1 A bill to be entitled
2 An act relating to a joint underwriting plan of insurers;
3 amending s. 627.311, F.S.; revising provisions requiring the
4 Office of Insurance Regulation to approve a joint underwriting
5 plan for workers' compensation and employer's liability
6 insurers; requiring plan rates to be noncompetitive with the
7 voluntary market for certain purposes; deleting authorization
8 for insureds to select certain alternative coverages; requiring
9 the plan of operation to establish three tiers for eligible
10 employers; specifying criteria and rates for each tier; deleting
11 provisions requiring establishment of certain subplans;
12 providing criteria for minimum premium policies; providing
13 requirements for premiums under such tiers; revising criteria,
14 requirements, and limitations for a required depopulation
15 program to reduce numbers of insureds under the tiers; providing
16 an application fee for administration and fraud prevention;
17 revising certain tier notice requirements; providing for funding
18 of the plan through deficit funding; providing for transferring
19 an appropriation in an amount not to exceed $10 million from the
20 Workers' Compensation Administration Trust Fund to the workers'
21 compensation joint underwriting plan for certain purposes;
22 providing procedures and requirements; providing for
23 establishing a contingency reserve for certain purposes;
24 providing for transfers of funds from the contingency reserve in
25 an amount not to exceed $10 million to the plan for purposes of
26 funding certain deficits; providing limitations; providing for
27 review of the reasonableness of the plan's administration;
28 providing a sunset date for deficit funding; providing a

29 mechanism for collecting deficit assessments; providing duties
30 of the office; providing requirements, procedures, and
31 limitations for collecting and enforcing deficit assessments;
32 providing for transfers of funds from the Workers' Compensation
33 Administration Trust Fund to the plan under certain
34 circumstances; providing an exclusion for deficit assessments
35 from certain taxes; specifying that deficit assessments are plan
36 funds when collected; providing notice requirements for certain
37 policies; providing for liability of certain insureds for
38 certain additional deficit assessments; specifying venue for
39 proceedings to enforce or collect assessments; expanding a
40 prohibition against providing certain persons with workers'
41 compensation and employers' liability insurance; providing an
42 exclusion for the plan from certain taxes and assessments;
43 requiring the Auditor General to conduct an operational audit of
44 the association; providing audit requirements; requiring the
45 association to comply with the Florida Single Audit Act, if
46 certain conditions are met; requiring a report; providing
47 appropriations; providing an exception from certain deficit
48 funding assessment provisions; providing a procedure for a
49 transition period; providing application; providing an effective
50 date.
51
52 Be It Enacted by the Legislature of the State of Florida:
53
54 Section 1. Paragraphs (a), (c), (d), (e), (g), and (p) of
55 subsection (5) of section 627.311, Florida Statutes, are
56 amended, and paragraph (q) is added to said subsection, to read:

57 627.311 Joint underwriters and joint reinsurers; public
58 records and public meetings exemptions.--
59 (5)(a) The office shall, after consultation with insurers,
60 approve a joint underwriting plan of insurers which shall
61 operate as a nonprofit entity. For the purposes of this
62 subsection, the term "insurer" includes group self-insurance
63 funds authorized by s. 624.4621, commercial self-insurance funds
64 authorized by s. 624.462, assessable mutual insurers authorized
65 under s. 628.6011, and insurers licensed to write workers'
66 compensation and employer's liability insurance in this state.
67 The purpose of the plan is to provide workers' compensation and
68 employer's liability insurance to applicants who are required by
69 law to maintain workers' compensation and employer's liability
70 insurance and who are in good faith entitled to but who are
71 unable to procure ~~purchase~~ such insurance through the voluntary
72 market. Except as provided herein, the plan must have
73 actuarially sound rates that ensure ~~assure~~ that the plan is
74 self-supporting.
75 (c) The operation of the plan shall be governed by a plan
76 of operation that is prepared at the direction of the board of
77 governors. The plan of operation may be changed at any time by
78 the board of governors or upon request of the office. The plan
79 of operation and all changes thereto are subject to the approval
80 of the office. The plan of operation shall:
81 1. Authorize the board to engage in the activities
82 necessary to implement this subsection, including, but not
83 limited to, borrowing money.

84 2. Develop criteria for eligibility for coverage by the
85 plan, including, but not limited to, documented rejection by at
86 least two insurers which reasonably assures that insureds
87 covered under the plan are unable to acquire coverage in the
88 voluntary market. ~~Any insured may voluntarily elect to accept~~
89 ~~coverage from an insurer for a premium equal to or greater than~~
90 ~~the plan premium if the insurer writing the coverage adheres to~~
91 ~~the provisions of s. 627.171.~~
92 3. Require notice from the agent to the insured at the
93 time of the application for coverage that the application is for
94 coverage with the plan and that coverage may be available
95 through an insurer, group self-insurers' fund, commercial self-
96 insurance fund, or assessable mutual insurer through another
97 agent at a lower cost.
98 4. Establish programs to encourage insurers to provide
99 coverage to applicants of the plan in the voluntary market and
100 to insureds of the plan, including, but not limited to:
101 a. Establishing procedures for an insurer to use in
102 notifying the plan of the insurer's desire to provide coverage
103 to applicants to the plan or existing insureds of the plan and
104 in describing the types of risks in which the insurer is
105 interested. The description of the desired risks must be on a
106 form developed by the plan.
107 b. Developing forms and procedures that provide an insurer
108 with the information necessary to determine whether the insurer
109 wants to write particular applicants to the plan or insureds of
110 the plan.

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111 c. Developing procedures for notice to the plan and the
112 applicant to the plan or insured of the plan that an insurer
113 will insure the applicant or the insured of the plan, and notice
114 of the cost of the coverage offered; and developing procedures
115 for the selection of an insuring entity by the applicant or
116 insured of the plan.
117 d. Provide for a market-assistance plan to assist in the
118 placement of employers. All applications for coverage in the
119 plan received 45 days before the effective date for coverage
120 shall be processed through the market-assistance plan. A market-
121 assistance plan specifically designed to serve the needs of
122 small, good policyholders as defined by the board must be
123 finalized by January 1, 1994.
124 5. Provide for policy and claims services to the insureds
125 of the plan of the nature and quality provided for insureds in
126 the voluntary market.
127 6. Provide for the review of applications for coverage
128 with the plan for reasonableness and accuracy, using any
129 available historic information regarding the insured.
130 7. Provide for procedures for auditing insureds of the
131 plan which are based on reasonable business judgment and are
132 designed to maximize the likelihood that the plan will collect
133 the appropriate premiums.
134 8. Authorize the plan to terminate the coverage of and
135 refuse future coverage for any insured that submits a fraudulent
136 application to the plan or provides fraudulent or grossly
137 erroneous records to the plan or to any service provider of the
138 plan in conjunction with the activities of the plan.

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139 9. Establish service standards for agents who submit
140 business to the plan.
141 10. Establish criteria and procedures to prohibit any
142 agent who does not adhere to the established service standards
143 from placing business with the plan or receiving, directly or
144 indirectly, any commissions for business placed with the plan.
145 11. Provide for the establishment of reasonable safety
146 programs for all insureds in the plan. All insureds of the plan
147 must participate in the safety program.
148 12. Authorize the plan to terminate the coverage of and
149 refuse future coverage to any insured who fails to pay premiums
150 or surcharges when due; who, at the time of application, is
151 delinquent in payments of workers' compensation or employer's
152 liability insurance premiums or surcharges owed to an insurer,
153 group self-insurers' fund, commercial self-insurance fund, or
154 assessable mutual insurer licensed to write such coverage in
155 this state; or who refuses to substantially comply with any
156 safety programs recommended by the plan.
157 13. Authorize the board of governors to provide the
158 services required by the plan through staff employed by the
159 plan, through reasonably compensated service providers who
160 contract with the plan to provide services as specified by the
161 board of governors, or through a combination of employees and
162 service providers.
163 14. Provide for service standards for service providers,
164 methods of determining adherence to those service standards,
165 incentives and disincentives for service, and procedures for

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166 terminating contracts for service providers that fail to adhere
167 to service standards.
168 15. Provide procedures for selecting service providers and
169 standards for qualification as a service provider that
170 reasonably assure that any service provider selected will
171 continue to operate as an ongoing concern and is capable of
172 providing the specified services in the manner required.
173 16. Provide for reasonable accounting and data-reporting
174 practices.
175 17. Provide for annual review of costs associated with the
176 administration and servicing of the policies issued by the plan
177 to determine alternatives by which costs can be reduced.
178 18. Authorize the acquisition of such excess insurance or
179 reinsurance as is consistent with the purposes of the plan.
180 19. Provide for an annual report to the office on a date
181 specified by the office and containing such information as the
182 office reasonably requires.
183 20. Establish multiple rating plans for various
184 classifications of risk which reflect risk of loss, hazard
185 grade, actual losses, size of premium, and compliance with loss
186 control. At least one of such plans must be a preferred-rating
187 plan to accommodate small-premium policyholders with good
188 experience as defined in sub-subparagraph 22.a.
189 21. Establish agent commission schedules.
190 22. <u>For employers otherwise eligible for coverage under</u>
191 <u>the plan, establish three tiers of employers meeting the</u>
192 <u>criteria and subject to the rate limitations specified in this</u>
193 <u>subparagraph.</u> ~~Establish four subplans as follows:~~

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194 a. Tier One.--
195 (I) Criteria; rated employers.--An employer that has an
196 experience modification rating shall be included in Tier One if
197 the employer meets all of the following:
198 (A) The experience modification is below 1.00.
199 (B) The employer had no lost-time claims subsequent to the
200 applicable experience modification rating period.
201 (C) The total of the employer's medical-only claims
202 subsequent to the applicable experience modification rating
203 period did not exceed 20 percent of premium.
204 (II) Criteria; non-rated employers.--An employer that does
205 not have an experience modification rating shall be included in
206 Tier One if the employer meets all of the following:
207 (A) The employer had no lost-time claims for the 3-year
208 period immediately preceding the inception date or renewal date
209 of the employer's coverage under the plan.
210 (B) The total of the employer's medical-only claims for
211 the 3-year period immediately preceding the inception date or
212 renewal date of the employer's coverage under the plan did not
213 exceed 20 percent of premium.
214 (C) The employer has secured workers' compensation
215 coverage for the entire 3-year period immediately preceding the
216 inception date or renewal date of the employer's coverage under
217 the plan.
218 (D) The employer is able to provide the plan with a loss
219 history generated by the employer's prior workers' compensation
220 insurer, except if the employer is not able to produce a loss
221 history due to the insolvency of an insurer, the receiver shall

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222 provide to the plan, upon the request of the employer or the
223 employer's agent, a copy of the employer's loss history from the
224 records of the insolvent insurer if the loss history is
225 contained in records of the insurer which are in the possession
226 of the receiver. If the receiver is unable to produce the loss
227 history, the employer may, in lieu of the loss history, submit
228 an affidavit from the employer and the employer's insurance
229 agent setting forth the loss history.
230 (E) The employer is not a new business.
231 (III) Premiums.--The premiums for Tier One insureds shall
232 be set at a premium level 25 percent above the comparable
233 voluntary market premiums until the plan has sufficient
234 experience as determined by the board to establish an
235 actuarially sound rate for Tier One, at which point the board
236 shall, subject to paragraph (e), adjust the rates, if necessary,
237 to produce actuarially sound rates, provided such rate
238 adjustment shall not take effect prior to January 1, 2007.
239 Subplan "A" must include those insureds whose annual premium
240 does not exceed $2,500 and who have neither incurred any lost-
241 time claims nor incurred medical-only claims exceeding 50
242 percent of their premium for the immediate 2 years.
243 b. Tier Two.--
244 (I) Criteria; rated employers.--An employer that has an
245 experience modification rating shall be included in Tier Two if
246 the employer meets all of the following:
247 (A) The experience modification is equal to or greater
248 than 1.00 but not greater than 1.10.

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249 (B) The employer had no lost-time claims subsequent to the
250 applicable experience modification rating period.
251 (C) The total of the employer's medical-only claims
252 subsequent to the applicable experience modification rating
253 period did not exceed 20 percent of premium.
254 (II) Criteria; non-rated employers.--An employer that does
255 not have any experience modification rating shall be included in
256 Tier Two if the employer is a new business. An employer shall be
257 included in Tier Two if the employer has less than 3 years of
258 loss experience in the 3-year period immediately preceding the
259 inception date or renewal date of the employer's coverage under
260 the plan and the employer meets all of the following:
261 (A) The employer had no lost-time claims for the 3-year
262 period immediately preceding the inception date or renewal date
263 of the employer's coverage under the plan.
264 (B) The total of the employer's medical-only claims for
265 the 3-year period immediately preceding the inception date or
266 renewal date of the employer's coverage under the plan did not
267 exceed 20 percent of premium.
268 (C) The employer is able to provide the plan with a loss
269 history generated by the workers' compensation insurer that
270 provided coverage for the portion or portions of such period
271 during which the employer had secured workers' compensation
272 coverage, except if the employer is not able to produce a loss
273 history due to the insolvency of an insurer, the receiver shall
274 provide to the plan, upon the request of the employer or the
275 employer's agent, a copy of the employer's loss history from the
276 records of the insolvent insurer if the loss history is

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277 contained in records of the insurer which are in the possession
278 of the receiver. If the receiver is unable to produce the loss
279 history, the employer may, in lieu of the loss history, submit
280 an affidavit from the employer and the employer's insurance
281 agent setting forth the loss history.
282 (III) Premiums.--The premiums for Tier Two insureds shall
283 be set at a rate level 50 percent above the comparable voluntary
284 market premiums until the plan has sufficient experience as
285 determined by the board to establish an actuarially sound rate
286 for Tier Two, at which point the board shall, subject to
287 paragraph (e), adjust the rates, if necessary, to produce
288 actuarially sound rates, provided such rate adjustment shall not
289 take effect prior to January 1, 2007. Subplan "B" must include
290 insureds that are employers identified by the board of governors
291 as high-risk employers due solely to the nature of the
292 operations being performed by those insureds and for whom no
293 market exists in the voluntary market, and whose experience
294 modifications are less than 1.00.
295 c. Tier Three.--
296 (I) Eligibility.--An employer shall be included in Tier
297 Three if the employer does not meet the criteria for Tier One or
298 Tier Two.
299 (II) Rates.--The board shall establish, subject to
300 paragraph (e), and the plan shall charge, actuarially sound
301 rates for Tier Three insureds. Subplan "C" must include all
302 insureds within the plan that are not eligible for subplan "A,"
303 subplan "B," or subplan "D."

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304 ~~d. Subplan "D" must include any employer, regardless of~~
305 ~~the length of time for which it has conducted business~~
306 ~~operations, which has an experience modification factor of 1.10~~
307 ~~or less and either employs 15 or fewer employees or is an~~
308 ~~organization that is exempt from federal income tax pursuant to~~
309 ~~s. 501(c)(3) of the Internal Revenue Code and receives more than~~
310 ~~50 percent of its funding from gifts, grants, endowments, or~~
311 ~~federal or state contracts. The rate plan for subplan "D" shall~~
312 ~~be the same rate plan as the plan approved under ss. 627.091-~~
313 ~~627.151, and each participant in subplan "D" shall pay the~~
314 ~~premium determined under such rate plan, plus a surcharge~~
315 ~~determined by the board to be sufficient to ensure that the plan~~
316 ~~does not compete with the voluntary market rate for any~~
317 ~~participant, but not to exceed 25 percent. However, the~~
318 ~~surcharge shall not exceed 10 percent for an organization that~~
319 ~~is exempt from federal income tax pursuant to s. 501(c)(3) of~~
320 ~~the Internal Revenue Code.~~
321 23. For Tier One or Tier Two employers which employ no
322 nonexempt employees or which report payroll which is less than
323 the minimum wage hourly rate for one full-time employee for 1
324 year at 40 hours per week, the plan shall establish actuarially
325 sound premiums, provided, however, that the premiums may not
326 exceed $2,500. These premiums shall be in addition to the fee
327 specified in subparagraph 26. When the plan establishes
328 actuarially sound rates for all employers in Tier One and Tier
329 Two, the premiums for employers referred to in this paragraph
330 are no longer subject to the $2,500 cap.

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331 24.~~23.~~ Provide for a depopulation program to reduce the
332 number of insureds in the plan ~~subplan "D."~~ If an employer
333 insured through the plan ~~subplan "D"~~ is offered coverage from a
334 voluntary market carrier:
335 a. During the first 30 days of coverage under the plan
336 ~~subplan~~;
337 b. Before a policy is issued under the plan ~~subplan~~;
338 c. By issuance of a policy upon expiration or cancellation
339 of the policy under the plan ~~subplan~~; or
340 d. By assumption of the plan's ~~subplan's~~ obligation with
341 respect to an in-force policy,
342
343 that employer is no longer eligible for coverage through the
344 plan. The premium for risks assumed by the voluntary market
345 carrier must be no greater than the ~~same~~ premium ~~plus, for the~~
346 ~~first 2 years, the surcharge as~~ the insured would have paid
347 under the plan, and shall be adjusted upon renewal to reflect
348 changes in the plan rates and the tier for which the insured
349 would qualify as of the time of renewal. The insured may be
350 charged such premiums only for the first 3 years of coverage in
351 the voluntary market. ~~determined in sub-subparagraph 22.d~~. A
352 premium under this subparagraph~~, including surcharge,~~ is deemed
353 approved and is not an excess premium for purposes of s.
354 627.171.
355 25.~~24.~~ Require that policies issued ~~under subplan "D"~~ and
356 applications ~~for such policies~~ must include a notice that the
357 policy ~~issued under subplan "D"~~ could be replaced by a policy
358 issued from a voluntary market carrier and that, if an offer of

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359 coverage is obtained from a voluntary market carrier, the
360 policyholder is no longer eligible for coverage through the plan
361 subplan "D." The notice must also specify that acceptance of
362 coverage under the plan subplan "D" creates a conclusive
363 presumption that the applicant or policyholder is aware of this
364 potential.
365 26. Require that each application for coverage and each
366 renewal premium be accompanied by a nonrefundable fee of $475 to
367 cover costs of administration and fraud prevention. The board
368 may, with the approval of the office, increase the amount of the
369 fee pursuant to a rate filing to reflect increased costs of
370 administration and fraud prevention. The fee is not subject to
371 commission and is fully earned upon commencement of coverage.
372 (d)1. The funding of the plan shall include premiums as
373 provided in subparagraph (c)22. and assessments as provided in
374 this paragraph. The plan must be funded through actuarially
375 sound premiums charged to insureds of the plan.
376 2.a. If the board determines that a deficit exists in Tier
377 One or Tier Two or that there is any deficit remaining
378 attributable to any of the plan's former subplans and that the
379 deficit cannot be funded without the use of deficit assessments,
380 the board shall request the office to levy, by order, a deficit
381 assessment against premiums charged to insureds for workers'
382 compensation insurance by insurers as defined in s. 631.904(5).
383 The office shall issue the order after verifying the amount of
384 the deficit. The assessment shall be specified as a percentage
385 of future premium collections, as recommended by the board and
386 approved by the office. The same percentage shall apply to

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387 premiums on all workers' compensation policies issued or renewed
388 during the 12-month period beginning on the effective date of
389 the assessment, as specified in the order.
390 b. With respect to each insurer collecting premiums that
391 are subject to the assessment, the insurer shall collect the
392 assessment at the same time as the insurer collects the premium
393 payment for each policy and shall remit the assessments
394 collected to the plan as provided in the order issued by the
395 office. The office shall verify the accurate and timely
396 collection and remittance of deficit assessments and shall
397 report such information to the board. Each insurer collecting
398 assessments shall provide such information with respect to
399 premiums and collections as may be required by the office to
400 enable the office to monitor and audit compliance with this
401 paragraph.
402 c. Deficit assessments are not considered part of an
403 insurer's rate, are not premium, and are not subject to the
404 premium tax, to the assessments under ss. 440.49 and 440.51, to
405 the surplus lines tax, to any fees, or to any commissions. The
406 deficit assessment imposed shall become plan funds at the moment
407 of collection and shall not constitute income to the insurer for
408 any purpose, including financial reporting on the insurer's
409 income statement. An insurer is liable for all assessments that
410 the insurer collects and must treat the failure of an insured to
411 pay an assessment as a failure to pay premium. An insurer is not
412 liable for uncollectible assessments.

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413 d. When an insurer is required to return unearned premium,
414 the insurer shall also return any collected assessments
415 attributable to the unearned premium.
416 e. Deficit assessments as described in this subparagraph
417 shall not be levied after July 1, 2007. The plan may issue
418 assessable policies only to those insureds in subplans "C" and
419 "D." Subject to verification by the department, the board may
420 levy assessments against insureds in subplan "C" or subplan "D,"
421 on a pro rata earned premium basis, to fund any deficits that
422 exist in those subplans. Assessments levied against subplan "C"
423 participants shall cover only the deficits attributable to
424 subplan "C," and assessments levied against subplan "D"
425 participants shall cover only the deficits attributable to
426 subplan "D." In no event may the plan levy assessments against
427 any person or entity, except as authorized by this paragraph.
428 Those assessable policies must be clearly identified as
429 assessable by containing, in contrasting color and in not less
430 than 10-point type, the following statements: "This is an
431 assessable policy. If the plan is unable to pay its obligations,
432 policyholders will be required to contribute on a pro rata
433 earned premium basis the money necessary to meet any assessment
434 levied."
435 3.a. All policies issued to Tier Three insureds shall be
436 assessable. All Tier Three assessable policies must be clearly
437 identified as assessable by containing, in contrasting color and
438 in not less than 10-point type, the following statement:
439

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440 "This is an assessable policy. If the plan is unable to
441 pay its obligations, policyholders will be required to
442 contribute on a pro rata earned premium basis the money
443 necessary to meet any assessment levied."
444
445 b. The board may from time to time assess Tier Three
446 insureds to whom the plan has issued assessable policies for the
447 purpose of funding plan deficits. Any such assessment shall be
448 based upon a reasonable actuarial estimate of the amount of the
449 deficit, taking into account the amount needed to fund medical
450 and indemnity reserves and reserves for incurred but not
451 reported claims, and allowing for general administrative
452 expenses, the cost of levying and collecting the assessment, a
453 reasonable allowance for estimated uncollectible assessments,
454 and allocated and unallocated loss adjustment expenses.
455 c. Each Tier Three insured's share of a deficit shall be
456 computed by applying to the premium earned on the insured's
457 policy or policies during the period to be covered by the
458 assessment the ratio of the total deficit to the total premiums
459 earned during such period upon all policies subject to the
460 assessment. If one or more Tier Three insureds fail to pay an
461 assessment, the other Tier Three insureds shall be liable on a
462 proportionate basis for additional assessments to fund the
463 deficit. The plan may compromise and settle individual
464 assessment claims without affecting the validity of or amounts
465 due on assessments levied against other insureds. The plan may
466 offer and accept discounted payments for assessments which are
467 promptly paid. The plan may offset the amount of any unpaid

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468 assessment against unearned premiums which may otherwise be due
469 to an insured. The plan shall institute legal action when
470 necessary and appropriate to collect the assessment from any
471 insured who fails to pay an assessment when due.
472 d. The venue of a proceeding to enforce or collect an
473 assessment or to contest the validity or amount of an assessment
474 shall be in the Circuit Court of Leon County.
475 e. If the board finds that a deficit in Tier Three exists
476 for any period and that an assessment is necessary, the board
477 shall certify to the office the need for an assessment. No
478 sooner than 30 days after the date of such certification, the
479 board shall notify in writing each insured who is to be assessed
480 that an assessment is being levied against the insured, and
481 informing the insured of the amount of the assessment, the
482 period for which the assessment is being levied, and the date by
483 which payment of the assessment is due. The board shall
484 establish a date by which payment of the assessment is due,
485 which shall be no sooner than 30 days nor later than 120 days
486 after the date on which notice of the assessment is mailed to
487 the insured.
488 f. Whenever the board makes a determination that the plan
489 does not have a sufficient cash basis to meet 3 months of
490 projected cash needs due to a deficit in Tier Three, the board
491 may request the department to transfer funds from the Workers'
492 Compensation Administration Trust Fund to the plan in an amount
493 sufficient to fund the difference between the amount available
494 and the amount needed to meet a 3-month projected cash need as
495 determined by the board and verified by the office, subject to

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496 the approval of the Legislative Budget Commission. If the
497 Legislative Budget Commission approves a transfer of funds under
498 this sub-subparagraph, the plan shall report to the Legislature
499 the transfer of funds and the Legislature shall review the plan
500 during the next legislative session or the current legislative
501 session, if the transfer occurs during a legislative session.
502 This sub-subparagraph shall not apply until the plan determines
503 and the office verifies that assessments collected by the plan
504 pursuant to sub-subparagraph b. are insufficient to fund the
505 deficit in Tier Three and to meet 3 months of projected cash
506 needs. ~~The plan may issue assessable policies with differing~~
507 ~~terms and conditions to different groups within subplans "C" and~~
508 ~~"D" when a reasonable basis exists for the differentiation.~~
509 4. The plan may offer rating, dividend plans, and other
510 plans to encourage loss prevention programs.
511 (e) The plan shall establish and use its rates and rating
512 plans, and the plan may establish and use changes in rating
513 plans at any time, but no more frequently than two times per any
514 rating class for any calendar year. By December 1, 1993, and
515 December 1 of each year thereafter, except as provided in
516 subparagraph (c)22., the board shall establish and use
517 actuarially sound rates for use by the plan to assure that the
518 plan is self-funding while those rates are in effect. Such rates
519 and rating plans must be filed with the office within 30
520 calendar days after their effective dates, and shall be
521 considered a "use and file" filing. Any disapproval by the
522 office must have an effective date that is at least 60 days from
523 the date of disapproval of the rates and rating plan and must

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524 have prospective effect only. The plan may not be subject to any
525 order by the office to return to policyholders any portion of
526 the rates disapproved by the office. The office may not
527 disapprove any rates or rating plans unless it demonstrates that
528 such rates and rating plans are excessive, inadequate, or
529 unfairly discriminatory.

530 (g) Whenever a deficit exists, the plan shall, within 90
531 days, provide the office with a program to eliminate the deficit
532 within a reasonable time. The deficit may be funded through
533 increased premiums charged to insureds of the plan for
534 subsequent years, through the use of policyholder surplus
535 attributable to any year, through the use of assessments as
536 provided in subparagraph (d)2., and through assessments on
537 ~~insureds in the plan if the plan uses~~ assessable policies as
538 provided in subparagraph (d)3.

539 (p) No insurer shall provide workers' compensation and
540 employer's liability insurance to any person who is delinquent
541 in the payment of premiums, assessments, penalties, or
542 surcharges owed to the plan or to any person who is an
543 affiliated person of a person who is delinquent in the payment
544 of premiums, assessments, penalties, or surcharges owed to the
545 plan. For purposes of this paragraph, the term "affiliated
546 person" of another person means:

547 1. The spouse of such other natural person;

548 2. Any person who directly or indirectly owns or controls,
549 or holds with the power to vote, 5 percent or more of the
550 outstanding voting securities of such other person;

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551 3. Any person who directly or indirectly owns 5 percent or
552 more of the outstanding voting securities that are directly or
553 indirectly owned or controlled, or held with the power to vote,
554 by such other person;
555 4. Any person or group of persons who directly or
556 indirectly control, are controlled by, or are under common
557 control with such other person;
558 5. Any officer, director, trustee, partner, owner,
559 manager, joint venturer, or employee, or other person performing
560 duties similar to persons in those positions, of such other
561 persons; or
562 6. Any person who has an officer, director, trustee,
563 partner, or joint venturer in common with such other person.
564 (q) Effective July 1, 2004, the plan is exempt from the
565 premium tax under s. 624.509 and any assessments under ss.
566 440.49 and 440.51.
567 Section 2. Notwithstanding the provisions of sections
568 440.50 and 440.51, Florida Statutes, for the 2004-2005 fiscal
569 year the sum of $10 million is appropriated from the Workers'
570 Compensation Administration Trust Fund in the Department of
571 Financial Services for transfer to the workers' compensation
572 joint underwriting plan provided in section 627.311(5), Florida
573 Statutes, as a capital contribution to fund any deficit in the
574 plan. The Chief Financial Officer shall transfer such funds to
575 the plan no later than July 31, 2004.
576 Notwithstanding the provisions of ss. 440.50 and 440.51,
577 Florida Statutes, subject to the following procedures and
578 approval, the Department of Financial Services may request

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579 transfer funds from the Workers' Compensation Administration
580 Trust Fund within the Department of Financial Services to the
581 workers' compensation joint underwriting plan provided in s.
582 627.311(5), Florida Statutes.
583 (1) The department shall establish a contingency reserve
584 within the Workers' Compensation Administration Trust Fund, from
585 which the department is authorized to expend funds as provided
586 in the subsection, in an amount not to exceed $15 million to be
587 released only upon the approval of a budget amendment presented
588 to the Legislative Budget Commission. For actuarial deficits
589 projected for policyholders, based on actuarial best estimates,
590 covered in subplan "D" prior to July 1, 2004, and upon
591 verification by the Office of Insurance Regulation, the plan is
592 authorized to request and the department is authorized to submit
593 a budget amendment in an amount not to exceed $15 million for
594 the purpose of funding deficits in subplan "D".
595 (2) After the contingency reserve is established, whenever
596 the board determines subplan “D” does not have a sufficient cash
597 basis to meet 3 months of projected cash needs due to any
598 deficit in subplan "D," the board is authorized to request the
599 department to transfer funds from the contingency reserve fund
600 within the Workers' Compensation Administration Trust Fund to
601 the plan in an amount sufficient to fund the difference between
602 the amount available and the amount needed to meet subplan “D”’s
603 projected cash need for the subsequent 3-month period. The board
604 and the office must first certify to the Department of Financial
605 Services that there is not sufficient cash within subplan “D” to
606 meet the projected cash needs in subplan "D" within the

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607 subsequent 3 months. The amount requested for transfer to
608 subplan "D" may not exceed the difference between the amount
609 available within subplan "D" and the amount needed to meet
610 subplan "D"'s projected cash need for the subsequent 3-month
611 period, as jointly certified by the board and the Office of
612 Insurance Regulation to the Department of Financial Services,
613 attributable to the former subplan "D" policyholders. The
614 Department of Financial Services may submit a budget amendment
615 to request release of funds from the Workers' Compensation
616 Administration Trust Fund, subject to the approval of the
617 Legislative Budget Commission. The board will provide, for
618 review of the Legislative Budget Commission, information on the
619 reasonableness of the plan's administration, including, but not
620 limited to, the plan of operations and costs, claims costs,
621 claims administration costs, overhead costs, claims reserves,
622 and the latest report submitted on administration cost reduction
623 alternatives as required in s. 627.311(5)(c)17., Florida
624 Statutes.
625 (3) This section expires July 1, 2007.
626 Section 3. The Auditor General shall perform an
627 operational audit, as defined in s. 11.45(1), Florida Statutes,
628 of the Workers' Compensation Joint Underwriting Association
629 created under s. 627.311(5), Florida Statutes. The scope of the
630 audit shall also include:
631 (1) An analysis of the adequacy and appropriateness of the
632 rates and reserves of the association. The Auditor General shall
633 engage an independent consulting actuary who is a member of the

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634 American Academy of Actuaries or the Casualty Actuarial Society
635 to evaluate the rates and the reserves of the association.
636 (2) An evaluation of costs associated with the
637 administration and servicing of the policies issued by the
638 association to determine alternatives by which costs can be
639 reduced.
640
641 The Auditor General shall submit a report to the Governor, the
642 President of the Senate, and the Speaker of the House of
643 Representatives no later than December 31, 2004.
644 Section 4. The Workers' Compensation Joint Underwriting
645 Association is subject to the Florida Single Audit Act, as
646 provided in s. 215.97, Florida Statutes, if the association
647 expends a total amount of state financial assistance equal to or
648 in excess of $300,000 in any fiscal year. Such audit reports
649 shall be submitted to the President of the Senate, the Speaker
650 of the House of Representatives, and the Governor pursuant to s.
651 215.97, Florida Statutes.
652 Section 5. The sum of $50,000 in nonrecurring funds is
653 appropriated from the Worker's Compensation Administration Trust
654 Fund to the Office of the Auditor General for the purpose of
655 engaging an actuary to evaluate the rates and reserves of the
656 Florida Workers' compensation Joint Underwriting Association as
657 required in section 3.
658 Section 6. Transitional provisions.--Effective upon this
659 act becoming a law:
660 (1) Notwithstanding s. 627.311(5), Florida Statutes, no
661 policy in subplan "D" of the Florida Workers' Compensation Joint

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662 Underwriting Association is subject to an assessment for the
663 purpose of funding a deficit.
664 (2) Any policy issued by the Florida's Workers'
665 Compensation Joint Underwriting Association with an effective
666 date between the date on which this act becomes a law and June
667 30, 2004, shall be rerated and placed in the appropriate tier
668 provided in s. 627.311(5), Florida Statutes, as amended,
669 effective July 1, 2004, and shall be subject to the premiums and
670 charges provided for in that section as amended.
671 Section 7. Except as otherwise provided herein, this act
672 shall take effect July 1, 2004.