CHAMBER ACTION

1 The Insurance Committee recommends the following:
2
3 **Council/Committee Substitute**
4 Remove the entire bill and insert:
5 A bill to be entitled
6 An act relating to the Florida Workers' Compensation Joint
7 Underwriting Association; amending s. 627.311, F.S.;
8 requiring the joint underwriting plan of insurers to
9 operate as the Florida Workers' Compensation Joint
10 Underwriting Association; revising the membership and
11 duties of the board of governors relating to the operation
12 of the joint underwriting plan; providing for continuous
13 review of the plan; authorizing the Office of Insurance
14 Regulation to withdraw approval of the plan under certain
15 circumstances; requiring the periodic review and update of
16 the market-assistance plan; providing requirements and
17 procedures for procurement of goods and services;
18 prohibiting the retention of certain lobbyist services;
19 providing requirements for legal services; authorizing
20 certain employees to provide lobbyist services;
21 authorizing the use of certain subplan surplus funds;
22 extending the deadline to levy deficit assessments;
23 requiring the board to request the transfer of funds from

24 the Workers' Compensation Administration Trust Fund under
25 certain circumstances; requiring that the plan be subject
26 to certain filing and approval rates and rating plan
27 requirements; deleting certain provisions limiting the
28 disapproval of rates by the Office of Insurance
29 Regulation; requiring that excess funds received by the
30 plan be returned to the state; providing applicability of
31 specified statutes regulating ethical standards; requiring
32 certain disclosure statements for plan employees;
33 prescribing limits on certain representation by former
34 plan employees; prohibiting a private individual's ability
35 to benefit from the plan's income; prohibiting employees
36 and board members from accepting gifts or expenditures
37 from persons and entities with certain relationships to
38 the plan; providing applicability; requiring the Office of
39 Insurance Regulation to perform periodic comprehensive
40 market examinations; prescribing disposition of assets of
41 the plan upon dissolution; providing exemption from the
42 corporate income tax; providing for the payment of premium
43 taxes; amending s. 2 of ch. 2004-266, Laws of Florida;
44 allowing the contingency reserve to be used to fund
45 certain deficits; extending the period for maintaining the
46 contingency reserve and projecting current cash needs;
47 requiring the plan to submit a request for an Internal
48 Revenue Service letter determining the plan's eligibility
49 as a tax-exempt organization; providing an effective date.
50
51 Be It Enacted by the Legislature of the State of Florida:

52

53 Section 1. Subsections (5), (6), and (7) of section
54 627.311, Florida Statutes, are amended to read:
55 627.311 Joint underwriters and joint reinsurers; public
56 records and public meetings exemptions.--
57 (5)(a) The office shall, after consultation with insurers,
58 approve a joint underwriting plan of insurers which shall be
59 known as the "Florida Workers' Compensation Joint Underwriting
60 Association, Inc.," and which shall operate as a corporation not
61 for profit ~~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 such insurance through the voluntary market.
72 Except as provided herein, the plan must have actuarially sound
73 rates that ensure that the plan is self-supporting.
74 (b) The operation of the plan is subject to the
75 supervision of a 9-member board of governors. Each member
76 described in subparagraph 1., subparagraph 2., subparagraph 3.,
77 or subparagraph 5. shall be appointed by the Financial Services
78 Commission and shall serve at the pleasure of the commission.
79 The board of governors shall be comprised of:

80 ~~1. Three members appointed by the Financial Services~~
81 ~~Commission. Each member appointed by the commission shall serve~~
82 ~~at the pleasure of the commission;~~
83 <u>1.</u>~~2.~~ Two <u>representatives</u> of the 20 domestic insurers, as
84 defined in s. 624.06(1), having the largest voluntary direct
85 premiums written in this state for workers' compensation and
86 employer's liability insurance~~, which shall be elected by those~~
87 ~~20 domestic insurers~~;
88 <u>2.</u>~~3.~~ Two <u>representatives</u> of the 20 foreign insurers as
89 defined in s. 624.06(2) having the largest voluntary direct
90 premiums written in this state for workers' compensation and
91 employer's liability insurance~~, which shall be elected by those~~
92 ~~20 foreign insurers~~;
93 <u>3.</u>~~4.~~ One <u>representative of</u> ~~person appointed by~~ the largest
94 property and casualty insurance agents' association in this
95 state; ~~and~~
96 <u>4.</u>~~5.~~ The consumer advocate appointed under s. 627.0613 or
97 the consumer advocate's designee<u>; and</u>~~.~~
98 <u>5. Three other persons appointed by the commission.</u>
99
100 Each board member shall <u>be appointed to</u> ~~serve~~ a 4-year term and
101 may <u>be appointed to</u> ~~serve~~ consecutive terms. A vacancy on the
102 board shall be filled in the same manner as the original
103 appointment for the unexpired portion of the term. The Financial
104 Services Commission shall designate a member of the board to
105 serve as chair. No board member shall be an insurer which
106 provides services to the plan or which has an affiliate which
107 provides services to the plan or which is serviced by a service

108 company or third-party administrator which provides services to
109 the plan or which has an affiliate which provides services to
110 the plan. The meetings and records ~~minutes, audits, and~~
111 ~~procedures~~ of the board of governors and the plan are subject to
112 chapters ~~chapter~~ 119 and 286, unless otherwise exempted by law.
113 (c) The operation of the plan shall be governed by a plan
114 of operation that is prepared at the direction of the board of
115 governors and approved by order of the office. The plan is
116 subject to continuous review by the office. The office may, by
117 order, withdraw approval of all or part of a plan if the office
118 determines that conditions have changed since approval was
119 granted and that the purposes of the plan require changes in the
120 plan. ~~The plan of operation may be changed at any time by the~~
121 ~~board of governors or upon request of the office. The plan of~~
122 ~~operation and all changes thereto are subject to the approval of~~
123 ~~the office.~~ The plan of operation shall:
124 1. Authorize the board to engage in the activities
125 necessary to implement this subsection, including, but not
126 limited to, borrowing money.
127 2. Develop criteria for eligibility for coverage by the
128 plan, including, but not limited to, documented rejection by at
129 least two insurers which reasonably assures that insureds
130 covered under the plan are unable to acquire coverage in the
131 voluntary market.
132 3. Require notice from the agent to the insured at the
133 time of the application for coverage that the application is for
134 coverage with the plan and that coverage may be available
135 through an insurer, group self-insurers' fund, commercial self-

136 insurance fund, or assessable mutual insurer through another
137 agent at a lower cost.
138 4. Establish programs to encourage insurers to provide
139 coverage to applicants of the plan in the voluntary market and
140 to insureds of the plan, including, but not limited to:
141 a. Establishing procedures for an insurer to use in
142 notifying the plan of the insurer's desire to provide coverage
143 to applicants to the plan or existing insureds of the plan and
144 in describing the types of risks in which the insurer is
145 interested. The description of the desired risks must be on a
146 form developed by the plan.
147 b. Developing forms and procedures that provide an insurer
148 with the information necessary to determine whether the insurer
149 wants to write particular applicants to the plan or insureds of
150 the plan.
151 c. Developing procedures for notice to the plan and the
152 applicant to the plan or insured of the plan that an insurer
153 will insure the applicant or the insured of the plan, and notice
154 of the cost of the coverage offered; and developing procedures
155 for the selection of an insuring entity by the applicant or
156 insured of the plan.
157 d. Provide for a market-assistance plan to assist in the
158 placement of employers. All applications for coverage in the
159 plan received 45 days before the effective date for coverage
160 shall be processed through the market-assistance plan. A market-
161 assistance plan specifically designed to serve the needs of
162 small, good policyholders as defined by the board must be
163 reviewed and updated periodically ~~finalized by January 1, 1994~~.

164 5. Provide for policy and claims services to the insureds
165 of the plan of the nature and quality provided for insureds in
166 the voluntary market.
167 6. Provide for the review of applications for coverage
168 with the plan for reasonableness and accuracy, using any
169 available historic information regarding the insured.
170 7. Provide for procedures for auditing insureds of the
171 plan which are based on reasonable business judgment and are
172 designed to maximize the likelihood that the plan will collect
173 the appropriate premiums.
174 8. Authorize the plan to terminate the coverage of and
175 refuse future coverage for any insured that submits a fraudulent
176 application to the plan or provides fraudulent or grossly
177 erroneous records to the plan or to any service provider of the
178 plan in conjunction with the activities of the plan.
179 9. Establish service standards for agents who submit
180 business to the plan.
181 10. Establish criteria and procedures to prohibit any
182 agent who does not adhere to the established service standards
183 from placing business with the plan or receiving, directly or
184 indirectly, any commissions for business placed with the plan.
185 11. Provide for the establishment of reasonable safety
186 programs for all insureds in the plan. All insureds of the plan
187 must participate in the safety program.
188 12. Authorize the plan to terminate the coverage of and
189 refuse future coverage to any insured who fails to pay premiums
190 or surcharges when due; who, at the time of application, is
191 delinquent in payments of workers' compensation or employer's

192 liability insurance premiums or surcharges owed to an insurer,
193 group self-insurers' fund, commercial self-insurance fund, or
194 assessable mutual insurer licensed to write such coverage in
195 this state; or who refuses to substantially comply with any
196 safety programs recommended by the plan.
197 13. Authorize the board of governors to provide the goods
198 and services required by the plan through staff employed by the
199 plan, through reasonably compensated service providers who
200 contract with the plan to provide services as specified by the
201 board of governors, or through a combination of employees and
202 service providers.
203 a. The procurement of goods with a value of less than
204 $2,500 shall be carried out using good purchasing practices,
205 such as the receipt of written quotes or written records of
206 telephone quotes. Purchases that equal or exceed $2,500 but are
207 less than or equal to $25,000 may be made by using good
208 purchasing practices, such as receipt of written quotes, written
209 records of telephone quotes, or informal bids, whenever
210 practical. The procurement of goods or services valued over
211 $25,000 are subject to competitive solicitation, except in
212 situations in which the goods or services are provided by a sole
213 source or are deemed an emergency purchase, or the services are
214 exempted from competitive solicitation requirements under s.
215 287.057(5)(f). Justification for the sole-sourcing or emergency
216 procurement must be documented. Contracts for goods or services
217 valued at or over $100,000 are subject to board approval.

218 b. In determining whether legal services should be
219 provided by staff attorneys or outsourced to private attorneys,
220 the plan shall consider the following factors:
221 (I) The nature of the attorney services to be provided and
222 the issues involved.
223 (II) The need for private attorneys rather than staff
224 attorneys, using the criteria provided in sub-subparagraph 13.c.
225 (III) The criteria by which the plan selected the private
226 attorney or law firm it proposes to employ, using the criteria
227 provided in sub-subparagraph 13.c.
228 (IV) Competitive fees for similar attorney services.
229 (V) The plan's analysis estimating the number of hours for
230 attorney services, the costs, the total contract amount, and,
231 when appropriate, a risk or cost-benefit analysis.
232 (VI) Which partners, associates, paralegals, research
233 associates, or other personnel will be used and how their time
234 will be billed to the plan.
235 (VII) Any other information that the plan deems
236 appropriate for the proper evaluation of the need for such
237 private attorney services.
238 c. The plan shall use the following criteria when
239 selecting outside firms for attorney services:
240 (I) The magnitude or complexity of the case.
241 (II) The firm's rating and certifications.
242 (III) The firm's minority status.
243 (IV) The firm's physical proximity to the case and the
244 plan.
245 (V) The firm's prior experience with the plan.

246 (VI) The firm's prior experience with similar cases or
247 issues.
248 (VII) The firm's billing methodology and proposed rate.
249 (VIII) The firm's current or past adversarial position or
250 conflict of interest with the plan.
251 (IX) The firm's willingness to use resources of the plan
252 to minimize costs.
253 d. The plan may not retain a lobbyist to represent it
254 before the legislative or executive branch. However, full-time
255 employees of the plan may register as lobbyists and represent
256 that employer before the legislative or executive branch.
257 14. Provide for service standards for service providers,
258 methods of determining adherence to those service standards,
259 incentives and disincentives for service, and procedures for
260 terminating contracts for service providers that fail to adhere
261 to service standards.
262 15. Provide procedures for selecting service providers and
263 standards for qualification as a service provider that
264 reasonably assure that any service provider selected will
265 continue to operate as an ongoing concern and is capable of
266 providing the specified services in the manner required.
267 16. Provide for reasonable accounting and data-reporting
268 practices.
269 17. Provide for annual review of costs associated with the
270 administration and servicing of the policies issued by the plan
271 to determine alternatives by which costs can be reduced.
272 18. Authorize the acquisition of such excess insurance or
273 reinsurance as is consistent with the purposes of the plan.

274 19. Provide for an annual report to the office on a date
275 specified by the office and containing such information as the
276 office reasonably requires.
277 20. Establish multiple rating plans for various
278 classifications of risk which reflect risk of loss, hazard
279 grade, actual losses, size of premium, and compliance with loss
280 control. At least one of such plans must be a preferred-rating
281 plan to accommodate small-premium policyholders with good
282 experience as defined in sub-subparagraph 22.a.
283 21. Establish agent commission schedules.
284 22. For employers otherwise eligible for coverage under
285 the plan, establish three tiers of employers meeting the
286 criteria and subject to the rate limitations specified in this
287 subparagraph.
288 a. Tier One.--
289 (I) Criteria; rated employers.--An employer that has an
290 experience modification rating shall be included in Tier One if
291 the employer meets all of the following:
292 (A) The experience modification is below 1.00.
293 (B) The employer had no lost-time claims subsequent to the
294 applicable experience modification rating period.
295 (C) The total of the employer's medical-only claims
296 subsequent to the applicable experience modification rating
297 period did not exceed 20 percent of premium.
298 (II) Criteria; non-rated employers.--An employer that does
299 not have an experience modification rating shall be included in
300 Tier One if the employer meets all of the following:

301 (A) The employer had no lost-time claims for the 3-year
302 period immediately preceding the inception date or renewal date
303 of the employer's coverage under the plan.
304 (B) The total of the employer's medical-only claims for
305 the 3-year period immediately preceding the inception date or
306 renewal date of the employer's coverage under the plan did not
307 exceed 20 percent of premium.
308 (C) The employer has secured workers' compensation
309 coverage for the entire 3-year period immediately preceding the
310 inception date or renewal date of the employer's coverage under
311 the plan.
312 (D) The employer is able to provide the plan with a loss
313 history generated by the employer's prior workers' compensation
314 insurer, except if the employer is not able to produce a loss
315 history due to the insolvency of an insurer, the receiver shall
316 provide to the plan, upon the request of the employer or the
317 employer's agent, a copy of the employer's loss history from the
318 records of the insolvent insurer if the loss history is
319 contained in records of the insurer which are in the possession
320 of the receiver. If the receiver is unable to produce the loss
321 history, the employer may, in lieu of the loss history, submit
322 an affidavit from the employer and the employer's insurance
323 agent setting forth the loss history.
324 (E) The employer is not a new business.
325 (III) Premiums.--The premiums for Tier One insureds shall
326 be set at a premium level 25 percent above the comparable
327 voluntary market premiums until the plan has sufficient
328 experience as determined by the board to establish an

329 actuarially sound rate for Tier One, at which point the board
330 shall, subject to paragraph (e), adjust the rates, if necessary,
331 to produce actuarially sound rates, provided such rate
332 adjustment shall not take effect prior to January 1, 2007.
333 b. Tier Two.--
334 (I) Criteria; rated employers.--An employer that has an
335 experience modification rating shall be included in Tier Two if
336 the employer meets all of the following:
337 (A) The experience modification is equal to or greater
338 than 1.00 but not greater than 1.10.
339 (B) The employer had no lost-time claims subsequent to the
340 applicable experience modification rating period.
341 (C) The total of the employer's medical-only claims
342 subsequent to the applicable experience modification rating
343 period did not exceed 20 percent of premium.
344 (II) Criteria; non-rated employers.--An employer that does
345 not have any experience modification rating shall be included in
346 Tier Two if the employer is a new business. An employer shall be
347 included in Tier Two if the employer has less than 3 years of
348 loss experience in the 3-year period immediately preceding the
349 inception date or renewal date of the employer's coverage under
350 the plan and the employer meets all of the following:
351 (A) The employer had no lost-time claims for the 3-year
352 period immediately preceding the inception date or renewal date
353 of the employer's coverage under the plan.
354 (B) The total of the employer's medical-only claims for
355 the 3-year period immediately preceding the inception date or

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

356 renewal date of the employer's coverage under the plan did not
357 exceed 20 percent of premium.
358 (C) The employer is able to provide the plan with a loss
359 history generated by the workers' compensation insurer that
360 provided coverage for the portion or portions of such period
361 during which the employer had secured workers' compensation
362 coverage, except if the employer is not able to produce a loss
363 history due to the insolvency of an insurer, the receiver shall
364 provide to the plan, upon the request of the employer or the
365 employer's agent, a copy of the employer's loss history from the
366 records of the insolvent insurer if the loss history is
367 contained in records of the insurer which are in the possession
368 of the receiver. If the receiver is unable to produce the loss
369 history, the employer may, in lieu of the loss history, submit
370 an affidavit from the employer and the employer's insurance
371 agent setting forth the loss history.
372 (III) Premiums.--The premiums for Tier Two insureds shall
373 be set at a rate level 50 percent above the comparable voluntary
374 market premiums until the plan has sufficient experience as
375 determined by the board to establish an actuarially sound rate
376 for Tier Two, at which point the board shall, subject to
377 paragraph (e), adjust the rates, if necessary, to produce
378 actuarially sound rates, provided such rate adjustment shall not
379 take effect prior to January 1, 2007.
380 c. Tier Three.--
381 (I) Eligibility.--An employer shall be included in Tier
382 Three if the employer does not meet the criteria for Tier One or
383 Tier Two.

384 (II) Rates.--The board shall establish, subject to
385 paragraph (e), and the plan shall charge, actuarially sound
386 rates for Tier Three insureds.
387 23. For Tier One or Tier Two employers which employ no
388 nonexempt employees or which report payroll which is less than
389 the minimum wage hourly rate for one full-time employee for 1
390 year at 40 hours per week, the plan shall establish actuarially
391 sound premiums, provided, however, that the premiums may not
392 exceed $2,500. These premiums shall be in addition to the fee
393 specified in subparagraph 26. When the plan establishes
394 actuarially sound rates for all employers in Tier One and Tier
395 Two, the premiums for employers referred to in this paragraph
396 are no longer subject to the $2,500 cap.
397 24. Provide for a depopulation program to reduce the
398 number of insureds in the plan. If an employer insured through
399 the plan is offered coverage from a voluntary market carrier:
400 a. During the first 30 days of coverage under the plan;
401 b. Before a policy is issued under the plan;
402 c. By issuance of a policy upon expiration or cancellation
403 of the policy under the plan; or
404 d. By assumption of the plan's obligation with respect to
405 an in-force policy, that employer is no longer eligible for
406 coverage through the plan. The premium for risks assumed by the
407 voluntary market carrier must be no greater than the premium the
408 insured would have paid under the plan, and shall be adjusted
409 upon renewal to reflect changes in the plan rates and the tier
410 for which the insured would qualify as of the time of renewal.
411 The insured may be charged such premiums only for the first 3

412 years of coverage in the voluntary market. A premium under this
413 subparagraph is deemed approved and is not an excess premium for
414 purposes of s. 627.171.
415 25. Require that policies issued and applications must
416 include a notice that the policy could be replaced by a policy
417 issued from a voluntary market carrier and that, if an offer of
418 coverage is obtained from a voluntary market carrier, the
419 policyholder is no longer eligible for coverage through the
420 plan. The notice must also specify that acceptance of coverage
421 under the plan creates a conclusive presumption that the
422 applicant or policyholder is aware of this potential.
423 26. Require that each application for coverage and each
424 renewal premium be accompanied by a nonrefundable fee of $475 to
425 cover costs of administration and fraud prevention. The board
426 may, with the prior approval of the office, increase the amount
427 of the fee pursuant to a rate filing to reflect increased costs
428 of administration and fraud prevention. The fee is not subject
429 to commission and is fully earned upon commencement of coverage.
430 (d)1. The funding of the plan shall include premiums as
431 provided in subparagraph (c)22. and assessments as provided in
432 this paragraph.
433 2.a. If the board determines that a deficit exists in Tier
434 One or Tier Two or that there is any deficit remaining
435 attributable to any of the plan's former subplans and that the
436 deficit cannot be fully funded by using policyholder surplus
437 attributable to former subplan C or, if the surplus in the
438 former subplan C does not fully fund the deficit and the deficit
439 cannot be fully funded by using any remaining funds in the

440 contingency reserve ~~without the use of deficit assessments~~, the
441 board shall request the office to levy, by order, a deficit
442 assessment against premiums charged to insureds for workers'
443 compensation insurance by insurers as defined in s. 631.904(5).
444 The office shall issue the order after verifying the amount of
445 the deficit. The assessment shall be specified as a percentage
446 of future premium collections, as recommended by the board and
447 approved by the office. The same percentage shall apply to
448 premiums on all workers' compensation policies issued or renewed
449 during the 12-month period beginning on the effective date of
450 the assessment, as specified in the order.
451 b. With respect to each insurer collecting premiums that
452 are subject to the assessment, the insurer shall collect the
453 assessment at the same time as the insurer collects the premium
454 payment for each policy and shall remit the assessments
455 collected to the plan as provided in the order issued by the
456 office. The office shall verify the accurate and timely
457 collection and remittance of deficit assessments and shall
458 report such information to the board. Each insurer collecting
459 assessments shall provide such information with respect to
460 premiums and collections as may be required by the office to
461 enable the office to monitor and audit compliance with this
462 paragraph.
463 c. Deficit assessments are not considered part of an
464 insurer's rate, are not premium, and are not subject to the
465 premium tax, to the assessments under ss. 440.49 and 440.51, to
466 the surplus lines tax, to any fees, or to any commissions. The
467 deficit assessment imposed shall become plan funds at the moment

468 of collection and shall not constitute income to the insurer for
469 any purpose, including financial reporting on the insurer's
470 income statement. An insurer is liable for all assessments that
471 the insurer collects and must treat the failure of an insured to
472 pay an assessment as a failure to pay premium. An insurer is not
473 liable for uncollectible assessments.
474 d. When an insurer is required to return unearned premium,
475 the insurer shall also return any collected assessments
476 attributable to the unearned premium.
477 e. Deficit assessments as described in this subparagraph
478 shall not be levied after July 1, 2011 ~~2007~~.
479 3.a. All policies issued to Tier Three insureds shall be
480 assessable. All Tier Three assessable policies must be clearly
481 identified as assessable by containing, in contrasting color and
482 in not less than 10-point type, the following statement:
483 "This is an assessable policy. If the plan is unable to pay its
484 obligations, policyholders will be required to contribute on a
485 pro rata earned premium basis the money necessary to meet any
486 assessment levied."
487 b. The board may from time to time assess Tier Three
488 insureds to whom the plan has issued assessable policies for the
489 purpose of funding plan deficits. Any such assessment shall be
490 based upon a reasonable actuarial estimate of the amount of the
491 deficit, taking into account the amount needed to fund medical
492 and indemnity reserves and reserves for incurred but not
493 reported claims, and allowing for general administrative
494 expenses, the cost of levying and collecting the assessment, a

495 reasonable allowance for estimated uncollectible assessments,
496 and allocated and unallocated loss adjustment expenses.
497 c. Each Tier Three insured's share of a deficit shall be
498 computed by applying to the premium earned on the insured's
499 policy or policies during the period to be covered by the
500 assessment the ratio of the total deficit to the total premiums
501 earned during such period upon all policies subject to the
502 assessment. If one or more Tier Three insureds fail to pay an
503 assessment, the other Tier Three insureds shall be liable on a
504 proportionate basis for additional assessments to fund the
505 deficit. The plan may compromise and settle individual
506 assessment claims without affecting the validity of or amounts
507 due on assessments levied against other insureds. The plan may
508 offer and accept discounted payments for assessments which are
509 promptly paid. The plan may offset the amount of any unpaid
510 assessment against unearned premiums which may otherwise be due
511 to an insured. The plan shall institute legal action when
512 necessary and appropriate to collect the assessment from any
513 insured who fails to pay an assessment when due.
514 d. The venue of a proceeding to enforce or collect an
515 assessment or to contest the validity or amount of an assessment
516 shall be in the Circuit Court of Leon County.
517 e. If the board finds that a deficit in Tier Three exists
518 for any period and that an assessment is necessary, the board
519 shall certify to the office the need for an assessment. No
520 sooner than 30 days after the date of such certification, the
521 board shall notify in writing each insured who is to be assessed
522 that an assessment is being levied against the insured, and

523 informing the insured of the amount of the assessment, the
524 period for which the assessment is being levied, and the date by
525 which payment of the assessment is due. The board shall
526 establish a date by which payment of the assessment is due,
527 which shall be no sooner than 30 days nor later than 120 days
528 after the date on which notice of the assessment is mailed to
529 the insured.
530 f. Whenever the board makes a determination that the plan
531 does not have a sufficient cash basis to meet 6 ~~3~~ months of
532 projected cash needs due to a deficit in Tier Three, the board
533 may request the department to transfer funds from the Workers'
534 Compensation Administration Trust Fund to the plan in an amount
535 sufficient to fund the difference between the amount available
536 and the amount needed to meet a 6-month ~~3-month~~ projected cash
537 need as determined by the board and verified by the office,
538 subject to the approval of the Legislative Budget Commission. If
539 the Legislative Budget Commission approves a transfer of funds
540 under this sub-subparagraph, the plan shall report to the
541 Legislature the transfer of funds and the Legislature shall
542 review the plan during the next legislative session or the
543 current legislative session, if the transfer occurs during a
544 legislative session. This sub-subparagraph shall not apply until
545 the plan determines and the office verifies that assessments
546 collected by the plan pursuant to sub-subparagraph b. are
547 insufficient to fund the deficit in Tier Three and to meet 6 ~~3~~
548 months of projected cash needs.
549 4. The plan may offer rating, dividend plans, and other
550 plans to encourage loss prevention programs.

551 (e) For rates and rating plans effective on or after
552 January 1, 2007, the plan shall be subject to the same
553 requirements of this part for the filing and approval of its
554 rates and rating plans as apply to workers' compensation
555 insurers, except as otherwise provided ~~establish and use its~~
556 ~~rates and rating plans, and the plan may establish and use~~
557 ~~changes in rating plans at any time, but no more frequently than~~
558 ~~two times per any rating class for any calendar year. By~~
559 ~~December 1, 1993, and December 1 of each year thereafter, except~~
560 ~~as provided in subparagraph (c)22., the board shall establish~~
561 ~~and use actuarially sound rates for use by the plan to assure~~
562 ~~that the plan is self-funding while those rates are in effect.~~
563 ~~Such rates and rating plans must be filed with the office within~~
564 ~~30 calendar days after their effective dates, and shall be~~
565 ~~considered a "use and file" filing. Any disapproval by the~~
566 ~~office must have an effective date that is at least 60 days from~~
567 ~~the date of disapproval of the rates and rating plan and must~~
568 ~~have prospective effect only. The plan may not be subject to any~~
569 ~~order by the office to return to policyholders any portion of~~
570 ~~the rates disapproved by the office. The office may not~~
571 ~~disapprove any rates or rating plans unless it demonstrates that~~
572 ~~such rates and rating plans are excessive, inadequate, or~~
573 ~~unfairly discriminatory~~.
574 (f) No later than June 1 of each year, the plan shall
575 obtain an independent actuarial certification of the results of
576 the operations of the plan for prior years, and shall furnish a
577 copy of the certification to the office. If, after the effective
578 date of the plan, the projected ultimate incurred losses and

579 expenses and dividends for prior years exceed collected
580 premiums, accrued net investment income, and prior assessments
581 for prior years, the certification is subject to review and
582 approval by the office before it becomes final.
583 (g) Whenever a deficit exists, the plan shall, within 90
584 days, provide the office with a program to eliminate the deficit
585 within a reasonable time. The deficit may be funded through
586 increased premiums charged to insureds of the plan for
587 subsequent years, through the use of policyholder surplus
588 attributable to any year, including policyholder surplus in
589 former subplan C as authorized in subparagraph (d)2., through
590 the use of assessments as provided in subparagraph (d)2., and
591 through assessments on assessable policies as provided in
592 subparagraph (d)3. Policyholders in former subplan C shall not
593 be subject to any assessments.
594 (h) Any premium or assessments collected by the plan in
595 excess of the amount necessary to fund projected ultimate
596 incurred losses and expenses of the plan and not paid to
597 insureds of the plan in conjunction with loss prevention or
598 dividend programs shall be retained by the plan for future use.
599 Any state funds received by the plan in excess of the amount
600 necessary to fund deficits in subplan D or any tier shall be
601 returned to the state.
602 (i) The decisions of the board of governors do not
603 constitute final agency action and are not subject to chapter
604 120.
605 (j) Policies for insureds shall be issued by the plan.

606 (k) The plan created under this subsection is liable only
607 for payment for losses arising under policies issued by the plan
608 with dates of accidents occurring on or after January 1, 1994.
609 (l) Plan losses are the sole and exclusive responsibility
610 of the plan, and payment for such losses must be funded in
611 accordance with this subsection and must not come, directly or
612 indirectly, from insurers or any guaranty association for such
613 insurers.
614 (m) Senior managers and officers, as defined in the plan
615 of operation, and members of the board of governors shall be
616 subject to part III of chapter 112, including, but not limited
617 to, the code of ethics and public disclosure and reporting of
618 financial interests under s. 112.3145. Senior managers,
619 officers, and board members are also required to file such
620 disclosures with the Office of Insurance Regulation. The
621 executive director of the plan or his or her designee shall
622 notify newly appointed and existing appointed members of the
623 board of governors, senior managers, and officers of their duty
624 to comply with the reporting requirements of part III of chapter
625 112. At least quarterly, the executive director of the plan or
626 his or her designee shall submit to the Commission on Ethics a
627 list of names of the senior managers, officers, and members of
628 the board of governors that are subject to the public disclosure
629 requirements under s. 112.3145 Each joint underwriting plan or
630 association created under this section is not a state agency,
631 board, or commission. However, for the purposes of s. 199.183(1)
632 only, the joint underwriting plan is a political subdivision of
633 the state and is exempt from the corporate income tax.

634 (n) On or before July 1 of each year, employees of the
635 plan are required to sign and submit a statement to the plan
636 attesting that they do not have a conflict of interest, as
637 defined in part III of chapter 112. As a condition of
638 employment, all prospective employees are required to sign and
639 submit a conflict-of-interest statement to the plan ~~Each joint~~
640 ~~underwriting plan or association may elect to pay premium taxes~~
641 ~~on the premiums received on its behalf or may elect to have the~~
642 ~~member insurers to whom the premiums are allocated pay the~~
643 ~~premium taxes if the member insurer had written the policy. The~~
644 ~~joint underwriting plan or association shall notify the member~~
645 ~~insurers and the Department of Revenue by January 15 of each~~
646 ~~year of its election for the same year. As used in this~~
647 ~~paragraph, the term "premiums received" means the consideration~~
648 ~~for insurance, by whatever name called, but does not include any~~
649 ~~policy assessment or surcharge received by the joint~~
650 ~~underwriting association as a result of apportioning losses or~~
651 ~~deficits of the association pursuant to this section~~.
652 (o) Any senior manager or officer of the plan who is
653 employed by the plan as of January 1, 2007, regardless of the
654 date of hire, and who subsequently retires or terminates
655 employment is prohibited from representing another person or
656 entity before the plan for 2 years after retirement or
657 termination of employment from the plan.
658 (p) No part of the income of the plan may inure to the
659 benefit of any private person.
660 (q) Notwithstanding ss. 112.3148 and 112.3149 or other
661 provisions of law, an employee or board member may not knowingly

662 accept, directly or indirectly, any expenditure or gift from a
663 person or entity, or an employee or representative of such
664 person or entity, that has a contractual relationship with the
665 plan or who is under consideration for a contract. An employee
666 or board member that fails to comply with this paragraph is
667 subject to penalties provided under ss. 112.317 and 112.3173.
668 (r) Nothing contained in this section shall be construed
669 as barring the plan from providing insurance coverage to any
670 employer with whom a former employee of the plan is affiliated
671 or employing or reemploying any former employee of the plan in a
672 part-time, full-time, temporary, or permanent capacity, so long
673 as such employment does not violate any provision of part III of
674 chapter 112.
675 (s) ~~(o)~~ Neither the plan nor any member of the board of
676 governors is liable for monetary damages to any person for any
677 statement, vote, decision, or failure to act, regarding the
678 management or policies of the plan, unless:
679 1. The member breached or failed to perform her or his
680 duties as a member; and
681 2. The member's breach of, or failure to perform, duties
682 constitutes:
683 a. A violation of the criminal law, unless the member had
684 reasonable cause to believe her or his conduct was not unlawful.
685 A judgment or other final adjudication against a member in any
686 criminal proceeding for violation of the criminal law estops
687 that member from contesting the fact that her or his breach, or
688 failure to perform, constitutes a violation of the criminal law;
689 but does not estop the member from establishing that she or he

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

690 had reasonable cause to believe that her or his conduct was
691 lawful or had no reasonable cause to believe that her or his
692 conduct was unlawful;
693 b. A transaction from which the member derived an improper
694 personal benefit, either directly or indirectly; or
695 c. Recklessness or any act or omission that was committed
696 in bad faith or with malicious purpose or in a manner exhibiting
697 wanton and willful disregard of human rights, safety, or
698 property. For purposes of this sub-subparagraph, the term
699 "recklessness" means the acting, or omission to act, in
700 conscious disregard of a risk:
701 (I) Known, or so obvious that it should have been known,
702 to the member; and
703 (II) Known to the member, or so obvious that it should
704 have been known, to be so great as to make it highly probable
705 that harm would follow from such act or omission.
706 (t) ~~(p)~~ No insurer shall provide workers' compensation and
707 employer's liability insurance to any person who is delinquent
708 in the payment of premiums, assessments, penalties, or
709 surcharges owed to the plan or to any person who is an
710 affiliated person of a person who is delinquent in the payment
711 of premiums, assessments, penalties, or surcharges owed to the
712 plan. For purposes of this paragraph, the term "affiliated
713 person" of another person means:
714 1. The spouse of such other natural person;
715 2. Any person who directly or indirectly owns or controls,
716 or holds with the power to vote, 5 percent or more of the
717 outstanding voting securities of such other person;

718 3. Any person who directly or indirectly owns 5 percent or
719 more of the outstanding voting securities that are directly or
720 indirectly owned or controlled, or held with the power to vote,
721 by such other person;
722 4. Any person or group of persons who directly or
723 indirectly control, are controlled by, or are under common
724 control with such other person;
725 5. Any officer, director, trustee, partner, owner,
726 manager, joint venturer, or employee, or other person performing
727 duties similar to persons in those positions, of such other
728 persons; or
729 6. Any person who has an officer, director, trustee,
730 partner, or joint venturer in common with such other person.
731 (u) ~~(q)~~ Effective July 1, 2004, the plan is exempt from the
732 premium tax under s. 624.509 and any assessments under ss.
733 440.49 and 440.51.
734 (v) The Office of Insurance Regulation shall periodically
735 perform a comprehensive market conduct examination of the plan
736 to determine compliance with its plan of operation and internal
737 operating policies and procedures.
738 (w) Upon dissolution of a plan, the assets of the plan
739 shall be applied first to pay all debts, liabilities, and
740 obligations of the plan, including the establishment of
741 reasonable reserves for any contingent liabilities or
742 obligations, and all remaining assets of the plan shall become
743 property of the state and shall be deposited in the Workers'
744 Compensation Administration Trust Fund. However, dissolution
745 shall not take effect as long as the plan has financial

746 obligations outstanding unless adequate provision has been made
747 for the payment of financial obligations pursuant to the
748 documents authorizing the financial obligations.
749 (6) Each joint underwriting plan or association created
750 under this section is not a state agency, board, or commission.
751 However, for the purposes of s. 199.183(1) only, the joint
752 underwriting plan created under subsection (5) is a political
753 subdivision of the state and is exempt from the corporate income
754 tax.
755 (7) Each joint underwriting plan or association may elect
756 to pay premium taxes on the premiums received on its behalf or
757 may elect to have the member insurers to whom the premiums are
758 allocated pay the premium taxes if the member insurer had
759 written the policy. The joint underwriting plan or association
760 shall notify the member insurers and the Department of Revenue
761 by January 15 of each year of its election for the same year. As
762 used in this paragraph, the term "premiums received" means the
763 consideration for insurance, by whatever name called, but does
764 not include any policy assessment or surcharge received by the
765 joint underwriting association as a result of apportioning
766 losses or deficits of the association under this section.
767 (8)(6) As used in this section and ss. 215.555 and
768 627.351, the term "collateral protection insurance" means
769 commercial property insurance of which a creditor is the primary
770 beneficiary and policyholder and which protects or covers an
771 interest of the creditor arising out of a credit transaction
772 secured by real or personal property. Initiation of such
773 coverage is triggered by the mortgagor's failure to maintain

774 insurance coverage as required by the mortgage or other lending
775 document. Collateral protection insurance is not residential
776 coverage.
777 (9)~~(7)~~(a) The Florida Automobile Joint Underwriting
778 Association created under this section shall be deemed to have
779 appointed its general manager as its agent to receive service of
780 all legal process issued against the association in any civil
781 action or proceeding in this state. Process so served shall be
782 valid and binding upon the insurer.
783 (b) Service of process upon the association's general
784 manager as the association's agent pursuant to such an
785 appointment shall be the sole method of service of process upon
786 the association.
787 Section 2. Section 2 of chapter 2004-266, Laws of Florida,
788 is amended to read:
789 Section 2. Notwithstanding the provisions of ss. 440.50
790 and 440.51, Florida Statutes, subject to the following
791 procedures and approval, the Department of Financial Services
792 may request transfer funds from the Workers' Compensation
793 Administration Trust Fund within the Department of Financial
794 Services to the workers' compensation joint underwriting plan
795 provided in s. 627.311(5), Florida Statutes.
796 (1) The department shall establish a contingency reserve
797 within the Workers' Compensation Administration Trust Fund, from
798 which the department is authorized to expend funds as provided
799 in the subsection, in an amount not to exceed $15 million to be
800 released only upon the approval of a budget amendment presented
801 to the Legislative Budget Commission. For actuarial deficits

802 projected for policyholders, based on actuarial best estimates,
803 covered in subplan D ~~"D"~~ prior to July 1, 2004, or Tier One or
804 Tier Two and upon verification by the Office of Insurance
805 Regulation, the plan is authorized to request and the department
806 is authorized to submit a budget amendment in an amount not to
807 exceed $15 million for the purpose of funding deficits in the
808 subplan or the tier ~~subplan "D"~~.
809 (2) After the contingency reserve is established, whenever
810 the board determines the subplan or the tier ~~subplan "D"~~ does
811 not have a sufficient cash basis to meet a 6-month period ~~3~~
812 ~~months~~ of projected cash needs due to any deficit in the subplan
813 or the tier ~~subplan "D,"~~ remaining after accessing any
814 policyholder surplus attributable to former subplan C, the board
815 is authorized to request the department to transfer funds from
816 the contingency reserve fund within the Workers' Compensation
817 Administration Trust Fund to the plan in an amount sufficient to
818 fund the difference between the amount available and the amount
819 needed to meet the subplan's or the tier's ~~subplan "D"'s~~
820 projected cash need for the subsequent 6-month ~~3-month~~ period.
821 The board and the office must first certify to the Department of
822 Financial Services that there is not sufficient cash within the
823 subplan or the tier ~~subplan "D"~~ to meet the projected cash needs
824 in the subplan or the tier ~~subplan "D"~~ within the subsequent 6-
825 month period ~~3 months~~. The amount requested for transfer to the
826 subplan or tier ~~subplan "D"~~ may not exceed the difference
827 between the amount available within the subplan or the tier
828 ~~subplan "D"~~ and the amount needed to meet the subplan's or the
829 tier's ~~subplan "D"'s~~ projected cash need for the subsequent 6-

830 month ~~3-month~~ period, as jointly certified by the board and the
831 Office of Insurance Regulation to the Department of Financial
832 Services, attributable to the former subplan or tier ~~subplan "D"~~
833 policyholders. The Department of Financial Services may submit a
834 budget amendment to request release of funds from the Workers'
835 Compensation Administration Trust Fund, subject to the approval
836 of the Legislative Budget Commission. The board will provide,
837 for review of the Legislative Budget Commission, information on
838 the reasonableness of the plan's administration, including, but
839 not limited to, the plan of operations and costs, claims costs,
840 claims administration costs, overhead costs, claims reserves,
841 and the latest report submitted on administration cost reduction
842 alternatives as required in s. 627.311(5)(c)17., Florida
843 Statutes.
844 (3) This section expires July 1, 2011 ~~2007~~.
845 Section 3. No later than January 1, 2007, the workers'
846 compensation joint underwriting plan provided for in s.
847 627.311(5), Florida Statutes, shall submit a request to the
848 Internal Revenue Service for a letter ruling or determination on
849 the plan's eligibility as a tax-exempt organization under s.
850 501(c)(3) of the Internal Revenue Code.
851 Section 4. This act shall take effect July 1, 2006.