By the Committee on General Government Appropriations; and Senator Garcia

601-2056-05

1 A bill to be entitled
2 An act relating to joint underwriters and
3 reinsurers; amending s. 627.311, F.S.;
4 providing requirements for the joint
5 underwriting plan of insurers that operates as
6 a nonprofit entity; requiring that the plan
7 maintain its headquarters in Tallahassee;
8 increasing the membership of the board of
9 governors that oversees operation of the joint
10 underwriting plan; authorizing the Financial
11 Services Commission to remove a board member
12 for cause; authorizing the board to select
13 service providers competitively; requiring that
14 the board provide notice of intent to solicit
15 bids; requiring that the board provide for an
16 annual review of the administrative costs of
17 the plan and determine alternatives for
18 procuring goods and services efficiently;
19 requiring that the Office of Insurance
20 Regulation review filings of the joint
21 underwriting plan of workers' compensation
22 insurers; requiring that the office annually
23 approve rates; deleting certain provisions
24 limiting the disapproval of rates by the
25 office; requiring that excess funds received by
26 the plan be returned to the state; providing an
27 effective date.
28
29 Be It Enacted by the Legislature of the State of Florida:
30
31

1 Section 1. Subsections (5), (6), and (7) of section
2 627.311, Florida Statutes, are amended to read:
3 627.311 Joint underwriters and joint reinsurers;
4 public records and public meetings exemptions.--
5 (5)(a) The office shall, after consultation with
6 insurers, approve a joint underwriting plan of insurers that
7 ~~which shall~~ operate as a nonprofit entity. For the purposes of
8 this subsection, the term "insurer" includes group
9 self-insurance funds authorized by s. 624.4621, commercial
10 self-insurance funds authorized by s. 624.462, assessable
11 mutual insurers authorized under s. 628.6011, and insurers
12 licensed to write workers' compensation and employer's
13 liability insurance in this state. The purpose of the plan is
14 to provide workers' compensation and employer's liability
15 insurance to applicants who are required by law to maintain
16 workers' compensation and employer's liability insurance and
17 who are in good faith entitled to but who are unable to
18 procure such insurance through the voluntary market. Except as
19 provided herein, the plan must have actuarially sound rates
20 that ensure that the plan is self-supporting. The plan shall
21 establish and maintain its headquarters in Tallahassee.
22 (b) The operation of the plan is subject to the
23 supervision of an 11-member ~~a 9-member~~ board of governors. The
24 board of governors shall be comprised of:
25 1. Five ~~Three~~ members appointed by the Financial
26 Services Commission. Each member appointed by the commission
27 shall serve at the pleasure of the commission;
28 2. Two of the 20 domestic insurers, as defined in s.
29 624.06(1), having the largest voluntary direct premiums
30 written in this state for workers' compensation and employer's
31

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1 liability insurance, which shall be elected by those 20
2 domestic insurers;
3 3. Two of the 20 foreign insurers as defined in s.
4 624.06(2) having the largest voluntary direct premiums written
5 in this state for workers' compensation and employer's
6 liability insurance, which shall be elected by those 20
7 foreign insurers;
8 4. One person appointed by the largest property and
9 casualty insurance agents' association in this state; and
10 5. The consumer advocate appointed under s. 627.0613
11 or the consumer advocate's designee.
12
13 Each board member shall serve a 4-year term and may serve
14 consecutive terms. A vacancy on the board shall be filled in
15 the same manner as the original appointment for the unexpired
16 portion of the term. The Financial Services Commission shall
17 designate a member of the board to serve as chair. The
18 Financial Services Commission may remove any member for cause.
19 No board member shall be an insurer which provides services to
20 the plan or which has an affiliate which provides services to
21 the plan or which is serviced by a service company or
22 third-party administrator which provides services to the plan
23 or which has an affiliate which provides services to the plan.
24 The meeting minutes, audits, and procedures of the board of
25 governors are subject to chapters ~~chapter~~ 119 and 286, unless
26 otherwise provided.
27 (c) The operation of the plan shall be governed by a
28 plan of operation that is prepared at the direction of the
29 board of governors. The plan of operation may be changed at
30 any time by the board of governors or upon request of the
31 office. The plan of operation and all changes thereto are

1 subject to the approval of the office. The plan of operation
2 shall:
3 1. Authorize the board to engage in the activities
4 necessary to implement this subsection, including, but not
5 limited to, borrowing money.
6 2. Develop criteria for eligibility for coverage by
7 the plan, including, but not limited to, documented rejection
8 by at least two insurers which reasonably assures that
9 insureds covered under the plan are unable to acquire coverage
10 in the voluntary market.
11 3. Require notice from the agent to the insured at the
12 time of the application for coverage that the application is
13 for coverage with the plan and that coverage may be available
14 through an insurer, group self-insurers' fund, commercial
15 self-insurance fund, or assessable mutual insurer through
16 another agent at a lower cost.
17 4. Establish programs to encourage insurers to provide
18 coverage to applicants of the plan in the voluntary market and
19 to insureds of the plan, including, but not limited to:
20 a. Establishing procedures for an insurer to use in
21 notifying the plan of the insurer's desire to provide coverage
22 to applicants to the plan or existing insureds of the plan and
23 in describing the types of risks in which the insurer is
24 interested. The description of the desired risks must be on a
25 form developed by the plan.
26 b. Developing forms and procedures that provide an
27 insurer with the information necessary to determine whether
28 the insurer wants to write particular applicants to the plan
29 or insureds of the plan.
30 c. Developing procedures for notice to the plan and
31 the applicant to the plan or insured of the plan that an

1 insurer will insure the applicant or the insured of the plan,
2 and notice of the cost of the coverage offered; and developing
3 procedures for the selection of an insuring entity by the
4 applicant or insured of the plan.
5 d. Provide for a market-assistance plan to assist in
6 the placement of employers. All applications for coverage in
7 the plan received 45 days before the effective date for
8 coverage shall be processed through the market-assistance
9 plan. A market-assistance plan specifically designed to serve
10 the needs of small, good policyholders as defined by the board
11 must be finalized by January 1, 1994.
12 5. Provide for policy and claims services to the
13 insureds of the plan of the nature and quality provided for
14 insureds in the voluntary market.
15 6. Provide for the review of applications for coverage
16 with the plan for reasonableness and accuracy, using any
17 available historic information regarding the insured.
18 7. Provide for procedures for auditing insureds of the
19 plan which are based on reasonable business judgment and are
20 designed to maximize the likelihood that the plan will collect
21 the appropriate premiums.
22 8. Authorize the plan to terminate the coverage of and
23 refuse future coverage for any insured that submits a
24 fraudulent application to the plan or provides fraudulent or
25 grossly erroneous records to the plan or to any service
26 provider of the plan in conjunction with the activities of the
27 plan.
28 9. Establish service standards for agents who submit
29 business to the plan.
30 10. Establish criteria and procedures to prohibit any
31 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 in the most cost-effective and efficient manner 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 the competitive selection of ~~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

1 concern and is capable of providing the specified services in
2 the manner required. <u>If the board of governors undertakes to</u>
3 <u>procure services from a servicing carrier required by the</u>
4 <u>plan, the board of governors shall provide reasonable notice</u>
5 <u>to potential service providers of its intent to solicit bids</u>
6 <u>for the procurement of such services by publishing a notice in</u>
7 <u>the Florida Administrative Weekly and at least one newspaper</u>
8 <u>of general circulation in this state, or in at least two</u>
9 <u>business trade journals.</u>
10 16. Provide for reasonable accounting and
11 data-reporting practices.
12 17. Provide for annual review of costs associated with
13 the <u>general administration of the plan and the</u> administration
14 and servicing of the policies issued by the plan to determine
15 alternatives by which costs can be reduced <u>and goods and</u>
16 <u>services can be procured and provided in the most</u>
17 <u>cost-effective and efficient manner</u>.
18 18. Authorize the acquisition of such excess insurance
19 or reinsurance as is consistent with the purposes of the plan.
20 19. Provide for an annual report to the office on a
21 date specified by the office and containing such information
22 as the office reasonably requires.
23 20. Establish multiple rating plans for various
24 classifications of risk which reflect risk of loss, hazard
25 grade, actual losses, size of premium, and compliance with
26 loss control. At least one of such plans must be a
27 preferred-rating plan to accommodate small-premium
28 policyholders with good experience as defined in
29 sub-subparagraph 22.a.
30 21. Establish agent commission schedules.
31

1 22. For employers otherwise eligible for coverage
2 under the plan, establish three tiers of employers meeting the
3 criteria and subject to the rate limitations specified in this
4 subparagraph.
5 a. Tier One.--
6 (I) Criteria; rated employers.--An employer that has
7 an experience modification rating shall be included in Tier
8 One if the employer meets all of the following:
9 (A) The experience modification is below 1.00.
10 (B) The employer had no lost-time claims subsequent to
11 the applicable experience modification rating period.
12 (C) The total of the employer's medical-only claims
13 subsequent to the applicable experience modification rating
14 period did not exceed 20 percent of premium.
15 (II) Criteria; non-rated employers.--An employer that
16 does not have an experience modification rating shall be
17 included in Tier One if the employer meets all of the
18 following:
19 (A) The employer had no lost-time claims for the
20 3-year period immediately preceding the inception date or
21 renewal date of the employer's coverage under the plan.
22 (B) The total of the employer's medical-only claims
23 for the 3-year period immediately preceding the inception date
24 or renewal date of the employer's coverage under the plan did
25 not exceed 20 percent of premium.
26 (C) The employer has secured workers' compensation
27 coverage for the entire 3-year period immediately preceding
28 the inception date or renewal date of the employer's coverage
29 under the plan.
30 (D) The employer is able to provide the plan with a
31 loss history generated by the employer's prior workers'

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1 compensation insurer, except if the employer is not able to
2 produce a loss history due to the insolvency of an insurer,
3 the receiver shall provide to the plan, upon the request of
4 the employer or the employer's agent, a copy of the employer's
5 loss history from the records of the insolvent insurer if the
6 loss history is contained in records of the insurer which are
7 in the possession of the receiver. If the receiver is unable
8 to produce the loss history, the employer may, in lieu of the
9 loss history, submit an affidavit from the employer and the
10 employer's insurance agent setting forth the loss history.
11 (E) The employer is not a new business.
12 (III) Premiums.--The premiums for Tier One insureds
13 shall be set at a premium level 25 percent above the
14 comparable voluntary market premiums until the plan has
15 sufficient experience as determined by the board to establish
16 an actuarially sound rate for Tier One, at which point the
17 board shall, subject to paragraph (e), adjust the rates, if
18 necessary, to produce actuarially sound rates, provided such
19 rate adjustment shall not take effect prior to January 1,
20 2007.
21 b. Tier Two.--
22 (I) Criteria; rated employers.--An employer that has
23 an experience modification rating shall be included in Tier
24 Two if the employer meets all of the following:
25 (A) The experience modification is equal to or greater
26 than 1.00 but not greater than 1.10.
27 (B) The employer had no lost-time claims subsequent to
28 the applicable experience modification rating period.
29 (C) The total of the employer's medical-only claims
30 subsequent to the applicable experience modification rating
31 period did not exceed 20 percent of premium.

1 (II) Criteria; non-rated employers.--An employer that
2 does not have any experience modification rating shall be
3 included in Tier Two if the employer is a new business. An
4 employer shall be included in Tier Two if the employer has
5 less than 3 years of loss experience in the 3-year period
6 immediately preceding the inception date or renewal date of
7 the employer's coverage under the plan and the employer meets
8 all of the following:
9 (A) The employer had no lost-time claims for the
10 3-year period immediately preceding the inception date or
11 renewal date of the employer's coverage under the plan.
12 (B) The total of the employer's medical-only claims
13 for the 3-year period immediately preceding the inception date
14 or renewal date of the employer's coverage under the plan did
15 not exceed 20 percent of premium.
16 (C) The employer is able to provide the plan with a
17 loss history generated by the workers' compensation insurer
18 that provided coverage for the portion or portions of such
19 period during which the employer had secured workers'
20 compensation coverage, except if the employer is not able to
21 produce a loss history due to the insolvency of an insurer,
22 the receiver shall provide to the plan, upon the request of
23 the employer or the employer's agent, a copy of the employer's
24 loss history from the records of the insolvent insurer if the
25 loss history is contained in records of the insurer which are
26 in the possession of the receiver. If the receiver is unable
27 to produce the loss history, the employer may, in lieu of the
28 loss history, submit an affidavit from the employer and the
29 employer's insurance agent setting forth the loss history.
30 (III) Premiums.--The premiums for Tier Two insureds
31 shall be set at a rate level 50 percent above the comparable

1 voluntary market premiums until the plan has sufficient
2 experience as determined by the board to establish an
3 actuarially sound rate for Tier Two, at which point the board
4 shall, subject to paragraph (e), adjust the rates, if
5 necessary, to produce actuarially sound rates, provided such
6 rate adjustment shall not take effect prior to January 1,
7 2007.
8 c. Tier Three.--
9 (I) Eligibility.--An employer shall be included in
10 Tier Three if the employer does not meet the criteria for Tier
11 One or Tier Two.
12 (II) Rates.--The board shall establish, subject to
13 paragraph (e), and the plan shall charge, actuarially sound
14 rates for Tier Three insureds.
15 23. For Tier One or Tier Two employers which employ no
16 nonexempt employees or which report payroll which is less than
17 the minimum wage hourly rate for one full-time employee for 1
18 year at 40 hours per week, the plan shall establish
19 actuarially sound premiums, provided, however, that the
20 premiums may not exceed $2,500. These premiums shall be in
21 addition to the fee specified in subparagraph 26. When the
22 plan establishes actuarially sound rates for all employers in
23 Tier One and Tier Two, the premiums for employers referred to
24 in this paragraph are no longer subject to the $2,500 cap.
25 24. Provide for a depopulation program to reduce the
26 number of insureds in the plan. If an employer insured through
27 the plan is offered coverage from a voluntary market carrier:
28 a. During the first 30 days of coverage under the
29 plan;
30 b. Before a policy is issued under the plan;
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1 c. By issuance of a policy upon expiration or
2 cancellation of the policy under the plan; or
3 d. By assumption of the plan's obligation with respect
4 to an in-force policy,
5
6 that employer is no longer eligible for coverage through the
7 plan. The premium for risks assumed by the voluntary market
8 carrier must be no greater than the premium the insured would
9 have paid under the plan, and shall be adjusted upon renewal
10 to reflect changes in the plan rates and the tier for which
11 the insured would qualify as of the time of renewal. The
12 insured may be charged such premiums only for the first 3
13 years of coverage in the voluntary market. A premium under
14 this subparagraph is deemed approved and is not an excess
15 premium for purposes of s. 627.171.
16 25. Require that policies issued and applications must
17 include a notice that the policy could be replaced by a policy
18 issued from a voluntary market carrier and that, if an offer
19 of coverage is obtained from a voluntary market carrier, the
20 policyholder is no longer eligible for coverage through the
21 plan. The notice must also specify that acceptance of coverage
22 under the plan creates a conclusive presumption that the
23 applicant or policyholder is aware of this potential.
24 26. Require that each application for coverage and
25 each renewal premium be accompanied by a nonrefundable fee of
26 $475 to cover costs of administration and fraud prevention.
27 The board may, with the approval of the office, increase the
28 amount of the fee pursuant to a rate filing to reflect
29 increased costs of administration and fraud prevention. The
30 fee is not subject to commission and is fully earned upon
31 commencement of coverage.

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1 (d)1. The funding of the plan shall include premiums
2 as provided in subparagraph (c)22. and assessments as provided
3 in this paragraph.
4 2.a. If the board determines that a deficit exists in
5 Tier One or Tier Two or that there is any deficit remaining
6 attributable to any of the plan's former subplans and that the
7 deficit cannot be funded without the use of deficit
8 assessments, the board shall request the office to levy, by
9 order, a deficit assessment against premiums charged to
10 insureds for workers' compensation insurance by insurers as
11 defined in s. 631.904(5). The office shall issue the order
12 after verifying the amount of the deficit. The assessment
13 shall be specified as a percentage of future premium
14 collections, as recommended by the board and approved by the
15 office. The same percentage shall apply to premiums on all
16 workers' compensation policies issued or renewed during the
17 12-month period beginning on the effective date of the
18 assessment, as specified in the order.
19 b. With respect to each insurer collecting premiums
20 that are subject to the assessment, the insurer shall collect
21 the assessment at the same time as the insurer collects the
22 premium payment for each policy and shall remit the
23 assessments collected to the plan as provided in the order
24 issued by the office. The office shall verify the accurate and
25 timely collection and remittance of deficit assessments and
26 shall report such information to the board. Each insurer
27 collecting assessments shall provide such information with
28 respect to premiums and collections as may be required by the
29 office to enable the office to monitor and audit compliance
30 with this paragraph.
31

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1 c. Deficit assessments are not considered part of an
2 insurer's rate, are not premium, and are not subject to the
3 premium tax, to the assessments under ss. 440.49 and 440.51,
4 to the surplus lines tax, to any fees, or to any commissions.
5 The deficit assessment imposed shall become plan funds at the
6 moment of collection and shall not constitute income to the
7 insurer for any purpose, including financial reporting on the
8 insurer's income statement. An insurer is liable for all
9 assessments that the insurer collects and must treat the
10 failure of an insured to pay an assessment as a failure to pay
11 premium. An insurer is not liable for uncollectible
12 assessments.
13 d. When an insurer is required to return unearned
14 premium, the insurer shall also return any collected
15 assessments attributable to the unearned premium.
16 e. Deficit assessments as described in this
17 subparagraph shall not be levied after July 1, 2007.
18 3.a. All policies issued to Tier Three insureds shall
19 be assessable. All Tier Three assessable policies must be
20 clearly identified as assessable by containing, in contrasting
21 color and in not less than 10-point type, the following
22 statement:
23
24 "This is an assessable policy. If the plan is
25 unable to pay its obligations, policyholders
26 will be required to contribute on a pro rata
27 earned premium basis the money necessary to
28 meet any assessment levied."
29
30 b. The board may from time to time assess Tier Three
31 insureds to whom the plan has issued assessable policies for

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1 the purpose of funding plan deficits. Any such assessment
2 shall be based upon a reasonable actuarial estimate of the
3 amount of the deficit, taking into account the amount needed
4 to fund medical and indemnity reserves and reserves for
5 incurred but not reported claims, and allowing for general
6 administrative expenses, the cost of levying and collecting
7 the assessment, a reasonable allowance for estimated
8 uncollectible assessments, and allocated and unallocated loss
9 adjustment expenses.
10 c. Each Tier Three insured's share of a deficit shall
11 be computed by applying to the premium earned on the insured's
12 policy or policies during the period to be covered by the
13 assessment the ratio of the total deficit to the total
14 premiums earned during such period upon all policies subject
15 to the assessment. If one or more Tier Three insureds fail to
16 pay an assessment, the other Tier Three insureds shall be
17 liable on a proportionate basis for additional assessments to
18 fund the deficit. The plan may compromise and settle
19 individual assessment claims without affecting the validity of
20 or amounts due on assessments levied against other insureds.
21 The plan may offer and accept discounted payments for
22 assessments which are promptly paid. The plan may offset the
23 amount of any unpaid assessment against unearned premiums
24 which may otherwise be due to an insured. The plan shall
25 institute legal action when necessary and appropriate to
26 collect the assessment from any insured who fails to pay an
27 assessment when due.
28 d. The venue of a proceeding to enforce or collect an
29 assessment or to contest the validity or amount of an
30 assessment shall be in the Circuit Court of Leon County.
31

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1 e. If the board finds that a deficit in Tier Three
2 exists for any period and that an assessment is necessary, the
3 board shall certify to the office the need for an assessment.
4 No sooner than 30 days after the date of such certification,
5 the board shall notify in writing each insured who is to be
6 assessed that an assessment is being levied against the
7 insured, and informing the insured of the amount of the
8 assessment, the period for which the assessment is being
9 levied, and the date by which payment of the assessment is
10 due. The board shall establish a date by which payment of the
11 assessment is due, which shall be no sooner than 30 days nor
12 later than 120 days after the date on which notice of the
13 assessment is mailed to the insured.
14 f. Whenever the board makes a determination that the
15 plan does not have a sufficient cash basis to meet 3 months of
16 projected cash needs due to a deficit in Tier Three, the board
17 may request the department to transfer funds from the Workers'
18 Compensation Administration Trust Fund to the plan in an
19 amount sufficient to fund the difference between the amount
20 available and the amount needed to meet a 3-month projected
21 cash need as determined by the board and verified by the
22 office, subject to the approval of the Legislative Budget
23 Commission. If the Legislative Budget Commission approves a
24 transfer of funds under this sub-subparagraph, the plan shall
25 report to the Legislature the transfer of funds and the
26 Legislature shall review the plan during the next legislative
27 session or the current legislative session, if the transfer
28 occurs during a legislative session. This sub-subparagraph
29 shall not apply until the plan determines and the office
30 verifies that assessments collected by the plan pursuant to
31

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sub-subparagraph b. are insufficient to fund the deficit in Tier Three and to meet 3 months of projected cash needs.

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

(e) The plan shall file with the office each manual of classifications, rules, and rates; each rating plan; and each modification pursuant to the requirements of this part which applies to workers' compensation insurers. The office shall review and approve or disapprove the filing pursuant to such requirements and the requirements of this section ~~establish and use its rates and rating plans, and the plan may establish and use changes in rating plans at any time, but no more frequently than two times per any rating class for any calendar year~~. By January 1 ~~December 1, 1993, and December 1~~ of each year thereafter, except as provided in subparagraph (c)22., the board shall establish and use actuarially sound rates approved by the office for use by the plan to assure that the plan is self-funding while those rates are in effect. ~~Such rates and rating plans must be filed with the office within 30 calendar days after their effective dates, and shall be considered a "use and file" filing. Any disapproval by the office must have an effective date that is at least 60 days from the date of disapproval of the rates and rating plan and must have prospective effect only. The plan may not be subject to any order by the office to return to policyholders any portion of the rates disapproved by the office. The office may not disapprove any rates or rating plans unless it demonstrates that such rates and rating plans are excessive, inadequate, or unfairly discriminatory.~~

(f) No later than June 1 of each year, the plan shall obtain an independent actuarial certification of the results

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1 of the operations of the plan for prior years, and shall
2 furnish a copy of the certification to the office. If, after
3 the effective date of the plan, the projected ultimate
4 incurred losses and expenses and dividends for prior years
5 exceed collected premiums, accrued net investment income, and
6 prior assessments for prior years, the certification is
7 subject to review and approval by the office before it becomes
8 final.
9 (g) Whenever a deficit exists, the plan shall, within
10 90 days, provide the office with a program to eliminate the
11 deficit within a reasonable time. The deficit may be funded
12 through increased premiums charged to insureds of the plan for
13 subsequent years, through the use of policyholder surplus
14 attributable to any year, through the use of assessments as
15 provided in subparagraph (d)2., and through assessments on
16 assessable policies as provided in subparagraph (d)3.
17 (h) Any premium or assessments collected by the plan
18 in excess of the amount necessary to fund projected ultimate
19 incurred losses and expenses of the plan and not paid to
20 insureds of the plan in conjunction with loss prevention or
21 dividend programs shall be retained by the plan for future
22 use. Any state funds received by the plan in excess of the
23 amount necessary to fund deficits in subplan "D" or any tier
24 shall be returned to the state.
25 (i) The decisions of the board of governors do not
26 constitute final agency action and are not subject to chapter
27 120.
28 (j) Policies for insureds shall be issued by the plan.
29 (k) The plan created under this subsection is liable
30 only for payment for losses arising under policies issued by
31

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1 the plan with dates of accidents occurring on or after January
2 1, 1994.
3 (l) Plan losses are the sole and exclusive
4 responsibility of the plan, and payment for such losses must
5 be funded in accordance with this subsection and must not
6 come, directly or indirectly, from insurers or any guaranty
7 association for such insurers.
8 ~~(m) Each joint underwriting plan or association~~
9 ~~created under this section is not a state agency, board, or~~
10 ~~commission. However, for the purposes of s. 199.183(1) only,~~
11 ~~the joint underwriting plan is a political subdivision of the~~
12 ~~state and is exempt from the corporate income tax.~~
13 ~~(n) Each joint underwriting plan or association may~~
14 ~~elect to pay premium taxes on the premiums received on its~~
15 ~~behalf or may elect to have the member insurers to whom the~~
16 ~~premiums are allocated pay the premium taxes if the member~~
17 ~~insurer had written the policy. The joint underwriting plan or~~
18 ~~association shall notify the member insurers and the~~
19 ~~Department of Revenue by January 15 of each year of its~~
20 ~~election for the same year. As used in this paragraph, the~~
21 ~~term "premiums received" means the consideration for~~
22 ~~insurance, by whatever name called, but does not include any~~
23 ~~policy assessment or surcharge received by the joint~~
24 ~~underwriting association as a result of apportioning losses or~~
25 ~~deficits of the association pursuant to this section.~~
26 <u>(m)</u>~~(o)~~ Neither the plan nor any member of the board of
27 governors is liable for monetary damages to any person for any
28 statement, vote, decision, or failure to act, regarding the
29 management or policies of the plan, unless:
30 1. The member breached or failed to perform her or his
31 duties as a member; and

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1 2. The member's breach of, or failure to perform,
2 duties constitutes:
3 a. A violation of the criminal law, unless the member
4 had reasonable cause to believe her or his conduct was not
5 unlawful. A judgment or other final adjudication against a
6 member in any criminal proceeding for violation of the
7 criminal law estops that member from contesting the fact that
8 her or his breach, or failure to perform, constitutes a
9 violation of the criminal law; but does not estop the member
10 from establishing that she or he had reasonable cause to
11 believe that her or his conduct was lawful or had no
12 reasonable cause to believe that her or his conduct was
13 unlawful;
14 b. A transaction from which the member derived an
15 improper personal benefit, either directly or indirectly; or
16 c. Recklessness or any act or omission that was
17 committed in bad faith or with malicious purpose or in a
18 manner exhibiting wanton and willful disregard of human
19 rights, safety, or property. For purposes of this
20 sub-subparagraph, the term "recklessness" means the acting, or
21 omission to act, in conscious disregard of a risk:
22 (I) Known, or so obvious that it should have been
23 known, to the member; and
24 (II) Known to the member, or so obvious that it should
25 have been known, to be so great as to make it highly probable
26 that harm would follow from such act or omission.
27 (n)~~(p)~~ No insurer shall provide workers' compensation
28 and employer's liability insurance to any person who is
29 delinquent in the payment of premiums, assessments, penalties,
30 or surcharges owed to the plan or to any person who is an
31 affiliated person of a person who is delinquent in the payment

1 of premiums, assessments, penalties, or surcharges owed to the
2 plan. For purposes of this paragraph, the term "affiliated
3 person" of another person means:
4 1. The spouse of such other natural person;
5 2. Any person who directly or indirectly owns or
6 controls, or holds with the power to vote, 5 percent or more
7 of the outstanding voting securities of such other person;
8 3. Any person who directly or indirectly owns 5
9 percent or more of the outstanding voting securities that are
10 directly or indirectly owned or controlled, or held with the
11 power to vote, by such other person;
12 4. Any person or group of persons who directly or
13 indirectly control, are controlled by, or are under common
14 control with such other person;
15 5. Any officer, director, trustee, partner, owner,
16 manager, joint venturer, or employee, or other person
17 performing duties similar to persons in those positions, of
18 such other persons; or
19 6. Any person who has an officer, director, trustee,
20 partner, or joint venturer in common with such other person.
21 (o)~~(q)~~ Effective July 1, 2004, the plan is exempt from
22 the premium tax under s. 624.509 and any assessments under ss.
23 440.49 and 440.51.
24 (6) Each joint underwriting plan or association
25 created under this section is not a state agency, board, or
26 commission. However, for the purposes of s. 199.183(1) only,
27 the joint underwriting plan created under subsection (5) is a
28 political subdivision of the state and is exempt from the
29 corporate income tax.
30 (7) Each joint underwriting plan or association may
31 elect to pay premium taxes on the premiums received on its

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1 behalf or may elect to have the member insurers to whom the
2 premiums are allocated pay the premium taxes if the member
3 insurer had written the policy. The joint underwriting plan or
4 association shall notify the member insurers and the
5 Department of Revenue by January 15 of each year of its
6 election for the same year. As used in this paragraph, the
7 term "premiums received" means the consideration for
8 insurance, by whatever name called, but does not include any
9 policy assessment or surcharge received by the joint
10 underwriting association as a result of apportioning losses or
11 deficits of the association pursuant to this section.
12 (8)~~(6)~~ As used in this section and ss. 215.555 and
13 627.351, the term "collateral protection insurance" means
14 commercial property insurance of which a creditor is the
15 primary beneficiary and policyholder and which protects or
16 covers an interest of the creditor arising out of a credit
17 transaction secured by real or personal property. Initiation
18 of such coverage is triggered by the mortgagor's failure to
19 maintain insurance coverage as required by the mortgage or
20 other lending document. Collateral protection insurance is not
21 residential coverage.
22 (9)~~(7)~~(a) The Florida Automobile Joint Underwriting
23 Association created under this section shall be deemed to have
24 appointed its general manager as its agent to receive service
25 of all legal process issued against the association in any
26 civil action or proceeding in this state. Process so served
27 shall be valid and binding upon the insurer.
28 (b) Service of process upon the association's general
29 manager as the association's agent pursuant to such an
30 appointment shall be the sole method of service of process
31 upon the association.

1 Section 2. This act shall take effect October 1, 2005.
2
3 STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
4 Senate Bill 1590
5
6 Corrects two cross references and clarifies a reference to the
Workers' Compensation Joint Underwriting Association.
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