

1 interest; prescribing limits on representing
2 persons or entities before the plan by former
3 senior managers or officers of the plan;
4 prohibiting any part of the plan's income from
5 inuring to the benefit of a private individual;
6 prohibiting employees and board members from
7 accepting expenditures from a person or an
8 entity; providing applicability; requiring
9 periodic comprehensive market examinations;
10 prescribing disposition of assets of the plan
11 upon dissolution; amending s. 2 of ch.
12 2004-266, Laws of Florida; extending the period
13 for maintaining the contingency reserve and the
14 period for projecting current cash needs;
15 requiring the plan to submit a request for an
16 Internal Revenue Service letter concerning the
17 plan's eligibility as a tax-exempt
18 organization; providing an effective date.

19
20 Be It Enacted by the Legislature of the State of Florida:

21
22 Section 1. Subsections (5), (6), and (7) of section
23 627.311, Florida Statutes, are amended to read:

24 627.311 Joint underwriters and joint reinsurers;
25 public records and public meetings exemptions.--

26 (5)(a) The office shall, after consultation with
27 insurers, approve a joint underwriting plan of insurers which
28 shall operate as the Florida Workers' Compensation Joint
29 Underwriting Association, Inc., a nonprofit entity. For the
30 purposes of this subsection, the term "insurer" includes group
31 self-insurance funds authorized by s. 624.4621, commercial

1 self-insurance funds authorized by s. 624.462, assessable
2 mutual insurers authorized under s. 628.6011, and insurers
3 licensed to write workers' compensation and employer's
4 liability insurance in this state. The purpose of the plan is
5 to provide workers' compensation and employer's liability
6 insurance to applicants who are required by law to maintain
7 workers' compensation and employer's liability insurance and
8 who are in good faith entitled to but who are unable to
9 procure such insurance through the voluntary market. Except as
10 provided herein, the plan must have actuarially sound rates
11 that ensure that the plan is self-supporting.

12 (b) The operation of the plan is subject to the
13 supervision of a 9-member board of governors. Each member
14 described in subparagraph 1., subparagraph 2., subparagraph
15 3., or subparagraph 5. shall be appointed by the Financial
16 Services Commission and shall serve at the pleasure of the
17 commission. The board of governors shall be comprised of:

18 ~~1. Three members appointed by the Financial Services~~
19 ~~Commission. Each member appointed by the commission shall~~
20 ~~serve at the pleasure of the commission;~~

21 ~~1.2.~~ Two representatives of the 20 domestic insurers,
22 as defined in s. 624.06(1), having the largest voluntary
23 direct premiums written in this state for workers'
24 compensation and employer's liability insurance, ~~which shall~~
25 ~~be elected by those 20 domestic insurers;~~

26 ~~2.3.~~ Two representatives of the 20 foreign insurers as
27 defined in s. 624.06(2) having the largest voluntary direct
28 premiums written in this state for workers' compensation and
29 employer's liability insurance, ~~which shall be elected by~~
30 ~~those 20 foreign insurers;~~

31

1 ~~3.4.~~ One representative of person appointed by the
2 largest property and casualty insurance agents' association in
3 this state; ~~and~~

4 ~~4.5.~~ The consumer advocate appointed under s. 627.0613
5 or the consumer advocate's designee; ~~and-~~

6 5. Three other persons appointed by the commission.
7

8 Each board member shall be appointed to ~~serve~~ a 4-year term
9 and may be appointed to ~~serve~~ consecutive terms. A vacancy on
10 the board shall be filled in the same manner as the original
11 appointment for the unexpired portion of the term. The
12 Financial Services Commission shall designate a member of the
13 board to serve as chair. No board member shall be an insurer
14 which provides services to the plan or which has an affiliate
15 which provides services to the plan or which is serviced by a
16 service company or third-party administrator which provides
17 services to the plan or which has an affiliate which provides
18 services to the plan. The meetings and records ~~minutes,~~
19 ~~audits, and procedures~~ of the board of governors and plan are
20 subject to chapters chapter 119 and 286, unless otherwise
21 exempted by law.

22 (c) The operation of the plan shall be governed by a
23 plan of operation that is prepared at the direction of the
24 board of governors and approved by order of the office. The
25 plan is subject to continuous review by the office. The office
26 may, by order, withdraw approval of all or part of a plan if
27 the office determines that conditions have changed since
28 approval was granted and that the purposes of the plan require
29 changes in the plan. 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 reviewed and updated periodically ~~finalized by January~~
12 ~~1, 1994.~~

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

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

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

23 8. Authorize the plan to terminate the coverage of and
24 refuse future coverage for any insured that submits a
25 fraudulent application to the plan or provides fraudulent or
26 grossly erroneous records to the plan or to any service
27 provider of the plan in conjunction with the activities of the
28 plan.

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

31

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

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

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

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

24 a. Purchases that equal or exceed \$2,500 but are less
25 than or equal to \$25,000, shall be made by receipt of written
26 quotes, telephone quotes, or informal bids, whenever
27 practical. The procurement of goods or services valued over
28 \$25,000 are subject to competitive solicitation, except in
29 situations in which the goods or services are provided by a
30 sole source or are deemed an emergency purchase, or the
31 services are exempted from competitive solicitation

1 requirements under s. 287.057(5)(f). Justification for the
2 sole-sourcing or emergency procurement must be documented.
3 Contracts for goods or services valued at or over \$100,000 are
4 subject to board approval.

5 b. The board shall determine whether it is more
6 cost-effective and in the best interests of the plan to use
7 legal services provided by in-house attorneys employed by the
8 plan rather than contracting with outside counsel. In making
9 such determination, the board shall document its findings and
10 shall consider the expertise needed; whether time commitments
11 exceed in-house staff resources; whether local representation
12 is needed; the travel, lodging, and other costs associated
13 with in-house representation; and such other factors that the
14 board determines are relevant.

15 c. The plan may not retain a lobbyist to represent it
16 before the legislative or executive branch. However, full-time
17 employees of the plan may register as lobbyists and represent
18 that employer before the legislative or executive branch.

19 14. Provide for service standards for service
20 providers, methods of determining adherence to those service
21 standards, incentives and disincentives for service, and
22 procedures for terminating contracts for service providers
23 that fail to adhere to service standards.

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

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

31

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

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

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

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

16 21. Establish agent commission schedules.

17 22. For employers otherwise eligible for coverage
18 under the plan, establish three tiers of employers meeting the
19 criteria and subject to the rate limitations specified in this
20 subparagraph.

21 a. Tier One.--

22 (I) Criteria; rated employers.--An employer that has
23 an experience modification rating shall be included in Tier
24 One if the employer meets all of the following:

25 (A) The experience modification is below 1.00.

26 (B) The employer had no lost-time claims subsequent to
27 the applicable experience modification rating period.

28 (C) The total of the employer's medical-only claims
29 subsequent to the applicable experience modification rating
30 period did not exceed 20 percent of premium.

31

1 (II) Criteria; non-rated employers.--An employer that
2 does not have an experience modification rating shall be
3 included in Tier One if the employer meets all of the
4 following:

5 (A) The employer had no lost-time claims for the
6 3-year period immediately preceding the inception date or
7 renewal date of the employer's coverage under the plan.

8 (B) The total of the employer's medical-only claims
9 for the 3-year period immediately preceding the inception date
10 or renewal date of the employer's coverage under the plan did
11 not exceed 20 percent of premium.

12 (C) The employer has secured workers' compensation
13 coverage for the entire 3-year period immediately preceding
14 the inception date or renewal date of the employer's coverage
15 under the plan.

16 (D) The employer is able to provide the plan with a
17 loss history generated by the employer's prior workers'
18 compensation insurer, except if the employer is not able to
19 produce a loss history due to the insolvency of an insurer,
20 the receiver shall provide to the plan, upon the request of
21 the employer or the employer's agent, a copy of the employer's
22 loss history from the records of the insolvent insurer if the
23 loss history is contained in records of the insurer which are
24 in the possession of the receiver. If the receiver is unable
25 to produce the loss history, the employer may, in lieu of the
26 loss history, submit an affidavit from the employer and the
27 employer's insurance agent setting forth the loss history.

28 (E) The employer is not a new business.

29 (III) Premiums.--The premiums for Tier One insureds
30 shall be set at a premium level 25 percent above the
31 comparable voluntary market premiums until the plan has

1 sufficient experience as determined by the board to establish
2 an actuarially sound rate for Tier One, at which point the
3 board shall, subject to paragraph (e), adjust the rates, if
4 necessary, to produce actuarially sound rates, provided such
5 rate adjustment shall not take effect prior to January 1,
6 2007.

7 b. Tier Two.--

8 (I) Criteria; rated employers.--An employer that has
9 an experience modification rating shall be included in Tier
10 Two if the employer meets all of the following:

11 (A) The experience modification is equal to or greater
12 than 1.00 but not greater than 1.10.

13 (B) The employer had no lost-time claims subsequent to
14 the applicable experience modification rating period.

15 (C) The total of the employer's medical-only claims
16 subsequent to the applicable experience modification rating
17 period did not exceed 20 percent of premium.

18 (II) Criteria; non-rated employers.--An employer that
19 does not have any experience modification rating shall be
20 included in Tier Two if the employer is a new business. An
21 employer shall be included in Tier Two if the employer has
22 less than 3 years of loss experience in the 3-year period
23 immediately preceding the inception date or renewal date of
24 the employer's coverage under the plan and the employer meets
25 all of the following:

26 (A) The employer had no lost-time claims for the
27 3-year period immediately preceding the inception date or
28 renewal date of the employer's coverage under the plan.

29 (B) The total of the employer's medical-only claims
30 for the 3-year period immediately preceding the inception date
31

1 or renewal date of the employer's coverage under the plan did
2 not exceed 20 percent of premium.

3 (C) The employer is able to provide the plan with a
4 loss history generated by the workers' compensation insurer
5 that provided coverage for the portion or portions of such
6 period during which the employer had secured workers'
7 compensation coverage, except if the employer is not able to
8 produce a loss history due to the insolvency of an insurer,
9 the receiver shall provide to the plan, upon the request of
10 the employer or the employer's agent, a copy of the employer's
11 loss history from the records of the insolvent insurer if the
12 loss history is contained in records of the insurer which are
13 in the possession of the receiver. If the receiver is unable
14 to produce the loss history, the employer may, in lieu of the
15 loss history, submit an affidavit from the employer and the
16 employer's insurance agent setting forth the loss history.

17 (III) Premiums.--The premiums for Tier Two insureds
18 shall be set at a rate level 50 percent above the comparable
19 voluntary market premiums until the plan has sufficient
20 experience as determined by the board to establish an
21 actuarially sound rate for Tier Two, at which point the board
22 shall, subject to paragraph (e), adjust the rates, if
23 necessary, to produce actuarially sound rates, provided such
24 rate adjustment shall not take effect prior to January 1,
25 2007.

26 c. Tier Three.--

27 (I) Eligibility.--An employer shall be included in
28 Tier Three if the employer does not meet the criteria for Tier
29 One or Tier Two.

30
31

1 (II) Rates.--The board shall establish, subject to
2 paragraph (e), and the plan shall charge, actuarially sound
3 rates for Tier Three insureds.

4 23. For Tier One or Tier Two employers which employ no
5 nonexempt employees or which report payroll which is less than
6 the minimum wage hourly rate for one full-time employee for 1
7 year at 40 hours per week, the plan shall establish
8 actuarially sound premiums, provided, however, that the
9 premiums may not exceed \$2,500. These premiums shall be in
10 addition to the fee specified in subparagraph 26. When the
11 plan establishes actuarially sound rates for all employers in
12 Tier One and Tier Two, the premiums for employers referred to
13 in this paragraph are no longer subject to the \$2,500 cap.

14 24. Provide for a depopulation program to reduce the
15 number of insureds in the plan. If an employer insured through
16 the plan is offered coverage from a voluntary market carrier:

17 a. During the first 30 days of coverage under the
18 plan;

19 b. Before a policy is issued under the plan;

20 c. By issuance of a policy upon expiration or
21 cancellation of the policy under the plan; or

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

24
25 that employer is no longer eligible for coverage through the
26 plan. The premium for risks assumed by the voluntary market
27 carrier must be no greater than the premium the insured would
28 have paid under the plan, and shall be adjusted upon renewal
29 to reflect changes in the plan rates and the tier for which
30 the insured would qualify as of the time of renewal. The
31 insured may be charged such premiums only for the first 3

1 | years of coverage in the voluntary market. A premium under
2 | this subparagraph is deemed approved and is not an excess
3 | premium for purposes of s. 627.171.

4 | 25. Require that policies issued and applications must
5 | include a notice that the policy could be replaced by a policy
6 | issued from a voluntary market carrier and that, if an offer
7 | of coverage is obtained from a voluntary market carrier, the
8 | policyholder is no longer eligible for coverage through the
9 | plan. The notice must also specify that acceptance of coverage
10 | under the plan creates a conclusive presumption that the
11 | applicant or policyholder is aware of this potential.

12 | 26. Require that each application for coverage and
13 | each renewal premium be accompanied by a nonrefundable fee of
14 | \$475 to cover costs of administration and fraud prevention.
15 | The board may, with the prior approval of the office, increase
16 | the amount of the fee pursuant to a rate filing to reflect
17 | increased costs of administration and fraud prevention. The
18 | fee is not subject to commission and is fully earned upon
19 | commencement of coverage.

20 | (d)1. The funding of the plan shall include premiums
21 | as provided in subparagraph (c)22. and assessments as provided
22 | in this paragraph.

23 | 2.a. If the board determines that a deficit exists in
24 | Tier One or Tier Two or that there is any deficit remaining
25 | attributable to any of the plan's former subplans and that the
26 | deficit cannot be fully funded by using policyholder surplus
27 | attributable to former subplan C or, if the surplus in the
28 | former subplan C does not fully fund the deficit and the
29 | deficit cannot be fully funded by using any remaining funds in
30 | the contingency reserve without the use of deficit
31 | ~~assessments~~, the board shall request the office to levy, by

1 order, a deficit assessment against premiums charged to
2 insureds for workers' compensation insurance by insurers as
3 defined in s. 631.904(5). The office shall issue the order
4 after verifying the amount of the deficit. The assessment
5 shall be specified as a percentage of future premium
6 collections, as recommended by the board and approved by the
7 office. The same percentage shall apply to premiums on all
8 workers' compensation policies issued or renewed during the
9 12-month period beginning on the effective date of the
10 assessment, as specified in the order.

11 b. With respect to each insurer collecting premiums
12 that are subject to the assessment, the insurer shall collect
13 the assessment at the same time as the insurer collects the
14 premium payment for each policy and shall remit the
15 assessments collected to the plan as provided in the order
16 issued by the office. The office shall verify the accurate and
17 timely collection and remittance of deficit assessments and
18 shall report such information to the board. Each insurer
19 collecting assessments shall provide such information with
20 respect to premiums and collections as may be required by the
21 office to enable the office to monitor and audit compliance
22 with this paragraph.

23 c. Deficit assessments are not considered part of an
24 insurer's rate, are not premium, and are not subject to the
25 premium tax, to the assessments under ss. 440.49 and 440.51,
26 to the surplus lines tax, to any fees, or to any commissions.
27 The deficit assessment imposed shall become plan funds at the
28 moment of collection and shall not constitute income to the
29 insurer for any purpose, including financial reporting on the
30 insurer's income statement. An insurer is liable for all
31 assessments that the insurer collects and must treat the

1 failure of an insured to pay an assessment as a failure to pay
2 premium. An insurer is not liable for uncollectible
3 assessments.

4 d. When an insurer is required to return unearned
5 premium, the insurer shall also return any collected
6 assessments attributable to the unearned premium.

7 e. Deficit assessments as described in this
8 subparagraph shall not be levied after July 1, 2011 ~~2007~~.

9 3.a. All policies issued to Tier Three insureds shall
10 be assessable. All Tier Three assessable policies must be
11 clearly identified as assessable by containing, in contrasting
12 color and in not less than 10-point type, the following
13 statement:

14
15 "This is an assessable policy. If the plan is
16 unable to pay its obligations, policyholders
17 will be required to contribute on a pro rata
18 earned premium basis the money necessary to
19 meet any assessment levied."
20

21 b. The board may from time to time assess Tier Three
22 insureds to whom the plan has issued assessable policies for
23 the purpose of funding plan deficits. Any such assessment
24 shall be based upon a reasonable actuarial estimate of the
25 amount of the deficit, taking into account the amount needed
26 to fund medical and indemnity reserves and reserves for
27 incurred but not reported claims, and allowing for general
28 administrative expenses, the cost of levying and collecting
29 the assessment, a reasonable allowance for estimated
30 uncollectible assessments, and allocated and unallocated loss
31 adjustment expenses.

1 c. Each Tier Three insured's share of a deficit shall
2 be computed by applying to the premium earned on the insured's
3 policy or policies during the period to be covered by the
4 assessment the ratio of the total deficit to the total
5 premiums earned during such period upon all policies subject
6 to the assessment. If one or more Tier Three insureds fail to
7 pay an assessment, the other Tier Three insureds shall be
8 liable on a proportionate basis for additional assessments to
9 fund the deficit. The plan may compromise and settle
10 individual assessment claims without affecting the validity of
11 or amounts due on assessments levied against other insureds.
12 The plan may offer and accept discounted payments for
13 assessments which are promptly paid. The plan may offset the
14 amount of any unpaid assessment against unearned premiums
15 which may otherwise be due to an insured. The plan shall
16 institute legal action when necessary and appropriate to
17 collect the assessment from any insured who fails to pay an
18 assessment when due.

19 d. The venue of a proceeding to enforce or collect an
20 assessment or to contest the validity or amount of an
21 assessment shall be in the Circuit Court of Leon County.

22 e. If the board finds that a deficit in Tier Three
23 exists for any period and that an assessment is necessary, the
24 board shall certify to the office the need for an assessment.
25 No sooner than 30 days after the date of such certification,
26 the board shall notify in writing each insured who is to be
27 assessed that an assessment is being levied against the
28 insured, and informing the insured of the amount of the
29 assessment, the period for which the assessment is being
30 levied, and the date by which payment of the assessment is
31 due. The board shall establish a date by which payment of the

1 assessment is due, which shall be no sooner than 30 days nor
2 later than 120 days after the date on which notice of the
3 assessment is mailed to the insured.

4 f. Whenever the board makes a determination that the
5 plan does not have a sufficient cash basis to meet 6 ~~3~~ months
6 of projected cash needs due to a deficit in Tier Three, the
7 board may request the department to transfer funds from the
8 Workers' Compensation Administration Trust Fund to the plan in
9 an amount sufficient to fund the difference between the amount
10 available and the amount needed to meet a 6-month ~~3-month~~
11 projected cash need as determined by the board and verified by
12 the office, subject to the approval of the Legislative Budget
13 Commission. If the Legislative Budget Commission approves a
14 transfer of funds under this sub-subparagraph, the plan shall
15 report to the Legislature the transfer of funds and the
16 Legislature shall review the plan during the next legislative
17 session or the current legislative session, if the transfer
18 occurs during a legislative session. This sub-subparagraph
19 shall not apply until the plan determines and the office
20 verifies that assessments collected by the plan pursuant to
21 sub-subparagraph b. are insufficient to fund the deficit in
22 Tier Three and to meet 6 ~~3~~ months of projected cash needs.

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

25 (e) For rates and rating plans effective on or after
26 January 1, 2007, the plan shall be subject to the same
27 requirements of this part for the filing and approval of its
28 rates and rating plans as apply to workers' compensation
29 insurers, except as otherwise provided. ~~establish and use its~~
30 ~~rates and rating plans, and the plan may establish and use~~
31 ~~changes in rating plans at any time, but no more frequently~~

1 ~~than two times per any rating class for any calendar year. By~~
2 ~~December 1, 1993, and December 1 of each year thereafter,~~
3 ~~except as provided in subparagraph (c)22., the board shall~~
4 ~~establish and use actuarially sound rates for use by the plan~~
5 ~~to assure that the plan is self funding while those rates are~~
6 ~~in effect. Such rates and rating plans must be filed with the~~
7 ~~office within 30 calendar days after their effective dates,~~
8 ~~and shall be considered a "use and file" filing. Any~~
9 ~~disapproval by the office must have an effective date that is~~
10 ~~at least 60 days from the date of disapproval of the rates and~~
11 ~~rating plan and must have prospective effect only. The plan~~
12 ~~may not be subject to any order by the office to return to~~
13 ~~policyholders any portion of the rates disapproved by the~~
14 ~~office. The office may not disapprove any rates or rating~~
15 ~~plans unless it demonstrates that such rates and rating plans~~
16 ~~are excessive, inadequate, or unfairly discriminatory.~~

17 (f) No later than June 1 of each year, the plan shall
18 obtain an independent actuarial certification of the results
19 of the operations of the plan for prior years, and shall
20 furnish a copy of the certification to the office. If, after
21 the effective date of the plan, the projected ultimate
22 incurred losses and expenses and dividends for prior years
23 exceed collected premiums, accrued net investment income, and
24 prior assessments for prior years, the certification is
25 subject to review and approval by the office before it becomes
26 final.

27 (g) Whenever a deficit exists, the plan shall, within
28 90 days, provide the office with a program to eliminate the
29 deficit within a reasonable time. The deficit may be funded
30 through increased premiums charged to insureds of the plan for
31 subsequent years, through the use of policyholder surplus

1 attributable to any year, including policyholder surplus in
2 former subplan C as authorized in subparagraph (d)2., through
3 the use of assessments as provided in subparagraph (d)2., and
4 through assessments on assessable policies as provided in
5 subparagraph (d)3. Any entity that was a policyholder of
6 former subplan C shall not be subject to any assessments that
7 are attributable to deficits in former subplan C.

8 (h) Any premium or assessments collected by the plan
9 in excess of the amount necessary to fund projected ultimate
10 incurred losses and expenses of the plan and not paid to
11 insureds of the plan in conjunction with loss prevention or
12 dividend programs shall be retained by the plan for future
13 use. Any state funds received by the plan in excess of the
14 amount necessary to fund deficits in subplan D or any tier
15 shall be returned to the state.

16 (i) The decisions of the board of governors do not
17 constitute final agency action and are not subject to chapter
18 120.

19 (j) Policies for insureds shall be issued by the plan.

20 (k) The plan created under this subsection is liable
21 only for payment for losses arising under policies issued by
22 the plan with dates of accidents occurring on or after January
23 1, 1994.

24 (l) Plan losses are the sole and exclusive
25 responsibility of the plan, and payment for such losses must
26 be funded in accordance with this subsection and must not
27 come, directly or indirectly, from insurers or any guaranty
28 association for such insurers.

29 (m) Senior managers and officers, as defined in the
30 plan of operation, and members of the board of governors shall
31 be subject to part III of chapter 112, including, but not

1 limited to, the code of ethics and public disclosure and
2 reporting of financial interests, pursuant to s. 112.3145.
3 Senior managers, officers, and board members are also required
4 to file such disclosures with the Office of Insurance
5 Regulation. The executive director of the plan or his or her
6 designee shall notify each newly appointed and existing
7 appointed member of the board of governors, senior manager and
8 officer of their duty to comply with the reporting
9 requirements of part III of chapter 112. At least quarterly,
10 the executive director of the plan or his or her designee
11 shall submit to the Commission on Ethics a list of names of
12 the senior managers, officers, members of the board of
13 governors that are subject to the public disclosure
14 requirements under s. 112.3145. ~~Each joint underwriting plan~~
15 ~~or association created under this section is not a state~~
16 ~~agency, board, or commission. However, for the purposes of s.~~
17 ~~199.183(1) only, the joint underwriting plan is a political~~
18 ~~subdivision of the state and is exempt from the corporate~~
19 ~~income tax.~~

20 (n) On or before July 1 of each year, employees of the
21 plan are required to sign and submit a statement to the plan
22 attesting that they do not have a conflict of interest, as
23 defined in part III of chapter 112. As a condition of
24 employment, all prospective employees are required to sign and
25 submit a conflict-of-interest statement to the plan. ~~Each~~
26 ~~joint underwriting plan or association may elect to pay~~
27 ~~premium taxes on the premiums received on its behalf or may~~
28 ~~elect to have the member insurers to whom the premiums are~~
29 ~~allocated pay the premium taxes if the member insurer had~~
30 ~~written the policy. The joint underwriting plan or association~~
31 ~~shall notify the member insurers and the Department of Revenue~~

1 ~~by January 15 of each year of its election for the same year.~~
2 ~~As used in this paragraph, the term "premiums received" means~~
3 ~~the consideration for insurance, by whatever name called, but~~
4 ~~does not include any policy assessment or surcharge received~~
5 ~~by the joint underwriting association as a result of~~
6 ~~apportioning losses or deficits of the association pursuant to~~
7 ~~this section.~~

8 (o) Any senior manager or officer of the plan who is
9 employed by the plan as of January 1, 2007, regardless of the
10 date of hire, and who subsequently retires or terminates
11 employment is prohibited from representing another person or
12 entity before the plan for 2 years after retirement or
13 termination of employment from the plan.

14 (p) No part of the income of the plan may inure to the
15 benefit of any private person.

16 (q) Notwithstanding ss. 112.3148 and 112.3149 or other
17 provision of law, an employee or board member may not
18 knowingly accept, directly or indirectly, any expenditure or
19 gift from a person or entity, or an employee or representative
20 of such person or entity, which has a contractual relationship
21 with the plan or who is under consideration for a contract. An
22 employee or board member that fails to comply with this
23 paragraph is subject to penalties provided under ss. 112.317
24 and 112.3173.

25 (r) Nothing contained in this section shall be
26 construed as barring the plan from providing insurance
27 coverage to any employer with whom a former employee of the
28 plan is affiliated or employing or reemploying any former
29 employee of the plan in a part-time, full-time, temporary, or
30 permanent capacity, so long as such employment does not
31 violate any provision of part III of chapter 112.

1 (s)~~(o)~~ Neither the plan nor any member of the board of
2 governors is liable for monetary damages to any person for any
3 statement, vote, decision, or failure to act, regarding the
4 management or policies of the plan, unless:
5 1. The member breached or failed to perform her or his
6 duties as a member; and
7 2. The member's breach of, or failure to perform,
8 duties constitutes:
9 a. A violation of the criminal law, unless the member
10 had reasonable cause to believe her or his conduct was not
11 unlawful. A judgment or other final adjudication against a
12 member in any criminal proceeding for violation of the
13 criminal law estops that member from contesting the fact that
14 her or his breach, or failure to perform, constitutes a
15 violation of the criminal law; but does not estop the member
16 from establishing that she or he had reasonable cause to
17 believe that her or his conduct was lawful or had no
18 reasonable cause to believe that her or his conduct was
19 unlawful;
20 b. A transaction from which the member derived an
21 improper personal benefit, either directly or indirectly; or
22 c. Recklessness or any act or omission that was
23 committed in bad faith or with malicious purpose or in a
24 manner exhibiting wanton and willful disregard of human
25 rights, safety, or property. For purposes of this
26 sub-subparagraph, the term "recklessness" means the acting, or
27 omission to act, in conscious disregard of a risk:
28 (I) Known, or so obvious that it should have been
29 known, to the member; and
30
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1 (II) Known to the member, or so obvious that it should
2 have been known, to be so great as to make it highly probable
3 that harm would follow from such act or omission.

4 ~~(t)~~~~(p)~~ No insurer shall provide workers' compensation
5 and employer's liability insurance to any person who is
6 delinquent in the payment of premiums, assessments, penalties,
7 or surcharges owed to the plan or to any person who is an
8 affiliated person of a person who is delinquent in the payment
9 of premiums, assessments, penalties, or surcharges owed to the
10 plan. For purposes of this paragraph, the term "affiliated
11 person" of another person means:

12 1. The spouse of such other natural person;

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

16 3. Any person who directly or indirectly owns 5
17 percent or more of the outstanding voting securities that are
18 directly or indirectly owned or controlled, or held with the
19 power to vote, by such other person;

20 4. Any person or group of persons who directly or
21 indirectly control, are controlled by, or are under common
22 control with such other person;

23 5. Any officer, director, trustee, partner, owner,
24 manager, joint venturer, or employee, or other person
25 performing duties similar to persons in those positions, of
26 such other persons; or

27 6. Any person who has an officer, director, trustee,
28 partner, or joint venturer in common with such other person.

29 ~~(u)~~~~(e)~~ Effective July 1, 2004, the plan is exempt from
30 the premium tax under s. 624.509 and any assessments under ss.
31 440.49 and 440.51.

1 (v) The Office of Insurance Regulation shall perform a
2 comprehensive market conduct examination of the plan
3 periodically to determine compliance with its plan of
4 operation and internal operating policies and procedures.

5 (w) Upon dissolution, the assets of the plan shall be
6 applied first to pay all debts, liabilities, and obligations
7 of the plan, including the establishment of reasonable
8 reserves for any contingent liabilities or obligations, and
9 all remaining assets of the plan shall become property of the
10 state and shall be deposited in the Workers' Compensation
11 Administration Trust Fund. However, dissolution shall not take
12 effect as long as the plan has financial obligations
13 outstanding unless adequate provision has been made for the
14 payment of financial obligations pursuant to the documents
15 authorizing the financial obligations.

16 (6) Each joint underwriting plan or association
17 created under this section is not a state agency, board, or
18 commission. However, for the purposes of s. 199.183(1) only,
19 the joint underwriting plan created under subsection (5) is a
20 political subdivision of the state and is exempt from the
21 corporate income tax.

22 (7) Each joint underwriting plan or association may
23 elect to pay premium taxes on the premiums received on its
24 behalf or may elect to have the member insurers to whom the
25 premiums are allocated pay the premium taxes if the member
26 insurer had written the policy. The joint underwriting plan or
27 association shall notify the member insurers and the
28 Department of Revenue by January 15 of each year of its
29 election for the same year. As used in this paragraph, the
30 term "premiums received" means the consideration for
31 insurance, by whatever name called, but does not include any

1 policy assessment or surcharge received by the joint
2 underwriting association as a result of apportioning losses or
3 deficits of the association pursuant to this section.

4 ~~(8)(6)~~ As used in this section and ss. 215.555 and
5 627.351, the term "collateral protection insurance" means
6 commercial property insurance of which a creditor is the
7 primary beneficiary and policyholder and which protects or
8 covers an interest of the creditor arising out of a credit
9 transaction secured by real or personal property. Initiation
10 of such coverage is triggered by the mortgagor's failure to
11 maintain insurance coverage as required by the mortgage or
12 other lending document. Collateral protection insurance is not
13 residential coverage.

14 ~~(9)(7)(a)~~ The Florida Automobile Joint Underwriting
15 Association created under this section shall be deemed to have
16 appointed its general manager as its agent to receive service
17 of all legal process issued against the association in any
18 civil action or proceeding in this state. Process so served
19 shall be valid and binding upon the insurer.

20 (b) Service of process upon the association's general
21 manager as the association's agent pursuant to such an
22 appointment shall be the sole method of service of process
23 upon the association.

24 Section 2. Section 2 of chapter 2004-266, Laws of
25 Florida, appearing as a footnote to section 627.311, Florida
26 Statutes, is amended to read:

27 Notwithstanding the provisions of ss. 440.50 and
28 440.51, Florida Statutes, subject to the following procedures
29 and approval, the Department of Financial Services may request
30 transfer funds from the Workers' Compensation Administration
31 Trust Fund within the Department of Financial Services to the

1 workers' compensation joint underwriting plan provided in s.
2 627.311(5), Florida Statutes.

3 (1) The department shall establish a contingency
4 reserve within the Workers' Compensation Administration Trust
5 Fund, from which the department is authorized to expend funds
6 as provided in the subsection, in an amount not to exceed \$15
7 million to be released only upon the approval of a budget
8 amendment presented to the Legislative Budget Commission. For
9 actuarial deficits projected for policyholders, based on
10 actuarial best estimates, covered in subplan~~"D"~~ prior to July
11 1, 2004, or Tier One or Tier Two, and upon verification by the
12 Office of Insurance Regulation, the plan is authorized to
13 request and the department is authorized to submit a budget
14 amendment in an amount not to exceed \$15 million for the
15 purpose of funding deficits in the subplan or the tier ~~subplan~~
16 ~~"D"~~.

17 (2) After the contingency reserve is established,
18 whenever the board determines the subplan or the tier ~~subplan~~
19 ~~"D"~~ does not have a sufficient cash basis to meet a 6-month
20 period ~~3 months~~ of projected cash needs due to any deficit in
21 the subplan or the tier remaining after accessing any
22 policyholder surplus attributable to former subplan C, ~~subplan~~
23 ~~"D,"~~ the board is authorized to request the department to
24 transfer funds from the contingency reserve fund within the
25 Workers' Compensation Administration Trust Fund to the plan in
26 an amount sufficient to fund the difference between the amount
27 available and the amount needed to meet the subplan's or the
28 tier's ~~subplan "D"'s~~ projected cash need for the subsequent
29 6-month ~~3-month~~ period. The board and the office must first
30 certify to the Department of Financial Services that there is
31 not sufficient cash within the subplan or the tier ~~subplan "D"~~

1 to meet the projected cash needs in the subplan or the tier
2 ~~subplan "D"~~ within the subsequent 6-month period ~~3 months~~. The
3 amount requested for transfer to the subplan or the tier
4 ~~subplan "D"~~ may not exceed the difference between the amount
5 available within the subplan or the tier ~~subplan "D"~~ and the
6 amount needed to meet the subplan's or the tier's ~~subplan~~
7 ~~"D"'s~~ projected cash need for the subsequent 6-month ~~3-month~~
8 period, as jointly certified by the board and the Office of
9 Insurance Regulation to the Department of Financial Services,
10 attributable to the former subplan or the tier ~~subplan "D"~~
11 policyholders. The Department of Financial Services may submit
12 a budget amendment to request release of funds from the
13 Workers' Compensation Administration Trust Fund, subject to
14 the approval of the Legislative Budget Commission. The board
15 will provide, for review of the Legislative Budget Commission,
16 information on the reasonableness of the plan's
17 administration, including, but not limited to, the plan of
18 operations and costs, claims costs, claims administration
19 costs, overhead costs, claims reserves, and the latest report
20 submitted on administration cost reduction alternatives as
21 required in s. 627.311(5)(c)17., Florida Statutes.

22 (3) This section expires July 1, 2011 ~~2007~~.

23 Section 3. No later than January 1, 2007, the plan
24 shall submit a request to the Internal Revenue Service for a
25 letter ruling or determination on the plan's eligibility as a
26 section 501(c)(3) tax-exempt organization.

27 Section 4. Except as otherwise expressly provided in
28 this act, this act shall take effect July 1, 2006.

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1 STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
2 COMMITTEE SUBSTITUTE FOR
3 Senate Bill 2118

- 4 1. Requires the Financial Services Commission to select and
5 appoint all nine board members of the Workers'
6 Compensation Joint Underwriting Association, including
7 five representatives of the insurance industry and the
8 consumer advocate. Currently the FSC appoints 3 of the 9
9 members and the insurance industry appoints 5 members.
- 10 2. Requires senior managers, officers, and board members be
11 subject to part III of ch. 112, F.S., including but not
12 limited to, standards of conduct, public disclosure and
13 reporting of financial interests to the Commission on
14 Ethics on an annual basis.
- 15 3. Prohibits any senior manager or officer, employed on
16 January 1, 2007, regardless of the original date of hire,
17 and who retires from the JUA from representing another
18 person before the JUA for a two-year period.
- 19 4. Prohibits employees and board members of the plan from
20 accepting any gift or expenditure of any value from any
21 person or entity who has a contractual relationship with
22 the plan or who is under consideration for a contract.
- 23 5. Requires competitive selection of goods and services
24 valued at over \$25,000, with exceptions. Any purchase
25 that exceeds \$100,000 requires approval by the board of
26 governors.
- 27 6. Provides guidelines for determining whether staff
28 attorneys or outside attorneys should be used.
- 29 7. Prohibits the JUA from retaining an outside lobbyist and
30 authorizes the JUA to employ a full-time employee of the
31 plan to register as a lobbyist for the plan.
8. Requires the use of surplus funds in subplan C to fund
deficits in Tiers one or two or subplan D, prior to using
any state funds or levying any assessments on
policyholders.
9. Extends the deadline for levying assessments to fund
deficits in any tier or former subplan from July 1, 2007,
to July 1, 2011.
10. Requires the JUA to obtain prior approval of rates prior
to their use, effective for rates and rating plans
effective on or after January 1, 2007.
11. Requires all assets of the JUA to be first used to pay
all debts and obligations of the plan and any remaining
assets to become property of the state upon dissolution
of the JUA to assist the JUA in achieving its tax-exempt
status.
12. Requires the JUA to seek a letter ruling or determination
from the IRS as to the JUA's eligibility as a 501(c)(3)

1 tax-exempt organization.
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