By Senator Bennett

21-1534A-07

A bill to be entitled

An act relating to the Florida Workers' Compensation Joint Underwriting Association, Inc.; amending s. 627.311, F.S.; creating the Florida Workers' Compensation Joint Underwriting Association; providing that the association shall operate as a not-for-profit corporation; providing for a board of governors appointed by the Financial Services Commission; authorizing the commission to remove any member of the board of governors for cause; requiring the association to review and update its market-assistance plan periodically; authorizing the board to use the surplus attributable to any former subplan to mitigate certain deficits; authorizing the board to calculate and levy deficit assessments; providing criteria for the calculation of deficit assessments; exempting policyholders of former subplan C from assessments attributable to deficits in former subplan C under certain conditions; eliminating a provision stating that assessments may not be levied after July 1, 2007; extending from 3 months to 6 months the period of projected cash needs which serves as the basis on which the board may request the transfer of funds from the Workers' Compensation Administration Trust Fund if the board finds that the association will have insufficient cash due to certain deficits; providing for the use of surplus attributable

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to former subplans as a means to fund a deficit; providing for dissolution of the association; providing that a joint underwriting plan and the association are exempt from the corporate income tax but may elect to pay premium taxes; creating s. 627.3121, F.S.; requiring the Department of Financial Services to establish a contingency reserve within the Workers' Compensation Administration Trust Fund; providing for transfers from the contingency reserve; providing for the dissolution of the contingency reserve; providing for the calculation of any excess state funds received by the plan from the reserve; providing for the return of such funds; requiring the association to submit to the Internal Revenue Service a request for a determination as to the association's status as a tax-exempt entity; providing an effective date.

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

Section 1. Subsection (5) of section 627.311, Florida Statutes, is amended, and subsections (8) and (9) are added to that section, to read:

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

(5)(a) The office shall, after consultation with insurers, approve a joint underwriting plan of insurers which shall <u>be known as the Florida Workers' Compensation Joint</u>

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Underwriting Association, Inc., and shall operate as a not-for-profit corporation ~~nonprofit entity~~. For the purposes of this subsection, the term "insurer" includes group self-insurance funds authorized by s. 624.4621, commercial self-insurance funds authorized by s. 624.462, assessable mutual insurers authorized under s. 628.6011, and insurers licensed to write workers' compensation and employer's liability insurance in this state. The purpose of the plan is to provide workers' compensation and employer's liability insurance to applicants who are required by law to maintain workers' compensation and employer's liability insurance and who are in good faith entitled to but who are unable to procure such insurance through the voluntary market. Except as provided herein, the plan must have actuarially sound rates that ensure that the plan is self-supporting.

(b) The operation of the plan is subject to the supervision of a 9-member board of governors. The board of governors shall be comprised of:

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

2. Two representatives of the 20 domestic insurers, as defined in s. 624.06(1), having the largest voluntary direct premiums written in this state for workers' compensation and employer's liability insurance, who ~~which~~ shall be appointed by the Financial Services Commission from a list of three nominees for each vacancy submitted ~~elected~~ by those 20 domestic insurers;

3. Two representatives of the 20 foreign insurers as defined in s. 624.06(2) having the largest voluntary direct premiums written in this state for workers' compensation and

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employer's liability insurance, who ~~which~~ shall be appointed by the Financial Services Commission from a list of three nominees for each vacancy submitted ~~elected~~ by those 20 foreign insurers;

4. One representative of ~~person appointed by~~ the largest property and casualty insurance agents' association in this state, who shall be appointed by the Financial Services Commission from a list of three nominees submitted by the association; and

5. The consumer advocate appointed under s. 627.0613 or the consumer advocate's designee.

Each board member shall be appointed to ~~serve~~ a 4-year term and may serve consecutive terms. A vacancy on the board shall be filled in the same manner as the original appointment for the unexpired portion of the term. The Financial Services Commission shall designate a member of the board to serve as chair. The Financial Services Commission may remove any members for cause. A ~~No~~ board member may not ~~shall~~ be an insurer that ~~which~~ provides services to the plan, that ~~or which~~ has an affiliate that ~~which~~ provides services to the plan, or that ~~which~~ is serviced by a service company or third-party administrator that ~~which~~ provides services to the plan or that ~~which~~ has an affiliate that ~~which~~ provides services to the plan. The minutes, audits, and procedures of the board of governors are subject to chapter 119.

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

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

2. Develop criteria for eligibility for coverage by the plan, including, but not limited to, documented rejection by at least two insurers which reasonably assures that insureds covered under the plan are unable to acquire coverage in the voluntary market.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15. Provide procedures for selecting service providers and standards for qualification as a service provider that reasonably assure that any service provider selected will

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continue to operate as an ongoing concern and is capable of providing the specified services in the manner required.

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

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

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

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

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

21. Establish agent commission schedules.

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

a. Tier One.--

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

(A) The experience modification is below 1.00.

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

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

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

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

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

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

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

(E) The employer is not a new business.

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

b. Tier Two.--

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

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

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

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

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

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

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

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

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

c. Tier Three.--

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

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

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

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

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

b. Before a policy is issued under the plan;

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

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

that employer is no longer eligible for coverage through the plan. The premium for risks assumed by the voluntary market carrier must be no greater than the premium the insured would have paid under the plan, and shall be adjusted upon renewal to reflect changes in the plan rates and the tier for which the insured would qualify as of the time of renewal. The insured may be charged such premiums only for the first 3 years of coverage in the voluntary market. A premium under this subparagraph is deemed approved and is not an excess premium for purposes of s. 627.171.

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

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

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

2.a.<u>(I)</u> If the board determines that a deficit exists in Tier One or Tier Two or that there is any deficit remaining attributable to any of the plan's former subplans<u>, the board may use some or all of the surplus attributable to any former subplan for the purpose of mitigating some or all of any such deficit.</u> ~~and that the~~

<u>(II) If the board determines that any</u> deficit cannot be funded without the use of deficit assessments, the board shall request the office to levy, by order, a deficit

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assessment against premiums charged to insureds for workers' compensation insurance by insurers as defined in s. 631.904(5). The office shall issue the order after verifying the amount of the deficit. The assessment shall be specified as a percentage of future premium collections, as recommended by the board and approved by the office. <u>Any such assessment shall be based upon a reasonable actuarial estimate of the amount of the deficit, taking into account the amount needed to fund medical and indemnity reserves and reserves for incurred claims. The actuarial estimate may not include the amount needed to fund reserves for reported claims. The actuarial estimate must also allow for general administrative expenses, the cost of levying and collecting assessments, a reasonable allowance for estimated uncollectable assessments, and allocated as well as unallocated loss-adjustment expenses.</u> The same percentage shall apply to premiums on all workers' compensation policies issued or renewed during the 12-month period beginning on the effective date of the assessment, as specified in the order.

<u>(III) If any surplus attributable to former subplan C is used to mitigate a deficit pursuant to the discretionary authority specified in this sub-sub-subparagraph, any entity that was a policyholder of former subplan C may not be subject to any policyholder assessments attributable to deficits from former subplan C.</u>

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

c. Deficit assessments are not considered part of an insurer's rate, are not premium, and are not subject to the premium tax, to the assessments under ss. 440.49 and 440.51, to the surplus lines tax, to any fees, or to any commissions. The deficit assessment imposed shall become plan funds at the moment of collection and shall not constitute income to the insurer for any purpose, including financial reporting on the insurer's income statement. An insurer is liable for all assessments that the insurer collects and must treat the failure of an insured to pay an assessment as a failure to pay premium. An insurer is not liable for uncollectible assessments.

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

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

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

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

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

c. Each Tier Three insured's share of a deficit shall be computed by applying to the premium earned on the insured's policy or policies during the period to be covered by the assessment the ratio of the total deficit to the total premiums earned during such period upon all policies subject to the assessment. If one or more Tier Three insureds fail to pay an assessment, the other Tier Three insureds shall be liable on a proportionate basis for additional assessments to fund the deficit. The plan may compromise and settle individual assessment claims without affecting the validity of or amounts due on assessments levied against other insureds. The plan may offer and accept discounted payments for assessments which are promptly paid. The plan may offset the amount of any unpaid assessment against unearned premiums which may otherwise be due to an insured. The plan shall institute legal action when necessary and appropriate to

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collect the assessment from any insured who fails to pay an assessment when due.

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

e. If the board finds that a deficit in Tier Three exists for any period and that an assessment is necessary, the board shall certify to the office the need for an assessment. No sooner than 30 days after the date of such certification, the board shall notify in writing each insured who is to be assessed that an assessment is being levied against the insured, and informing the insured of the amount of the assessment, the period for which the assessment is being levied, and the date by which payment of the assessment is due. The board shall establish a date by which payment of the assessment is due, which shall be no sooner than 30 days nor later than 120 days after the date on which notice of the assessment is mailed to the insured.

f. Whenever the board makes a determination that the plan does not have a sufficient cash basis to meet 6 months ~~3 months~~ of projected cash needs due to a deficit in Tier Three, the board may request the department to transfer funds from the Workers' Compensation Administration Trust Fund to the plan in an amount sufficient to fund the difference between the amount available and the amount needed to meet a 6-month ~~3-month~~ projected cash need as determined by the board and verified by the office, subject to the approval of the Legislative Budget Commission. If the Legislative Budget Commission approves a transfer of funds under this sub-subparagraph, the plan shall report to the Legislature the transfer of funds and the Legislature shall review the plan

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during the next legislative session or the current legislative session, if the transfer occurs during a legislative session. This sub-subparagraph shall not apply until the plan determines and the office verifies that assessments collected by the plan pursuant to sub-subparagraph b. are insufficient to fund the deficit in Tier Three and to meet <u>6 months</u> ~~3 months~~ of projected cash needs.

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

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

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

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furnish a copy of the certification to the office. If, after the effective date of the plan, the projected ultimate incurred losses and expenses and dividends for prior years exceed collected premiums, accrued net investment income, and prior assessments for prior years, the certification is subject to review and approval by the office before it becomes final.

(g) Whenever a deficit exists, the plan shall, within 90 days, provide the office with a program to eliminate the deficit within a reasonable time. The deficit may be funded through increased premiums charged to insureds of the plan for subsequent years;~~,~~ through the use of policyholder surplus attributable to any year, including the use of surplus attributable to any former subplan as provided in sub-subparagraph (d)2.a.; through the use of assessments as provided in subparagraph (d)2.;~~,~~ and through assessments on assessable policies as provided in subparagraph (d)3.

(h) Any premium or assessments collected by the plan in excess of the amount necessary to fund projected ultimate incurred losses and expenses of the plan and not paid to insureds of the plan in conjunction with loss prevention or dividend programs shall be retained by the plan for future use.

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

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

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

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

~~(m) Each joint underwriting plan or association created under this section is not a state agency, board, or commission. However, for the purposes of s. 199.183(1) only, the joint underwriting plan is a political subdivision of the state and is exempt from the corporate income tax.~~

~~(n) Each joint underwriting plan or association may elect to pay premium taxes on the premiums received on its behalf or may elect to have the member insurers to whom the premiums are allocated pay the premium taxes if the member insurer had written the policy. The joint underwriting plan or association shall notify the member insurers and the Department of Revenue by January 15 of each year of its election for the same year. As used in this paragraph, the term "premiums received" means the consideration for insurance, by whatever name called, but does not include any policy assessment or surcharge received by the joint underwriting association as a result of apportioning losses or deficits of the association pursuant to this section.~~

<u>(m)</u>~~(o)~~ Neither the plan nor any member of the board of governors is liable for monetary damages to any person for any statement, vote, decision, or failure to act, regarding the management or policies of the plan, unless:

1. The member breached or failed to perform her or his duties as a member; and

2. The member's breach of, or failure to perform, duties constitutes:

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a. A violation of the criminal law, unless the member had reasonable cause to believe her or his conduct was not unlawful. A judgment or other final adjudication against a member in any criminal proceeding for violation of the criminal law estops that member from contesting the fact that her or his breach, or failure to perform, constitutes a violation of the criminal law; but does not estop the member from establishing that she or he had reasonable cause to believe that her or his conduct was lawful or had no reasonable cause to believe that her or his conduct was unlawful;

b. A transaction from which the member derived an improper personal benefit, either directly or indirectly; or

c. Recklessness or any act or omission that was committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property. For purposes of this sub-subparagraph, the term "recklessness" means the acting, or omission to act, in conscious disregard of a risk:

(I) Known, or so obvious that it should have been known, to the member; and

(II) Known to the member, or so obvious that it should have been known, to be so great as to make it highly probable that harm would follow from such act or omission.

<u>(n)</u>~~(p)~~ No insurer shall provide workers' compensation and employer's liability insurance to any person who is delinquent in the payment of premiums, assessments, penalties, or surcharges owed to the plan or to any person who is an affiliated person of a person who is delinquent in the payment of premiums, assessments, penalties, or surcharges owed to the

plan. For purposes of this paragraph, the term "affiliated person" of another person means:

1. The spouse of such other natural person;

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

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

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

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

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

(o)~~(q)~~ Effective July 1, 2004, the plan is exempt from the premium tax under s. 624.509 and any assessments under ss. 440.49 and 440.51.

(p) Upon dissolution of a plan, the assets of the plan shall be applied first to pay all debts, liabilities, and obligations of the plan, including the establishment of reasonable reserves for any contingent liabilities or obligations. All remaining assets of the plan shall become property of the state and shall be deposited into the Workers' Compensation Administration Trust Fund. However, dissolution may not take effect as long as the plan has financial obligations outstanding unless adequate provisions have been made in the documents authorizing those financial obligations for the payment thereof.

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

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

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

(8) Each joint underwriting plan or association created under this section is not a state agency, board, or commission. However, for the purpose of s. 199.183(1) only, the joint underwriting plan is a political subdivision of the state and is exempt from corporate income tax.

(9) Each joint underwriting plan or association may elect to pay premium taxes on the premiums received on its behalf or to have the member insurers to whom the premiums are allocated pay the premium taxes if the member insurer wrote

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the policy. The joint underwriting plan or association shall notify the member insurers and the Department of Revenue by January 15 of each year of its election for that year. As used in this paragraph, the term "premiums received" means any consideration received in exchange for insurance, but does not include any policy assessments or surcharges received by the joint underwriting association as a result of apportioning losses or deficits of the association pursuant to this section.

Section 2. Section 627.3121, Florida Statutes, is created to read:

627.3121 Contingency reserve.--Notwithstanding the provisions of ss. 440.50 and 440.51 and subject to the following procedures, the Department of Financial Services may request the transfer of funds from the Workers' Compensation Administration Trust Fund within the department to the workers' compensation joint underwriting plan provided in s. 627.311(5).

(1) The department shall establish a contingency reserve within the Workers' Compensation Administration Trust Fund from which the department may expend funds, as provided in s. 627.311(5), in an amount not to exceed $15 million, to be released only upon the approval of a budget amendment presented to the Legislative Budget Commission. For actuarial deficits projected for policyholders, based on actuarial best estimates, covered in subplan "D" prior to July 1, 2004, and upon verification by the Office of Insurance Regulation, the plan may request and the department may submit a budget amendment in an amount not to exceed $15 million for the purpose of funding deficits in subplan D.

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(2) After the contingency reserve is established and whenever the board determines that subplan D does not have a sufficient cash basis to meet 6 months of projected cash needs due to any deficit in subplan D, the board may request that the department transfer funds from the contingency reserve fund within the Workers' Compensation Administration Trust Fund to the plan in an amount sufficient to fund the difference between the amount available and the amount needed to meet subplan D's projected cash needs for the subsequent 6-month period. The board and the office must first certify to the department that there is insufficient cash within subplan D to meet the projected cash needs in subplan D for the subsequent 6 months. The amount requested for transfer to subplan D may not exceed the difference between the amount available in subplan D and the amount needed to meet subplan D's projected cash needs for the subsequent 6-month period, as jointly certified by the board and the Office of Insurance Regulation to the department, attributable to the former subplan "D" policyholders. The department may submit a budget amendment to request release of funds from the Workers' Compensation Administration Trust Fund, subject to the approval of the Legislative Budget Commission. The board shall provide, for the commission's review, information regarding the reasonableness of the plan's administration, including, but not limited to, the plan of operations and costs, claims costs, claims administration costs, overhead costs, claims reserves, and the latest report submitted on administration cost-reduction alternatives as required in s. 627.311(5)(c)17.

(3) The contingency reserve created under this section shall be dissolved on July 1, 2012. No later than December 31, 2012, the plan must provide a report to the Legislative Budget

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Commission stating the amount of any state funds received by the plan in excess of the amount needed to fund the deficit in subplan D. If any excess funds exist, the plan must return all excess funds to the Workers' Compensation Administration Trust Fund.

Section 3. At its earliest reasonable opportunity, the plan must submit a request to the Internal Revenue Service for a letter ruling or determination of the plan's status as a tax-exempt entity.

Section 4. This act shall take effect July 1, 2007.

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SENATE SUMMARY

Creates the Florida Workers' Compensation Joint Underwriting Association. Provides that the association shall operate as a not-for-profit corporation. Provides for a board of governors. Provides for appointment of members of the board of governors. Authorizes the Financial Services Commission to remove any member of the board of governors for cause. Requires the association to review and update its market-assistance plan periodically. Authorizes the board to use the surplus attributable to any former subplan to mitigate certain deficits. Authorizes the board to calculate and levy deficit assessments. Provides criteria for the calculation of deficit assessments. Exempts certain policyholders from certain assessments under specific conditions. Extends from 3 months to 6 months the period of projected cash needs which serves as the basis on which the board may request the transfer of funds from the Workers' Compensation Administration Trust Fund if the board finds that the association will have insufficient cash due to certain deficits. Provides for the use of surplus attributable to former subplans as a means to fund a deficit. Provides for dissolution of the association. Requires the Department of Financial Services to establish a contingency reserve within the Workers' Compensation Administration Trust Fund. Provides procedures for the release and transfer of funds from the contingency reserve. Provides for dissolution of the contingency reserve. Requires the association to calculate and report any state funds received in excess of the amount needed to fund certain deficits. Requires the association to return any excess funds to the Workers' Compensation Administration Trust Fund. Requires the association to submit to the Internal Revenue Service a request for a determination as to the association's status as a tax-exempt entity.

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