By the Committees on Appropriations; and Banking and Insurance

309-2528-04

A bill to be entitled

An act relating to workers' compensation; amending s. 627.311, F.S.; establishing three tiers of employers eligible for coverage under the plan; providing for criteria and rates for each tier; deleting references to subplans; providing for assessments to cover deficits in tiers one and two; providing procedures to collect the assessment; exempting the plan from specified premium tax and assessments; appropriating moneys from the Workers' Compensation Administration Trust Fund to fund plan deficits; providing transitional provisions to subplan "D" policies; providing legislative intent to create a state workers' compensation mutual fund under certain conditions; establishing the Workers' Compensation Insurance Market Evaluation Committee; providing for appointment of members; requiring the committee to monitor and report; requiring the Office of Insurance Regulation and workers' compensation insurers to report certain information; specifying meeting dates and interim reports for the committee; providing for reimbursement for travel and per diem; providing legislative intent as to the type of mutual fund it intends to create; prohibiting insurers from providing coverage 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; providing effective dates.

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

Section 1. Subsection (5) of section 627.311, Florida Statutes, is amended 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 operate as a 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 <u>procure</u> ~~purchase~~ such insurance through the voluntary market. The plan must have actuarially sound rates that <u>are not competitive with approved voluntary market rates so that the plan functions as a residual market mechanism</u> ~~assure 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 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, which shall be elected by those 20 domestic insurers;

3. Two 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 employer's liability insurance, which shall be elected by those 20 foreign insurers;

4. One person appointed by the largest property and casualty insurance agents' association in this state; and

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

Each board member shall 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. No board member shall be an insurer which provides services to the plan or which has an affiliate which provides services to the plan or which is serviced by a service company or third-party administrator which provides services to the plan or which has an affiliate 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. ~~Any insured may voluntarily elect to accept coverage from an insurer for a premium equal to or greater than the plan premium if the insurer writing the coverage adheres to the provisions of s. 627.171.~~

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 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.

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 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. <u>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.</u>

<u>a. Tier One.--</u>

(I) Criteria, rated employers.--An employer that has an experience modification rating shall be included in Tier One if it 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; and

(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, nonrated employers.--An employer that does not have an experience modification rating shall be included in Tier One if it 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 its 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 its coverage under the plan did not exceed 20 percent of premium;

(C) It has secured workers' compensation coverage for the entire three-year period immediately preceding the inception date or renewal date of its coverage under the plan;

(D) It is able to provide the plan with a loss history generated by its prior workers' compensation insurer, except that if the employer is not able to produce a loss history due to the insolvency of an insurer, 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; and

(E) It is not a new business.

(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, credible 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 rate, if necessary, to produce actuarially sound rates; provided the rate adjustment does not take effect until 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 it 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; and

(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 it is a new business. An employer shall be included in Tier Two if it has less than 3 years of loss experience in the 3-year period immediately preceding the inception date or renewal date of its coverage under the plan and it 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 its 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 its coverage under the plan did not exceed 20 percent of premium; and

(C) It 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. If the employer is not able to produce a loss history due to the insolvency of an insurer, 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.

(IV) Premiums.--The premiums for Tier Two insureds shall be set at a premium level 50 percent above the comparable voluntary market premiums until the plan has sufficient, credible 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 rate, if necessary, to produce actuarially sound rates; provided the rate adjustment does not take effect until January 1, 2007.

c. Tier Three.--

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

(II) Rates.--The board shall establish, subject to paragraph (e), and the plan shall charge actuarially sound rates for the Tier Three insureds.~~Establish four subplans as follows:~~

~~a. Subplan "A" must include those insureds whose annual premium does not exceed $2,500 and who have neither~~

~~incurred any lost-time claims nor incurred medical-only claims exceeding 50 percent of their premium for the immediate 2 years.~~

~~b. Subplan "B" must include insureds that are employers identified by the board of governors as high-risk employers due solely to the nature of the operations being performed by those insureds and for whom no market exists in the voluntary market, and whose experience modifications are less than 1.00.~~

~~c. Subplan "C" must include all insureds within the plan that are not eligible for subplan "A," subplan "B," or subplan "D."~~

~~d. Subplan "D" must include any employer, regardless of the length of time for which it has conducted business operations, which has an experience modification factor of 1.10 or less and either employs 15 or fewer employees or is an organization that is exempt from federal income tax pursuant to s. 501(c)(3) of the Internal Revenue Code and receives more than 50 percent of its funding from gifts, grants, endowments, or federal or state contracts. The rate plan for subplan "D" shall be the same rate plan as the plan approved under ss. 627.091-627.151, and each participant in subplan "D" shall pay the premium determined under such rate plan, plus a surcharge determined by the board to be sufficient to ensure that the plan does not compete with the voluntary market rate for any participant, but not to exceed 25 percent. However, the surcharge shall not exceed 10 percent for an organization that is exempt from federal income tax pursuant to s. 501(c)(3) of the Internal Revenue Code.~~

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 one 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.~~23.~~ Provide for a depopulation program to reduce the number of insureds in the plan.~~subplan "D."~~If an employer insured through the plan ~~subplan "D"~~is offered coverage from a voluntary market carrier:

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

b. Before a policy is issued under the plan ~~subplan~~;

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

d. By assumption of the plan's ~~subplan'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 ~~same~~ 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 2 years of coverage in the voluntary market ~~plus, for the first 2 years, the surcharge as determined in sub-subparagraph 22.d~~. A premium under this subparagraph~~, including surcharge,~~is

deemed approved and is not an excess premium for purposes of s. 627.171.

25.~~24.~~ Require that policies issued ~~under subplan "D"~~ and applications ~~for such policies~~ must include a notice that the policy ~~issued under subplan "D"~~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.~~subplan "D."~~The notice must also specify that acceptance of coverage under the plan ~~subplan "D"~~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. If the board determines that a deficit exists in Tier One or Tier Two or that there is any deficit remaining attributable to the former subplan "D" and that the deficit cannot reasonably be funded without the use of deficit assessments, the board shall request the Office of Insurance Regulation to levy, by order, a deficit 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. 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.

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 it 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 of Insurance Regulation. The office shall verify the accurate and timely collection and remittance of deficit assessments and shall report the information to the board. Each insurer collecting assessments shall provide the 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 a 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 becomes plan funds at the moment of collection and does not constitute income for any purpose, including financial reporting on the insurer's income statement. An insurer is liable for all assessments that it 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, it shall also return any collected assessments attributable to the unearned premium.

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 statements: "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 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 both 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 the period upon all policies subject to the assessment. In the event 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 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, it shall certify to the office the need for an assessment. No sooner than 30 days after the date of the 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 may not be sooner than 30 days or later than 120 days after the date on which notice of the assessment is mailed to the insured.~~The plan must be funded through actuarially sound premiums charged to insureds of the plan.~~

~~2. The plan may issue assessable policies only to those insureds in subplans "C" and "D." Subject to verification by the department, the board may levy assessments against insureds in subplan "C" or subplan "D," on a pro rata earned premium basis, to fund any deficits that exist in those~~

~~subplans. Assessments levied against subplan "C" participants shall cover only the deficits attributable to subplan "C," and assessments levied against subplan "D" participants shall cover only the deficits attributable to subplan "D." In no event may the plan levy assessments against any person or entity, except as authorized by this paragraph. Those assessable policies must be clearly identified as assessable by containing, in contrasting color and in not less than 10-point type, the following statements: "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."~~

~~3. The plan may issue assessable policies with differing terms and conditions to different groups within subplans "C" and "D" when a reasonable basis exists for the differentiation.~~

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, the board shall, except as provided in subparagraph (c)22., 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 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, <u>through the use of assessments as provided in subparagraph (d)2.,</u>and through assessments on ~~insureds in the plan if the plan uses~~ assessable policies <u>as provided in subparagraph (d)3</u>.

(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.

(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:

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.

(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 the 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 person; or

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

(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.

Section 2. Notwithstanding the provisions of sections 440.50 and 440.51, Florida Statutes, for the 2004-2005 fiscal year:

(1) The sum of $25 million is appropriated from the Workers' Compensation Administration Trust Fund in the Department of Financial Services for transfer to the workers' compensation joint underwriting plan provided in section 627.311(5), Florida Statutes, as a capital contribution to fund any deficit in the plan. The Chief Financial Officer shall transfer the funds to the plan no later than July 31, 2004.

(2) The workers' compensation joint underwriting plan set forth in section 627.311(5), Florida Statutes, may request the Department of Financial Services to transfer an amount not to exceed $10 million from the Workers' Compensation Administration Trust Fund to the plan subject to the approval of the Legislative Budget Commission under sections 216.181 and 216.292, Florida Statutes. The workers' compensation joint underwriting plan board of governors and the Office of Insurance Regulation must first certify to the Department of Financial Services that a deficit exists in the workers' compensation joint underwriting plan. The amount requested for transfer to the plan may not exceed the deficit amount jointly certified by the board of governors and the Office of Insurance Regulation to exist in Tier One or Tier Two or for any deficit remaining attributable to the former subplan "D" which cannot be funded without the use of deficit assessments as authorized by section 627.351(5)(d), Florida Statutes.

Section 3. Transitional provisions.--Effective upon this act becoming a law:

(1) Notwithstanding section 627.311(5), Florida Statutes, to the contrary, no policy in subplan "D" of the Florida Workers' Compensation Joint Underwriting Association is subject to an assessment for the purpose of funding a deficit.

(2) Any policy issued by the Florida Workers' Compensation Joint Underwriting Association with an effective date between the date on which this act becomes a law and June 30, 2004, shall be rerated and placed in the appropriate tier provided in section 627.311(5), Florida Statues, as amended effective July 1, 2004, and shall be subject to the premiums and charges provided for in that section as amended.

Section 4. Effective upon this act becoming a law:

(1) The Legislature intends to create a state workers' compensation mutual fund if workers' compensation coverage is not generally available and affordable to small employers in Florida by October 1, 2005. In order to make this determination, there is established the Workers' Compensation Insurance Market Evaluation Committee which shall consist of one member appointed by the Governor, who shall serve as chair; two members appointed by the President of the Senate; and two members appointed by the Speaker of the House of Representatives. The committee shall monitor and report on the number of insurers actively writing workers' compensation insurance in this state for small employers, the number of policies issued, premium volume written, types of underwriting restrictions utilized, and the extent to which actual premiums charged vary from standard rates, such as the use of excess rates pursuant to section 627.171, Florida Statutes, and rate deviations pursuant to section 627.211, Florida Statutes. The Office of Insurance Regulation shall provide such related

information to the committee as is requested, and workers' compensation insurers shall report such information to the office in the manner and format specified by the office.

(2) The committee shall meet once each month, beginning in August 2004, and shall provide interim reports to the appointing officers on October 1, 2004, December 1, 2004, and March 1, 2005, and at such additional times as the President of the Senate and the Speaker of the House of Representatives jointly require. Members of the committee shall be entitled to reimbursement for travel and per diem pursuant to section 112.061, Florida Statutes.

(3) If the Legislature determines that workers' compensation coverage is not generally available and affordable to small employers in Florida, the Legislature intends to create a state mutual fund as a nonprofit entity for the benefit of its small employer policyholders. The state mutual fund would compete with private carriers and would be charged with the public mission of customer service, quality loss prevention, timely claims management, active fighting of fraud, and compassionate care for injured workers, at the lowest cost consistent with actuarial sound rates. The fund should primarily rely on an in-house staff of professional employees, rather than contracting with servicing carriers. It is further intended that the state appropriate adequate initial capitalization for the fund and that the fund be subject to the same financial and other requirements as apply to an authorized insurer.

Section 5. Except as otherwise expressly provided in this act, and except for this section, which shall take effect upon becoming a law, this act shall take effect July 1, 2004.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN COMMITTEE SUBSTITUTE FOR CS for SB 2270

The committee substitute:

(1) Restructures the current workers' compensation joint underwriting plan (JUA), s. 627.311(5), F.S., by eliminating the current subplans and creating Tiers One, Two and Three.

(2) Provides employers in Tiers One and Two who have no employees or a payroll that is less than the minimum wage for one full-time non-exempt employee access to purchase minimum premium policies not to exceed $2,500, plus a $475 annual administrative fee.

(3) Provides a one time appropriation of $25 million from the Workers' Compensation Administration Trust Fund to the Department of Financial Services for transfer to the JUA to fund the deficit incurred for subplan D policies.

(4) Provides authority to the JUA to request transfer from the Department of Financial Services an amount not to exceed $10 million from the Workers' Compensation Administration Trust Fund to fund deficits anticipated to occur in Fiscal Year 2004-2005. The transfer amount is subject to approval by the Legislative Budget Commission and may not exceed the deficit amount jointly certified by the JUA board of governors and the Office of Insurance Regulation.