A bill to be entitled

An act relating to a joint underwriting plan of insurers; amending s. 627.311, F.S.; revising provisions requiring the Office of Insurance Regulation to approve a joint underwriting plan for workers' compensation and employer's liability insurers; requiring plan rates to be noncompetitive with the voluntary market for certain purposes; deleting authorization for insureds to select certain alternative coverages; revising criteria, requirements, and limitations for certain required subplans; requiring participants in certain subplans to pay certain plan premiums plus a surcharge imposed by the plan's board of governors for certain purposes; deleting a surcharge limitation for certain organizations; revising criteria, requirements, and limitations for a required depopulation program to reduce numbers of insureds under certain subplans; revising certain subplan notice requirements; providing for funding of the plan through deficit funding; providing for a one-time capital contribution from the Workers' Compensation Administration Trust Fund to defray certain subplan deficits prior to certain assessments; authorizing the board of governors of the plan to levy assessments to cover certain subplan deficits under certain circumstances; providing criteria and limitations; providing an effective date.

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

Section 1. Paragraphs (a), (c), (d), and (g) of subsection (5) of section 627.311, Florida Statutes, are amended to read:

627.311 Joint underwriters and joint reinsurers; public records and public meetings exemptions.--

(5)(a) The office shall, after consultation with insurers, approve a joint underwriting plan of insurers which shall operate as a nonprofit entity. For the purposes of this subsection, the term "insurer" includes group self-insurance funds authorized by s. 624.4621, commercial self-insurance funds authorized by s. 624.462, assessable mutual insurers authorized under s. 628.6011, and insurers licensed to write workers' compensation and employer's liability insurance in this state. The purpose of the plan is to provide workers' compensation and employer's liability insurance to applicants who are required by law to maintain workers' compensation and employer's liability insurance and who are in good faith entitled to but who are unable to procure ~~purchase~~ such insurance through the voluntary market. The plan must have actuarially sound rates that are not competitive with approved voluntary market rates so that the plan functions as a residual market mechanism ~~assure that the plan is self-supporting~~.

(c) The operation of the plan shall be governed by a plan of operation that is prepared at the direction of the board of governors. The plan of operation may be changed at any time by the board of governors or upon request of the office. The plan of operation and all changes thereto are subject to the approval of the office. The plan of operation shall:

1. Authorize the board to engage in the activities necessary to implement this subsection, including, but not limited to, borrowing money.

2. Develop criteria for eligibility for coverage by the plan, including, but not limited to, documented rejection by at least two insurers which reasonably assures that insureds covered under the plan are unable to acquire coverage in the voluntary market. ~~Any insured may voluntarily elect to accept coverage from an insurer for a premium equal to or greater than the plan premium if the insurer writing the coverage adheres to the provisions of s. 627.171.~~

3. Require notice from the agent to the insured at the time of the application for coverage that the application is for coverage with the plan and that coverage may be available through an insurer, group self-insurers' fund, commercial self-insurance fund, or assessable mutual insurer through another agent at a lower cost.

4. Establish programs to encourage insurers to provide coverage to applicants of the plan in the voluntary market and to insureds of the plan, including, but not limited to:

a. Establishing procedures for an insurer to use in notifying the plan of the insurer's desire to provide coverage to applicants to the plan or existing insureds of the plan and in describing the types of risks in which the insurer is interested. The description of the desired risks must be on a form developed by the plan.

b. Developing forms and procedures that provide an insurer with the information necessary to determine whether the insurer wants to write particular applicants to the plan or insureds of the plan.

c. Developing procedures for notice to the plan and the applicant to the plan or insured of the plan that an insurer will insure the applicant or the insured of the plan, and notice of the cost of the coverage offered; and developing procedures for the selection of an insuring entity by the applicant or insured of the plan.

d. Provide for a market-assistance plan to assist in the placement of employers. All applications for coverage in the plan received 45 days before the effective date for coverage shall be processed through the market-assistance plan. A market-assistance plan specifically designed to serve the needs of small, good policyholders as defined by the board must be finalized by January 1, 1994.

5. Provide for policy and claims services to the insureds of the plan of the nature and quality provided for insureds in the voluntary market.

6. Provide for the review of applications for coverage with the plan for reasonableness and accuracy, using any available historic information regarding the insured.

7. Provide for procedures for auditing insureds of the plan which are based on reasonable business judgment and are designed to maximize the likelihood that the plan will collect the appropriate premiums.

8. Authorize the plan to terminate the coverage of and refuse future coverage for any insured that submits a fraudulent application to the plan or provides fraudulent or grossly

erroneous records to the plan or to any service provider of the plan in conjunction with the activities of the plan.

9. Establish service standards for agents who submit business to the plan.

10. Establish criteria and procedures to prohibit any agent who does not adhere to the established service standards from placing business with the plan or receiving, directly or indirectly, any commissions for business placed with the plan.

11. Provide for the establishment of reasonable safety programs for all insureds in the plan. All insureds of the plan must participate in the safety program.

12. Authorize the plan to terminate the coverage of and refuse future coverage to any insured who fails to pay premiums or surcharges when due; who, at the time of application, is delinquent in payments of workers' compensation or employer's liability insurance premiums or surcharges owed to an insurer, group self-insurers' fund, commercial self-insurance fund, or assessable mutual insurer licensed to write such coverage in this state; or who refuses to substantially comply with any safety programs recommended by the plan.

13. Authorize the board of governors to provide the services required by the plan through staff employed by the plan, through reasonably compensated service providers who contract with the plan to provide services as specified by the board of governors, or through a combination of employees and service providers.

14. Provide for service standards for service providers, methods of determining adherence to those service standards, incentives and disincentives for service, and procedures for

terminating contracts for service providers that fail to adhere to service standards.

15. Provide procedures for selecting service providers and standards for qualification as a service provider that reasonably assure that any service provider selected will continue to operate as an ongoing concern and is capable of providing the specified services in the manner required.

16. Provide for reasonable accounting and data-reporting practices.

17. Provide for annual review of costs associated with the administration and servicing of the policies issued by the plan to determine alternatives by which costs can be reduced.

18. Authorize the acquisition of such excess insurance or reinsurance as is consistent with the purposes of the plan.

19. Provide for an annual report to the office on a date specified by the office and containing such information as the office reasonably requires.

20. Establish multiple rating plans for various classifications of risk which reflect risk of loss, hazard grade, actual losses, size of premium, and compliance with loss control. At least one of such plans must be a preferred-rating plan to accommodate small-premium policyholders with good experience as defined in sub-subparagraph 22.a.

21. Establish agent commission schedules.

22. Establish four subplans as follows:

a. Subplan "A" must include those insureds whose manual ~~annual~~ premium does not exceed $20,000 at the time of application, ~~$2,500 and~~ who have neither incurred any lost-time claims nor incurred medical-only claims exceeding 20 ~~50~~ percent of their premium for the immediately preceding 3 ~~immediate 2~~ years of available data, and who have an experience modification factor of 1.05 or less. The rate plan for subplan "A" shall be the same rate plan as the plan approved under ss.627.091-627.151, and each participant in subplan "A" shall pay the premium determined under such rate plan, plus a surcharge determined by the board to be sufficient to ensure that the plan does not compete with the voluntary market rate for any participant, but not to exceed 25 percent.

b. Subplan "B" must include insureds that are employers identified by the board of governors as high-risk employers due solely to the nature of the operations being performed by those insureds ~~and for whom no market exists in the voluntary market,~~ and who have an ~~whose~~ experience modification factor of ~~modifications are less than~~ 1.00 or less. The rate plan for subplan "B" shall be the same rate plan as the plan approved under ss.627.091-627.151, and each participant in subplan "B" shall pay the premium determined under such rate plan, plus a surcharge determined by the board to be sufficient to ensure that the plan does not compete with the voluntary market rate for any participant, but not to exceed 50 percent.

c. Subplan "C" must include all insureds within the plan that are not eligible for subplan "A," subplan "B," or subplan "D." The rates for subplan "C" shall be actuarially sound to assure that subplan "C" is self-supporting.

d. Subplan "D" must include any employer, regardless of the length of time for which it has conducted business operations, which has an experience modification factor of 1.10 or less and either employs 15 or fewer employees or is an organization that is exempt from federal income tax pursuant to s. 501(c)(3) of the Internal Revenue Code and receives more than 50 percent of its funding from gifts, grants, endowments, or federal or state contracts. The rate plan for subplan "D" shall be the same rate plan as the plan approved under ss. 627.091-627.151, and each participant in subplan "D" shall pay the premium determined under such rate plan, plus a surcharge determined by the board to be sufficient to ensure that the plan does not compete with the voluntary market rate for any participant, but not to exceed 35 ~~25~~ percent. ~~However, the surcharge shall not exceed 10 percent for an organization that is exempt from federal income tax pursuant to s. 501(c)(3) of the Internal Revenue Code.~~

23. Provide for a depopulation program to reduce the number of insureds in subplans "A," "B," and ~~subplan~~ "D." If an employer insured through subplan "A," subplan "B," or subplan "D" is offered coverage from a voluntary market carrier:

a. During the first 30 days of coverage under the subplan;

b. Before a policy is issued under the subplan;

c. Effective ~~By issuance of a policy~~ upon the renewal date ~~expiration or cancellation~~ of the policy under the subplan; or

d. By assumption of the subplan's obligation with respect to an in-force policy,

that employer is no longer eligible for coverage through the plan. As part of the depopulation program, ~~The premium for risks assumed by~~ the voluntary market carrier may offer the employer coverage at approved voluntary market ~~must be the same~~ premium plus, for the first 2 years, the surcharge ~~as~~ determined for the subplan in which the employer is insured ~~in sub-subparagraph 22.d~~. A premium under this subparagraph, including surcharge, for an offer of coverage by a voluntary market carrier is deemed approved and is not an excess premium for purposes of s. 627.171.

24. Require that policies issued under subplans "A," "B," and ~~subplan~~ "D" and applications for such policies must include a notice that the policy issued under subplan "A," subplan "B," or subplan "D" could be replaced by a policy issued from a voluntary market carrier and that, if an offer of coverage is obtained from a voluntary market carrier, the policyholder is no longer eligible for coverage through subplan "D." The notice must also specify that acceptance of coverage under subplan "A," subplan "b," or subplan "D" creates a conclusive presumption that the applicant or policyholder is aware of this potential.

(d)1. The plan must be funded through actuarially sound premiums charged to insureds of the plan and deficit funding as provided for in paragraph (g). However, a one-time capital contribution is appropriated from the Workers' Compensation Administration Trust Fund in the amount of $10 million to defray any deficit in subplans "A," "B," and "D" prior to levying assessments.

2. The plan may issue assessable policies only to those insureds in subplan ~~subplans~~ "C." ~~and "D."~~ Subject to verification by the department, the board may levy assessments against insureds in subplan "C" ~~or subplan "D~~," on a pro rata earned premium basis, to fund any deficits that exist in those subplans. Assessments levied against subplan "C" participants shall cover only the deficits attributable to subplan "C~~," and~~

~~assessments levied against subplan "D" participants shall cover only the deficits attributable to subplan "D~~." In no event may the plan levy assessments against any person or entity, except as authorized by this paragraph for deficits attributable to subplan "C." Those assessable policies must be clearly identified as assessable by containing, in contrasting color and in not less than 10-point type, the following statements: "This is an assessable policy. If the plan is unable to pay its obligations, policyholders will be required to contribute on a pro rata earned premium basis the money necessary to meet any assessment levied."

~~3. The plan may issue assessable policies with differing terms and conditions to different groups within subplans "C" and "D" when a reasonable basis exists for the differentiation.~~

3.~~4.~~ The plan may offer rating, dividend plans, and other plans to encourage loss prevention programs.

(g) Whenever a deficit exists in subplan "A," subplan "B," or subplan "D," the board shall levy, after verification by the office, assessments for as many years as necessary to cover the deficits but not to exceed 2 percent of premium annually to be collected by insurers to be paid by their workers' compensation policyholders in this state on a pro rata basis as a line item in addition to the calculated premium. Whenever a deficit exists in subplan "C," the plan shall, within 90 days, provide the office with a program to eliminate the deficit within a reasonable time. The deficit in subplan "C" may be funded through increased premiums charged to insureds of the plan for subsequent years, through the use of policyholder surplus attributable to any year, and through assessments on insureds in the plan ~~if the plan uses assessable policies~~.

Section 2. This act shall take effect upon becoming a law.