPRACTICE JOINT UNDERWRITING ASSOCIATION (FMMJUA)

Department: N/A

Purpose: The FMMJUA operates to provide medical malpractice coverage to health care providers unable to obtain coverage in the voluntary market. Limits of coverage are provided up to $250,000 per claim, with an annual aggregate of $750,000.

Rates are required to be adequate, but in the event of a deficit, the policyholders are subject to an assessment of up to one-third of their annual premium for the year giving rise to the assessment. If a deficit remains, property and casualty insurers are then subject to assessment based on their liability and malpractice writings in the State. There has never been a policyholder or insurer assessment in the FMMJUA.

In 1983, the FMMJUA reached its peak with about 4,000 policies insured. As of March 1998, only about 142 health care providers obtained malpractice coverage from the FMMJUA, with nurses and dentists representing the top two categories.

Membership: A majority of the board members of the FMMJUA are not appointed by the Insurance Commissioner but are instead selected by private organizations.

Representatives of five participating insurers, an attorney designated by the Florida Bar, a physician designated by the Florida Medical Association, a dentist designated by the Florida Dental Association, and a hospital representative designated by the Florida Hospital Association.

Reports: No reports are required by statute.

[1975; s. 627.351(4), F.S.]

FLORIDA RESIDENTIAL PROPERTY AND CASUALTY JOINT UNDERWRITING ASSOCIATION (RPCJUA)

Department: N/A

Purpose: After Hurricane Andrew in 1992, the Legislature created the RPCJUA as an insurer of last resort for persons unable to obtain residential property coverage (homeowners' and similar coverages) in the voluntary market.

If the RPCJUA sustains a deficit, insurers are assessed on a market share basis to cover the deficit. Assessments against insurers in any one year are capped at 10 percent of the total statewide premium for residential property insurance or 10 percent of the deficit, whichever is greater ("regular assessments"). If the entire deficit cannot be collected in assessments in one year, municipal bonds can be issued to cover the deficit, funded entirely by future year assessments ("emergency assessments"). Insurers may pass regular assessments through to policyholders; emergency assessments are collected by insurers from policyholders.

Membership: The RPCJUA board of governors consists of 13 members: the Insurance Consumer Advocate, five members designated by the insurance industry, five consumer representatives appointed by the Insurance Commissioner, two of whom are RPCJUA policyholders at the time of appointment, and two insurance industry representatives appointed by the Insurance Commissioner.

Reports: No reports are required by statute.

[1992; s. 627.351(6), F.S.]

FLORIDA SELF-INSURERS GUARANTY ASSOCIATION (FSIGA)

Department: N/A

Purpose: The FSIGA is a non-profit corporation established pursuant to Chapter 440.385, F.S. The FSIGA provides for payment of claims of employees when individually self-insured employers become insolvent. The FSIGA is funded by assessments on individually self-insured employers based on premium the employer would have paid had it not been self-insured. The assessment cannot exceed one percent of the annual premium during the calendar year preceding the date of assessment.

Membership: The board of directors of the FSIGA consists of nine members, each appointed by the Secretary of Labor and Employment Security upon the recommendation of the members of the FSIGA. Board members serve a four-year term.

Reports: No reports are required by statute.

[1982; s. 440.385, F.S.]

FLORIDA SURPLUS LINES SERVICE OFFICE

Department: Department of Insurance

Purpose: The Florida Surplus Lines Service Office is a nonprofit association of which all surplus lines agents are members. Such agents file with the service office a copy of, or information on, each surplus lines policy or other document required by the service office

plan of operation. When the insurer or an adjuster representing the insurer receives a claim notice under a policy subject to these filing requirements, the insurer or adjuster notifies the service office of the claim and the policy under which the claim was made. The service office determines whether the policy was filed as required, and reports any unfiled policy to the department. The service office also collects the surplus lines tax and remits it to the Department of Insurance.

Membership: The service office operates under a board of governors appointed by the Department of Insurance. The membership consists of five members of the Florida Surplus Lines Association, a representative who is a surplus lines agent form each of the two major Florida associations of insurance agents, a risk manager for a large domestic commercial enterprise, and the Insurance Consumer Advocate.

Reports: The Florida Surplus Lines Service Office is required to report monthly to the Department of Insurance regarding all policies reported to the service office. Quarterly, the service office is required to prepare a report of each surplus lines agent's business.

[1997; s. 626.921, F.S.]

FLORIDA WINDSTORM UNDERWRITING ASSOCIATION (FWUA)

Department: N/A

Purpose: Since 1970, the FWUA has provided windstorm and hail insurance to persons unable to obtain coverage, but only in those geographic areas that have been determined to meet specified eligibility criteria. In order to be eligible, the Department of Insurance must determine that due to the lack of windstorm insurance, economic growth and development are being deterred and financial institutions are unable to make loans, the county or area is enforcing the state minimum building codes, and extending coverage would be consistent with laws governing coastal management, comprehensive planning, beach preservation, and related laws.

Policies issued by the FWUA provide windstorm and hail coverage only. Other property insurance risks (e.g., fire or theft) would be obtained in the voluntary market by obtaining an "ex-wind" policy.

Insurers are subject to assessments for losses in the FWUA, but insurers also are provided credits against assessments based on their voluntary writings in windstorm pool areas. Also, insurers with less than a $20 million surplus which write 25 percent or more of their premiums in Florida, are not required to participate in the amount of any assessment that exceeds $50 million. Legislation following Hurricane Andrew limited assessments against all insurers for losses in the windstorm pool, in the same manner that assessments are limited in the RPCJUA.

Membership: Specified in the FWUA Plan of Operation, as approved by the Department of Insurance.

Reports: No reports are required by statute.

[1970; s. 627.351(2), F.S.]

FLORIDA WORKERS' COMPENSATION INSURANCE GUARANTY ASSOCIATION (FWCIGA)

Department: N/A

Purpose: The FWCIGA is a non-profit corporation established pursuant to Chapter 631, Part V. The FWCIGA provides for payment of claims under workers' compensation insurance policies issued by insurers and group self-insurance funds that have become insolvent. The FWCIGA does not cover claims from individually self-insured employers -- these are covered by the Florida Self-Insurers Guaranty Association.

The FWCIGA is funded by assessments (not to exceed 2 percent annually for insurers or 1.5 percent for group self-insurance funds) upon all insurers and group self-insurance funds based on their net direct written premium in the preceding calendar year. Effective July 1, 1999, if assessments collected are not adequate to pay claims on a current basis, Florida law authorizes the FWCIGA to levy an additional separate "deemed approved" assessment whose rate shall not exceed 1.5 percent.

The FWCIGA, created in 1997, is the result of a merger between the Florida Self-Insurance Fund Guaranty Association (FSIFGA) and the workers' compensation insurance account from the FIGA.

Membership: The board of directors of the FWCIGA consists of 11 members -- one insurance consumer advocate; one appointee of the Insurance Commissioner, six persons selected by private carriers from among the 20 largest insurers; and three persons selected by self-insurance funds.

Reports: No reports are required by statute. The board may make reports and recommendations to the Department of Insurance, and assist it in the detection and prevention of insolvencies.

[1997; s. 631.901, F.S., et. seq.]

FLORIDA'S WORKERS' COMPENSATION JOINT UNDERWRITING ASSOCIATION (FWCJUA)

Department: N/A

Purpose: The FWCJUA is the residual market insurer for workers' compensation insurance. The FWCJUA's purpose is to provide insurance coverage to employers who cannot find coverage in the voluntary market. These are typically higher risk employers -- i.e., very small employers and employers with a high incidence of workplace injuries.

Prior to 1993, an assigned risk plan for workers' compensation insurance operated in Florida, which was not created by statute but was voluntarily formed and operated by workers' compensation insurers in Florida. Losses in the assigned risk plan were absorbed by Florida insurers, but not by self-insurance funds, which were prominent in Florida in the late 1980's and early 1990's.

The FWCJUA is funded entirely by policyholder premiums and policyholder assessments. In this sense, it is much more like a self-insurance fund than a

traditional joint underwriting association. The FWCJUA provides insurance for employers in three distinct subplans -- subplans A, B, and C. Subplan A is designed to provide coverage for small employers -- those with less than $2,500 in premium. Subplan B is designed to provide coverage to employers classified as high risk by the nature of their business, but with a lower than average number of claims. Policies issued under subplans A and B are not assessable. All other employers in the FWCJUA fall into subplan C and can be issued assessable policies funded by increased premiums upon renewal, direct assessments, or both.

Membership: The board of governors is comprised of 13 members, and includes five domestic insurers, five foreign insurers, a chairman appointed by the Insurance Commissioner, a representative from the insurance agents, and a consumer advocate.

Reports: The board is required to provide an annual report to the Department of Insurance containing information which the Department may require of the FWCJUA.

[1994; s. 627.311(4), F.S.]

HURRICANE LOSS MITIGATION PROGRAM ADVISORY COUNCIL

Department: Department of Community Affairs

Purpose: The purpose of the council is to develop programs in consultation with the Department of Community Affairs to improve the wind resistance of residences and mobile homes, to retrofit public hurricane shelters, and to research and develop hurricane loss reduction techniques and devices.

Membership: The Hurricane Loss Mitigation Program Advisory Council consists of six members appointed by the Secretary of Department of Community Affairs representing the Department of Insurance; homebuilders; the insurance industry; the Federation of Mobile Home Owners; the Florida Association of Counties; and the Florida Manufactured Housing Association.

Reports: No reports are required by statute.

[1999; s. 215.559, F.S.]

INTERAGENCY ADVISORY COUNCIL ON LOSS PREVENTION

Department: Department of Insurance

Purpose: The advisory council is required to meet at least quarterly to discuss safety problems within state government, to attempt to find solutions, and to assist in the implementation of these solutions. The advisory council is also authorized to recognize employees, agents, and volunteers making exceptional contributions to the reduction and control of employment-related accidents.

Membership: The advisory council is comprised of the safety coordinators from each department, in addition to representatives designated by the Division of State Fire Marshal and the Division of Risk Management within the Department of Insurance.

Reports: The advisory council reports annually to the Governor by January 15 of each year on any actions taken to prevent job-related employee accidents, along with suggestions for safeguards and improvements.

[1979; s. 284.50, F.S.]

OFFICE OF THE JUDGES OF COMPENSATION CLAIMS

Department: Department of Labor and Employment Security

Purpose: To conduct formal dispute resolution proceedings in workers' compensation cases.

Membership: Chief Judge and 31 Judges of Compensation Claims

Reports: Annual litigation report prepared jointly with the Division of Workers' Compensation for submission to the Governor and Legislature (Section 440.45(6), F.S.)

Annual report summarizing late final orders submitted to the Governor, Legislature, Secretary of Department of Labor and Employment Security, Florida Bar, and appellate judicial nominating commissions (Section 440.25(4)(f), F.S.)

Reporting of attorney's fees to the Division of Workers' Compensation to be compiled into an annual report to the Workers' Compensation Oversight Board (Section 440.345, F.S.)

Summary of lump-sum settlement reports (Section 440.20(11)(a), F.S.)

[1993; s. 440.45, F.S.]

PUBLIC DEPOSITS ADVISORY COMMITTEE

Department: Department of Insurance

Purpose: To review and recommend criteria to be used by the Treasurer to protect public deposits and the depositories that are a part of the Public Depository Program.

Membership: The Treasurer appoints all six members. Each appointee must represent an active qualified public depository and must possess knowledge, skill, and experience in one or more of the following areas: financial analysis, trend analysis, accounting, banking, risk management, or investment management.

Reports: No reports are required by statute.

[1988; s. 280.05, F.S.]

RESIDUAL PROPERTY INSURANCE MARKET COORDINATING COUNCIL

Department: N/A

Purpose: To assure that the RPCJUA and the FWUA are informed of the activities and plans of the other.

Membership: The Insurance Consumer Advocate; Executive Director, RPCJUA; Executive Director, FWUA; Chair, RPCJUA; and Chair, FWUA.

Reports: May recommend proposals to improve coordination between the associations and eliminate unnecessary duplication of efforts.

By March 1 of each year, provide the Legislature with a report of their activities.

[1997; s. 627.3516, F.S.]

SPECIAL DISABILITY TRUST FUND PRIVATIZATION COMMISSION (SDTFPC) (Inactive)

Department: N/A

Purpose: The SDTFPC was established for the purpose of determining the feasibility of privatizing the Special Disability Trust Fund (SDTF). The Legislature created the SDTF in 1955 to encourage employers to hire or retain employees with pre-existing disabilities or conditions.

Florida law authorized the Commission to determine the liabilities of the SDTF and develop and issue a request for proposal to transfer the liabilities of the SDTF to a qualified entity. The law also authorized the commission, in consultation with the Division of Workers' Compensation, to develop and issue a request for proposal for assumption of administration of certain functions related to the SDTF.

On January 21, 2000, the Commission voted not to accept any of the proposals and not to privatize the SDTF. On the same day, it adopted a series of recommendations, including a recommendation that the Legislature repeal the statutory provisions creating the SDTFPC.

Membership: The Commission is composed of three members -- one member selected by the Governor, one member selected by the Insurance Commissioner, and one member selected by the Comptroller.

Reports: No reports are required by statute.

[1998; s. 440.49(13), F.S.]

WORKERS' COMPENSATION OVERSIGHT BOARD

Department: Labor and Employment Security

Purpose: This labor-management board is responsible for reviewing the performance of the workers' compensation system, making recommendations regarding rules and laws, and issuing reports on issues critical to the maintenance and improvement of the system.

Membership: The board is comprised of 12 appointed members: six chosen by the Governor, three by the President of the Senate, and three by the Speaker of the House. These members include a cross-section of employer and employee representatives from both the construction and non-construction industries and from both small and large businesses. In addition, the Insurance Commissioner and the Secretary of the Department of Labor and Employment Security serve as non-voting ex-officio members.

Report: The board is required to formulate workers' compensation legislation and amendments; review, advise, and appear before the Legislature on workers' compensation issues; advise the Division of Workers' Compensation on policy and legislative issues; and appear before state and federal agencies

in connection with workers' compensation matters. [1994; s. 440.4416, F.S.]

C. BIOGRAPHICAL SKETCHES

DEPARTMENT OF INSURANCE

Tom Gallagher, State Treasurer and Insurance Commissioner – Mr. Gallagher, a Delaware native, moved to Florida in 1961 to attend the University of Miami, where he received a bachelor's degree in business administration. Mr. Gallagher's life in public service began in 1974, when for seven out of 13 years, he was the only Republican elected to the Florida House of Representatives from Dade County. In 1987, then Governor Bob Martinez appointed him as the Secretary of the Department of Professional Regulation. In 1988, he was first elected State Treasurer, Insurance Commissioner and Fire Marshal. After serving as Education Commissioner from 1998-2000, he was again elected to the post of Treasurer and took office January 3, 2001.

Paul Mitchell, Chief-of-Staff - Mr. Mitchell served as Chief of Staff for the Department of Education the past two years. Prior to joining the Department of Education, Paul was Chief Cabinet Aide to former Secretary of State Sandra Mortham for four years. He spent six years in the Department of Insurance as an Assistant to the Treasurer.

He holds a bachelor's degree in Communications from Florida State University.

Karen Chandler, Deputy Chief-of-Staff - For the past two years, Ms. Chandler served as Communications Director for the Department of Education. From 1994-98, she was the spokesperson for the Senate President's office, serving in the same capacity for both Senator Toni Jennings and Senator Jim Scott. Prior to joining the Legislature, Ms. Chandler worked in the communications office of the Department of Insurance for six years.

She holds a bachelor's degree in Communications from Florida State University.

Mark Casteel, General Counsel - Prior to joining the Department, Mr. Casteel served four years as a chief advisor to former Senate President Toni Jennings. From 1990-96, he was Assistant Vice President in Government and Industry Affairs for the National Council on Compensation Insurance. Mr. Casteel also served as Legislative Counsel with the United Services Automobile Association and as a legislative analyst with the Senate Commerce Committee.

He holds a bachelor's degree in Economics from the University of Missouri and a juris doctorate degree from Stetson University College of Law.

Kevin McCarty, Deputy Insurance Commissioner - Mr. McCarty started with the Department of Insurance in 1991 as a Senior Management Analyst in the Division of Insurer Services. Since 1991, he has served in a number of capacities, most recently serving as Division Director of Insurer Services. From 1988-91, he was a research associate for the Department of Labor and Employment Security. In addition, Mr. McCarty was adjunct professor with Lakeland College.

He holds a bachelor's degree in Political Science and a juris doctorate degree from the University of Florida.

Kenney Shipley, Deputy Commissioner of Consumer Services - Ms. Shipley served as Assistant Commissioner for the Colorado

Department of Insurance from 1997-2000. She worked for the Florida Department of Insurance as Bureau Chief of Life and Health Forms and Rates and has extensive experience in a number of insurance lines, including health, property and worker's compensation. She serves as a member and chairman of a variety of committees for the National Association of Insurance Commissioners. She holds a bachelor's degree in Economics from the University of West Florida.

Michelle Newell, Division Director of Insurer Services - Most recently, Ms. Newell served as Bureau Chief of Life and Health Solvency and Market Conduct for the Department of Insurance. Prior to joining the Department, she was the Director of Accounting Services for American General Life Insurance Company of New York for 14 years.

She attended Syracuse University and the State University of New York.

John Hale, Division Director of Agent and Agency Services - Mr. Hale has worked for the Department of Insurance for 16 years, serving in a variety of roles. He is currently the Division Director of Agent and Agency Services and has worked as an attorney in regulating insurance companies and agents. He has also played an important role in guiding the Department's legislative agenda.

He holds a bachelor's degree in Political Science from Florida A&M University, a master's degree from Emory University and a juris doctorate degree from University of Florida

Elsie B. Crowell, Insurance Consumer Advocate - Ms. Crowell was appointed as Consumer Advocate in July 1997 by Commissioner Nelson. Ms. Crowell represents the interests of the general public of Florida. She sits on the respective governing boards of the Florida Surplus Lines Service Office, Residential Property and Casualty Joint Underwriting Association, the Florida Windstorm Underwriting Association, the Worker's Compensation Joint Underwriting Association, the Residual Property Insurance Market Coordinating Council, and the Commission on Hurricane Loss Projection Methodology. As Insurance Consumer Advocate, Ms. Crowell further serves as Chair of the Statewide Provider and Subscriber Assistance Panel, and as a member of the Worker's Compensation Classification Appeals Board.

Prior to her appointment, Ms. Crowell served as Director of Insurance Consumer Services for six years. She has been employed by the Department of Insurance since 1989. Ms. Crowell holds a bachelor's degree in business and a master's degree in education, both from Florida A & M University.

Jose A. Diez-Arguelles, Director of Policy Analysis and Intergovernmental Affairs - Mr. Diez-Arguelles joined the Department of Insurance in December 1998 in the Office of Policy Analysis and Intergovernmental Relations and is responsible for coordinating the Department's legislative activities.

Mr. Diez-Arguelles began his government career in 1983 as a staff attorney with the Florida Public Service Commission. He became staff attorney with the Finance and Taxation Committee in 1985. In 1987, he served as Staff Director of the House Insurance Committee. After 14 months as a Hearing Officer with the Florida Division of Administrative Hearings, he returned to the House of Representatives to serve as Staff Director of the Finance and Taxation Committee from 1989 to 1993. From 1993 until

he joined the Department, Mr. Diez-Arguelles was associated with a law firm in Tallahassee.

Mr. Diez-Arguelles received a bachelor's degree in International Affairs, a juris doctorate degree from Florida State University, and a master's degree in tax law from Boston University School of Law.

Jim Watford, Actuary - Mr. Watford has been with the Department since 1982, and has been involved with workers' compensation insurance for the last eight years. His responsibilities include the actuarial analysis of workers' compensation rate filings and deviations, and the collection of data for statutorily required reports.

Mr. Watford has served as chairman of the National Association of Insurance Commissioners (NAIC) Exam Oversight Group.

Mr. Watford received a degree in Business Administration from Florida State University and is currently an Associate with the Casualty Actuarial Society.

DEPARTMENT OF LABOR AND EMPLOYMENT SECURITY

Mary Hooks, Secretary - Ms. Hooks was appointed Secretary of the Department of Labor and Employment Security in January 1999. Ms. Hooks was elected to the West Palm Beach City Commission in 1993, where she served until her appointment to her current position. She served two terms as chairman of that commission. As a commissioner, she helped establish the Minority Business Enterprise and Preference Goals Program, which helps minorities and women-owned businesses apply and qualify for government contracts.

Ms. Hooks is the owner of M. B. Hooks & Associates, a West Palm Beach insurance agency, which specializes in life, group health, disability, and annuities. She is a past president of the Palm Beach Association of Life Underwriters.

Charles D. Williams, Director of Division of Workers' Compensation - Mr. Williams was appointed Director of the Division of Workers' Compensation in February 1999. Mr. Williams has been in the insurance field since 1965. He has managed a general lines independent insurance agency and owned and managed Williams and Associates Insurance, Inc. for six years.

Mr. Williams served as a county commissioner in Suwannee County from 1988 until 1992 and as a State Senator representing District 4 until November 1998. Mr. Williams graduated from Florida State University in 1961 with a bachelor's degree in Business.

Margaret Young, Assistant Director of Division of Workers' Compensation - Ms. Young graduated from the Florida State University College of Law with honors in 1989. After law school, Ms. Young joined the law firm of Roberts, Baggett, LaFace & Richards as an associate and practiced in the area of administrative law for three and a half years.

After leaving the private sector, Ms. Young joined the Department as a lawyer in the general counsel's office where she was assigned to work on cases relating to the Division. In 1997, Ms. Young was appointed Chief of the Bureau of Compliance within the Division. Since 2000, she has served as Assistant Director of the Division.

Ms. Young is also a member of the Florida Bar Workers' Compensation Rules Committee.

FLORIDA RESIDENTIAL PROPERTY AND CASUALTY JOINT UNDERWRITING ASSOCIATION

James W. (Jay) Newman, Executive Director - Mr. Newman is the Executive Director of the Florida Residential Property and Casualty Joint Underwriting Association (FPCJUA).

Mr. Newman has a long career in the insurance industry, beginning with the Virginia Bureau of Insurance. He began as Deputy Commissioner in 1976, and moved on to become Commissioner of Insurance in 1978, where he was responsible for all aspects of insurance regulation in the State of Virginia. Mr. Newman spent more than 11 years in the private sector, principally with the CIGNA Corporation, where he rose to the position of Vice President for Commercial Shared Market Services. He also served as Senior Vice President with RAI Insurance Services, with responsibility over several lines of insurance. In addition, he served on the boards of the All-Industry Research Advisory Council, and the Worker's Compensation Research Institute. Throughout his career in insurance, Mr. Newman has been active at senior levels of the National Association of Insurance Commissioners, specifically chairing the Market Conduct and Consumer Affairs Subcommittee, the Advisory Committee on Worker's Compensation Group Self-Insurance, and the Advisory Committee on Occupational Disease.

Mr. Newman has also served in government, first as an administrator at Florida State University, and later as the Executive Director of the Governor's Advisory Committee on Transportation, and then the Legislative Programs Coordinator in the Florida Department of Transportation.

FLORIDA WINDSTORM UNDERWRITING ASSOCIATION

Rebecca J. Fussell, Executive Director - Ms. Fussell is the Executive Director of the Florida Windstorm Underwriting Association (FWUA). She has worked for the FWUA since 1982, serving in several capacities, including Treasurer and Acting Manager. Ms. Fussell also sits on both the Executive Committee and the Executive Board of the Property Insurance Plans Service Office. She also is a member of the Insurance Accounting and Systems Association (IASA).

Ms. Fussell has a bachelor's degree in accounting from the University of North Florida.

Ron Natherson. Public Affairs Manager - Mr. Natherson is the Public Affairs Manager of the Florida Windstorm Underwriting Association (FWUA). His responsibilities include all media and public relations for the association, coordinating internal and external communications, serving as company spokesman, and lobbying the Florida Legislature.

Mr. Natherson joined the FWUA in January 2000, after serving as Director of Alumni Services for the University of North Florida for six years. He received his undergraduate degree in Banking and Finance and his master's degree in Public Administration, both from the University of North Florida.

He is a member of the Steering Committee for the Florida Alliance for Safe Homes (FLASH), Public Relations Committee Chair for the Windstorm Insurance Network, Inc., and a member of the Public Relations Society of America. Mr. Natherson also participates in the Residual Property Insurance Market

Coordinating Council and the Public Relations Committee of the Florida Insurance Council

FLORIDA HURRICANE CATASTROPHE FUND

Jack E. Nicholson, Chief Operating Officer - Jack Nicholson is the Chief Operating Officer of the Florida Hurricane Catastrophe Fund for the State Board of Administration. Dr. Nicholson serves on the Board of Directors and is President of the Florida Hurricane Catastrophe Fund Finance Corporation. He also is on the Florida Commission on Hurricane Loss Projection Methodology.

Prior to coming to the State Board of Administration, Dr. Nicholson worked for the Florida Department of Insurance, holding the positions of Director of the Office of Insurance Research and Data Analysis, Deputy Director of Property and Casualty Insurers, Assistant Director of Rating, and Bureau Chief of Rates. He also served as the Insurance Department's liaison with the State Board of Administration regarding the Cat Fund.

Dr. Nicholson holds a Ph.D. degree in Risk Management and Insurance and a bachelor's degree in Business with a major in Insurance from the University of Georgia. He also received a M.B.A. from the University of North Dakota.

D. MAJOR GROUPS/ORGANIZATIONS IMPACTED BY COMMITTEE

Alliance of American Insurers--national organization primarily representing smaller insurance companies.

Allstate Insurance Companies--property and casualty insurer with the second-highest market share in Florida.

American Council of Life Insurance--national organization representing life insurers.

American Insurance Association--national organization primarily representing insurers using the independent agency system to distribute their products; an association of commercial carriers.

Florida Association of Health Plans-- represents 15 health maintenance organizations in Florida.

Florida Association of Insurance Agents-- represents 10,000 independent insurance agents through 1100 agencies.

Florida Association of Insurance and Financial Advisors--represents 5000 health, life, and multi-lines agents and financial advisors.

Florida Association of Self-Insurance (FASI)-- represents both individual and group self-insurance funds.

Florida Employers Insurance Service Company (FEISCO)--third-party administrator for FCCI Mutual Insurance Company.

Florida Group Risk Association--association of group self-insurance funds.

Florida Homebuilders Association--16,000 member trade organization composed of local associations, affiliated with the National Association of Home Builders.

Florida Insurance Council--represents 55 member groups consisting of over 250 insurance companies doing business in Florida.

Florida Land Title Association--represents title insurance companies and agents.

Health Insurance Association of America, **Inc**.--represents the private health care system. Its 294 members provide health, long-term care, dental, disability and supplemental coverage to more than 123 million Americans.

National Association of Independent Insurers--national organization representing primarily direct-writer insurers (insurers that use one-company agents, rather than independent agents).

National Council on Compensation Insurance (NCCI)--A workers' compensation rating organization which files rates for worker's compensation insurers.

Professional Insurance Agents--represents insurance agents.

State Farm Insurance Companies--property and casualty insurer with the highest market share in Florida.

III. POLICY NARRATIVES

A. INTRODUCTION

Insurance is a form of financial security that protects life and property. It is bought to protect assets or provide financial security. In some instances, insurance may be required by law in furtherance of a public purpose or social policy, as in the case of auto insurance or workers' compensation insurance. Insurance may also be required contractually by another party as in the case of a creditor wanting to protect a security interest in property. Homeowners' insurance required under a mortgage is one example of this.

1. KINDS OF INSURANCE

There are many different kinds of insurance. The two major groupings are property and casualty, and life and health. Other kinds of insurance include surety, marine, and title.

Property insurance covers the loss of or damage to the property of policyholders. It includes personal lines residential (i.e., coverage provided by homeowners', mobile homeowners', dwelling, tenants' and condominium unit owners' policies), and commercial lines residential (coverage provided by condominium associations and apartment buildings). Property also includes commercial property insurance coverage.

Casualty insurance generally covers policyholder liability for injuries or damages suffered by other persons (i.e., third parties) or the property of others. It includes motor vehicle, workers' compensation, liability, credit, credit property, and malpractice insurance.

Health insurance generally provides coverage for hospital, physician, and other medical expenses resulting from illness or injury. It also includes coverage for the accidental loss of life, limb or sight.

Life insurance provides protection to beneficiaries upon the death of the insured. Life insurance contracts take many forms from term life to whole life to credit life.

Surety, marine, and title insurance are three other forms of insurance. A surety generally agrees to pay the debt of another person or performance of some obligation. Marine insurance covers any kinds of losses or damage to vessels, aircraft, cars, freights and all other kinds of property in connection with the risks of navigation. Title insurance insures against losses resulting from defects of title in, or encumbrances or liens on, real property.

2. KINDS OF INSURERS

Insurers are classified according to a variety of characteristics.

a. By authority to transact insurance: authorized or unauthorized

The Insurance Code distinguishes between insurers based on their status as "authorized" or "unauthorized." An "authorized" insurer is an insurer which has been issued a certificate of authority from the Department to transact insurance in this state. Unauthorized insurers may be permitted to write coverage in this state if they qualify as an eligible surplus lines insurer.

b. By place of domicile: domestic, foreign, or alien

The Insurance Code also distinguishes between insurers based on their place of domicile. Insurers may be "domestic," "foreign," or "alien." A "domestic" insurer is one formed under the laws of Florida; a "foreign" insurer one formed under the laws of another state; and an "alien" insurer one formed under the laws of another country. When issued a certificate of authority by the Department to transact insurance, a foreign or alien insurer may do business in Florida just as a domestic insurer does. However, domestic insurers generally must meet more rigid statutory requirements for initial certification and financial solvency. Additionally, the Department is given greater responsibility for overseeing domestic insurer operations. There is virtually no regulatory distinction among domestic, foreign, and alien insurers when it comes to policies sold in Florida.

c. By form: company, reciprocal, self-insurance fund, or joint underwriting association

1) Insurance company

The insurer can may operate as a stock or mutual insurance company. A stock insurer has capital stock and is owned by its shareholders; a mutual insurer has no capital stock and is owned by its policyholders who are called "member." Insurance companies frequently are referred to as insurance carriers.

2) Reciprocal insurer

An insurer may be organized as a reciprocal insurer. A reciprocal is an unincorporated association with each insured insuring the other insureds within the association.[2] The reciprocal insurer and the insurer has no capital stock. There are no domestic reciprocal insurers. Two examples of reciprocal insurers are the United Services Automobile Association and the Erie Insurance Exchange.

3) Self-insurance fund

A self-insurance fund is an organization of two or more employers, typically sponsored by a trade or professional association and operated through a trust or corporation, in which each member shares in

[2] Barron's Business Guide, Dictionary of Insurance Terms, 4th Ed., 2000, p. 421.

the risks written by other fund members.[3] Florida law recognizes three different forms: "group," "commercial," and "local government." Self-insurance funds commanded a substantial share of the workers' compensation market in the early 1990's when workers' compensation rates were spiraling upwards. In 1994, there were 33 self-insurance funds writing workers' compensation; today, there are only four, with the largest being the Florida Retail Federation Self-Insurance Fund.

4) Joint underwriting association

A joint underwriting association (JUA) is a residual market entity—entities commonly referred to as "insurers of last resort." A JUA is generally described as an association of insurers providing coverage for those risks unable to obtain coverage in the voluntary market. Workers' compensation, motor vehicle, and residential property and casualty lines all have a joint underwriting association. Table 1 profiles the features of each.

Table 1. Features of joint underwriting associations operating in Florida, 12/31/99.

	Florida Workers' Compensation Joint Underwriting Association	Florida (Auto) Joint Underwriting Association	Residential Property and Casualty Joint Underwriting Association	Florida Windstorm Underwriting Association
Coverage	Workers' compensation	Private passenger and commercial motor vehicles	Personal and commercial residential property	Windstorm-only coverage for residential and commercial multi-peril in eligible areas
Date established	1994	1973	1992	1970
Governing body	13-member board	11-member board	13-member board	15-member board
Market share (based on share of total direct written premium, 12/31/99)	0.2%	0.1%	5.4%	Statewide: Residential--8.3% Commercial--6.2% In eligible areas: Residential--78% Commercial--62%
Policies-in-force	424	10,000	66,695	433,074
Exposure	N/A	N/A	$10.4B	$92.1B
Rate filing method	Use-file	File-use	Use-file	File-use or use-file
Assessment cap	None	None	10% of aggregate statewide premium or 10% of deficit, whichever is greater	10% of aggregate statewide premium or 10% of deficit, whichever is greater
Assessments since 1985 (Year/ amount)	None levied	1985--$8M	1994: $17.7M 1995: $22.8M	1985: $3.2M 1992: $16.2M 1993: $3.2M 1995: $117M

[3] One distinction between an insurance company and a self-insurance fund is that fund members generally are liable for assessments if premiums prove to be inadequate to cover the fund's expenses. Policyholders of insurance companies typically are not liable for additional premium to cover past losses (except for some assessable mutuals and experience-rated plans which are based in part on a policyholder's own loss experience).

				1998: $100M
Surplus	$1.3M	$71.8M	$146.8M	$88.3M

Insurers may be the primary insurer of a risk or reinsure the risk for which another insurer is primarily obligated. The reinsurer effectively insures the insurer.

d. By type of insurance written

Finally, insurers may be distinguished by the kind of insurance they write (e.g., property and casualty insurer or life and health insurer, title insurer).

3. MARKET SUMMARY

Table 2 is a limited market summary of insurers and premium volume for selected lines of insurance. It shows insurer premium volume, the number of authorized insurers and authorized insurers based on domicile, compares market share for the voluntary and residual markets based on premium volume, and provides a weighted average measure of insurer financial strength.

Table 2. Summary of insurers and premium volume for selected lines, 12/31/99.

	Workers' Compensation	Pvt. Passenger. Auto	Commercial Auto	Homeowners'	Commercial Multi-Peril
Insurers:					
•Authorized	443	541	555	483	520
Domestic	40	49	47	55	44
Foreign	403	492	508	428	476
•Writing premium (#, %)	255(58%)	286(53%)	302(54%)	198(41%)	249(48%)
Mutual insurer	33	23	31	24	28
Stock insurer	211	259	266	170	217
Self-insurance fund	4	0	0	0	0
Other	7	4	5	4	4
•Financial ratings:[a]					
Avg. rating	A	A+	A	A	A
# unrated	3	0	0	6	0

Premium:[b]					
•Total	$2,534M[c]	$7,379M	$1,141M	$2,982M	$704M
Voluntary	$2,528M	$7,373M	$1,136M	$2,576M	$680M
Residual	$6M	$6M	$5M	$406M	$24M
•Market share					
Voluntary	99.80%	99.99%	99.99%	86.40%	96.6%
Residual	0.20%	0.01%	0.01%	13.60%[d]	3.4%
•Residual entity	FWCJUA	FJUA [Auto]	FJUA [Auto]	RPCJUA and FWUA	FWUA
•Top writers					
Top 3	$486M	$1,744M	$113M	$889M	$99M
Top 10	$1,014M	$3,323M	$268M	$1,529M	$248M

Notes:

[a]As calculated by staff of the House Committee on Insurance using A.M. Best Co. financial ratings for each insurer as of 12/31/99, weighted based on relative premium volume for the top 70 percent of the voluntary market, excluding A.M. Best Co.'s unrated companies and unrated self-insurance funds (number of excluded companies that fell within the top 70 percent is listed under "# unrated" insurers). A.M. Best Co.'s ratings obtained through their web site: http://www.ambest.com.

[b]Premium is "direct written premium" as reported to the National Association of Insurance Commissioners in insurer annual statements for 1999: line 16 for workers' compensation; lines 19.1, 19.2, and 21.1 for private passenger motor vehicle insurance; lines 19.3, 19.4, and 21.2 for commercial motor vehicle insurance, line 4 for homeowners', and line 5.1 for commercial multi-peril insurance. Residual market premiums for homeowners' insurance represents the direct written premium for the RPCJUA plus the personal and commercial lines residential portion of FWUA total direct written premium. The commercial portion of the FWUA premium is included under the commercial multi-peril property column.

[c]Direct written premium for voluntary market insurers includes approximately $70 million in "assessable" premium imputed to the four group self-insurance funds by the Department of Labor when determining their liability for Workers" Compensation Administration Trust Fund assessments.

[d]The FRPCJUA, which writes general property insurance, writes 5.4% of the market and the FWUA, which writes windstorm insurance only, writes 8.2%.

4. TYPES OF INSURANCE REPRESENTATIVES AND MARKETING SYSTEMS

a. Types of insurance representatives

There are many different types of insurance representatives. These include agents, customer service representatives, solicitors, brokers, adjusters, and others.

1) Agents

An insurance agent transacts insurance on behalf of an insurer or insurers. Agents must be licensed by the Department to act as *an* agent for an insurer, and be appointed (i.e., given the authority by an insurance company to transact business on its behalf) by at least one insurer to act as the agent for *that particular appointing insurer or insurers.*

Agents may be classified according to the number of products they are allowed to sell, the type of products they may sell, and their place of residency (e.g., resident or non-resident agent).

a) By number of products: general and limited agents

"General lines agents" are authorized under state law to transact any or all of the following lines of insurance: property, casualty, surety, health, and marine insurance. However, a general lines agent may sell health insurance without being separately licensed as a health agent only for those insurers also represented by that same agent as to property and casualty insurance. Otherwise, only licensed health agents may sell health insurance. "Limited lines agents" are individuals, or in some cases entities, licensed as agents to sell one or more of the following forms of insurance (each requiring a separate license): motor vehicle physical damage and mechanical breakdown; industrial fire or burglary; personal accident; baggage and motor vehicle excess liability; credit insurance; credit property; crop hail and multiple peril crop insurance; or in-transit and storage personal property. Neither general lines nor limited lines agents may sell life insurance. General lines agents also may transact limited lines of insurance other than personal accident and crop insurance products.

b) By type of product: life, health, title

Certain agents are further identified in law by the specific type of insurance they sell. "Life agents" represent insurers as to life insurance and annuity contracts. They also can sell two limited lines of insurance: credit life or disability, and personal accident. Life agents are authorized to accept applications, but may not bind coverage. The insurance company must approve life insurance applications. "Health agents" are those licensed to represent health maintenance organizations or an insurance company as to health insurance only. They also can sell two limited lines of insurance: credit life or disability, and personal accident. "Title" agents are persons licensed to issue and countersign commitments or policies of title insurance.

c) By place of residency: resident and nonresident agent

"Resident agents" are agents domiciled and residing in the state of Florida. "Nonresident agents" may sell insurance only under the supervision of a licensed resident agent. All insurance policies issued by a nonresident agent are required to be countersigned by a resident agent.

2) Customer and service representatives

"Customer representatives" are appointed by general lines agents or agencies to assist them in insurance transactions. They work under the direct supervision of the appointing agent and may not leave the office to sell insurance. A "limited customer service representative" is one involved in only private passenger motor vehicle insurance. "Service representatives" are directly employed and appointed by insurers or managing general agents to assist in negotiating and effecting insurance when accompanied by a general lines agent. In practice, a service representative works in an insurance company's main office or regional office, rather than in an insurance agency.

3) Brokers

"Brokers" represent the consumer in obtaining coverage with insurers. Brokers are not usually appointed by the insurers with whom they place business.

4) Adjusters

"Adjusters" evaluate, investigate and settle insurance claims. The three types of adjusters are: a company adjuster employed by an insurer; an independent adjuster employed by an independent adjusting firm, which may contract with one or more insurers to adjust claims; and a public adjuster, who contracts with policyholders to assist them in settling a claims with insurers and is paid a percentage of the claims settlement.

b. Marketing system

In Florida, insurance must be purchased from a licensed and appointed agent. The methods used to market insurance products in the state vary among insurance companies. Some insurers use the independent agency system, while other companies, such as State Farm and Nationwide, direct write using only exclusive agents.

1) Independent agency system

An independent agency system is one in which insurers sell and service their products through agents representing more than one insurance company. These agents are known as independent agents and are paid on a commission basis. When an insurance policy placed by an independent agent comes up for renewal, the independent agent has the option of placing the business with another insurance company.

2) Exclusive agency system

An exclusive agency system is one in which insurers distribute their products through agents representing only one insurance company or group of insurance companies. These agents are known as "exclusive" agents or "captive" agents. They are restricted by contract from submitting business to any other insurance company. Exclusive agents may be paid on a commission or salary basis.

B. REGULATION OF INSURANCE

1. REGULATORY FUNDAMENTALS

a. Goals of regulation

Insurance regulation has many different goals, chief among them being to assure the price of insurance is not "inadequate, excessive, or unfairly discriminatory"; insurers are financially solvent and capable of paying benefits as contractually promised; insurers offer a reasonable level of benefits; and marketing practices are not unfair or deceptive.

b. Regulatory responsibility

Insurance regulation is primarily the responsibility and function of state government. In 1945, Congress passed the McCarran-Ferguson Act—an act delegating insurance regulation to the states and granting insurers a limited exemption from federal antitrust laws. Within constitutional limits, states may regulate virtually any aspect of the insurance business they deem necessary and appropriate.

Every state, to varying degrees, regulates insurers and insurer representatives (e.g., agents), rates, policy forms, and business practices. In Florida, the Department of Insurance (hereinafter referred to as the "Department") is the chief regulatory entity.[4] The Treasurer, an elected constitutional officer, is the statutorily-designated head of the Department, and is commonly referred to as the Commissioner of Insurance when performing insurance regulatory responsibilities.[5]

Regulation of insurers and insurer representatives is expressly preempted to the state under Florida law: local governments are prohibited from requiring any authorization, permit, or registration of any kind.[6]

c. Scope of regulation

Florida has an extensive set of regulatory requirements. With few exceptions, these laws are found in Chapters 624 through 651 of the Florida Statutes. These laws constitute the Insurance Code. Exceptions include workers' compensation insurance, unemployment compensation insurance, and Medicaid.[7] The workers' compensation system, for example, is administered primarily through Chapter 440; however, workers' compensation insurers are subject to the regulatory requirements in the Insurance Code applicable to insurers generally and ratemaking requirements specific to workers' compensation insurers.

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[4] However, the Department of Labor and Employment Security has programmatic responsibility for the workers' compensation system.
[5] The Treasurer is the elected constitutional officer to whom the statutory duties of insurance regulation have been assigned. By statute the head of the department is named the "Insurance Commissioner and Treasurer." [s. 20.13(1), F.S.]
[6] Section 624.401(3), F.S.
[7] Chapters 440, 443, and 409, F.S., respectively.

Table 3. Selected chapters of the Insurance Code	
Chapter	Regulated entity or activity
624	Types of insurance; insurer licensing; financial reporting and examinations; surplus requirements; self-insurance; fee schedule for insurers, agents, adjusters, and others; administrative supervision.
625	Insurer accounting practices; assets, liabilities, investments, and deposits.
626	Insurance agents and other representatives; unfair insurance trade practices; viatical settlements
627	Insurance rates and contracts (forms); premium financing and premium finance companies.
631	Insurer solvency (rehabilitation and liquidation); guaranty funds.
634	Motor vehicle service agreements and warranty associations
635	Mortgage guaranty insurance
648	Bail bonds

2. REGULATION OF INSURERS

a. Licensing

1) Initial issuance of a certificate of authority

Insurers, including self-insurance funds, must apply for and receive a certificate of authority from the Department before transacting insurance business in Florida.[8] To qualify for a certificate of authority, an insurer must submit an application and fees along with a copy of its financial statement, maintain certain specified reserves, meet minimum surplus requirements, and deposit funds with the Department. Requirements vary depending on the way in which an insurer is organized. The management of the insurer must not be found to be incompetent, lacking in experience to such a degree as to jeopardize the reasonable promise of a successful operation, or dishonest. Foreign and alien insurers must also submit a copy of their most recent financial examination by the regulator in their state of domicile or entry along with a certificate authorizing them to transact insurance in their state or country of domicile. If it finds an insurer complies with all of these requirements, the Department must issue the insurer a certificate of authority. The certificate will specify the kinds or lines of insurance the insurer may transact. The Insurance Code places restrictions on the kinds of insurance insurers are authorized to transact.[9] For instance, the same insurer cannot, using the same corporate entity, transact both property and casualty insurance, and life and health insurance; additionally, reciprocal insurers cannot transact life insurance.

2) Maintenance of a certificate of authority

Certificates of authority continue in effect until revoked or suspended, or terminated at the request of the insurer, subject to payment of annual licensing fees and filing of annual financial statements.

[8] A domestic insurer likewise may not be *formed* without the approval of the Department. Section 628.051, F.S.
[9] Section 624.406, F.S.

Insurers must comply with minimum surplus requirements applicable to existing insurers rather than those applicable to insurers at time of initial licensure.

3) Suspension or revocation of a certificate of authority

By order, the Department can revoke or suspend an insurer's certificate of authority. The Department must revoke or suspend the certificate if the insurer is in unsound financial condition, is operating in a way that is hazardous to its policyholders or to the public, has not timely paid outstanding judgments rendered against it in this state, or no longer meets the requirements for initial issuance of a certificate. The Department has the discretion to suspend or revoke a certificate when an insurer has violated any order or rule of the Department; refused to be examined or pay proper claims; been convicted of, or otherwise entered a plea of not guilty or no contest, to a felony relating to the transaction of insurance; or has a premium-to-surplus ratio exceeding 4-to-1 leading the Department to believe policyholder interests are endangered.

b. Rates and forms

1) Rates

Rates are the amounts charged per unit of insurance. Premium is determined by multiplying the rate by the units of insurance purchased. The terms frequently are used interchangeably.

Ratemaking policy generates a great deal of public interest and legislative attention. Most types of property and casualty insurance are subject to rate regulation. Life insurance is not subject to rate regulation. Title insurance rates are established in statute.[10] Ratemaking requirements also exist for specialty insurers such as warranty companies and associations.

Rating laws determine how and when an insurance company files its rates, if and when those rates become effective, and if or when insurers may depart from that rate. Rating laws specify the standards regulators must use in reviewing rate filings. Rate review includes examination of any rates, rating schedules or plans, and rating manuals.

The rating laws in effect in Florida for property and casualty insurance prohibit rates from being "excessive,[11] inadequate, or unfairly discriminatory."[12] These terms are defined in statute for property

[10] On October 19, 2000, in *Chicago Title Insurance Company v. Butler*, 770 So. 2d 1210 (Fla. 2000), the Florida Supreme Court affirmed a lower court order declaring several statutes unconstitutional to the extent they prohibited title insurance agents from rebating some or all of their share of the risk premium from the sale of a title insurance policy to those purchasing title insurance. After the lower court ruling, the Legislature in 1999, revised various sections of the statute in response to the lower court order. The Legislature also exempted title insurance agents from a state statute applicable to agents generally that permits rebating by agents selling other lines of insurance so long as rebates are provided in a nondiscriminatory manner. With the Supreme Court ruling, title insurance agents (unlike other agents) can rebate freely without having to grant rebates in a nondiscriminatory manner

[11] Several types of property and casualty insurance are subject to excess profits laws in Florida. While insurance rate regulation is a fairly common feature of most state rating laws, excess profits laws are not. Florida is one of the few states with these laws. By statute, excess profits are realized for a motor vehicle insurer if the insurer's actual underwriting profit exceeds the anticipated (approved) underwriting

and motor vehicle insurance rate filings, but not for workers' compensation rate filings. As the rate standards suggest, rates are regulated primarily to make sure insurers have enough rate to remain solvent and meet their contractual obligations to policyholders (requirement of "adequate" rates), without overcharging policyholders (prohibition against "excessive" rates), and to make sure rates are not "unfairly discriminatory." "Affordability" is not a standard against which rates are evaluated.

Insurers must make an annual filing: either a filing proposing revisions to existing rates or, if no rate change is proposed, a filing certifying the adequacy of existing rates. Rate certification is intended to prevent rates from becoming inadequate and creating solvency problems and to avoid the sticker shock that could occur if an insurer requests less frequent, but more substantial, rate increases.

Insurers may file rates on a "file and use" or "use and file" basis. Under "file and use," insurers must obtain Department approval prior to implementing the proposed rate change. If the Department does not reject the filing, then the filing is deemed approved. Under "use and file," insurers may implement a rate change prior to receiving Department approval of the proposed rates. Under this approach, the insurer must notify the Department after implementing the rate. If it rejects the rate filing, then the Department may order insurers to refund portions of the rate declared excessive.

Insurers generally challenge Department rejection of a rate filing through an administrative hearing. For certain lines, such as property insurance,[13] insurers may request binding arbitration as an alternative to final action on the rate filing by the elected Commissioner of Insurance.

a) Workers' compensation rates

Workers' compensation insurance rates are established by employment classification (i.e., "class codes") and expressed as a certain dollar amount per $100 of payroll. Employer premiums are determined by multiplying this "manual" rate by annual payroll by an experience factor representing the employer's claim history as compared to the average employer in the same business (i.e., premium = manual rate x payroll x experience mod). This factor is called an "experience mod," short for "experience modification factor".

Compared to most states, Florida's regulation of workers' compensation insurance rates is restrictive and rigid. Insurers must receive the approval of the Department prior to using a proposed rate and, except for the Workers' Compensation Joint Underwriting Association, may not exercise the "use

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profit, plus 5 percent, over a three-year period. Auto insurers are required to refund to policyholders excess profits earned over a three-year period.

A second excess profits law applies to workers' compensation insurance, generally referred to as the commercial excess profits law. This law is similar to the auto excess profits law, except that the test for determining excess profits is different. The test is for a four-year period, rather than a three-year period, and excess profits are realized if profits exceed the anticipated (approved) underwriting profit factor, plus 4 percent, rather than 5 percent. Also, the excess profits trigger could be lower for workers' compensation insurance than for auto insurance since the Department could approve a negative underwriting profit factor for workers' compensation. For auto insurance, the Department must use a positive underwriting factor.

[12] For financial guaranty insurance which includes surety bonds, rates also must not be "destructive of competition, or detrimental to the solvency of the insurer." [s. 627.974(2), F.S.]

[13] A reading of applicable statutes raises some question about whether or not arbitration is an option for disputed motor vehicle insurance rate filings, or is limited to property insurance rate filings.

and file" option. Although insurers may make individual rate filings, none do. Instead, the National Council on Compensation Insurance (NCCI), as the Department-approved rating organization, makes a single rate filing on behalf of all insurers to which all insurers must adhere. Florida has always had a rating organization file a single uniform rate for the industry.

Insurers may depart from the Department-approved rate using one of several rate variation options, all of which must be approved by the Department. Among the most common methods are deviations, retrospective rating plans, and dividends. Deviations are granted infrequently. Deviations permit insurers to depart from the approved rate by some percentage amount. The use of retrospective rating plans is another option. In these plans, the employer's final premium is calculated at the end of the policy period based on the actual losses for the year. Dividends are non-guaranteed moneys paid to employers at the end of a policy period, generally based on the financial success of the insurer.

Florida law authorizes drug-free workplace premium credits and safety program premium credits.

b) Property and motor vehicle insurance rates

The property insurance and motor vehicle insurance rating laws are similar. With respect to rate standards, both contain the same basic definition of "inadequate" and "excessive." A rate is "inadequate" if it is clearly insufficient, together with investment income, to sustain projected losses and expenses in the class of business to which it applies. A rate is "excessive" if it is likely to produce a profit from Florida business that is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered. The property and motor vehicle rating laws also contain similar factors for the Department to consider in determining whether or not rates are excessive, inadequate, or unfairly discriminatory, such as past and prospective loss experience, expenses, the degree of competition, investment income, and a reasonable margin for underwriting profit.

One of the differences between the two laws has to do with an insurer's allowable underwriting profit, after consideration of investment income. The motor vehicle insurance rating law requires the Department to use a positive underwriting profit allowance in calculating an insurer's investment income.

Rating law provisions specifically applicable to property insurance include:

- requiring rate filings to include appropriate discounts or credits for fixtures actuarially demonstrated to reduce the amount of loss in a windstorm (e.g., hurricane shutters);
- requiring rate filings to include rate factors reflecting the quality of enforcement of the State Building Code adopted by a particular jurisdiction;
- requiring insurers to provide discounts for mobile homes meeting the construction standards adopted by the U.S. Department of Housing and Urban Development in 1994;
- allowing insurers to base their rate filings on computer models for loss projection approved by the Florida Commission on Hurricane Loss Projection Methodology. Commission findings are deemed "admissible and relevant," but not binding on the Department;

- requiring insurers to file their rates for hurricane coverage separately and use premium notices that distinguish between the premium for hurricane coverage and the premium for other coverages; and,
- authorizing insurers to grant mobile home discounts of up to 10 percent if tie-downs have been properly installed and are in good working order.

There are certain required discounts unique to motor vehicle insurance, including one for persons completing approved safety courses and one for vehicles with specified equipment such as anti-lock brakes, anti-theft devices, or air bags.

2) Forms

The Department has broad authority to review and approve forms used by insurers.[14] These include application forms, policy forms, printed riders or endorsements, renewal certificate forms, binders, and other forms. This also extends to forms used by premium finance companies and warranty associations.

Generally, these forms must be filed with and approved by the Department before being used, typically 30 days in advance.[15] In most instances, the Department then has 30 days to approve or disapprove the particular form, or it is deemed approved for use by the insurer.

The Department may exempt forms from review when approval is not necessary to protect the public or approval is "impractical."

c. Solvency

1) Financial requirements

Insurers must satisfy numerous financial requirements to transact insurance. The specific requirements vary depending on the line of insurance and the type of insurer.[16] These requirements are designed to prevent insurers from becoming insolvent and unable to fulfill contractual obligations to policyholders. The Code:

- requires insurers to have and maintain a specified minimum amount of surplus, equivalent to a net worth requirement, at time of initial licensure and on an ongoing basis.[17]

[14] 627.410, F.S.
[15] In the case of financial guaranty insurance, forms must be filed 30 days *after* their use and for warranty associations, *within* 30 days of their use. For credit life or disability and mortgage insurance, forms must be approved before use, without regard to any specific number of days.
[16] The amount of required minimum surplus is just one example. A workers' compensation carrier licensed after December 1, 1993, must maintain a surplus of $4 million compared to only a "positive" surplus requirement for self-insurance funds.
[17] 624.407(1) and 624.408, F.S. Surplus requirements vary for initial licensure and on an ongoing basis, and for stock or mutual insurers. For example, mutual insurers transacting property insurance must have a minimum surplus of $200,000 at time of initial licensure and then maintain surplus of $150,000 thereafter. In contrast, a stock insurer transacting property insurance must have surplus of at least $5 million at time of licensure and thereafter maintain $4 million of surplus.

- controls the maximum amount of insurance an insurer may write by requiring insurers to maintain a certain ratio of surplus-as-to-policyholder (s. 624.4095, F.S.). This ratio measures insurer use of underwriting capacity.
- describes the assets or liabilities insurers may include in their financial statements (Ch. 625, Part I, F.S.).
- regulates surplus adequacy based on an insurer's unique mix of investment, credit, off-balance sheet, and underwriting risk (s. 624.4085, F.S.).
- controls the value insurers may assign to their assets.
- regulates the reserve practices of insurers, that is the amount insurers must set aside as a liability to pay known and expected claims (ss. 625.041 and 625.091, F.S.).
- regulates insurer investments (reflecting a concern that the investment portfolio of an insurer be sound as a whole, as well as that of the individual components of the portfolio) (Ch. 625, Part II, F.S.).

2) Financial reporting requirements

All authorized insurers are required by law to file annual and quarterly financial statements[18] using statutory accounting principles.[19] Annual reports must be submitted by March 1; quarterly reports must be submitted within 45 days following the end of each quarter. These statements describe their financial condition, transactions, and affairs, in a generally uniform format specified by the National Association of Insurance Commissioners, and consist of a balance sheet, income statement, and supporting schedules. The annual statements must include a statement of opinion on loss adjustment expense reserves.[20] Authorized insurers having transacted property and casualty insurance for less than three years are also required to compute and report patterns of premium growth.[21]

All authorized insurers must also file audited annual financial reports by June 1 for the preceding calendar year. The Department uses these to gauge the accuracy of the annual statements submitted by insurers.

Additionally, all domestic insurers must submit an annual risk-based capital report to the National Association of Insurance Commissioners and file a copy with the Department by March 1. These reports gauge the adequacy of insurer surplus based on degree of investment risk, credit risk, off-balance sheet risk, and underwriting risk.

Insurers have two principle sources of income: premium and investment earnings. Expenses include payment of benefits or loss payments, and payment of agent commissions.

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[18] 624.424(1)(a), F.S.
[19] "Statutory accounting principles" are considered a more conservative measure of an insurer's financial condition than that produced using "generally accepted accounting principles (GAAP)." Statutory accounting principles emphasize surplus adequacy and are directed towards determining an insurer's financial condition as of a date certain—in particular, the ability to fulfill policyholder obligations as of that date. The GAAP considers an insurer as a going concern and emphasizes overall profitability.
[20] 624.424(1)(b), F.S.
[21] 624.4243(1), F.S.

3) Examinations

a) Financial examinations

The Department is required by law to conduct a full-scale examination of the "financial affairs, transactions, accounts, records, and assets of all authorized insurers."[22]

These so-called "desk exams" may occur any time the Department deems it necessary to protect policyholders; however, all insurers must be examined at least every certain number of years, depending on the length of time they have held a certificate of authority. (See Table 4.)

Table 4. Minimum frequency of insurer financial examinations.

Years with certificate of authority	Minimum exam frequency
Fewer than 3	Every year for domestics
3-15	Every 3 years for domestics
15+	Every 5 years

Instead of conducting its own examinations of foreign insurers, the Department may accept a full report of the last examination conducted by the insurer's state of domicile.

b) Market conduct examinations

"As often as it deems necessary," the Department may conduct market conduct examinations of insurers.[23] These examinations are designed to determine insurer compliance with sections of the Insurance Code regulating such matters as business practices, sales practices, claims handling, and rating.

4) Enforcement

a) General powers

The Department has a wide range of options when it determines through financial reports, examinations, or other sources that an insurer has failed any of the solvency tests or is otherwise in unsound financial condition. General powers include the following: suspending or revoking an insurer's certificate of authority; imposing administrative fines; issuing cease-and-desist orders; and removing, suspending, or restricting the activities of those individuals operating or directing the affairs of the insurer.

b) Administrative supervision

In addition to these general powers, the Department may place certain insurers of "unsound condition" under administrative supervision.[24] These included domestic, commercially domiciled, and specialty insurers. Administrative supervision is an administrative proceeding in which the Department,

[22] 624.316(1)(a), F.S.
[23] 624.3161(1), F.S.
[24] Ch. 624, Pt. VI, F.S.

with the consent of a financially troubled insurance company, supervises the management of the insurance company in an attempt to cure the company's troubles rather than close it down.

c) Rehabilitation and liquidation

When solvency protections fail, the Department may seek to be appointed receiver through a judicial proceeding for the purpose of rehabilitating an impaired insurer or, if rehabilitation is unsuccessful or otherwise inappropriate, liquidating the insolvent company. The goal of rehabilitation is to restore the financial solvency of the insurer. When the company is beyond rehabilitation, the Department acts to secure and maximize the assets of the insolvent company for the benefit of its policyholders through liquidation. Insurers are generally exempt from federal bankruptcy laws. State law is the "sole and exclusive method of liquidating, rehabilitating, reorganizing, or conserving an insurer."[25]

The choice between rehabilitation and liquidation requires the Department to balance the prospects for restoring the insurer's financial stability against the size of the potential insolvency and impact on policyholders and other creditors. Delaying the liquidation of an insolvent insurer frequently can increase the size of the insolvency and increase the burden on the guaranty association created to pay claims under policies issued by an insolvent company. Rehabilitation enables the insurer to continue to participate in the market without burdening the applicable guaranty association.

5) Guaranty Funds

Three guaranty funds exist to pay claims of insolvent insurers to the extent the assets of the insolvent insurer are insufficient to do so or the terms of any takeover or purchase by another insurer do not provide for the assumption of this obligation.[26] The Florida Insurance Guaranty Association pays the claims of insolvent property and casualty insurers other than workers' compensation. The Florida

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[25] s. 631.021, F.S.

[26] *Florida Insurance Guaranty Association (FIGA).* Most types of property and casualty insurance are covered under the FIGA, such as auto property, and liability coverages. Lines of insurance not covered includes workers' compensation insurance, mortgage guaranty insurance, financial guaranty insurance, fidelity or surety bonds, title insurance, surplus lines insurance, warranty contracts, and legal expense insurance. Claims against insolvent insurers are covered if they are in excess of $100 and less than $300,000. With respect to policies covering condominium associations, the maximum amount recoverable is $100,000 multiplied by the number of condominium units. All of these amounts are further limited by any coverage limits of the policy itself or any other exclusion in the policy. The FIGA basically stands in the place of the insolvent insurer and may raise any coverage defense that the insolvent insurer could have raised.

The FIGA is divided into three accounts, which effectively results in three segregated guaranty funds for purposes of assessments against insurers and total funds available to pay claims. These three accounts are: (1) auto liability, (2) auto physical damage, and (3) all other property and casualty. Insurers are subject to a maximum annual assessment of 2 percent of their net direct written premiums in Florida for each of these accounts. Insurers previously received full credits against their premium taxes for these assessments, but the current tax credit is only 0.1 percent of an assessment for each year following the year in which the assessment is paid.

Florida Workers' Compensation Insurance Guaranty Association (FWCIGA). In 1997, the Legislature merged the Florida Self-Insurance Fund Guaranty Association (the "FSIFGA") and the workers' compensation insurance account within the Florida Insurance Guaranty Association (the "FIGA") to form the successor entity known as the FWCIGA, Inc. The Legislature lifted the bar prohibiting compensation to claimants with injuries which pre-dated January 1, 1994. Effective since July 1, 1997, carriers may be assessed a maximum of 2 percent to pay covered claims, and self-insurance funds may be assessed up to 1.5 percent. Effective July 1, 1999, if the FWCIGA is unable to pay claims on a current basis after levying the maximum assessment, then the board may levy an additional assessment --referred to as a "deemed approved" assessment -- of up to an additional 1.5 percent against carriers and self-insurance funds.

Workers' Compensation Insurance Guaranty Association pays the claims of insolvent workers' compensation insurers other than individually self-insured employers, and the Florida Life and Health Insurance Guaranty Association pays the claims of life and health insurers, both subject to certain conditions and limitations.

The guaranty funds operate as non-profit corporations. They are not state agencies. As a condition of receiving a license to transact insurance in this state, insurers writing property and casualty insurance, workers' compensation, and life and health insurance are required to participate in the respective guaranty association. The Department appoints a board of governors for each association and approves their respective plans of operation. Payment of covered claims of insolvent insurers is funded by assessments against insurers, up to specified limits. Terms of the assessment authority vary among the three associations.

3. REGULATION OF INSURANCE REPRESENTATIVES

a. Licensing

Insurance representatives are required by Florida law to be licensed by the Department prior to conducting business in the state. The Department issues over 70 different types of licenses for insurance company representatives, including 32 different types for agents and 30 different types for adjusters.

The purpose of a license is to authorize and enable an insurance representative to actively and in good faith to engage in the insurance business with respect to the public and to facilitate the public supervision these activities in the public interest.

Generally, applicants for licensure by the Division of Agents and Agency Services within the Department of Insurance must be at least 18 years old; be a resident of the state; pass a state licensing examination; maintain a place of business in the state; and be fingerprinted. Applicants also must fulfill certain educational requirements and pay a licensing fee. The Department of Insurance also licenses nonresident agents.

Certain applicants for licensure are exempt from the examination requirements. For example, agent applicants holding certain designations, such as a CPCU (Chartered Property and Casualty Underwriter) or CLU (Certified Life Underwriter), may be exempt from taking the examination. Additionally, adjusters who are attorneys in good standing with the Florida Bar are not required to be licensed by the Department.

The Department may deny, suspend, or revoke a license for good cause. Reasons for denial, suspension, or revocation can include lack of qualifications; the use of fraudulent information in the license application; willful misrepresentation of an insurance policy; failure to comply with the Insurance Code; or a demonstrated lack of trustworthiness to engage in the insurance business.

b. Appointments

In addition to being licensed, an agent must be appointed by an insurer to act on its behalf within the scope of the agency.

c. Continuing Education

Most insurance representatives licensed by the Department are required to complete twenty-eight hours of continuing education every two years. Courses, instructors, and schools must be approved by the Department.

C. SELECTED LINES OF INSURANCE

1. PROPERTY INSURANCE

PROPERTY INSURANCE IN BRIEF

Table 5. Property insurance in Florida, 12/31/99.		
All insurers	Residential	Commercial
Exposure	$736B	Not available
Direct written premium	$2.98B	$704M
Top 10 insurers—DWP	$1.5B	$248M
Top 10 insurers--% of total DWP	50.3 %	35.2 %
Voluntary market insurers	Residential	Commercial
Number of authorized insurers	198	249
Total direct written premium	$2.57B	$680M
Residual market insurers	Residential	Commercial
Total direct written premium	$406M	$24M
RPCJUA	$161M	N/A
FWUA	$245M	$24M
Market share	13.6 %	3.4 %
RPCJUA	5.4 %	N/A
FWUA	8.2 %	3.4 %

Property insurance helps pay to repair or rebuild a home or other property damaged as the result of theft, fire, or other disaster. Personal residential property insurance refers to the coverage of a single-family dwelling, condominium unit, or apartment unit. Coverage for a condominium unit or an apartment typically covers contents only. The term "homeowners' insurance," a type of personal residential property insurance, refers to the coverage provided for single-family dwellings and other structures and their contents, but not for dwellings which are mobile homes or manufactured homes. Coverage for mobile homes or manufactured homes is called "mobile homeowners' insurance." The term "commercial residential" property insurance refers to insurance covering a condominium building or an apartment building. Florida law does not require property owners to obtain property insurance, although most lending institutions require full insurance coverage for mortgaged homes or structures.

a. The Impact of Hurricane Andrew

Until August 24, 1992, the regulation of property insurance policies received relatively little legislative attention. Hurricane Andrew, causing $16 billion in insured losses, changed that. Literally overnight, a property insurance crisis was created in Florida that resulted in sweeping legislative changes intended to stabilize the property insurance market.

One of the lasting consequences of Hurricane Andrew, the most costly natural disaster ever to occur in the United States, was a severe dislocation of Florida's property insurance market. Hurricane Andrew left many Florida property owners unable to obtain insurance. The devastation left 11 insurance companies insolvent and unable to honor or renew policies. A number of insurance companies cancelled

or nonrenewed existing policies to reduce their exposure to hurricane-related risk. For the same reasons, other insurance companies restricted the growth of their Florida exposures.

In the aftermath of Hurricane Andrew, insurers found it extremely difficult to obtain reinsurance. The supply of reinsurance dried up and, to the extent available, dramatically increased in cost. This exacerbated the insurance availability problems of Florida homeowners by further limiting insurer capacity to obtain the capital necessary to underwrite more risks and increasing the pressure on insurers to unload exposures by nonrenewing many of their existing higher risk policies.

The insurance availability shortages resulting from Hurricane Andrew greatly increased Floridians' reliance on state-created property insurers of last resort: the Florida Windstorm Underwriting Association (FWUA) and the Residential Property and Casualty Joint Underwriting Association (RPCJUA), both of which are funded in part by assessments on insurance companies and their policyholders.

Hurricane Andrew also changed the ratemaking landscape in a dramatic fashion. According to the Department, average homeowners= insurance premiums in Florida have increased by 118 percent since the date of Hurricane Andrew (i.e., August 24, 1992) through November 2000.[27] In February 2000, the FWUA received approval for an average statewide increase in the windstorm portion of residential property insurance rates of 96 percent. This rate increase is being phased in over a three-year period beginning with new or renewing policies July 1, 2000. As part of the phase-in period, an FWUA policyholder's rate may not increase more than 20 percent the first year, 30 percent the second year, and 40 percent the third year. After the third year, the FWUA policyholder would be charged the full rate.

In the post-Hurricane Andrew environment, premiums no longer represent the entirety of property insurance costs paid by consumers. Consumers are subject to mandatory charges known as Aassessments@ when: 1) losses paid by the RPCJUA or the FWUA exceed their resources, voluntary market residential

[27] Homeowners' insurance premiums vary greatly within a county for homes of similar type and value. Table 6 shows the variance between the lowest and highest premiums for the top 20 insurers for standard homeowners= coverage for a five-year old $75,000 frame house with a $500 deductible:

Table 6. Premium comparisons for homeowners' insurance.

County	Premium		Difference
	Lowest	Highest	
Alachua	$324	$785	242%
Broward	$804	$1,486	185%
Dade	$1,019	$1,671	164%
Escambia	$511	$921	180%
Lee	$497	$948	191%
Leon	$336	$757	225%
Orange	$406	$810	200%
Palm Beach	$715	$1,328	186%
Pinellas	$443	$933	210%
Volusia	$383	$833	217%

Source: Department of Insurance website (www.doi.state.fl.us)

property insurance policyholders can be assessed directly or indirectly to cover the deficit; [28] 2) the Florida Hurricane Catastrophe Fund borrows money to reimburse insurers under reimbursement contracts, voluntary market policyholders (including automobile, commercial liability, and other non-property insurance policyholders) may be assessed to pay off the bonds. Residual market assessments operate as subsidies of residual market policyholders by voluntary market policyholders.[29]

b. Stabilizing and Restoring the Property Insurance Market in Florida

In the immediate aftermath of Hurricane Andrew and in the years since, the Legislature has taken numerous steps intended to stabilize and restore the property insurance market in Florida.

1) Paying the claims of insolvent insurers

The Florida Insurance Guaranty Association (FIGA), created by the Legislature in 1972, to pay the claims of insolvent insurers, lacked the funds to pay the extraordinary volume of claims resulting from Hurricane Andrew. The Legislature called a special session in December 1992, authorizing municipalities "substantially affected by Hurricane Andrew" to issue up to $500 million in tax-free bonds to fund an assistance program in conjunction with the FIGA to pay these claims. The municipal bond, ultimately issued through the city of Homestead, generated $472.6 million. In the end, the FIGA paid over $499 million in Andrew-related claims.

2) Preventing wholesale cancellations and nonrenewals

In May 1993, the Legislature imposed a moratorium on cancellations and non-renewals of personal residential property insurance policies. The moratorium prohibited insurers from canceling or non-renewing in any 12-month period, more than 5 percent of the personal residential policies in effect on November 14, 1993, or more than 10 percent in any county, for the purpose of reducing hurricane exposure. The moratorium has been extended by the Legislature twice since it was originally enacted and applies to policies in effect as of June 1, 1996. Unless extended again, it will expire on June 1, 2001.

3) Expanding options for coverage through residual market insurers

a) <u>Creation of the RPCJUA; expansion of the FWUA</u>

At the time Hurricane Andrew occurred, Floridians had no residual market insurer from which to purchase property insurance coverage, other than windstorm-only coverage through the Florida Windstorm Underwriting Association (FWUA) for properties in Monroe County and certain barrier

[28]"Regular" assessments are levied against insurers who may then recoup these assessments from policyholders. "Emergency" assessments are levied directly against residential property insurance policyholders. Policyholders typically pay these through a policy surcharge. The maximum amount assessable by either association for regular assessments is 10 percent of the aggregate statewide premium for lines of business written by member insurers or 10 percent of the deficit whichever is greater. For emergency assessments, the maximum is 10 percent needed to cover the original deficit in excess of that funded through regular assessments or 10 percent of the aggregate statewide direct written premium for lines of business written by member insurers.

[29]See House staff report entitled *Consumer Impacts of Property Insurance Surcharges in Florida*, October 1997.

islands in another 24 counties. Immediately after Hurricane Andrew, the Legislature created the Residential Property and Casualty Joint Underwriting Association (RPCJUA) and effected an expansion of the FWUA.

After Hurricane Andrew, the Legislature broadened the statutory criteria used by the Department to determine which areas or counties would be eligible to obtain windstorm-only coverage through the FWUA.[30] This led to the addition of parts of Dade, Broward, Palm Beach, and Pasco. For example, in Dade County, homes located *east* of I-95 are eligible for coverage by the FWUA, although those *west* of I-95 are not. Except for Monroe County, in all FWUA-eligible counties only certain areas are eligible for coverage. These are coastal areas at higher risk for a hurricane. This dramatically expanded the number of properties eligible for windstorm coverage through the FWUA and increased the potential assessment liability of non-FWUA policyholders. It also meant that insurers could write so-called "ex-wind" policies, or policies that cover all perils but windstorm in a larger area, and meant that the typical FWUA policyholder would need two policies: one from a voluntary market insurer or the RPCJUA covering all perils but windstorm (an "ex-wind" policy) and a second policy from the FWUA covering damage from windstorms.

The Legislature created the RPCJUA during a special session in December 1992, as an insurer of last resort for those unable to obtain residential property insurance in the voluntary market. During the first 21 months of its existence, the RPCJUA grew at a rate of 33,000 policies a month.

b) Establishing rate benchmarks

To prevent the RPCJUA and FWUA from underwriting risks insurable by voluntary market insurers, the Legislature established rate benchmarks for both associations so that the residual market insurers would not become insurers of *first* resort. The Legislature prohibited the RPCJUA and the FWUA from charging rates that competed with those of voluntary market insurers. By law, RPCJUA rates for personal lines residential coverage must be no lower than the average rates charged by the insurer having the highest average rates among the top 20 insurers with the greatest total direct written premium in the state for that particular line of insurance. The FWUA rates must be "reflective" of approved rates for windstorm insurance in the voluntary market.

c) Depopulating the RPCJUA

In September 1996, the RPCJUA peaked at 936,837 policies in force, representing $98 billion in exposure and accounting for 17.7 percent of total residential property insurance policies statewide. The RPCJUA had become the second largest property insurer in the state and was seen by the Legislature as an "impediment to the restoration of a stable and competitive residential property insurance market."

[30]Eligible counties include Bay, Brevard, Broward Charlotte, Collier, Dade, Duval, Escambia, Flagler, Franklin, Gulf, Hernando, Indian River, Lee, Levy, Manatee, Monroe, Nassau, Okaloosa, Palm Beach, Pasco, Pinellas, St. Lucie, Santa Rosa, Sarasota, Volusia, Wakulla, and Walton.

Because of this explosive growth, the Legislature, in 1995, authorized the RPCJUA to offer financial incentives, such as per-policy take-out bonuses of up to $100 and FWUA deficit assessment credits, in an effort to encourage private market insurers to remove policies from the RPCJUA.

Since then, the RPCJUA has implemented 10 different takeout programs, under which 34 insurers have removed 1.18 million policies. Twenty of these insurers have had a certificate of authority for less than one year. The lowest bonus awarded has been $33.33 per-policy and the highest bonus $300 per policy. However, in some take-outs, the RPCJUA also has offered insurers a "contingency reserve" of $210 per policy for a total "incentive" of over $500 per policy. The RPCJUA has placed approximately $123 million into escrow to pay take-out bonuses. As of December 2000, the RPCJUA had paid out $40 million of the escrowed funds.

d) Status of the residual market

As of October 2000, the RPCJUA had 66,004 policies in force, almost exclusively in Dade, Broward, and Palm Beach counties, with an exposure of $10.3 billion and a 100-year probable maximum loss of $749 million. As of October 2000, the FWUA had 433,074 policies in force, with an exposure of $92.1 billion and a 100-year probable maximum loss of $5.4 billion. Like the RPCJUA, most of the policies in the FWUA, 65 percent, are located in Dade, Broward, Palm Beach and Monroe counties. Additionally, 64 percent of the exposure of the FWUA is located in these four southeast Florida counties.

Table 7. Profile of residual market entities for property insurance.

	Residential Property and Casualty Joint Underwriting Association (RPCJUA)	Florida Windstorm Underwriting Association (FWUA)
Types of property insured	Personal and commercial residential	Personal and commercial residential; commercial multiperil (e.g., for a building owned by a business)
Perils covered	All perils in all non-FWUA-eligible areas; in FWUA-eligible areas, all perils other than windstorm ("ex-wind" policies).	Windstorm only and only within FWUA-eligible areas
Year established	1992	1970
Governing body	13-member board	15-member board
Policies in Force:		
Total	66,004	433,074
In Southeast[31] Florida	64,928 (98%)	281,996 (65%)
Exposure:		
Total	$10.4B	$92.1B
In Southeast[32] Florida	$10.3B (99%)	$59.2B (64%)
Direct written premium	$161.4M	$295M

[31] Dade, Broward, Palm Beach, and Monroe counties
[32] Dade, Broward, Palm Beach, and Monroe counties

Average annual expected hurricane loss	$30M	$317,982
100-year probable maximum loss	$749M	$5.4B
Surplus	$146.8M	$88.3M
Assessment base	Regular: $4.6B Emergency: $4.7B	Regular: $4.6B Emergency: $4.7B
Assessment history	1994: $17.7M 1995: $22.8M	1985: $3.2M 1992: $16.2M 1993: $3.2M 1995: $117M 1998: $100M

4) Creating a stable source of reimbursement for insurers with excessive hurricane losses

In 1993, the Legislature created the Florida Hurricane Catastrophe Fund (or Cat Fund, as it is commonly known) to provide a source of reimbursement for insurers for excessive losses due to hurricanes without the availability and price fluctuations characteristic of the private reinsurance market. The State Board of Administration, consisting of the Governor, the Comptroller, and the Treasurer (Insurance Commissioner), administers the Cat Fund.

All authorized insurers writing property insurance in Florida, including the RPCJUA and the FWUA, must enter into reimbursement contracts with the Cat Fund in which, in exchange for premium, the Cat Fund agrees to reimburse insurers for an insurer-selected percentage (i.e., 45, 75 or 90 percent) of their hurricane losses in excess of a specified amount, known as the insurer's "retention." Insurers may then recoup Cat Fund reimbursement premiums from their policyholders. The Cat Fund expects to have received approximately $428 million in premium revenues for 2000 by December 31, 2000. Aggregate insurer retention as of October 30, 2000, was approximately $3.2 billion.

In 1999, the Legislature capped the Cat Fund payout for any single contract year at $11 billion, and granted the Cat Fund additional assessment authority to fund obligations under reimbursement contracts entered into in a subsequent contract year.

The Cat Fund can assess insurers for up to four percent of their gross direct written premium to meet contractual obligations *for* any single contract year. However, with a projected fund balance of $3.68 billion as of December 31, 2000, the Cat Fund would reach the maximum payout amount, generating an additional 7.32 billion, using just 3.35 percent of its assessment authority. Were the Cat Fund to reach its maximum payout under this scenario, its total claims-paying capacity for claims arising in a subsequent contract year would be restored to $5.9 billion virtually immediately, comprised of $445 million in cash and bond proceeds of $5.45 billion, based on the ability to levy the remaining 0.65 assessment plus the 2 percent authorized expressly for a subsequent contract year.

The Catastrophe Fund is exempt from federal income taxation.

5) Reducing hurricane losses:

The Legislature is required to appropriate from the Cat Fund at least $10 million, but no more than 35 percent,[33] of the fund's investment income, "to support programs intended to improve hurricane preparedness, reduce potential losses in the event of a hurricane, provide research into means to reduce such losses, educate or inform the public as to means to reduce hurricane losses, assist the public in determining the appropriateness of particular upgrades to structures or in the financing of such upgrades, or protect local infrastructure from potential damage from a hurricane."

In 1999, the Legislature created the Hurricane Loss Mitigation Program, requiring $7 million of the $10 million annual appropriation be earmarked for the Department of Community Affairs. The Legislature required that in the first year of the program, at least 40 percent of the $7 million be used for mobile homes, including programs to inspect and improve tie-downs, construct and provide safety structures, and provide other means to reduce losses. In the second year of the program, at least 30 percent, and thereafter at least 20 percent, must be used for such purposes. Additionally, 10 percent of the $7 million appropriation is allocated to the State University System for hurricane research, to support programs of research and development regarding hurricane loss reduction devices and techniques for residences and mobile homes. As part of this program, the Department of Community Affairs is required to develop programs in consultation with an advisory council appointed by the Secretary of the Department of Community Affairs.

During the 2000 session, the Legislature enacted a unified building code for the state (Ch. 2000-141, L.O.F.). As part of this legislation, the Legislature required insurers to offer discounts, credits, or rate differentials to policyholders for the installation of devices or the use of construction techniques that would reduce losses due to hurricanes. Insurers are required to make a rate filing with the Department that includes discounts, credits, or other rate differentials by June 1, 2002.

6) Regulating the amount of financial risk assumed by policyholders

To increase insurer capacity but at the same time limit the amount of risk insurers could transfer to policyholders, the Legislature implemented minimum and maximum hurricane deductibles. See Table 8 for a summary of these deductibles amounts.

[33] Moneys in excess of $10 million are not available for appropriation if the State Board of Administration finds that such an appropriation would jeopardize the actuarial soundness of the fund.

Table 8. Summary of deductibles for residential property insurance.		
	Deductible amounts	
	Minimum	Maximum
Personal residential	*Perils other than hurricane:* $500 mandatory offer	*Perils other than hurricane:* None
	Hurricane: Tied to value of risk-- •$0-$50,000—*may* offer minimum of $250 deductible; *must* offer $500. •More than $50,000—must offer minimum of $500 •More than $100,000—may offer 2% in lieu of $500 minimum mandatory if guarantee renewal •$250,000 or more —*may* offer minimum of $500, but *must* offer 2%	*Hurricane:* Tied to value of risk— •Less than $100K—2%; •More than $100K—5%; •More than $500K—unlimited
Commercial residential	*Perils other than hurricane:* None	*Perils other than hurricane:* None
	Hurricane: None	*Hurricane:* 5% for condominium or cooperative associations, and 10% for other commercial residential, if at the time of said offer, the insurer also offers 3% deductible

Note: Insurers were required to provide "wind" deductibles until the effective date of the insurer's rate filing made after January 1, 1997, and, thereafter, provide the more limited "hurricane" deductibles.

c. Other Legislative Results of Hurricane Andrew

Other legislative responses to Hurricane Andrew directly affected property insurance policies, include:

1) *Mandatory Offers of Coverage:* Insurers must offer replacement cost coverage, which pays losses up to the insured value without deducting for depreciation, and law and ordinance coverage, which pays costs required to upgrade a home to meet new building codes when a house must be rebuilt or substantially repaired.

2) *Notice of Cancellation or Non-renewal:* Policyholders must be given 90 days advance notice of cancellation or non-renewal of residential property insurance policies (increased from the previous 45-day requirement).

3) *Mediation:* The Department is required to create a program for mediation of disputed property insurance claims.

4) *Florida Commission on Hurricane Loss Projection Methodology:* The Florida Commission on Hurricane Loss Projection Methodology is charged with evaluating and approving actuarial methods and

models to be used in insurer rate filings. Using the 1999 standards, the Commission approved the use of five models. During the 2000 session, the Legislature funded a so-called "public" model to be developed in partnership with the Department,

5) *Rate Arbitration:* The Legislature created the option of arbitration of a disputed rate filing for insurers as an alternative to an administrative challenge of an order issued by the Insurance Commissioner.

2. MOTOR VEHICLE INSURANCE

Motor Vehicle Insurance In Brief

Table 9. Motor vehicle insurance in Florida, 12/31/99.		
All insurers	Private passenger	Commercial
Total direct written premium	$7.379B	$1.141B
Top 10 insurers—DWP	$3.323B	$268M
Top 10 insurers--% of total DWP	45%	23.5%
Voluntary market	Private passenger	Commercial
Number of authorized insurers	286	302
Direct written premium	$7.373B	$1.136B
% of total DWP	>99.99%	>99.99%
Residual market	Private passenger	Commercial
Direct written premium	$6M	$5M
% of total DWP	<0.01%	<0.01%

Motor vehicle insurance consists of both private passenger and commercial motor vehicle insurance.

a. Private Passenger Motor Vehicles

1) No-Fault Motor Vehicle Insurance

The Legislature enacted the Florida Motor Vehicle No-Fault Law effective January 1, 1972. Under this no-fault system, insurers pay benefits up to certain dollar amount or in the case of certain injuries regardless of fault. Those with personal injury protection (PIP) coverage, the required no-fault component of the motor vehicle insurance policy, receive limited immunity from tort liability for damages to the extent the economic loss is compensated under the PIP policy. This limited immunity protects against non-economic damages, such as pain and suffering. However, immunity does not extend to injuries consisting of: (1) significant and permanent loss of an important bodily functions; (2) permanent injury within a reasonable degree of medical probability (other than scarring or disfigurement); (3) significant and permanent scarring or disfigurement; or (4) death. In short, a plaintiff must suffer a permanent injury in order to seek pain and suffering damages against a motorist with PIP coverage.

2) Coverages

Florida law requires motor vehicle owners to carry both PIP insurance and property damage liability insurance. Drivers subject to the Financial Responsibility Law because convicted of certain traffic offenses or unable to pay liability debts from an earlier accident must also carry bodily injury liability protection. The types of coverages are described in Table 10.

Table 10. Summary of private passenger motor vehicle coverages.		
Type	Description	Required / Optional
Personal injury protection	Regardless of fault, PIP covers: 80 percent of medical expenses, 60 percent of lost wages, 100 percent of replacement services, and $5,000 in funeral expenses; covers the insured and pedestrians and passengers without PIP coverage.	Required. Florida motorists must carry at least $10,000 PIP insurance.
Property damage liability	Covers damages to other people's property caused by the insured or members of the insured's household.	Required. Florida motorists must carry $10,000 of coverage.
Bodily injury Liability	Covers injuries to others caused by the insured or members of the insured's household; pays medical bills and lost wages; provides legal representation and attorneys' fees to the insured, if sued.	Required only for those subject to the Financial Responsibility Law; $10,000 per person and $20,000 per occurrence, or $30,000 combined bodily injury/property damage limit.
Uninsured motorist	Covers injury to others caused by a motorist without bodily liability coverage; pays medical expenses and lost wages exceeding PIP benefits, and pain and suffering.	Optional, but insurers must offer up to the same limits as bodily injury liability limits purchased.
Collision	Pays for repair or replacement of an insured's motor vehicle, regardless of fault. However, if the other driver is at fault and has property damage liability coverage, the insured may attempt to recover under the other driver's policy rather than the insured's own policy.	Optional.
Comprehensive	Pays for repair or replacement of an insured's vehicle for losses from incidents other than collision, such as theft, vandalism, or flood.	Optional.
Medical payments	Pays for medical expenses for the insured up to the limits of the policy, regardless of fault.	Optional.

3) Payment of PIP Claims

Benefits available under PIP insurance are primary to other types of insurance.[34] This means that if a person were involved in an automobile accident, his or her personal injury protection insurance would pay for injuries before any other insurance would pay. For example, Driver A has health insurance with Health Insurer 1 and auto insurance with Auto Insurer 1. If Driver A sustains injuries as the result of an auto accident, Driver A's PIP insurance with Auto Insurer 1 would pay benefits up to the limits of Driver A's PIP policy. Any treatment for Driver A above the limits of his PIP policy could be paid for by his health insurer, Health Insurer 1, subject to any exclusion in Driver A's contract with Health Insurer 1.

[34] s. 627.736(4), F.S.

Individual insurers may require that the policyholder give written notice "as soon as practicable" after an accident, but they are not authorized by statute to require notice of treatment.[35] Insurers are required by law to notify their policyholders in writing within 21 days of receiving notice of a claim or accident in which PIP benefits are payable of the benefits available under their PIP coverage. Florida law requires the notice to include a description of the benefits, including the specific types of services for which medical benefits are paid, disability benefits, death benefits, significant exclusions and limitations on PIP benefits, when payments are due, how benefits are coordinated with other insurance benefits that the insured may have, penalties and interest that may be imposed on insurers for failure to make timely payments, and rights of parties regarding disputes.[36]

Health care providers are required to submit medical bills directly to insurers within 30 days of the date of treatment.[37] If the medical provider notifies the insurer within 21 days after first examination or treatment, the provider may submit medical bills within 60 days of the date of treatment. Neither the insurer nor the injured person is required to pay medical bills that are not submitted within this time frame and any agreement to the contrary is unenforceable. Exceptions to this requirement are provided for medical services billed by a hospital for services rendered at a hospital-owned facility, for emergency services rendered by a hospital emergency department, or transport and treatment rendered by an ambulance provider. Once a medical provider submits a claim to an insurer, the law requires the claim to be paid within 30 days, thus giving the insurer 30 days to determine if the treatment is necessary, reasonable, or related to the motor vehicle accident.

An insurer may refuse to pay when it determines the treatment, based on a medical examination conducted by an insurer-selected physician, also known as an "independent medical examination" or IME, is unreasonable, not related to the covered motor vehicle accident, or unnecessary. To exercise its right to require an IME, the insurer must be aware that treatment is being provided.

Medical service providers assigned benefits under a PIP policy are prohibited from pursuing a breach of contract claim in court.[38] Rather, providers must submit to binding arbitration to resolve any dispute arising with the insurance company. Furthermore, the prevailing party is entitled to attorney's fees and costs.

In Nationwide Mutual Fire Ins. Co. v. Pinnacle Medical Inc., the Florida Supreme Court declared s. 627.736(5)(c), F.S., unconstitutional.[39] The Supreme Court found the arbitration provision violated the right of a medical service provider to have equal access to the court system and the attorney fee provision infringed on a medical service provider's substantive due process rights under the Florida Constitution.

4) Policy Provisions

[35] s. 627.736(4)(a), F.S.
[36] s. 627.7401, F.S.
[37] s. 627.736, F.S.
[38] s. 627.736(5)(c), F.S.
[39] Nationwide Mutual Fire Ins. Co. v. Pinnacle Medical Inc., 753 So. 2d 55 (Fla. 2000)

a) Notification of cancellation or nonrenewal

Insurers must notify policyholders at least 45-days prior to canceling or nonrenewing their motor vehicle insurance policies. However, insurers must give policyholders only 10-days notice before canceling or non-renewing policies for nonpayment of premium.

b) Accidents and traffic violations

Insurers may not nonrenew or cancel a policy if the policyholder has paid premium for at least five years and is involved in a single accident or is at fault in only one accident in a three-year period. If, however, the policyholder has three or more accidents, regardless of fault, in a three-year period, the insurer may cancel or nonrenew the policy.

Insurers may not collect additional premium from policyholders involved in motor vehicle accidents unless the policyholder is at fault.

c) Premium down payments

Insurers are required to collect at least two months premium from policyholders prior to issuing a motor vehicle insurance policy. Exceptions include: when the policy is renewed by the same insurance company or group of insurance companies; when payment for the policy is made through payroll deduction or automatic electronic funds transfer; or when an insured is adding additional coverage or adding a vehicle to his or her existing motor vehicle insurance policy.

d) Notification of insured's rights to PIP benefits

Insurers are required to notify their policyholders of their rights to receive benefits under their PIP coverage within 21 days after receiving a claim from a policyholder.

b. Commercial Motor Vehicles

All commercial motor vehicles, except taxicabs, school buses and limousines, are required to carry at least $10,000 of PIP coverage. Additionally, commercial motor vehicles must have minimum liability coverage depending upon the gross vehicle weight, ranging from $50,000 per occurrence to $300,000 per occurrence, covering both bodily injury and property damage. Also, nonpublic-sector buses must have liability coverage in amounts of $100,000 for bodily injury to one person, $300,000 for bodily injury to two or more persons in any one accident, and $50,000 property damage liability.

3. WORKERS' COMPENSATION INSURANCE

a. Fundamentals of Workers' Compensation

1) The Workers' Compensation Compromise

Workers' compensation laws represent a compromise between labor and management. Under this compromise, employees injured on the job receive medical care and a portion of their lost wages (called indemnity benefits), regardless of fault. In exchange for these no-fault benefits, employees give up the right to sue their employers in tort and, as a result, give up the right to be compensated for pain and suffering associated with the workplace injury. In the United States, workers' compensation statutes date back to the beginnings of the Industrial Revolution -- a period when both the frequency and severity of injuries were expected to increase because of increased mechanization in the workplace.

2) Legislative Intent

It is the stated intent of Florida's workers' compensation act "to ensure the prompt delivery of benefits to injured worker" and "facilitate the employee's return to gainful employment at a reasonable cost to the employer." It is also the intent of the Legislature that the workers' compensation system be an efficient and self-executing system and not be an administrative or economic burden.

3) Agency Jurisdiction

The Department of Labor and Employment Security, Division of Workers' Compensation (hereinafter referred to as "Division") is responsible for the administration of Florida's workers' compensation system. Its functions include:

- enforcing employer compliance with workers' compensation coverage requirements;
- overseeing reemployment of injured employees;
- monitoring and auditing the delivery of benefits;
- operating the Employee Assistance Office; and
- administering the Special Disability Trust Fund.

The Agency for Health Care Administration (hereinafter referred to as "Agency") is responsible for regulating workers' compensation managed care arrangements.

The Department of Insurance (hereinafter referred to as "Department") regulates workers' compensation insurers and group self-insurance funds. This includes regulating the rates for both the voluntary market and the Workers' Compensation Joint Underwriting Association. The Department also investigates (and refers for prosecution) criminal insurance fraud, including workers' compensation fraud.

b. Funding the Administration of the Workers' Compensation System

To pay the expenses of administering Florida's workers' compensation system, the Division annually assesses workers' compensation insurers based on the amount of "net premiums collected" by the insurer. These expenses include those of the Division and the workers' compensation-related activities of the Agency for Health Care Administration and the Department of Insurance. Assessment revenues are paid into the Workers' Compensation Administration Trust Fund (WCATF).[40] The assessment rate is calculated using the following formula:

$$\frac{\text{Annual administrative expenses}}{\text{Total net premium collected}} = \text{Assessment rate}$$

For example, if expenses total $100 million and reported premium is $2.5 billion, then the resulting assessment rate is 2.5 percent. The Division then assesses insurers 2.5 percent of their share of reported premiums; therefore, an insurer with $100 million in premium pays an assessment of $2.5 million.

Since January 1, 2001, the assessment rate has been capped at 2.75 percent. Prior to that date, the rate could not exceed 4 percent. The Legislature reduced the rate cap in the 2000 session in conjunction with a broadening of the premium base and reduction of expenses.

Since the assessment levied on insurers is factored into the premium rates insurers charge employers, employers ultimately pay the assessment and bear the cost to administer the system.

c. Securing Worker's Compensation Coverage

1) Coverage requirements

Employers with the requisite number of "employees" must provide workers' compensation coverage to every "employee" not otherwise exempt from coverage.[41] Determining whether or not the law requires workers' compensation coverage for an employer involves several considerations including the nature of the business, the statutory definition of "employee," the number of employees, and the effect of "exemptions."

a) <u>The nature of the business</u>

[40] The Workers' Compensation Administration Trust Fund (WCATF) is one of two trust funds administered by the Division of Workers' Compensation. The Legislature created the Special Disability Trust Fund (SDTF) in 1955, as an incentive for employers to hire workers with pre-existing physical impairments. Specifically, the Legislature intended to encourage prospective employers to hire previously injured employees, decrease litigation between insurers on apportionment issues, and protect employers from excess liability by reimbursing insurers for a portion of claims paid on employees with preexisting injuries. Reimbursements to insurers are funded through assessments on insurers, which are calculated in a manner very similar to the WCATF assessments.

In 1997, the Legislature terminated the SDTF, effective with accidents occurring on or after January 1, 1998. The Legislature also capped the assessment rate at 4.52 percent indefinitely. The SDTF is still paying claims for accidents occurring prior to January 1, 1998. The Department of Labor and Employment Security is to report periodically to the Legislature on the status of the SDTF.

[41] A sole proprietor or a partner in a non-construction business may elect to be covered by workers' compensation if the business has a workers' compensation policy.

The type of employer – construction or non-construction – determines the number of employees required to trigger coverage requirements.

b) "Employee"

The law specifically defines "employee." "Employee" includes persons traditionally thought of as employees. As shown in Table 11, the term "employee" also includes:

- all officers of a corporation, regardless of the type of industry;
- sole proprietors actively engaged in the construction industry; and
- partners in a partnership actively engaged in the construction industry.

The term "employee" does not include, among others:

- independent contractors;[42]
- real estate agents paid by commission only;
- musicians and actors;
- casual laborers;
- certain volunteers;
- taxi or limo drivers; and
- persons who qualify for and elect their exemption.

c) The number of "employees"

In a non-construction business, the employer must provide workers' compensation coverage if there are four or more "employees." In a construction business, the employer must provide coverage if there is one or more "employees."

d) "Exemptions"

As illustrated in Table 11, certain "employees" may qualify for and elect an "exemption" under the workers' compensation law. In construction corporations, up to three corporate officers may elect an exemption from workers' compensation coverage. In a construction sole proprietorship, the sole proprietor may elect to be exempt from workers' compensation coverage. In construction partnerships, up to three partners may elect an exemption from workers' compensation coverage. And in non-construction businesses, without limit, any corporate officer may elect to be exempt from workers' compensation coverage.

[42] A general contractor who employs excluded persons (such as, excluded independent contractors) may not be responsible for providing coverage for those exempt persons, but the general contractor may be liable for providing coverage for any employees of an excluded independent contractor, if that independent contractor fails to do so. The exposed employees of the independent contractor become "statutory employees" of the general contractor. See §440.10(1)(b), F.S.

Qualified employees elect an exemption on a form prescribed by the Division. The election of exemption is granted based on the information provided on the form; independent verification is not made unless an on-site audit occurs at a later time. Construction industry employees may receive a certificate of exemption from the Division.[43] Non-construction industry corporate officers may receive an exemption letter. When an "employee" receives an exemption, they are no longer "employees" under the Workers' Compensation Law. As such, "exempt" employees are not covered under workers' compensation.

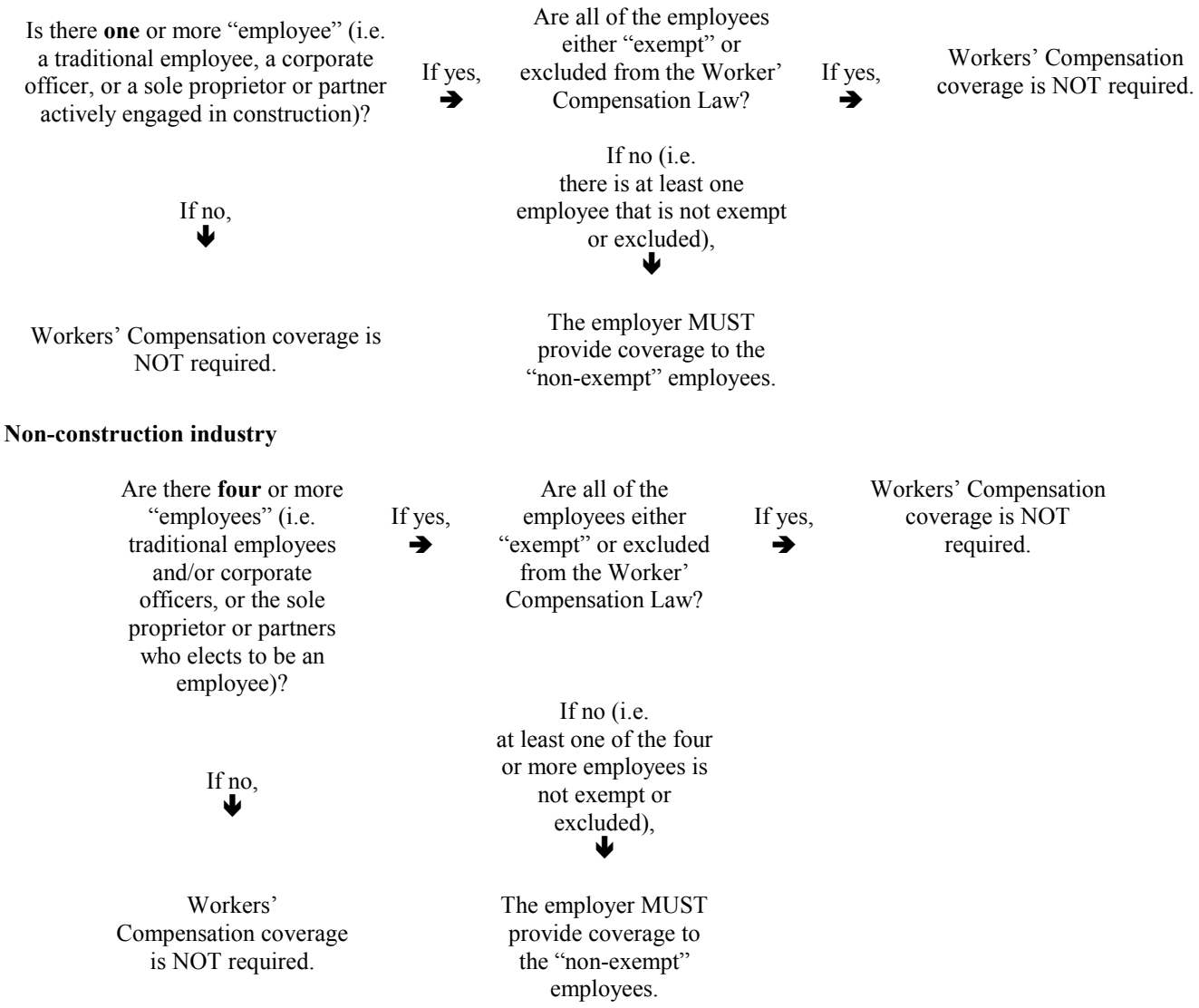
Table 11. Employee status and exemption limitations.

	Corporate officers	**Sole proprietors**	**Partners**
Non-construction industry	Status: **Employees**, however, any officer may elect to be exempt from coverage. There is no limitation on the number of exemptions in this instance.	Status: **Not an Employee**, however, they may elect to be covered if the business has a workers' compensation policy.	Status: **Not an Employee**, however, they may elect to be covered if the business has a workers' compensation policy.
Construction industry	Status: **Employees**, however, a maximum of three officers may elect to be exempt.	Status: **Not an Employee, generally**, however, they may elect to be covered. Status: **Employee**, if actively engaged in construction. However, they may elect to be exempt.	Status: **Employee**, if actively engaged in construction. A maximum of three partners may elect to be exempt.

Figure 1 shows when is a business required to provide workers' compensation coverage to its employees.

[43] The Division issues certificates of exemption to qualified employers. Effective January 1999, the exemption process was altered to limit the life of construction industry exemptions to two years (rather than for life) with an option to renew every two years, increase the exemption fee for the construction industry to a mandatory $50, and permit the Division to revoke an exemption if it finds the exempt employer no longer qualifies for the exemption.

Figure 1. Determining when workers' compensation is required.



Employers apply to insurers for coverage on a form approved by the Department of Insurance. The employer must identify the type of business, past and prospective payroll, estimated revenues, previous workers' compensation experience, employee names and classifications, and any other information necessary for the insurer to underwrite the risk.

2) Compliance enforcement

Compliance refers not only to employers obtaining workers compensation coverage, but also to obtaining the proper amount of coverage. Enforcement is concerned with both of these.

Insurers audit employers to verify payrolls and classifications; in short, to make sure employers are not underinsured. Employers must make available to insurers the necessary information to complete the audit and permit physical inspections of their operations. Employers found to have concealed payroll or employee duties, or intentionally misrepresented payroll, must pay a penalty equal to ten times the amount of the difference in premium they should have paid.

The Division is directed to enforce employer compliance with coverage requirements by conducting investigations, issuing stop-work orders, and assessing monetary penalties.

The Division is authorized to issue stop-work orders, ceasing all business operations, to any employers not meeting workers' compensation coverage requirements. An employer may have a stop-work order lifted by securing coverage for their employees and paying a $100 a day fine for each day of noncompliance.

In addition to issuing a stop-work order, the Division may fine the employer in an amount equal to:

- twice the amount of premium the employer would have paid had it secured the proper coverage in the preceding three year period, or

- $1,000, whichever is greater.

In 1997, the Workers' Compensation Oversight Board and the Statewide Grand Jury on Workers' Compensation Fraud criticized the Division for being too lenient in enforcing compliance with coverage requirements. The Board criticized the Division's policy of fining first time offenders $1,000, regardless of the amount of premium evaded. The Division subsequently altered its policy and, according to the Division, now levies the statutorily-required penalty amounts for any offending construction employer and any second-time non-construction offenders.

Employers also have role in enforcement. State law gives a construction employer with the losing bid on a construction project a cause of action for damages against the winning bidder if the loser can establish that the winning bidder knew or should have known that he or she was in violation of the requirements to secure workers' compensation insurance coverage.

d. Return to Work

Florida's workers' compensation act also places an emphasis on returning injured employees to work. Employers with 50 or more employees are obligated to make a good faith effort to rehire injured employees within their physical limitations. Employers failing to comply can be fined by the Division. The Division has never enforced the return to work provisions and has never levied a fine against an employer.

The Division offers reemployment review, training and education services to qualified injured employees.

e. Benefits

There are two types of workers' compensation benefits: medical and indemnity. For both types of benefits, benefits can be paid periodically or in a lump sum. Insurers typically negotiate lump sum payouts for injured employees in exchange for a release from liability for future indemnity and medical benefits.

1) Medical Benefits

Workers' compensation medical benefits consist of medically-necessary remedial treatment, care, and attendance for as long as the nature of the injury or process of recovery may require. Employees may begin receiving medical benefits from the time injured through the recovery process.

Since January 1, 1997, employers have been required to furnish medical benefits to injured workers solely through managed care arrangements authorized by the Agency that are offered or used by insurers. This requirement was adopted by the Legislature in November 1993.

A managed care arrangement is a health care provider or facility, or a group of providers or facilities, an approved exclusive provider organization, or a health maintenance organization, used or offered by an insurer to provide and manage medical care for injured employees. Before an insurer may use or offer a managed care arrangement, the Agency must find the insurer has the ability to provide a quality of care "consistent with the prevailing professional standards" and the Agency must approve the managed care plan of operation filed by the insurer to ensure that it meets the requirements of the statute.

The plan of operation must show that medical services can be delivered with reasonable promptness; providers of a sufficient number exist within the service area; emergency care is available 24 hours a day, 7 days a week; and providers will not bill any injured worker for services rendered. The plan must also describe the service area, grievance procedures, and quality assurance program, and include written procedures for preventing inappropriate or excessive treatment, managing the care of injured employees, and providing insurers with timely medical records and information.

Within a managed care arrangement, care is managed by a "medical care coordinator," i.e., a primary care physician within a provider network. This includes determining the health care providers and facilities to which the injured employee is referred for evaluation or treatment. Managed care arrangements must contain a contracted network of health care providers (e.g., physicians, hospitals, and therapists) covering all of the required specialties and located within a geographic location reasonably accessible to covered employees.

The Agency may revoke or suspend the authority of an insurer to use or offer a managed care arrangement. It may also fine an insurer for failure to operate in accordance with the authorized plan of

operation. Although managed care has been mandatory for the past four years, it is estimated that approximately 20 percent of self insured employers do not currently have an authorized managed care arrangement and are not in compliance with the law.

Injured employees generally receive initial care through a primary care provider participating in the provider network of the managed care arrangement, except in emergency situations. Continuing services must be provided through the same primary care physician unless the medical care coordinator authorizes services from another provider. Injured employees must be permitted one change within the same specialty and provider network if requested of the medical care coordinator. Treatment received from outside the arrangement generally is not compensable unless preapproved by the insurer.

For services provided outside of a managed care arrangement, if an insurer finds "overutilization" of medical services has occurred, i.e., that a health care provider has furnished unnecessary or substandard care to a patient, it may reduce or withhold payments to the health care provider. The health care provider must then petition the Division to resolve the dispute. If it finds a pattern or practice of overutilization, the Division may bar payment to the health care provider, deauthorize the care, decertify the health care provider, or levy a fine. Under the self executing provisions of managed care, the insurer is responsible for monitoring provider performance and taking appropriate corrective action if problems are identified with specific providers. Providers may appeal any action taken by the insurer through the dispute resolution processes of the managed care arrangement.

In a dispute over medical benefits, overutilization, disability, or compensability, the insurer and the employee each may select an independent medical examiner to perform an independent medical examination. The independent medical examiner may be a health care provider treating or providing other care to the injured employee. Employees will typically select an independent medical examiner from outside the insurer's provider network. Independent medical examiners may not render an opinion outside their area of expertise. Either party may request, or a judge of compensation claims may order, designation of a Division-certified expert medical advisor as an independent medical examiner.

2) Indemnity Benefits

To indemnify someone is to compensate or reimburse them for their loss. Under the Florida workers' compensation law, indemnity benefits are not payable for the first seven days after an injury occurs, unless the injured employee remains disabled for more than 21 days. In that case, indemnity benefits are allowed from the date of the injury. Depending on the nature of their disability, employees injured after January 1, 1994, may be eligible for one of several types of indemnity benefits: temporary partial disability, temporary total disability, permanent partial disability (permanent impairment and supplemental benefits), permanent total disability, and death.

Employees generally receive *temporary* indemnity benefits during their recovery phase. Temporary benefits are meant to replace a portion of the employee's pre-injury wage until the employee recovers, i.e., until reaching "maximum medical improvement." Employees receive *permanent* indemnity benefits for the permanent residual effects from an injury after completion of the recovery phase or upon

reaching maximum medical improvement. The insurer and the employee have the right to obtain one independent medical examination on the issue of permanent impairment, except that whichever selected the treating physician may not obtain an alternate opinion on the issue of permanent impairment. Table 12 contains a schedule of indemnity benefits and a summary of eligibility requirements and length and amount of benefits.

Table 12. Schedule of indemnity benefits.

Type of Benefit (post-1/1/94)	Temporary Disability		Permanent Disability		
			Partial		
	Partial (TP)	Total (TT)	Impairment Income	Supplemental Income	Total
When payable	After 7 days of disability	TT and TT catastrophic = after 7 days of disability TT rehabilitation = After Division approves training and education program	Maximum medical improvement (MMI), impairment rating, and 20 days after carrier notification	After the impairment benefits end	After the doctor certifies there is an injury defined below
Conditions for eligibility	Doctor determines able to return to modified duty; and Earning less than 80% of previous average weekly wage (AWW)	TT = doctor determines unable to return to work and not receiving unemployment compensation TT Catastrophic = meets TT conditions and suffers catastrophic injury TT Rehabilitation = worker or carrier requests screening and Division determines eligible for reemployment services	Doctor determines worker is at MMI and assigns impairment rating or temporary benefits end and impairment rating is assigned	Impairment rating must be 20% or more Make good faith effort to find suitable work Not able to earn at least 80% of AWW Complete form and return to carrier	Unable to work and have one of following conditions: * Spinal cord injury causing paralysis * Loss of arm, leg, hand, or foot *Severe brain or head injury * 2nd or 3rd degree burns over 25% of body, or 3rd degree burns to 5% of face and hand * Total or industrial blindness * Any other injury qualifying for SS benefits
Amount of payment	80% of the difference between 80% of AWW and current earning ability	TT = 66 2/3% of AWW, but not exceeding max comp rate. If receiving social security (SS)	50% of average weekly TT benefits Sworn law	80% of the difference between 80% of the AWW and earning ability after	66 2/3% of AWW, but not exceeding max comp rate For injuries after 6/30/55, benefits

	Cannot exceed 66 2/3% of AWW or max comp rate Sworn law enforcement officers maliciously or intentionally injured receive 100% of AWW	benefits and worker is under 62, combined TT and SS benefits cannot exceed 80% of AWW. Sworn law enforcement officers maliciously or intentionally injured receive 100% of AWW TT Catastrophic = 80% of AWW, but not more than $700 per week TT Rehabilitation = 66 2/3%, but not exceeding max comp rate	enforcement officers maliciously or intentionally injured receive 100% of AWW	MMI Not greater than 66 2/3% of AWW or max comp rate Sworn law enforcement officers maliciously or intentionally injured receive 100% of AWW	increase until age 62 at rate of 5% per year up to the max comp rate If receiving SS benefits and worker is under 62, combined PTD and SS benefits cannot exceed 80% of AWW. Sworn law enforcement officers maliciously or intentionally injured receive 100% of AWW
Length of Benefit	Combined 104 weeks for TT and TP benefits or MMI	TT = Combined 104 weeks for TT and TP or MMI TT Catastrophic = Until worker has been retrained, but not more than 6 months from date of injury TT Rehabilitation = 26 weeks in addition to TT or up to 52 weeks with JCC order	Until death or 3 weeks of benefits for each percentage point of impairment rating	Until 401 weeks have passed since the date of injury	Until reemployed or death No more than 700 weeks for injuries occurring prior to 7/1/55 Payment suspended if incarcerated, except in case of dependents, who receive benefits as if worker deceased.

f. Dispute Resolution

In the course of navigating the workers' compensation system, disputes frequently arise between employees and employers/carriers. Examples of disputes include those arising over the amount of indemnity benefits, whether or not an injured person is covered by workers'compensation, whether or not employees can see the physician of their choice, or whether or not the employee is able to return to work. Disputes within the system are resolved through several mechanisms.

1) Informal Dispute Resolution

a) Employee Assistance and Ombudsman Office

The Legislature created the Employee Assistance and Ombudsman Office (EAO) in 1993, as a mechanism for resolving disputes informally, without undue expense and delay, and the need for costly litigation. Persons believing they are being denied benefits to which they are entitled may request EAO assistance in resolving the dispute by filing a request for assistance. They must first exhaust this informal process before filing a petition for benefits with the Office of the Judges of Compensation Claims.

The EAO has 30 days to resolve the dispute. To this end, it may compel parties to participate in conferences or assign an ombudsman to assist the employee in resolving the dispute.

In every year since its inception, the EAO has seen an increase in the total number of cases submitting requests for assistance, the total number of requests for assistance, the total number of issues submitted, the average number of issues per request for assistance, the average number of issues per case, and the percentage of requests for assistance filed by attorneys.[44] In 1999, attorneys filed over 95 percent of the requests for assistance. The EAO also has received an increasing number of issues beyond its jurisdiction to resolve. For example, many attorneys include requests for attorney's fees, which are statutorily prohibited during this process, and for penalties and interest, which can only be granted by a judge of compensation claims. For the fourth quarter of 1999, 34 percent of the issues submitted were "non-resolvable."[45]

b) Managed Care Arrangement Grievance Process

Insurers must establish written procedures for handling complaints and grievances from injured employees dissatisfied with the medical care provided through a managed care arrangement. These procedures must provide for timely review of grievances by decision-makers with authority to take corrective action. Injured workers need not exhaust the grievance process before filing a request for assistance with the Employee Assistance Office. These processes often occur simultaneously. However, before filing a petition for benefits with the Office of the Judges of Compensation Claims, injured workers must exhaust the managed care grievance process.

The grievance process must be completed within 60 days from the date the insurer receives the grievance, unless the parties agree to an extension.[46] If information needed to resolve the grievance must be obtained from outside the service area, then an additional 30 days may be allowed.

[44] Division of Workers' Compensation, 2000 Dispute Resolution Report
[45] www.fdles.state.fl.us/wc/dwc/statistics/assis.html
[46] Rule 59A-23.006, Florida Administrative Code

2) Formal Dispute Resolution

Once the informal dispute resolution processes have been exhausted, injured employees may file a petition for benefits with the Office of the Judge of Compensation Claims.

Filing a petition sets in motion a series of procedural events, each of which is required to occur within a specified period of time. The first is mandatory mediation, required to be held within 21 days from the date the petition is filed. If the dispute remains unresolved after mediation, then a pretrial hearing must be held within 10 days following the conclusion of the mediation. The final hearing must be held within 45 days (within which time the parties are allowed at least 30 days to conduct discovery) following the pretrial hearing. Finally, judges of compensation claims must issue their final order within 14 days after the final hearing. In sum, the formal dispute resolution process, including the 30-day informal EAO process, is limited statutorily to 120 days, or, including the managed care grievance process, 150 days

However, this process actually took 268 days – more than twice as long as the statute requires based on the findings of a study completed by legislative staff.[47]

On average, it took 138 days to get to state mediation – 117 days longer than the statute requires. However, approximately 85 percent of the employees exit the litigation process in fewer than 164 days by settling their case at or before mediation. Table 13 summarizes the committee's findings.

Table 13. Formal dispute resolution time lines: statutory v. actual.

Step	Statute	Actual
EAO/managed care grievance	30 / 60 days	25 / 30 days
Petition to Mediation	21 days	138 days
Mediation to Pretrial Hearing	10 days	30 days
Pretrial Hearing to Final Hearing	45 days	45 days
Final Hearing to Final Order	14 days	30 days
Total	120 / 150 days	268 / 273 days

The study also revealed the following:

- the Office of the Judges of Compensation Claims had not adopted uniform rules of procedure, nor had it enacted measures regarding the performance of the office as was required by the 1993 reforms;

- the expedited dispute resolution procedure, authorized in section 440.25(4)(j), F.S., is rarely used – less than 1 percent of the cases; and

- some judges of compensation claims interpret the statute as not requiring them to issue final orders within 14 days of the final hearing.

[47]Florida House of Representatives, Committee on Insurance, "Resolving Workers' Compensation Disputes According to Statutory Time Lines: Policy Options for Consideration," October 22, 1999.

g. Claimant Attorney Fees

While an attorney may not receive an award of claimant attorney fees payable by an employer or carrier for the period preceding the filing of a petition for benefits,[48] chapter 440, F.S., provides for the payment of claimant attorney fees. In addition to the information presented here, there are many other claimant attorney fee issues established in case law.

A Judge of Compensation Claim or a court must approve as reasonable all fees paid under the law. Attorneys are permitted to charge claimants pursuant to a statutory contingency fee schedule. The fee schedule is as follows:

- 20% of the first $5,000 in benefits secured,
- 15% of the next $5,000 in benefits secured,
- 10% of the remaining benefit amount to be provided during the first 10 years, and
- 5% of the benefits secured for after 10 years from the date the claim is filed.

However, the Judge of Compensation Claims or court may increase or decrease the fee and award claimant attorney fees on an hourly basis[49] based on the following statutory criteria:

- the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly,
- the fee customarily charged in the locality for similar legal services,
- the amount involved in the controversy and the benefits resulting to the claimant,
- the time limitation imposed by the claimant or the circumstances,
- the experience, reputation, and ability of the lawyer or lawyers performing services,
- the contingency or certainty of a fee.

The attorney may only receive a fee for the benefits secured as a result of the representation. That is, the increase in benefits secured must be as a result of the legal services rendered in the pursuit of the claim. However, this does not include medical benefits provided more than five years after the claim is filed.

A prevailing claimant may collect attorney fees from the employer/carrier. The statute provides for this in four instances:

- in medical-only claims,
- where the employer/carrier has filed a notice of denial,
- where the employer/carrier denies that a compensable injury occurred, or
- where the claimant prevails in an enforcement or modification proceeding.

[48] This is a period of at least thirty days. The law requires that the claimant exhaust the informal dispute resolution process provided by filing a request for assistance with the Employee Assistance and Ombudsman Office at the Division of Workers' Compensation. Attorneys file 95 percent of the requests for assistance.

[49] According to the Division of Workers' Compensation's *Performance Indicators for Judges of Compensation Claims*, August 2000, average attorney fees continue to surpass the statutory guideline.

If a claimant is responsible for his or her own attorney fees, the attorney fee represents a lien upon the compensation. Attorney fees are reported to and summarized by the Division.[50]

h. Florida Workers' Compensation Joint Underwriting Association

The Florida Workers' Compensation Joint Underwriting Association (FWCJUA) is the insurer of last resort for those employers unable to secure coverage from a voluntary market insurer. Employers in the FWCJUA typically are higher risk employers, i.e., very small employers and employers with a high incidence of workplace injuries.

The FWCJUA is funded entirely by policyholder premiums and policyholder assessments and does not assess insurers for its losses. In this sense, it is much more like a self-insurance fund than a traditional joint underwriting association. The FWCJUA provides insurance for employers in three distinct subplans – subplans A, B, and C.

Subplan A is designed to provide coverage for small employers – those with less than $2,500 in premium. Subplan B is designed to provide coverage for employers considered high risk because of the nature of their business, but with a lower than average number of claims. Policies issued under subplans A and B are not assessable. All other employers in the FWCJUA fall into Subplan C and can be issued assessable policies, which can be funded by increased premiums upon renewal, direct assessments, or both.

Approximately 30 to 40 percent of the insurance policies written by the FWCJUA are called "minimum premium policies." "Minimum premium" is the lowest amount of premium required to provide workers' compensation insurance coverage. Each classification of employment requires a different minimum premium in order obtain insurance. There are two types of minimum premium policies: (1) those with small amounts of payroll (i.e., exposure) and (2) those with no payroll (i.e., no exposure), which are referred to as "if any" policies. An example of an employer with a small payroll would be a sole proprietor with fewer than four employees (who, if not in the construction industry, by law does not need to provide workers' compensation for his employees) purchasing workers' compensation coverage for one part-time payroll clerk. The sole proprietor would purchase a minimum premium policy because the rate for the employee multiplied by the clerk's payroll will not exceed the minimum premium for that classification. An example of an employer having no payroll could be a building contractor. The contractor must show proof of workers' compensation insurance when bidding a job. At the time of bidding, the contractor does not have any employees; therefore, the contractor would purchase a minimum premium policy. However, once the contractor obtains the job and hires employees, the contractor should notify the insurer and revise the payroll estimates so that the premium may be revised to reflect the actual number of employees.

[50] Although, attorney fees in lump-sum settlements have not typically been reported, the Division has recently begun tracking this information. Additionally, the proposed Uniform Practices and Procedures of the Office of Judges of Compensation Claims include a provision to require the reporting of attorney fees.

i. Workplace Safety

1) Federal Law

In 1970, Congress enacted the Occupational Safety and Health Act (OSH Act). The stated purpose of the OSH Act is "to assure so far as possible every working man and woman in the Nation safe and healthful working conditions and to preserve our human resources." The OSH Act provides for the promulgation and enforcement of safety and health standards in the workplace.

The OSH Act applies to all 50 states and obligates employers to provide a place of employment that is free from hazards that could cause death or injury to employees. The OSH Act is administered by the Secretary of the U. S. Department of Labor sitting as the head of the Occupational Safety and Health Administration (OSHA). As defined in the OSH Act, an "employer" is "any person engaged in a business affecting commerce who has employees, but does not include the United States or any State or political subdivision of a State." Therefore, the OSH Act generally covers private employers, but does not cover public employers.

States have authority over private sector employers in two instances under the OSH Act. One, a state may assert jurisdiction over "any occupational safety or health issue with respect to which no standard is in effect" under federal law. The term "occupational safety and health standard" is defined as a standard which requires the "use of one or more practices, means, methods, operations, or processes, reasonably necessary or appropriate to provide safe or healthful employment and places of employment."

Two, a state may assume responsibility for the development and enforcement of occupational safety and health standards to which a federal standard has been promulgated by submitting a state plan to OSHA for approval. If approved by the OSHA, these so-called "state-plan states" or "OSHA-approved states" are authorized to exercise regulatory authority over the development and enforcement of occupational safety and health standards in the private sector, in addition to the public sector. Florida is not a "state-plan state." Thus, the OSHA retains jurisdiction over private sector occupational safety and health in Florida with respect to any safety or health issue for which a standard is in effect.

2) Florida Law

In 1993, the Legislature enacted the Florida Occupational Safety and Health Act, Chapter 442, F.S., and created the Division of Safety within the Department of Labor and Employment Security to administer the act. Unlike the federal OSH Act, which only applies to private employers, Chapter 442, F.S., applied to "every place of employment" and all "employers" without distinction between the public and private sector.

In the 1999 session, the Legislature passed CS/CS/SB 230, 2nd Eng., which scheduled Chapter 442, F.S., for repeal on July 1, 2000, and required the Department of Labor and Employment Security to submit to the Governor and Legislature a report on a proposed reauthorization of the Division of Safety and Chapter 442, F.S. A report was completed, but the Legislature did not reauthorize Chapter 442, F.S.,

in the 2000 session. As a result, the Division of Safety and Chapter 442, F.S., were repealed effective July 1, 2000.

Currently, there is no state agency responsible for enforcing workplace safety for the public or private sector. But, the Governor, by Executive Order 00-292, dated September 25, 2000, directed the Departments of Business and Professional Regulation, Children and Families, Citrus, Community Affairs, Corrections, Elder Affairs, Environmental Protection, Health, Juvenile Justice, Labor and Employment Security, Lottery, Management Services, and Transportation and the Agency for Health Care Administration to review their existing policies and practices with respect to workplace safety, to voluntarily comply with certain provisions of the federal OSH Act, and to coordinate their safety review efforts by entering into interagency agreements. The Governor also requested other Departments and political subdivisions to review their existing policies and implement any procedures made necessary by the repeal of Chapter 442.

3) Safety Consultations

Prior to its repeal, the Division of Safety operated two safety consultation programs: the federal 7(c)(1) program and the state consultation program for public sector employers. The state consultation program for public employers was funded completely by state funds, but the section (7)(c)1 program was mostly federally funded. Under section 7(c)(1) of the federal OSH Act, the state contracts with OSHA for a grant to perform safety consultations for private sector employers. The federal grant provides 90 percent of the funds to conduct private sector consultations.

After the repeal of the Division of Safety and Chapter 442, F.S., the Governor designated the University of South Florida as the recipient of the federal OSH Act grants to continue the federal (7)(c)1 private sector consultations. Public sector consultations are no longer performed.

j. Florida's Workers' Compensation Market Profile

1) Workers' Compensation Rates

The following table lists the annual overall rate changes approved by the Department since 1992.

Table 14. Approved NCCI rate revisions for Florida since 1992.

Effective year	Effective date	Overall premium change
1992	January 1	+21.2%
1993	January 1	+7.2%
1994	January 1	-10.6%
1995	no filing	0.0%
1996	no filing	0.0%
1997	January 1	-11.3%
1998	January 1	-1.7%
1999	January 1	+1.6%

Table 14. Approved NCCI rate revisions for Florida since 1992.		
2000	January 1	+2.5%
2001	January 1	0.0%

Source: National Council on Compensation Insurance

2) Workers' Compensation Total Premium and Market Structure

Workers' compensation insurance carriers and group self-insurance funds combined for direct written premium of $2.53 billion and assessable net premium collected of $2.06 billion in 1999. Assessable net premium collected attributable to individual self-insured employers for 1999 totaled an additional $720,098,264. Table 15 compares the makeup of the market in Florida for the years 1984, 1987, 1994 and 1997.

Table 15. Market share based on volume of assessable premium[a]—commercial insurers v. self-insurers: 1984, 1987, 1994, 1997.

Year	Insurance carriers		Self-insurers			
			Group		Individual	
	%	$	%	$	%	$
1984	69.2%	$705M	13.4%	$136M	17.4%	$177M
1987	62.6%	$939M	24.5%	$368M	12.9%	$193M
1994	28.8%	$1,002M	40.6%	$1,414M	30.6%	$1,064M
1997	54.1%	$1,963M	5.6%	$172M	40.3%	$1,065M

[a] Net premium collected for purposes of calculating insurer assessments for the Workers Compensation Administration Trust Fund as reported by carriers (or imputed to self-insurers) in the year specified. Source of information used to compile this table: Division of Workers' Compensation, Department of Labor and Employment Security

Table 16 compares the percentage of premium written in the voluntary market to that written in the residual market for odd number years since 1993.

Table 16. Workers' compensation insurer market share—voluntary v. residual market, 1993-1999.		
Calendar Year	Voluntary	Residual
1993	65	35
1995	96	4
1997	>99%	<1%
1999	>99%	<1%

Source: FWCJUA

Table 17 lists the top ten workers' compensation insurers based on calendar year 1999 direct written premium. Among the top ten insurers, domestics account for 61 percent of the premium volume, foreign insurers for the remaining 39 percent. The top ten insurers account for 40 percent of total direct written premium for workers' compensation insurers.

Table 17. Top 10 workers' compensation insurers in Florida based on calendar year 1999 direct written premium				
Rank	Insurer	Status	Premium	Market share
1	FCCI Mutual Ins. Co.	Domestic	$232M	9.2%
2	Bridgefield Employers Ins. Co.*	Domestic	$149M	5.9%
3	Associated Industries Ins. Co.	Domestic	$105M	4.2%
4	Zenith Ins. Co.	Foreign	$99M	3.9%
5	Transportation Ins. Co.	Foreign	$93M	3.7%
6	AMCOMP Preferred Ins. Co.	Domestic	$89M	3.5%
7	ZC Ins. Co.	Foreign	$86M	3.4%
8	Insurance Co. of the State of Pa.	Foreign	$62M	2.5%
9	Liberty Mutual Ins. Co.	Foreign	$53M	2.1%
10	Fla. Retail Federation SIF	Domestic	$49M	1.9%

Source: Florida Department of Insurance.
*Liberty Mutual Ins. Co. owns Bridgefield Employers Ins. Co.

3) Availability of Workers' Compensation Insurance in Florida

The availability of workers' compensation insurance in Florida's voluntary market can be gauged by examining the size of the FWCJUA. Table 18 shows the changes in the size of the FWCJUA since 1993.

Table 18. FWCJUA since 1993.				
	1993	1995	1997	1999
Direct written premium	$328.1M	$69.1M	$13.9M	$6.4M
Percentage of market	35%	4%	<1%	<1%
Number of policies	48,430	10,339	3,171	623

Source: FWCJUA

4. LIFE INSURANCE

Life insurance is one of several kinds of insurance products. Life insurance is a death benefit contract: it pays a benefit to survivors upon the death of the insured. State law regulates both the insurers selling life insurance and the life insurance product itself. Life insurance is sold as individual or group policies. Life insurers doing business in Florida reported $5.2 billion in premium for calendar year 1999, with over 10 million policies in force as of December 31, 1999.

a. Types of Life Insurance Contracts

Life insurance policies come in many different forms, although they generally are classified as ordinary, industrial, and credit life.

1) Ordinary life insurance

Ordinary life insurance includes term and whole life products and their many permutations, in addition to variable life and endowment contracts. It also includes accidental death benefit (i.e., "double indemnity") coverage, typically provided in the form of a rider attached to a life or health policy. Ordinary life insurance accounted for 6.8 million individual policies and 218,000 group policies, or 70 percent of all life insurance policies as of December 31, 1999. Premium volume for individual and group policies combined totaled nearly $5.1 billion, or almost 97 percent of total direct written premium for that same year.

Term life is a form of life insurance providing protection for a specified period of time with no cash surrender or loan value. These are generally employee plans. If the insured survives the term, no benefits are paid. The premium generally increases with the age of the insured. Variations include level, increasing, and decreasing term policies.

Whole life is a form of cash value life insurance. It pays the face value of the policy upon the death of the insured, regardless of when the insured dies. It also accumulates a cash value against which the insured may withdraw or borrow. Straight life is a common whole life product, although there are several other varieties. These include limited-payment [premiums payable over a specified number of years], single premium [premium paid upfront as a lump-sum amount], and excess interest whole life policies.

Universal life is a type of whole life policy in which an insured may vary the amount and timing of premium payments, plus increase or decrease the death benefit.[51]

Variable life is a type of policy in which the death benefits vary according to the investment results of the assets underlying the policy.[52]

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[51] Insurance Handbook for Reporters, p. 110
[52] Id. at p. 10

Endowment policies provide for the payment of the full-face amount . . . upon the death of the insured within a fixed term of years or at the end of a fixed term of years if the insured is living.[53]

2) Industrial life insurance

Industrial life is a class of whole life policy typically having a face value of less than $1,000, with premiums paid weekly or monthly and collected directly by insurance agents. Premiums may be paid for the life of the insured or be paid up in a specified period of years. Industrial life policyholders, unlike whole life policyholders, may not borrow against the cash value of their policy. They generally have small cash surrender values. Industrial life accounted for just $7.7 million, or just under 1.5 percent, of the reported $5.2 billion in premium for all life insurance products.

3) Credit life insurance

Credit life or disability insurance covers a credit holder=s debt in case of death or disability. Credit life accounted for $158 million, or 3 percent, of total life insurance premiums for calendar year 1999.

Annuities differ from death-benefit insurance contracts in that the insurance is designed to pay a benefit to the insured while alive rather than pay a benefit upon the death of the insured. The insurer agrees to pay the annuitant a stipulated sum for a specified period of time.[54] Annuities can be immediate or deferred in terms of when the annuitant begins to receive benefits, fixed or variable in terms of the value of the annuity. The primary benefit paid is an income benefit, although some pay a cash-surrender benefit.[55]

b. Standard Policy Terms in Life Insurance Contracts

The Insurance Code requires life insurers to include certain terms as standard contractual provisions depending on the particular life insurance product. These include a grace period for payment of premium, incontestability of policy terms, secondary notice requirements prior to lapsing a policy for nonpayment of premium, dividend payments, policy loans, maximum rates of interest on loans, policy reinstatement after default due to nonpayment of premium, table of installment payments for paying life insurance proceeds, and nonforfeiture benefits.

Incontestability clauses prevent an insurer from disputing a policy when it has been in force for a certain period of time. Under Florida law, a policy is incontestable if it has been in force during the lifetime of the insured for a period of two years from the date issued except for nonpayment of premium

[53] Arthur Andersen & Co., The Insurance Industry: An Introduction, 1991, p. 64
[54] Id. at p. 64
[55] Insurance Handbook for Reporters, p. 121-122

and provisions related to payment of benefits in the event of disability and granting of additional insurance for accidental death.[56]

Secondary notice, or notice of impending termination sent to a secondary addressee designated by the policyholder, is required before a life insurer can lapse (i.e., terminate) a policy for nonpayment of premium for policyholders 64 years of age or older. Secondary notice is required only for those industrial life insurance policies issued after October 1, 1997. Virtually all of the 1.2 million policies in force were issued before October 1, 1997, and therefore secondary notice is not required.

Nonforfeiture clauses permit an insured to surrender or discontinue a policy and receive a nonforfeiture [i.e., cash surrender] value. This can be in the form of cash, reduced paid-up insurance, or extended term. This is an option for the insured while living. Florida has adopted a "Standard Nonforfeiture Law for Life Insurance."[57]

c. Pricing Life Insurance Policies

Whole life and term insurance policies are priced according to the 1980 Mortality Table. The price of industrial life insurance policies is based on the 1961 Mortality Table. Using an older mortality table may result in higher rates because life expectancies increase over time. (A mortality table is a statistical table used by the industry to identify death probabilities by age.)

d. Viatical Settlement Agreements

A viatical settlement is an agreement under which the owner ("viator") of a life insurance policy (typically, but not necessarily, an owner with a terminal illness) sells the policy to another person in exchange for an up-front payment, which is generally less than the expected death benefit under the policy. The person who buys the policy from the original policy owner takes over premium payments, and, upon the death of the original policy owner, collects the death benefit under the policy.

The Department regulates the viatical settlement industry. The major elements of regulation under the law are the licensure of viatical settlement providers, brokers, and sales agents; prior approval of viatical settlement contract forms; examination of provider records; mandatory disclosures to viators and purchasers; and unfair trade practices and prohibited acts.

[56] Section 627.455, F.S.
[57] Section 627.476, F.S. This law requires that in the event of a default in premium payments, after premiums have been paid for one year (three years in the case of industrial life), the insurer must grant the policyholder a paid up nonforfeiture benefit or an actuarially equivalent paid-up nonforfeiture benefit which pays a greater amount or longer period of death benefits or a greater or earlier payment of endowment benefits.

5. SPECIALTY INSURANCE PRODUCTS

Florida law identifies several different specialty "lines" of insurance. Companies that sell these products are designated "specialty insurers" and are supervised by the Bureau of Specialty Insurers in the Department. As an introduction to the specialty insurance market, three different specialty insurance lines (warranty companies, premium finance companies, and legal expense insurers) are described.

a. Warranty companies and associations

Warranty companies and associations indemnify against the loss or cost of repair of consumer appliances and major purchases. State law recognizes three types: motor vehicle service agreement companies, service warranty associations, and home warranty associations. Florida-licensed companies and associations transact over $6 billion worth of warranty protection nationwide.

Much of the substantive regulation is the same for warranty companies and associations, although they warrant different products. They all must be organized in the United States (with the added requirement that motor vehicle companies be domiciled in Florida), comply with a general form filing law, file a deposit with the Department, and meet minimum net worth requirements. Warranty companies and associations must also have either an unearned premium reserve or an insurance policy to cover their liability exposure.

Table 19 compares specific provisions related to warranty companies and associations.

Table 19. Warranty companies and associations.

	Motor vehicle service agreement companies	Service warranty associations	Home warranty associations
Type of product offered	Indemnification against loss arising out of ownership or operation of a motor vehicle.	Indemnification against the cost of repair or replacement of consumer products that suffer operational failure. Also includes maintenance contracts greater than one year.	Indemnification, offered within certain statutory parameters, against the cost of repair or replacement of any structural component or appliance of a home due to wear and tear or inherent defect.
Licensure requirements	License Required. The company must be a Florida corporation.	License Required. Associations must be organized under the laws of the U.S. if not a natural person.	License Required. Associations must be solvent and organized under the laws of the U.S.
Premium volume*			
All licensed insurers			
U.S.	$2.2B	$3.7B	$136M
Florida	$1B	N/A	N/A

Top 3 Insurers U.S. Florida	 $1.7B $543M	 $2.8B $316M	 $90M $43M
Filing requirements			
Form filings	Agreement forms must be submitted 30 days prior to use and approved by the department. *Initial* sales literature and advertisement communication must be approved by the department upon application for a license. Filings are deemed approved if not affirmatively disapproved within 30 days of the filing date.	Agreement forms must be submitted 30 days prior to use and approved by the department. *Initial* sales literature and advertisement communication must be approved by the department upon application for a license. Filings are deemed approved if not affirmatively disapproved within 30 days of the filing date.	Agreement forms must be submitted 30 days prior to use and approved by the department. *Initial* sales literature and advertisement communication must be approved by the department upon application for a license. Filings are deemed approved if not affirmatively disapproved within 30 days of the filing date.
Rate filings	Rate filings are required 30 days prior to the effective date.	Rate filings are not required.	Rate filings are for informational purposes only.
Financial requirements			
Required net assets/net worth	$500,000 maintained within the United States	$25,000 if less than half of the company's gross income comes from svc. warranties. $300,000 if greater.	None, other than compliance with the gross written premium to net asset ratio requirement.
Unearned premium reserve/contractual liability insurance	One or the other is required. Companies must have either an unencumbered reserve equal to 50% of the unearned gross written premium or insure 100% of the claims exposure.	One or the other is required. Associations must have either an unencumbered reserve equal to 25% of the gross written premium or insure 100% of the claims exposure. ***	One or the other is required. Associations must have either an unencumbered reserve equal to 25% of the gross written premium or insure 100% of the claims exposure. **
Gross written premium to net asset ratio	10 - 1 if utilizing an Unearned Premium Reserve, unless a statutory exemption under s. 634.041, F.S. applies.	7 - 1, subject to statutory exemptions under s. 634.406 (4)-(6), F.S..	6 - 1, unless assets are $500,000 or more and a funded unearned premium reserve is maintained equal to a minimum of 40% of gross written premium.
Financial reporting	Annual and quarterly statements are required.	Annual and quarterly statements are required.	Annual and quarterly statements are required.
Financial examinations	At least once every three years.	At least once every three years.	At least once every three years.
Deposit	Initial deposit of $200,000. However,	Between $50K and $100K depending on	Initial deposit of $100,000 or $25,000

	only $100,000 needs to be deposited if the company's gross written premium is less than $750,000. If the company is using an unearned premium reserve, the deposit must equal 15% of the reserve.	amount of the gross written premium. If the association is using an unearned premium reserve, the deposit must equal 10% of the gross written premium on all Florida Contracts.	with a $75,000 surety bond.
Other requirements	None.	None.	None.
Statutory authority	s. 634, Pt. 1, F.S.	s. 634, Pt. 3, F.S.	s. 634, Pt. 2, F.S.

** Premium Volume is measured as the gross written premium in force up to 6/30/00 as reported to the Bureau of Specialty Insurers of the Department of Insurance. The numbers are calculated for all Florida licensed insurance organizations regardless of domicile.

*** Service and home warranty associations' reserve accounts are measured against the total amount of gross written premium.

b. Premium Finance Companies

Premium finance companies provide money on credit to pay the insurance premiums of insureds. Since they do not transact insurance, they do not have to file a deposit with the Department and do not have to maintain a reserve account. Rather, premium finance companies must hold a $500,000 errors and omissions policy and meet simple net worth and licensing requirements. Florida-licensed companies finance over $15 billion worth of premiums annually nationwide.

c. Legal Expense Insurance

Often referred to as "prepaid legal insurance," legal expense insurance policies provide for the reimbursement of legal expenses in the event of an unforeseen legal action. Prepaid legal companies are required to meet the same general licensing standards as regular insurance providers. They must file a deposit with the Department, and they are required to meet minimum net worth levels. Prepaid legal companies also must have an unearned premium reserve. Florida-licensed companies sell over $5 million worth of prepaid legal insurance nationwide.

IV. GLOSSARY OF ACRONYMS & TERMS

(Legend for sources found at end of glossary)

-A, B-

"A" rates: Rates based on the judgment of the underwriter on an individual risk basis, not backed up by loss experience statistics. [Source: INS]

"A" rated risks: Individual risks that are not rated in accordance with an insurer's rates, rating schedules, rating manuals, and underwriting rules.

Accelerated death benefit: Allows the insured to receive a percentage of the face amount of a life insurance policy when diagnosed with a terminal illness.

Accident year: A loss accounting definition whereby claims data are summarized by the calendar year in which an accident occurred and the premium was earned. See "Calendar year."

Actuary: A highly specialized mathematician professionally trained in the risk aspects of insurance, whose functions include performing the calculations involved in determining insurance rates and evaluating reserves. [Source: AH]

Adjuster: An individual who ascertains or determines the amount of any claim, loss, or damage payable under an insurance contract or undertakes to effect settlement of such claim, loss, or damage. See also, "Independent adjuster" and "Public adjuster."

Administrative supervision: An administrative proceeding initiated by the state insurance regulator directing an insurer that is exceeding its powers or is of unsound condition to take certain corrective actions.

Admitted asset: An asset an insurer may include in its financial statements.

Admitted insurer: An insurer licensed to do business in Florida. Also referred to as an "authorized" insurer.

Agent: A person licensed by the state insurance regulator to engage in the insurance business as a representative of an insurance company.

Alien insurer: An insurer domiciled outside of the United States.

All-other-perils policy: An insurance policy covering perils (also called risks) other than windstorm.

Annuity: A life insurance company contract that pays a periodic income benefit either for a specific period of time or for the annuitant's lifetime. In contrast to a life insurance policy which pays benefits upon the death of the insured, an annuity pays benefits while the annuitant is alive. [Source: III]

Appointed agent: An agent designated by an insurance company to represent that company in the state.

Appointment: Authorization from an insurance company or other entity for an individual to act for that company or entity in a specific capacity (e.g., agent, adjuster, customer representative, service representative or managing general agent).

Arbitration: An alternative dispute resolution process in which neutral third parties render a decision after a hearing in which the parties have an opportunity to be heard. It is intended to avoid the formalities, delay and expense of ordinary litigation. [Source: Black's] When the Insurance Commissioner issues a notice to disapprove an insurer's rate filing, an insurer may choose arbitration in lieu of an administrative hearing under the Administrative Procedures Act. The arbitration panel has three (3) members: one chosen by the insurer, one chosen by the Insurance Commissioner, and a neutral party chosen by the other two. The decision of the arbitration panel is binding.

Assessment: A charge levied against insurers and/or their policyholders to cover residual market deficits, guaranty fund claims payments, workers' compensation system administration, or Florida Hurricane Catastrophe Fund payouts on reimbursement contracts. See also "Emergency assessment" and "Regular Assessment."

Assigned risk: Risks that insurers would not ordinarily insure, but are required to because of state law or otherwise. These risks are handled through a pool of insurers and are assigned to companies in turn.

Authorized insurer: An insurer licensed to do business in Florida. Also referred to as an "admitted" insurer.

Average annual expected hurricane loss: The amount of hurricane loss an insurer would expect to sustain in a typical year. These losses are calculated by using hurricane models.

Average Weekly Wage (AWW): The wage used to calculate an injured employee's workers' compensation indemnity benefits. It is the average weekly wage earned by an injured worker during the 13 weeks before the injury.

Binder: Temporary insurance contract providing coverage until a permanent policy is issued.

Binding authority: Authority given to an agent by an insurance company to provide temporary coverage until a permanent policy is issued.

Book of business: Total amount of insurance written by an insurer or agent at a certain point in time.

-C-

Calendar year: The 12-month period beginning January 1 and ending December 31. Also, the experience of earned premium and incurred losses occurring within the calendar year, irrespective of the contractual dates of the policies and the dates of the accidents.

Capacity: In a narrow sense, the dollar amount of risk an insurer can assume based on its surplus and the nature of the risk; in a broad sense, the largest amount of insurance or reinsurance available in the marketplace. [Source: RAA]

Captive agent: An agent who sells insurance for only one company as opposed to an agent representing several companies. See also, "Exclusive agent." [Source: INS]

Captive insurer: A legally recognized insurance company formed to insure the risks of its parent corporation. [Source: Barron's] This is usually done when business insurance for a certain commercial risk cannot be obtained. [Source: MR]

Case reserve: The estimated amount of future loss payments remaining on an outstanding claim. [Source: AA]

Cash surrender value: The money available to borrow as a life insurance policy loan or withdraw upon surrender of policy before maturity. [Source: Department]

Casualty insurance: Insurance primarily concerned with the legal liability for losses caused by injury to persons or damage to the property of others (under Florida law, coverages include automobile, workers' compensation and employer liability, general liability, burglary and theft, credit, and malpractice, among others. [Source: AH]

Cat: Insurance industry slang for catastrophe.

Catastrophe reinsurance: Form of insurance written in order to improve the spread of risk against unknown concentrations of liability subject to one occurrence. Insurers are reimbursed when their losses due to a catastrophe exceed a specified amount (retention). [Source: AH]

Ceded premium: Premium paid by insurer to a reinsurer as consideration for transferring risk to the reinsurers.

Certificate of authority: The license issued by the Department of Insurance that authorizes an insurer to transact insurance business in Florida.

Churning: Illegal practice of using the value in an existing life policy or annuity contract to purchase another policy or contract with the same insurer for the purpose of deriving additional premiums, fees, commissions or compensation.

Combined ratio: The most common measure of an insurer's underwriting profitability, derived by dividing total premium by the sum of losses, expenses, and policyholder dividends. Insurers with a combined ratio of less than 100 collect enough premium to cover losses and expenses; those with a combined ratio exceeding 100, do not collect enough premium to cover their losses and expenses. Unlike the "IRIS ratio" (the two year overall "operating ratio"), the combined ratio does not reflect an insurer's earnings from investments of premium dollars. Therefore, an insurer may have a combined ratio of 105 percent (an indication that losses and expenses exceed the amount of premium collected by 5 percent), but be profitable because investment income earned is greater than 5 percent.

Commercial lines: Types of insurance written for business risks.

Community rating: A method of developing health insurance rates which takes into account the medical and hospital costs in the entire community or area to be covered. In pure community rating, individual characteristics of the insured employer are not considered. Florida utilizes a variation on this method, called "modified community rating," which allows carriers to consider a limited set of individual characteristics relating to the individuals actually covered. These factors include age, gender, family composition, tobacco usage, geographic location, health status, claims history, and duration of coverage.

Compensation rate (Comp Rate or CR): 66 2/3 percent of the injured workers' average weekly wage, up to a maximum of 100 percent of the statewide average weekly wage.

Continuing care contracts: A form of insurance under which an individual receives, in

exchange for a substantial one-time premium or entry fee and, typically, monthly maintenance fees, the right to reside in a residential unit or nursing home at a continuing care retirement community for the rest of his or her life, together with rights to health-related services and food service.

Copayment: The percentage of a loss for which the insured is responsible. For example, if a policy has a 10 percent copayment and the loss is $1,000, the insured must pay $100, and if the loss is $10,000, the insured must pay $1,000.

Countersignature: Generally refers to laws requiring that any insurance contract issued in a state be countersigned by a licensed agent or other representative of the insurer located in that state. [Source: INS]

Credit insurance: Insurance against loss or damage resulting from failure of debtors to pay their obligations to the creditor, except for reasons of death or disability of the debtors.

Credit life insurance: Insurance that the repays the policyholder's loans in the event the policyholder dies.

Credit property insurance: Insurance against the loss of personal property used as collateral for securing a loan or on personal property purchased under an installment sales agreement.

-D, E-

Declarations: That part of an insurance policy describing the named insured, address, effective date, policy terms, coverages, and premium. [Source: AH]

Deductible: That share of an insured loss borne by the policyholder; the amount a policyholder agrees to pay, per claim or per accident, toward the total amount of an insured loss. For example, if a homeowners' policy has a $1,000 deductible and the loss is $1,500, the insurer must pay $500 of the loss, or if the loss is $50,000, the insurer must pay $49,000.

Delinquency proceeding: A proceeding brought by the state insurance regulator against an insurer for the purpose of liquidating, rehabilitating, reorganizing, or conserving the insurer.

Depopulation: Term used to refer to the reduction in the number of risks covered by a residual market insurer.

Deviation: A rate that varies from the approved rate. Member insurers must file with, and receive approval from, the Department of Insurance before using the deviation. Since 1992, the Department of Insurance has approved very few deviations for workers' compensation insurers.

Direct writer: A salaried or commissioned licensed agent employee of a single insurance company or affiliated group of insurance companies. Also refers to an insurer that markets insurance through such company agents. [Source: AA]

Direct written premium: Total premiums on all policies written by an insurer during a specific period of time. [Source: INS]

DLES: Florida Department of Labor and Employment Security

DOI: Florida Department of Insurance

Domestic insurer: An insurer formed under the laws of and located in Florida.

Earned premium: That part of the premium applicable to the expired portion of the policy term.

Emergency assessment: A type of premium surcharge which the Residential Property and Casualty Joint Underwriting Association and the Florida Windstorm Underwriting Association may levy directly on all residential property insurance policyholders when premium revenues and other resources, including revenues collected through regular assessments, are insufficient to pay claims. The Florida Hurricane Catastrophe Fund may also levy emergency assessments to fund revenue bonds issued to pay obligations to insurers under reimbursement contracts. Emergency assessments have not yet been levied by any of these entities.

Endorsement: A written or printed form attached to a policy which alters the provisions of the insurance contract. [Source: INS]

Excess insurance: Coverage against losses greater than those provided under an insureds primary coverage.

Exclusive agent: A licensed agent employee or representative of only one insurance company or group of affiliated companies, seeking and servicing business exclusively for that company or group usually on a commission basis. [Source: AA, AH]

Experience modification factor: Referred to as an "experience mod," this factor represents an employer's claims history relative to the average employer in the same line of business. Experience modifiers are expressed as a factor of 1, with those employers experiencing a higher than average number of workplace injury claims having an experience mod of greater than 1, while those with a lower than average number of injury claims having an experience mod of less than 1.

Experience rating: The practice of adjusting employers' workers' compensation insurance premiums based on their experience mod. The National Council on Compensation Insurance (NCCI) files the experience rating plan for the State of Florida.

Exposure: The probability of loss; loss potential as measured by the type of construction, area, or values; a unit of measure of the amount of risk a company assumes. [Source: AH]

-F-

Federal Emergency Management Agency (FEMA): An independent federal emergency management agency founded in 1979 that reports to the President of the United States. The FEMA works to reduce risks, strengthen support systems and help people and their communities prepare for and cope with disasters.

FIGA: Florida Insurance Guaranty Association

Financial responsibility law: A law requiring licensed motorists to produce evidence, either before or after an automobile accident, of the ability to pay for damages. To comply with the Financial Responsibility Law in Florida, a licensed motorist must carry bodily injury insurance in the amount of $10,000 per person/$20,000 per occurrence.

Financial statement: A statement filed annually and quarterly with the Department of Insurance on or before March 1 of each year by all authorized insurers describing their financial condition for the corresponding period of time. Under Florida law, the annual statement must

include a statement of opinion on loss and loss adjustment expense reserves.

First-party insurance: Insurance under which the insurer pays its insured for certain losses (as distinguished from liability insurance, under which the insurer compensates a third party for losses caused by its insured).

FJUA: Florida [Automobile] Joint Underwriting Association. See "Residual Market."

Florida Hurricane Catastrophe Fund (FHCF or Cat Fund): The FHCF is a state reinsurance pool for major hurricanes administered by the State Board of Administration. Each insurer that writes residential property insurance in Florida is required to participate and pay into the fund an actuarially-determined premium based on its actual hurricane exposure. In turn, the fund contracts to reimburse the insurer for a specified percentage (45%, 75%, or 90%, as selected by the insurer) of hurricane losses in excess of the insurer's "retention."

Florida Insurance Guaranty Association (FIGA): The guaranty association for property and casualty insurance. See "Guaranty Association."

FMMJUA: Florida Medical Malpractice Joint Underwriting Association. See "Residual Market."

Foreign insurer: An insurer domiciled within the U.S., but outside of Florida.

FWCIGA: The Florida Workers' Compensation Insurance Guaranty Association, the guaranty association for workers' compensation insurers. See "Guaranty Association."

FWCJUA: The Florida Workers' Compensation Joint Underwriting Association. See "Residual Market."

FWUA: Florida Windstorm Underwriting Association. See "Residual Market."

-G-

GAAP: Generally Accepted Accounting Principles are designed to report the operating results and financial condition of an insurer on a going-concern basis. The emphasis is on profitability.

GAO: (U.S.) General Accounting Office

Group life insurance: A life insurance policy insuring the lives of more than one person.

Guaranty association: An entity created by law to pay policyholders' claims under policies issued by an insurer that has become insolvent. Guaranty associations are funded by assessments on all insurers of a particular class.

-H, I, J, K-

Hard market: "Seller's market." A market environment/sales cycle in which insurance is expensive and in short supply. [Source: III]

HO-3: The most common property insurance policy type. An HO-3 policy typically covers a home for all perils, except for those specifically excluded. Covered perils include fire or lightning; windstorm or hail; explosion; riot or civil commotion; aircraft; vehicles; smoke; vandalism; theft; falling objects; weight of ice, snow, or sleet; accidental discharge or overflow of water or steam; accidental tearing apart, cracking, burning, or bulging; freezing;

accidental damage from an artificially generated electrical current; and volcanic eruption.

Impairment rating: A determination of an injured worker's loss of physical functions as a percentage of total bodily function or mobility. This percentage represents the extent to which a work-related injury has permanently impaired the injured worker.

Impairment rating guide: The impairment guide is designed to aid medical providers in establishing an impairment rating associated with the loss of a body part or loss of bodily function or mobility. This impairment rating is established only after maximum medical improvement has been obtained by the injured worker. The impairment rating assigned to the injured worker by the physician is then used to determine the amount of disability benefits to be awarded the injured worker.

Incontestability: Provision of a policy that prevents a life insurance company from invalidating a policy after the policy has been in effect for a certain length of time (under Florida law, two years), except for nonpayment of premium or other stated circumstances. [Source: AH]

Incurred but not reported (IBNR): Losses which have occurred during a stated period such as a calendar year, but which have not yet been reported to the insurer as of the date under consideration.

Incurred losses: See "Losses, incurred."

Indemnity: Restoring the victim of a loss by payment, repair, or replacement. [Source: INS]

Independent adjuster: An adjuster that works as an independent contractor representing the interests of insurance companies. [Source: INS]

Independent agent: An independent business person who usually represents two or more insurance companies in a sales and service capacity and is paid on a commission basis. [Source: AA]

Industrial life insurance: A form of life insurance under which the premiums are paid weekly or monthly and are collected directly by an agent.

Insolvent: Insurer lacks enough assets to discharge all liabilities or insurer is unable to pay debts as they become due.

Insurance Code: Chapters 624-651, Florida Statutes, except for chapters 633 and 650.

Insurance exchange: A reinsurance marketplace modeled after Lloyd's of London for hard-to-place risks and for the placement of excess or surplus lines. [Source: Barron's]

ISO: Insurance Services Office.

Joint Underwriting Association (JUA): An association or pool of insurers providing insurance to those unable to obtain coverage in the voluntary market for a particular risk. See "Residual Market"

Judge of Compensation Claims: Official appointed by the Governor to preside over disputed workers' compensation cases. There are thirty-one judges of compensation claims.

Keep out: A phrase used to used to refer to strategies and programs adopted by residual

market entities to exclude risks insurable in the voluntary market.

-L-

Lapsed policy: Policy terminated for nonpayment of premium.

Liability insurance: Insurance covering legal claims against the insured.

Limited agent: Agent authorized to transact only a limited form of insurance such as credit property insurance. [Source: INS]

Limited apportionment company: A company that has surplus as to policyholders of $20 million or less and more than 25 percent of its total premium written in Florida. A limited apportionment company is only subject to FWUA assessments on the first $50 million in losses.

Liquidation: Dissolution of an insurer by the state insurance regulator as receiver. Liquidation involves securing and converting the assets of a debtor insurer, and distributing these assets to creditors.

Loss costs: The portion of an insurance rate representing the amount of premium needed to cover the losses for the coming year. Also, all of the components of an insurance rate, excluding expenses and profit. In more than 30 states, workers' compensation insurers file loss costs for the industry, while individual insurers file the expenses and profit portion of their rate (called a "loss cost multiplier").

Loss cost multiplier: A factor representing the profit and expense portion of an insurance rate. In states where rating organizations file loss costs, individual insurers typically can file loss cost multipliers.

Loss ratio: The percentage of premiums (usually earned premiums) used to pay losses and loss adjustment expenses.

Loss reserve: Estimated liability for unpaid claims, known losses not yet due, and losses incurred but not yet reported. [Source: INS]

Losses, incurred: Losses which have occurred during a particular period, whether paid or not. [Source: INS]

Losses, paid: Losses which have been paid.

Losses, unpaid: Losses which have been incurred, but not yet paid.

Lost-time cases: A phrase used by the Division of Workers' Compensation to describe a work-related injury which results in at least seven days away from work. The seven day threshold is required under Florida's workers' compensation law before indemnity benefits are payable. Lost time cases are the opposite of "medical only cases."

-M-

Managed Care Arrangement (MCA): Also called a workers' compensation managed care arrangement, the mechanism through which workers' compensation medical benefits are required to be provided. Managed care arrangements are approved and regulated by the Agency for Health Care Administration.

Managed care: Managed care is a health care delivery system or program. Some basic elements such as utilization review, fee schedules or capitation, prior authorization, and

restriction on physician choice are typically found in most managed care systems.

Managing general agent: An agent authorized by an insurance company to manage all or a part of the insurer's business in a specific geographic territory. Activities on behalf of the insurer may include marketing, underwriting, issuing policies, collecting premiums, appointing and supervising other agents, paying claims, and negotiating reinsurance. [Source: Rupp's]

Manual: A book published by an insurer, rating association, or bureau containing its rates, classifications, and rules for rating policies. [Source: AH]

Manual rates: The cost per unit of insurance as published in the pertinent manual. For workers' compensation insurance, the manual rate refers to the rate listed in the rate pages of the Basic Manual of the National Council on Compensation Insurance.

Market conduct exam: An examination in which the Department of Insurance reviews the marketing and sales practices of an insurer or agent to ensure compliance with the Insurance Code.

Maximum medical improvement (MMI): The date after which further recovery from or lasting improvement to an injury or disease can no longer be anticipated based upon reasonable medical probability.

Medical-only case: A phrase used by the Division of Workers' Compensation to describe a work-related injury resulting in the payment of medical benefits, but not indemnity benefits. Because indemnity benefits are payable only after a seven day absence from work, medical only cases can include work-related injuries where up to six days of work are missed as a result of the injury.

Minimum premium policy: The lowest premium required in order to purchase a workers' compensation insurance policy. Minimum premium policies, also called "if any" policies, are typically purchased by general contractors, who have no employees, but who have independent contractors working for them. The minimum premium policy protects the general contractor in the event one of the independent contractors is injured and is deemed by a judge of compensation claims to be an employee and, therefore, eligible for workers' compensation benefits.

Mitigation: A loss prevention measure. Any action taken to permanently reduce or eliminate long-term risk to people and their property from the effects of hazards.

Moratorium: The common term for a series of restrictions on an insurer's ability to cancel or nonrenew residential property insurance policies for reasons of reducing the insurer's exposure to hurricane loss. The current version of the moratorium generally prohibits an insurer from canceling or nonrenewing in any 12-month period more than 5% of the homeowners' policies, mobile home policies, or condominium association policies it had in force on June 1, 1996. The current moratorium expires on June 1, 2001.

Mutual insurance holding company: A company without permanent capital stock which owns one or more controlled subsidiary insurance companies and which may consist of an intermediate stock holding company. Mutual insurance holding companies are owned by the policyholders of the controlled subsidiary insurance companies. Mutual insurers are

allowed under Florida law to reorganize into this structure, called a mutual insurance holding company system.

Mutual insurer: An insurance company that is owned by its policyholders in contrast to a stock insurer owned by its shareholders. Earnings over and above payment of losses and operating expenses, and reserves belong to the policyholders. A mutual insurer may be classified as assessable or nonassessable; that is, one in which the insurer may or may not assess policyholders.

-N-

NAIC: The National Association of Insurance Commissioners. An organization of state insurance regulators that develops model acts, collects data, and provides standardized financial reporting. The NAIC also accredits state insurance departments.

National Council on Compensation Insurance (NCCI): A rating organization and statistical agent, the NCCI makes workers' compensation filings, including rate filings, with the Department of Insurance on behalf of its member insurance companies. Almost all workers' compensation insurance companies are members of the NCCI.

NCOIL: The National Conference of Insurance Legislators. The NCOIL is an organization of legislators with an interest in insurance regulation. It serves as a forum for policy discussions on a wide range of insurance issues. In addition to providing educational services to legislators, the NCOIL also develops model acts for various insurance issues.

Net of reinsurance: After deducting any applicable reinsurance, as in the amount of loss absorbed by an insurance company after deducting any reinsurance applicable to the loss.

No-fault automobile insurance: Insurance in which claims arising from an accident are paid without regard to fault on the part of the insureds. In Florida, the amount payable to an insured without regard to fault is $10,000—the minimum amount of personal injury protection coverage motor vehicle owners are required to carry. Tort damages are not recoverable to the extent damages are payable under PIP, except in the case of accidents causing death, or certain injuries or diseases specified in statute.

Nonadmitted insurer: An insurer that is not licensed to transact insurance business in Florida. Also known as "unauthorized" insurer.

Nonforfeiture benefit: Provision that the equity in a life insurance policy cannot be forfeited. The policyholder can select four benefit options: cash surrender value, extended term insurance, loan value, or paid-up insurance. If none is selected, the policy will stipulate the option that goes into effect automatically. [Source: Barron's]

Nonrenewal: The refusal of an insurer to renew an insurance policy upon expiration.

Nonstandard auto insurance: "High-risk" automobile insurance. Insurance for motorists who have poor driving records or have had their insurance cancelled or been refused insurance. Typically a much higher premium is charged for nonstandard auto than for standard auto due to the higher risks. [Source: AMB]

-O, P-

Operating ratio: Ratio which measures an insurance company's overall operational profitability from underwriting and investment

activities. The ratio does not reflect other operating income/expenses, capital gains, or income taxes. [Source: AMB]

Paid losses: See "Losses, unpaid."

Peril: An event that is insured against (for example, fire or windstorm).

Permanent impairment: Any anatomical or functional abnormality or loss existing after the date of maximum medical improvement, which results from the injury.

Permanent partial disability: Any permanent disability that is partial in nature.

Permanent total disability (PTD): Disability resulting from a catastrophic injury which causes employee to lack substantial earning capacity.

Personal injury protection (PIP): Type of personal injury coverage required under Florida's no-fault automobile insurance law. It covers the policyholder's medical expenses and loss of income arising out of an accident without regard to fault, up to $10,000.

Personal lines: Insurance for individuals and families such as private passenger automobile insurance and homeowners' policies. [Source: INS]

Policy limits: The maximum amount of losses payable under an insurance policy.

Policy year: A premium and loss accounting definition whereby experience is summarized for all policies with effective dates in a given calendar year period.

Practice parameters: Guidelines used by medical providers to determine the appropriate course and level of treatment rendered to patients. These parameters are viewed as an effective method of both reducing and containing medical costs. When providers render a course of treatment that is within the parameters, it is considered proper, absent extenuating circumstances, and may be used as evidence that the treatment provided was correct under the circumstances.

Premium: The amount paid by an insured to insure a risk.

Premium finance company: A company that advances funds to an insured for the payment of insurance premiums. In exchange, the company earns interest and receives service charges as limited by law.

Premium-to-surplus ratio: Ratio computed by dividing net premiums written by surplus. It is designed to measure the adequacy of an insurer's surplus "cushion" and thus the company's financial strength. The lower the ratio, the stronger the company is financially. [Source: AMB]

Primary coverage: Coverage for the first dollar of losses above any applicable deductible up to policy limits, as distinguished from excess coverage. [Source: INS]

Probable maximum loss (PML): The highest expected dollar value of loss from a given peril at a given probability. For example, if an insurer has a 100-year hurricane probable maximum loss of $1 billion, this means that $1 billion is the highest loss the insurer expects from a hurricane the probability of which is 1 percent.

Property and casualty insurance: Most varieties of insurance other than life and health, including homeowners' and other property

insurance, motor vehicle insurance, liability insurance, and workers' compensation insurance.

Public adjuster: Insurance adjuster that represents the insured on a fee-for-service basis in claims determinations and settlements. [Source: INS]

-Q, R-

Rated policy: Sometimes called an "extra-risk" policy. A life insurance policy issued at a higher-than-standard premium rate to reflect a unique impairment, occupation, or hazard. [Source: Barron's]

Rate variation method: Any technique used by insurers to alter the basic insurance rate approved by the state regulator. Rate variation methods include deviations, schedule rating, retrospective rating, fixed credits, dividends, and deductibles.

Rating law: Statutes regulating insurance rates. A rating law typically governs the requirements for filing rates with the state regulator as well as the requirements for approval of the rate by the state regulator.

Rating plan: The rules governing the application of certain rate variation methods, such as retrospective rating plans, schedule rating plans, and experience rating plans.

Rebate: The return of any portion of an agent's commission as an inducement for an applicant to purchase insurance from the agent. [Source: Barron's]

Receivership: Legal or equitable proceeding in which a court places an insolvent insurance company under the control of the state insurance department to preserve its assets for the benefit of affected parties. [Source: Barron's, Black's]

Regular assessment: A type of surcharge levied on all residential property insurers in the state by either the Residential Property and Casualty Joint Underwriting Association or the Florida Windstorm Underwriting Association. When the premium revenues and other resources are insufficient to pay claims, the RPCJUA and the FWUA have the authority to levy regular assessments. Insurance companies may recoup these costs from policyholders.

Reinsurance: Insurance coverage procured by an insurer for its own protection.

Reserve: A balance sheet liability created by an insurer in anticipation of losses.

Residual market: The market of last resort for those unable to obtain coverage in the voluntary (or private) market. In Florida, the residual market includes the Florida Workers' Compensation Joint Underwriting Association (FWCJUA), Florida [Automobile] Joint Underwriting Association (FJUA), Florida Windstorm Underwriting Association (FWUA), Florida Medical Malpractice Joint Underwriting Association (FMMJUA), Residential Property and Casualty Joint Underwriting Association (RPCJUA), and the Florida Workers' Compensation Joint Underwriting Association (FWCJUA). Except for the Workers' Compensation Joint Underwriting Association, these entities are associations of insurance companies in which each insurer is required by law to participate, and whose losses are shared by participating insurers in proportion to their voluntary market share. In the case of the Workers' Compensation Joint Underwriting Association, losses are shared by certain policyholders of the association.

Retention: The dollar amount of losses payable by an insurer before qualifying for reimbursements under reinsurance agreements. For example, if a reinsurance contract requires the reinsurer to pay 80 percent of losses in excess of $1 billion, up to a total of $2 billion, the insurer's retention would be $1 billion. See "Florida Hurricane Catastrophe Fund."

Retrospective rating: An optional rate variation method, often used in workers' compensation insurance, wherein the employer's premium is calculated at the end of the policy year based on the employer's actual losses. Under retrospective rating, the employer pays the standard premium at the beginning of the policy. Then, at the end of the policy year, the employer's losses are inserted into a formula to determine whether the employer owes additional premium or whether the employer is entitled to a refund of premium.

Risk: An item that is insured (e.g., house, car).

Risk management: Management of the risks of a company or entity by analyzing all exposures to the possibility of loss and determining how to handle these exposures through such practices as risk avoidance, reduction, retention, or transfer (i.e., insurance). [Source: INS]

RPCJUA: Residential Property and Casualty Joint Underwriting Association. See "Residual Market."

-S-

Schedule rating: An optional rate variation method (typically used in workers' compensation insurance), required to be filed with, and approved by, the state regulator, which allows insurers to adjust the premium for an individual risk by applying credits or debits reflecting the characteristics of the employer's risk. These characteristics may include on-site medical facilities, safety devices, employee training and selection methods, and management cooperation with the insurance carrier. Most states limit the percentage an insurer may increase or decrease a particular rate.

Self-insurance: The assumption of some or all of one's own risk, rather than paying an insurance company to assume it. [Source: III]

Sliding: Representing to a policyholder that a certain coverage is required by law when it is not, representing that a certain coverage is included without additional charge when additional charge is necessary, or charging a policyholder for additional coverage without the policyholder's consent. Sliding is considered an unfair and deceptive trade practice under the Insurance Code.

Soft market: "Buyer's market." A market environment or sales cycle in which insurance is plentiful and sold at a lower cost. [Source: III]

Specialty insurer: A term used in Florida law in referring to a mix of entities providing insurance or insurance-related products or services. Included are insurers providing prepaid legal expense insurance, entities offering insurance-related products such as motor vehicle service agreements or home warranties, and premium finance companies.

Statutory accounting principles: Accounting principles for insurers prescribed by law or rule. Statutory accounting principles are directed towards a determination of the financial condition of an insurer on a specific date. Statutory accounting principles emphasizes surplus adequacy and is intended to value an enterprise on a liquidation basis, while generally

accepted accounting principles are intended to value an enterprise as a going concern.

Stock insurer: An insurer that issues capital stock and is owned by shareholders in contrast to a mutual insurer owned by its policyholders.

Stop loss: A policy provision designed to limit the losses of an insurer to a given dollar amount. [Source: INS]

Surplus: Generally, the difference between admitted assets and total liabilities, further reduced by the stated capital represented by issued capital shares.

Surplus-as-to-policyholders: The insurance company equivalent of net worth. In most states, surplus as to policyholders is known as "capital and surplus."

Surplus lines insurance: Insurance coverage provided by an insurer that is not licensed in a particular state, but nonetheless permitted to do business in the state because the particular coverage offered is not available from a licensed company. [Source: Barron's]

Surplus lines insurer: An insurer not licensed in Florida, but licensed in some other state. Surplus lines insurers are allowed to participate in the Florida market on a limited basis (generally, when the coverage they provide is not available from authorized insurers in Florida), but are not regulated by the Florida Department of Insurance as to either rates or the content of policies.

-T-

Temporary partial disability: A disability that is not permanent in nature, resulting from an injury that reduces the earning capacity of the injured worker to below the full rate of pay following an occupational injury and before the employee has reached maximum medical improvement.

Temporary total disability: A disability that is not permanent in nature, resulting from an injury that completely incapacitates the injured worker, preventing return to gainful employment for a period of time.

Title insurance: Insurance that protects against defects in a title to real property. A mortgagor's title insurance policy protects the owner of the property, and a mortgagee's title insurance policy protects the mortgage lender.

-U, V-

Unauthorized insurer: An insurer that is not licensed to transact insurance business in Florida. Also known as "nonadmitted" insurer.

Underwriter: An individual or company that evaluates and insures risks.

Unearned premium: That portion of the premium applicable to the unexpired portion of the policy term.

Unpaid losses: See "Losses, unpaid."

Viatical settlement: The sale of a life insurance policy by the policyholder. The purchaser, usually a non-insurance investment company, pays a portion of the policy value to the insured and is named the beneficiary. The purchaser pays the premiums until the policyholder dies and then collects the death benefit under the policy upon the death of the original owner.

Voluntary market: The private sector insurance market. The "voluntary" market is distinguished

from the "residual" market in that insurers in the voluntary market can choose whether or not to insure given risks, while a residual market insurer is generally required to accept risks that have been rejected by voluntary market insurers.

-W, X, Y, & Z-

Warranty associations: Under Florida law, any person, other than an authorized insurer, issuing service warranties or home warranties.

Legend for sources:

AA = Arthur Anderson & Co., *The Insurance Industry*, 3rd Ed., 1991.
AH = Allstate Insurance Co., *Insurance Handbook for Reporters*,
AMB = A. M. Best Co. @ www.ambest.com/resource/glossary.html
Barron's = Barron's Business Guides, *Dictionary of Insurance Terms*, 4th Ed., 2000.
Department = The Florida Department of Insurance, *Life Insurance and Annuities Consumers' Guide*, 2000.
III = Insurance Information Institute, *Handbook for Reporters*, 1993.
INS = InsWeb Corporation @ www.insweb.com
MR = Morris & Reynolds Insurance @ www.morris-reynolds.com
Rupp's = Rupp's Insurance and Risk Management Glossary @ www.nils.com/rupps

V. APPENDICES

A. RECENT STAFF REPORTS

1. **Managing Mandated Health Benefit Policy Options for Consideration (Insurance, 1/00)** State laws frequently require private health insurance policies and health maintenance organization contracts to include specific coverages for particular treatments, conditions, persons, or providers. These are referred to as mandated [health] benefits. The primary purpose of this report is to present legislators with policy options for considering proposed mandated health benefits legislation and managing the cumulative impact of mandated benefits. Before presenting these options, this report discusses the health care coverage status of Floridians and health benefit and premium costs nationally, mandated benefits in Florida, and legislative mechanisms used in Florida and other states to manage mandated benefits. This report does not examine the merits of any particular mandated benefit or mandated benefits generally.

2. **Resolving Workers' Compensation Disputes According to Statutory Time Lines: Policy Options for Consideration (Insurance, 10/99)** In the workers' compensation act, the Legislature has expressed the intent that the workers' compensation system be self-executing, resolving disputes without undue expense, costly litigation, or delay in the provision of benefits. Statutory time lines exist, at least in part, to achieve this result. The purpose of this report is to: (1) determine if the statutory time lines for resolving workers' compensation disputes are being met and, if not, offer reasons why practice differs from statute; and (2) identify policy options for Members to consider.

3. **Status Update on the Status of Funding for the Workers' Compensation Administration Trust Fund and the Special Disability Trust Fund (Insurance, 11/99)** The premium base used as the basis for funding the administration of the workers' compensation system and insurer reimbursements under the Special Disability Trust Fund has declined dramatically in recent years and could shrink even further in the near future. Two trends contributing to the decline are the purchase of large deductible policies by a large number of formerly self-insured employers and the exclusion of ceded reinsurance premiums from the premium base. This issue paper examines these two trends and offers options for policymakers to consider should they conclude a legislative response is warranted.

4. **Consumer Services and Advocacy in Financial Regulatory Agencies (Financial Services, 10/98)** This staff report examines the consumer assistance and information activities of both agencies. Included are the results of a user satisfaction survey conducted as a part of this report. The report also describes the statutory authority and history of the Insurance Consumer Advocate and examines characteristics of independent advocacy through review of the Office of Public Counsel. Finally, the report identifies

public policy issues and options for consideration.

5. **Status Report: Growth and Depopulation in the Residual Property Insurance Market (Financial Services, 10/98)** The size of the residual market affects all Florida property owners. Assessments levied on insurance companies and their policyholders provide the funding for the residual market whenever the premiums charged by the Florida Windstorm Underwriting Association or the Residential Property and Casualty Joint Underwriting Association are not sufficient to pay claims. The purpose of this report is to provide legislators with information on the growth of Florida's residual market for property insurance and a status report on efforts to "depopulate" (i.e., reduce the number of risks covered by) the residual market. Specifically, this report: summarizes the structure and legislative history of the residual property insurance market; analyzes growth trends in the residual market, on both a statewide and a regional basis; describes the statutory requirements for depopulation of the residual market and the depopulation plans that have been implemented; presents a framework for legislative consideration of costs and benefits of various depopulation efforts; compares depopulation incentives for the residual property insurance market to depopulation methods in other residual markets; and presents policy issues that may arise in response to the changing market.

6. **Deregulation of Workers' Compensation Pricing (Financial Services, 10/98)** Since 1981, more than 30 states have moved away from the more heavily regulated workers' compensation pricing system in effect in Florida today. They have adopted a more market-based system where insurers file their own expense and profit component, rate approval requirements are less restrictive, and rate variation methods are used. California and North Carolina are two of the most recent examples of states that have "deregulated" workers' compensation insurance ratemaking. Florida is one of only nine states where a rating organization still files one uniform full rate for the industry.

   The purpose of this report is to identify ways that the workers' compensation rating law could be changed to make the ratemaking process more market driven and increase opportunities for competitive pricing. To do so, the report examines the rating laws of seven states that have deregulated their workers' compensation ratemaking process.

7. **Mitigation: Reducing the Cost of Hurricanes in Florida (Financial Services, 10/97)** The report highlights mitigation activities underway in this state and in other states such as California, North Carolina and Indiana, as options for legislators to consider in appropriating mitigation funds. By working with the Florida Department of Community Affairs and the Institute for Business and Home Safety (formerly the Insurance Institute for Property Loss Reduction) and speaking with personnel from emergency management divisions around the state and nation, staff has prepared a reference guide describing selected mitigation activities.

8. **Consumer Impacts of Property Insurance Surcharges in Florida (Financial Services, 10/97)** The report describes the circumstances in which residential property insurance consumers in Florida may be required to pay surcharges which support the

insurance costs of other Florida consumers. The report is intended to provide legislators with information on questions such as to what extent are subsidies relied on to fund the residential property insurance system in Florida and how subsidy costs are distributed among Florida consumers?

9. **Issue Paper on Workers' Compensation Fraud (Financial Services, 11/97)** This issue paper addresses the following policy question: what additional steps, if any, can the Legislature take to reduce the incidence of workers' compensation fraud, and increase compliance with workers' compensation coverage requirements?

10. **Solvency Safeguards for Group Self-Insurance Funds (Financial Services, 11/97)** The report details the origin, growth, and present status of the group self-insurance funds (SIF) in Florida, compare state solvency regulations governing the SIF operations to those governing commercial carriers and to the NAIC Model Act on self-insurance fund regulation, and present agency, industry, and SIF perspectives on the adequacy of SIF solvency safeguards. This informational report identifies several arguments for the reader to consider both for and against future reform to the laws regulating self-insurance funds.

Selected Staff Reports Prior to 1996

11. **1993 Workers' Compensation Reform Context and Content (Commerce, 7/94)** Report provides a review of the Florida workers' compensation environment starting with the reform legislation in 1990 and 1991, but focuses mainly on the reforms passed during the 1993 Special Session.

12. **Florida's Property Insurance Crisis (Insurance, 11/94)** Report provides a crisis overview and chronology. Report also details joint underwriting associations, the Florida hurricane catastrophe fund, rating law issues, the moratorium on policy cancellations, and moratorium phaseout enforcement.

B. CONSUMER PUBLICATIONS AND SOURCES OF ASSISTANCE

*All documents listed are available from the respective department.

1. DEPARTMENT OF INSURANCE

Florida Department of Insurance, State Treasurer, and State Fire Marshal
(850) 922-3100

The Department of Insurance publishes the following informational consumer guides and brochures:

Automobile Insurance Consumers' Guide
Automobile Claims Mediation Program
Auto Rate Fact Sheet
Accelerated Death Benefits, Viatical Settlements and You
Boat Owner's Insurance
Health Insurance Consumers' Guide
Industrial Life Insurance
Insuring Your Home Consumers' Guide
Life Insurance and Annuities Consumers' Guide
Medicare Supplement Consumers' Guide
Mobile Home Tie Down Brochure
National Disasters
Options for Lifelong Care
Property Insurance Mediation Program
Small Business Owners' Insurance Consumers' Guide

Access to these publications is available by request to the Division of Insurance Consumer Services or on the department's web site: http://www.doi.state.fl.us

The department has two toll free telephone numbers, one for consumer's insurance complaints and the other for reporting suspicions of insurance fraud. The numbers are as follows:

1-800-342-2762	Insurance Consumer Helpline
1-800-378-0445	Insurance Fraud Hotline

The department's Division of Insurance Consumer Services maintains ten field offices located throughout the state. Consumer Field office locations and phone numbers are as follows:

Daytona Beach	(904) 254-3290	SC 380-3920
Plantation	(954) 327-6027	SC 423-6027
Fort Myers	(941) 332-6948	SC 748-6948
Jacksonville	(904) 727-5505	SC 841-5505
Miami	(305) 377-5235	SC 452-5235
Pensacola	(850) 595-8040	SC 695-8040
Orlando	(407) 245-0870	SC 344-0870
Largo	(727) 588-3638	SC 513-1922
Tampa	(813) 987-6741	SC 512-5019
West Palm Beach	(561) 681-6392	SC 256-6392

2. DEPARTMENT OF LABOR AND EMPLOYMENT SECURITY DIVISION OF WORKERS' COMPENSATION

Bureau of Research and Education
Annual Reports 850-488-5837
*Assessment of Florida's Workers' Compensation System through a Survey of Injured Worker 850-488-5837
*2000 Dispute Resolution Report850-488-5837
*Workplace Injuries by Risk Classification 850-488-5837
Defining, Measuring & Predicting Return to Work in Florida 850-488-5837
Workers' Compensation and You – Getting to Know the System 850-921-6966
Division of Workers' Compensation System Guide 850-921-6966
*Drug Free Workplace Standards 850-921-6966
*Employer Instructions for Completing the DWC-1 (first notice of injury or illness) 850-921-6966
*Employer's Guide to a Drug Free Workplace 850-921-6966
*Employer's Handbook 850-921-6966
*Florida WC Employer Information (revised 1999) 850-921-6966
*Workers' Compensation Insolvency Brochure 850-921-6966
*440 News 850-921-6966
Hurt at Work Brochure 850-921-6966
What Employees Need to Know About WC in Florida 850-921-6966

Special Disability Trust Fund
Facts about Florida's Special Disability Trust Fund 850-488-4896

Employee Assistance Office
Workers' Compensation Managed Care Arrangements 850-488-5201
Employee Assistance Office Early Intervention Program Employers Brochure 850-488-5201

Bureau of Rehabilitation and Medical Services
Employer Brochure 850-488-3431
Injured Worker Brochure 850-488-3431
*Florida WC Reimbursement Manual for Hospitals (1999 edition) 850-488-3431

1-800-342-1741	Injured Employee Hotline
1-850-921-6966	Employer Help Line
1-850-488-2333	Workers' Compensation Coverage Verification
1-800-742-2214	Employer Non-Compliance Hotline
1-800-378-0445	Department of Insurance Workers'Compensation Fraud

*Available from the Division's homepage www2.myflorida.com/les/wc/

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