597-2015-06
Proposed Committee Substitute by the Committee on Banking and Insurance

1 A bill to be entitled
2 An act relating to the Florida Workers'
3 Compensation Joint Underwriting Association;
4 amending s. 627.311, F.S.; providing
5 requirements for the joint underwriting plan of
6 insurers which operates as the association;
7 revising the membership of the board of
8 governors that oversees operation of the joint
9 underwriting plan; providing for continuous
10 review of the plan; requiring that the
11 market-assistance plan be periodically reviewed
12 and updated; providing guidelines for
13 procurement of goods and services, including
14 legal services; prohibiting hiring an outside
15 lobbyist; authorizing the use of surplus funds
16 of former plan C; extending the deadline to
17 access contingency reserves; authorizing the
18 board of the association to request a transfer
19 of funds from the Workers' Compensation
20 Administration Trust Fund under certain
21 circumstances; providing that the plan is
22 subject to the same requirements for filing and
23 approval of rating plans as workers'
24 compensation insurers; deleting certain
25 provisions limiting the disapproval of rates by
26 the Office of Insurance Regulation; requiring
27 that excess funds received by the plan be
28 returned to the state; providing applicability
29 of specified statutes regulating ethical
30 standards; requiring annual statements by plan
31 employees that they do not have conflicts of

1 interest; prescribing limits on representing
2 persons or entities before the plan by former
3 senior managers or officers of the plan;
4 prohibiting any part of the plan's income from
5 inuring to the benefit of a private individual;
6 prohibiting employees and board members from
7 accepting expenditures from a lobbyist or a
8 lobbyist's principal; providing applicability;
9 requiring periodic comprehensive market
10 examinations; prescribing disposition of assets
11 of the plan upon dissolution; amending s. 2 of
12 ch. 2004-266, Laws of Florida; extending the
13 period for maintaining the contingency reserve
14 and the period for projecting current cash
15 needs; requiring the plan to submit a request
16 for an Internal Revenue Service letter
17 concerning the plan's eligibility as a
18 tax-exempt organization; providing an effective
19 date.
20
21 Be It Enacted by the Legislature of the State of Florida:
22
23 Section 1. Subsections (5), (6), and (7) of section
24 627.311, Florida Statutes, are amended to read:
25 627.311 Joint underwriters and joint reinsurers;
26 public records and public meetings exemptions.--
27 (5)(a) The office shall, after consultation with
28 insurers, approve a joint underwriting plan of insurers which
29 shall operate as the Florida Workers' Compensation Joint
30 Underwriting Association, a nonprofit entity. For the purposes
31 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. Each member described in subparagraph 1., subparagraph 2., subparagraph 3., or subparagraph 5. shall be appointed by the Financial Services Commission and shall serve at the pleasure of the commission. 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;~~

1.~~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~~, which shall be elected by those 20 domestic insurers~~;

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

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

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

5. Three other persons appointed by the commission.

Each board member shall be appointed to ~~serve~~ a 4-year term and may be appointed to ~~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 meetings and records ~~minutes, audits, and procedures~~ of the board of governors and plan are subject to chapters ~~chapter~~ 119 and 286, unless otherwise exempted by law.

(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 and approved by order of the office. The plan is subject to continuous review by the office. The office may, by order, withdraw approval of all or part of a plan if the office determines that conditions have changed since approval was granted and that the purposes of the plan require changes in the plan. ~~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~~

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

597-2015-06

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

1 agent who does not adhere to the established service standards
2 from placing business with the plan or receiving, directly or
3 indirectly, any commissions for business placed with the plan.
4 11. Provide for the establishment of reasonable safety
5 programs for all insureds in the plan. All insureds of the
6 plan must participate in the safety program.
7 12. Authorize the plan to terminate the coverage of
8 and refuse future coverage to any insured who fails to pay
9 premiums or surcharges when due; who, at the time of
10 application, is delinquent in payments of workers'
11 compensation or employer's liability insurance premiums or
12 surcharges owed to an insurer, group self-insurers' fund,
13 commercial self-insurance fund, or assessable mutual insurer
14 licensed to write such coverage in this state; or who refuses
15 to substantially comply with any safety programs recommended
16 by the plan.
17 13. Authorize the board of governors to provide the
18 goods and services required by the plan through staff employed
19 by the plan, through reasonably compensated service providers
20 who contract with the plan to provide services as specified by
21 the board of governors, or through a combination of employees
22 and service providers.
23 9. The procurement of goods with a value of less than
24 $2,500 shall be carried out using good purchasing practices,
25 such as the receipt of written quotes or written records of
26 telephone quotes. Purchases that equal or exceed $2,500 but
27 are less than or equal to $25,000, may be made by using best
28 purchasing practices, such as receipt of written quotes,
29 written record of telephone quotes, or informal bids, whenever
30 practical. The procurement of goods or services valued over
31 $25,000 are subject to competitive solicitation, except in

1 situations in which the goods or services are provided by a
2 sole source or are deemed an emergency purchase, or the
3 services are exempted from competitive solicitation
4 requirements under s. 287.057(5)(f). Justification for the
5 sole-sourcing or emergency procurement must be documented.
6 Contracts for goods or services valued at or over $100,000 are
7 subject to board approval.
8 b. In determining whether legal services should be
9 provided by staff attorneys or outsourced to private
10 attorneys, the plan shall consider the following factors:
11 (I) The nature of the attorney services to be provided
12 and the issues involved.
13 (II) The need for use of private attorneys, rather
14 than staff attorneys, using the criteria provided in
15 sub-subparagraph c.
16 (III) The criteria by which the plan selected the
17 private attorney or law firm it proposes to employ, using the
18 criteria provided in sub-subparagraph c.
19 (IV) Competitive fees for similar attorney services.
20 (V) The plan's analysis estimating the number of hours
21 for attorney services, the costs, the total contract amount,
22 and, when appropriate, a risk or cost-benefit analysis.
23 (VI) Which partners, associates, paralegals, research
24 associates, or other personnel will be used and how their time
25 will be billed to the plan.
26 (VII) Any other information that the plan deems
27 appropriate for the proper evaluation of the need for such
28 private attorney services.
29 c. The plan shall use the following criteria when
30 selecting outside firms for attorney services:
31 (I) The magnitude or complexity of the case.

1 (II) The firm's rating and certifications.
2 (III) The firm's minority status.
3 (IV) The firm's physical proximity to the case and the
4 plan.
5 (V) The firm's prior experience with the plan.
6 (VI) The firm's prior experience with similar cases or
7 issues.
8 (VII) The firm's billing methodology and proposed
9 rate.
10 (VIII) The firm's current or past adversarial
11 position, or conflict of interest, with the plan.
12 (IX) The firm's willingness to use resources of the
13 plan to minimize costs.
14 d. The plan may not retain a lobbyist to represent it
15 before the legislative or executive branch. However, full-time
16 employees of the plan may register as lobbyists and represent
17 that employer before the legislative or executive branch.
18 14. Provide for service standards for service
19 providers, methods of determining adherence to those service
20 standards, incentives and disincentives for service, and
21 procedures for terminating contracts for service providers
22 that fail to adhere to service standards.
23 15. Provide procedures for selecting service providers
24 and standards for qualification as a service provider that
25 reasonably assure that any service provider selected will
26 continue to operate as an ongoing concern and is capable of
27 providing the specified services in the manner required.
28 16. Provide for reasonable accounting and
29 data-reporting practices.
30 17. Provide for annual review of costs associated with
31 the administration and servicing of the policies issued by the

1 plan to determine alternatives by which costs can be reduced.
2 18. Authorize the acquisition of such excess insurance
3 or reinsurance as is consistent with the purposes of the plan.
4 19. Provide for an annual report to the office on a
5 date specified by the office and containing such information
6 as the office reasonably requires.
7 20. Establish multiple rating plans for various
8 classifications of risk which reflect risk of loss, hazard
9 grade, actual losses, size of premium, and compliance with
10 loss control. At least one of such plans must be a
11 preferred-rating plan to accommodate small-premium
12 policyholders with good experience as defined in
13 sub-subparagraph 22.a.
14 21. Establish agent commission schedules.
15 22. For employers otherwise eligible for coverage
16 under the plan, establish three tiers of employers meeting the
17 criteria and subject to the rate limitations specified in this
18 subparagraph.
19 a. Tier One.--
20 (I) Criteria; rated employers.--An employer that has
21 an experience modification rating shall be included in Tier
22 One if the employer meets all of the following:
23 (A) The experience modification is below 1.00.
24 (B) The employer had no lost-time claims subsequent to
25 the applicable experience modification rating period.
26 (C) The total of the employer's medical-only claims
27 subsequent to the applicable experience modification rating
28 period did not exceed 20 percent of premium.
29 (II) Criteria; non-rated employers.--An employer that
30 does not have an experience modification rating shall be
31 included in Tier One if the employer meets all of the

1 following:
2 (A) The employer had no lost-time claims for the
3 3-year period immediately preceding the inception date or
4 renewal date of the employer's coverage under the plan.
5 (B) The total of the employer's medical-only claims
6 for the 3-year period immediately preceding the inception date
7 or renewal date of the employer's coverage under the plan did
8 not exceed 20 percent of premium.
9 (C) The employer has secured workers' compensation
10 coverage for the entire 3-year period immediately preceding
11 the inception date or renewal date of the employer's coverage
12 under the plan.
13 (D) The employer is able to provide the plan with a
14 loss history generated by the employer's prior workers'
15 compensation insurer, except if the employer is not able to
16 produce a loss history due to the insolvency of an insurer,
17 the receiver shall provide to the plan, upon the request of
18 the employer or the employer's agent, a copy of the employer's
19 loss history from the records of the insolvent insurer if the
20 loss history is contained in records of the insurer which are
21 in the possession of the receiver. If the receiver is unable
22 to produce the loss history, the employer may, in lieu of the
23 loss history, submit an affidavit from the employer and the
24 employer's insurance agent setting forth the loss history.
25 (E) The employer is not a new business.
26 (III) Premiums.--The premiums for Tier One insureds
27 shall be set at a premium level 25 percent above the
28 comparable voluntary market premiums until the plan has
29 sufficient experience as determined by the board to establish
30 an actuarially sound rate for Tier One, at which point the
31 board shall, subject to paragraph (e), adjust the rates, if

1 necessary, to produce actuarially sound rates, provided such
2 rate adjustment shall not take effect prior to January 1,
3 2007.
4 b. Tier Two.--
5 (I) Criteria; rated employers.--An employer that has
6 an experience modification rating shall be included in Tier
7 Two if the employer meets all of the following:
8 (A) The experience modification is equal to or greater
9 than 1.00 but not greater than 1.10.
10 (B) The employer had no lost-time claims subsequent to
11 the applicable experience modification rating period.
12 (C) The total of the employer's medical-only claims
13 subsequent to the applicable experience modification rating
14 period did not exceed 20 percent of premium.
15 (II) Criteria; non-rated employers.--An employer that
16 does not have any experience modification rating shall be
17 included in Tier Two if the employer is a new business. An
18 employer shall be included in Tier Two if the employer has
19 less than 3 years of loss experience in the 3-year period
20 immediately preceding the inception date or renewal date of
21 the employer's coverage under the plan and the employer meets
22 all of the following:
23 (A) The employer had no lost-time claims for the
24 3-year period immediately preceding the inception date or
25 renewal date of the employer's coverage under the plan.
26 (B) The total of the employer's medical-only claims
27 for the 3-year period immediately preceding the inception date
28 or renewal date of the employer's coverage under the plan did
29 not exceed 20 percent of premium.
30 (C) The employer is able to provide the plan with a
31 loss history generated by the workers' compensation insurer

1 that provided coverage for the portion or portions of such
2 period during which the employer had secured workers'
3 compensation coverage, except if the employer is not able to
4 produce a loss history due to the insolvency of an insurer,
5 the receiver shall provide to the plan, upon the request of
6 the employer or the employer's agent, a copy of the employer's
7 loss history from the records of the insolvent insurer if the
8 loss history is contained in records of the insurer which are
9 in the possession of the receiver. If the receiver is unable
10 to produce the loss history, the employer may, in lieu of the
11 loss history, submit an affidavit from the employer and the
12 employer's insurance agent setting forth the loss history.
13 (III) Premiums.--The premiums for Tier Two insureds
14 shall be set at a rate level 50 percent above the comparable
15 voluntary market premiums until the plan has sufficient
16 experience as determined by the board to establish an
17 actuarially sound rate for Tier Two, at which point the board
18 shall, subject to paragraph (e), adjust the rates, if
19 necessary, to produce actuarially sound rates, provided such
20 rate adjustment shall not take effect prior to January 1,
21 2007.
22 c. Tier Three.--
23 (I) Eligibility.--An employer shall be included in
24 Tier Three if the employer does not meet the criteria for Tier
25 One or Tier Two.
26 (II) Rates.--The board shall establish, subject to
27 paragraph (e), and the plan shall charge, actuarially sound
28 rates for Tier Three insureds.
29 23. For Tier One or Tier Two employers which employ no
30 nonexempt employees or which report payroll which is less than
31 the minimum wage hourly rate for one full-time employee for 1

597-2015-06

1 year at 40 hours per week, the plan shall establish
2 actuarially sound premiums, provided, however, that the
3 premiums may not exceed $2,500. These premiums shall be in
4 addition to the fee specified in subparagraph 26. When the
5 plan establishes actuarially sound rates for all employers in
6 Tier One and Tier Two, the premiums for employers referred to
7 in this paragraph are no longer subject to the $2,500 cap.
8 24. Provide for a depopulation program to reduce the
9 number of insureds in the plan. If an employer insured through
10 the plan is offered coverage from a voluntary market carrier:
11 a. During the first 30 days of coverage under the
12 plan;
13 b. Before a policy is issued under the plan;
14 c. By issuance of a policy upon expiration or
15 cancellation of the policy under the plan; or
16 d. By assumption of the plan's obligation with respect
17 to an in-force policy,
18
19 that employer is no longer eligible for coverage through the
20 plan. The premium for risks assumed by the voluntary market
21 carrier must be no greater than the premium the insured would
22 have paid under the plan, and shall be adjusted upon renewal
23 to reflect changes in the plan rates and the tier for which
24 the insured would qualify as of the time of renewal. The
25 insured may be charged such premiums only for the first 3
26 years of coverage in the voluntary market. A premium under
27 this subparagraph is deemed approved and is not an excess
28 premium for purposes of s. 627.171.
29 25. Require that policies issued and applications must
30 include a notice that the policy could be replaced by a policy
31 issued from a voluntary market carrier and that, if an offer

1 of coverage is obtained from a voluntary market carrier, the
2 policyholder is no longer eligible for coverage through the
3 plan. The notice must also specify that acceptance of coverage
4 under the plan creates a conclusive presumption that the
5 applicant or policyholder is aware of this potential.
6 26. Require that each application for coverage and
7 each renewal premium be accompanied by a nonrefundable fee of
8 $475 to cover costs of administration and fraud prevention.
9 The board may, with the prior approval of the office, increase
10 the amount of the fee pursuant to a rate filing to reflect
11 increased costs of administration and fraud prevention. The
12 fee is not subject to commission and is fully earned upon
13 commencement of coverage.
14 (d)1. The funding of the plan shall include premiums
15 as provided in subparagraph (c)22. and assessments as provided
16 in this paragraph.
17 2.a. If the board determines that a deficit exists in
18 Tier One or Tier Two or that there is any deficit remaining
19 attributable to any of the plan's former subplans and that the
20 deficit cannot be fully funded by using policyholder surplus
21 attributable to former subplan C or, if the surplus in the
22 former subplan C does not fully fund the deficit and the
23 deficit cannot be fully funded by using any remaining funds in
24 the contingency reserve ~~without the use of deficit~~
25 ~~assessments~~, the board shall request the office to levy, by
26 order, a deficit assessment against premiums charged to
27 insureds for workers' compensation insurance by insurers as
28 defined in s. 631.904(5). The office shall issue the order
29 after verifying the amount of the deficit. The assessment
30 shall be specified as a percentage of future premium
31 collections, as recommended by the board and approved by the

597-2015-06

1 office. The same percentage shall apply to premiums on all
2 workers' compensation policies issued or renewed during the
3 12-month period beginning on the effective date of the
4 assessment, as specified in the order.
5 b. With respect to each insurer collecting premiums
6 that are subject to the assessment, the insurer shall collect
7 the assessment at the same time as the insurer collects the
8 premium payment for each policy and shall remit the
9 assessments collected to the plan as provided in the order
10 issued by the office. The office shall verify the accurate and
11 timely collection and remittance of deficit assessments and
12 shall report such information to the board. Each insurer
13 collecting assessments shall provide such information with
14 respect to premiums and collections as may be required by the
15 office to enable the office to monitor and audit compliance
16 with this paragraph.
17 c. Deficit assessments are not considered part of an
18 insurer's rate, are not premium, and are not subject to the
19 premium tax, to the assessments under ss. 440.49 and 440.51,
20 to the surplus lines tax, to any fees, or to any commissions.
21 The deficit assessment imposed shall become plan funds at the
22 moment of collection and shall not constitute income to the
23 insurer for any purpose, including financial reporting on the
24 insurer's income statement. An insurer is liable for all
25 assessments that the insurer collects and must treat the
26 failure of an insured to pay an assessment as a failure to pay
27 premium. An insurer is not liable for uncollectible
28 assessments.
29 d. When an insurer is required to return unearned
30 premium, the insurer shall also return any collected
31 assessments attributable to the unearned premium.

1 e. Deficit assessments as described in this
2 subparagraph shall not be levied after July 1, 2011 ~~2007~~.
3 3.a. All policies issued to Tier Three insureds shall
4 be assessable. All Tier Three assessable policies must be
5 clearly identified as assessable by containing, in contrasting
6 color and in not less than 10-point type, the following
7 statement:
8
9 "This is an assessable policy. If the plan is
10 unable to pay its obligations, policyholders
11 will be required to contribute on a pro rata
12 earned premium basis the money necessary to
13 meet any assessment levied."
14
15 b. The board may from time to time assess Tier Three
16 insureds to whom the plan has issued assessable policies for
17 the purpose of funding plan deficits. Any such assessment
18 shall be based upon a reasonable actuarial estimate of the
19 amount of the deficit, taking into account the amount needed
20 to fund medical and indemnity reserves and reserves for
21 incurred but not reported claims, and allowing for general
22 administrative expenses, the cost of levying and collecting
23 the assessment, a reasonable allowance for estimated
24 uncollectible assessments, and allocated and unallocated loss
25 adjustment expenses.
26 c. Each Tier Three insured's share of a deficit shall
27 be computed by applying to the premium earned on the insured's
28 policy or policies during the period to be covered by the
29 assessment the ratio of the total deficit to the total
30 premiums earned during such period upon all policies subject
31 to the assessment. If one or more Tier Three insureds fail to

1 pay an assessment, the other Tier Three insureds shall be
2 liable on a proportionate basis for additional assessments to
3 fund the deficit. The plan may compromise and settle
4 individual assessment claims without affecting the validity of
5 or amounts due on assessments levied against other insureds.
6 The plan may offer and accept discounted payments for
7 assessments which are promptly paid. The plan may offset the
8 amount of any unpaid assessment against unearned premiums
9 which may otherwise be due to an insured. The plan shall
10 institute legal action when necessary and appropriate to
11 collect the assessment from any insured who fails to pay an
12 assessment when due.
13 d. The venue of a proceeding to enforce or collect an
14 assessment or to contest the validity or amount of an
15 assessment shall be in the Circuit Court of Leon County.
16 e. If the board finds that a deficit in Tier Three
17 exists for any period and that an assessment is necessary, the
18 board shall certify to the office the need for an assessment.
19 No sooner than 30 days after the date of such certification,
20 the board shall notify in writing each insured who is to be
21 assessed that an assessment is being levied against the
22 insured, and informing the insured of the amount of the
23 assessment, the period for which the assessment is being
24 levied, and the date by which payment of the assessment is
25 due. The board shall establish a date by which payment of the
26 assessment is due, which shall be no sooner than 30 days nor
27 later than 120 days after the date on which notice of the
28 assessment is mailed to the insured.
29 f. Whenever the board makes a determination that the
30 plan does not have a sufficient cash basis to meet <u>6</u> ~~3~~ months
31 of projected cash needs due to a deficit in Tier Three, the

1 board may request the department to transfer funds from the
2 Workers' Compensation Administration Trust Fund to the plan in
3 an amount sufficient to fund the difference between the amount
4 available and the amount needed to meet a 6-month ~~3-month~~
5 projected cash need as determined by the board and verified by
6 the office, subject to the approval of the Legislative Budget
7 Commission. If the Legislative Budget Commission approves a
8 transfer of funds under this sub-subparagraph, the plan shall
9 report to the Legislature the transfer of funds and the
10 Legislature shall review the plan during the next legislative
11 session or the current legislative session, if the transfer
12 occurs during a legislative session. This sub-subparagraph
13 shall not apply until the plan determines and the office
14 verifies that assessments collected by the plan pursuant to
15 sub-subparagraph b. are insufficient to fund the deficit in
16 Tier Three and to meet 6 ~~3~~ months of projected cash needs.
17 4. The plan may offer rating, dividend plans, and
18 other plans to encourage loss prevention programs.
19 (e) For rates and rating plans effective on or after
20 January 1, 2007, the plan shall be subject to the same
21 requirements of this part for the filing and approval of its
22 rates and rating plans as apply to workers' compensation
23 insurers, except as otherwise provided. ~~establish and use its~~
24 ~~rates and rating plans, and the plan may establish and use~~
25 ~~changes in rating plans at any time, but no more frequently~~
26 ~~than two times per any rating class for any calendar year. By~~
27 ~~December 1, 1993, and December 1 of each year thereafter,~~
28 ~~except as provided in subparagraph (c)22., the board shall~~
29 ~~establish and use actuarially sound rates for use by the plan~~
30 ~~to assure that the plan is self-funding while those rates are~~
31 ~~in effect. Such rates and rating plans must be filed with the~~

1 ~~office within 30 calendar days after their effective dates,~~
2 ~~and shall be considered a "use and file" filing. Any~~
3 ~~disapproval by the office must have an effective date that is~~
4 ~~at least 60 days from the date of disapproval of the rates and~~
5 ~~rating plan and must have prospective effect only. The plan~~
6 ~~may not be subject to any order by the office to return to~~
7 ~~policyholders any portion of the rates disapproved by the~~
8 ~~office. The office may not disapprove any rates or rating~~
9 ~~plans unless it demonstrates that such rates and rating plans~~
10 ~~are excessive, inadequate, or unfairly discriminatory.~~
11 (f) No later than June 1 of each year, the plan shall
12 obtain an independent actuarial certification of the results
13 of the operations of the plan for prior years, and shall
14 furnish a copy of the certification to the office. If, after
15 the effective date of the plan, the projected ultimate
16 incurred losses and expenses and dividends for prior years
17 exceed collected premiums, accrued net investment income, and
18 prior assessments for prior years, the certification is
19 subject to review and approval by the office before it becomes
20 final.
21 (g) Whenever a deficit exists, the plan shall, within
22 90 days, provide the office with a program to eliminate the
23 deficit within a reasonable time. The deficit may be funded
24 through increased premiums charged to insureds of the plan for
25 subsequent years, through the use of policyholder surplus
26 attributable to any year, including policyholder surplus in
27 former subplan C as authorized in subparagraph (d)2., through
28 the use of assessments as provided in subparagraph (d)2., and
29 through assessments on assessable policies as provided in
30 subparagraph (d)3. Any entity that was a policyholder of
31 former subplan C shall not be subject to any assessments that

1 are attributable to deficits in former subplan C.
2 (h) Any premium or assessments collected by the plan
3 in excess of the amount necessary to fund projected ultimate
4 incurred losses and expenses of the plan and not paid to
5 insureds of the plan in conjunction with loss prevention or
6 dividend programs shall be retained by the plan for future
7 use. Any state funds received by the plan in excess of the
8 amount necessary to fund deficits in subplan D or any tier
9 shall be returned to the state.
10 (i) The decisions of the board of governors do not
11 constitute final agency action and are not subject to chapter
12 120.
13 (j) Policies for insureds shall be issued by the plan.
14 (k) The plan created under this subsection is liable
15 only for payment for losses arising under policies issued by
16 the plan with dates of accidents occurring on or after January
17 1, 1994.
18 (l) Plan losses are the sole and exclusive
19 responsibility of the plan, and payment for such losses must
20 be funded in accordance with this subsection and must not
21 come, directly or indirectly, from insurers or any guaranty
22 association for such insurers.
23 (m) Senior managers and officers, as defined in the
24 plan of operation, and members of the board of governors shall
25 be subject to part III of chapter 112, including, but not
26 limited to, the code of ethics and public disclosure and
27 reporting of financial interests, pursuant to s. 112.3145.
28 Senior managers, officers, and board members are also required
29 to file such disclosures with the Office of Insurance
30 Regulation. The executive director of the plan or his or her
31 designee shall notify each newly appointed and existing

1 appointed member of the board of governors, senior manager and
2 officer of their duty to comply with the reporting
3 requirements of part III of chapter 112. At least quarterly,
4 the executive director of the plan or his or her designee
5 shall submit to the Commission on Ethics a list of names of
6 the senior managers, officers, members of the board of
7 governors that are subject to the public disclosure
8 requirements under s. 112.3145. ~~Each joint underwriting plan~~
9 ~~or association created under this section is not a state~~
10 ~~agency, board, or commission. However, for the purposes of s.~~
11 ~~199.183(1) only, the joint underwriting plan is a political~~
12 ~~subdivision of the state and is exempt from the corporate~~
13 ~~income tax.~~
14 (n) On or before July 1 of each year, employees of the
15 plan are required to sign and submit a statement to the plan
16 attesting that they do not have a conflict of interest, as
17 defined in part III of chapter 112. As a condition of
18 employment, all prospective employees are required to sign and
19 submit a conflict-of-interest statement to the plan. ~~Each~~
20 ~~joint underwriting plan or association may elect to pay~~
21 ~~premium taxes on the premiums received on its behalf or may~~
22 ~~elect to have the member insurers to whom the premiums are~~
23 ~~allocated pay the premium taxes if the member insurer had~~
24 ~~written the policy. The joint underwriting plan or association~~
25 ~~shall notify the member insurers and the Department of Revenue~~
26 ~~by January 15 of each year of its election for the same year.~~
27 ~~As used in this paragraph, the term "premiums received" means~~
28 ~~the consideration for insurance, by whatever name called, but~~
29 ~~does not include any policy assessment or surcharge received~~
30 ~~by the joint underwriting association as a result of~~
31 ~~apportioning losses or deficits of the association pursuant to~~

1 ~~this section.~~
2 (o) Any senior manager or officer of the plan who is
3 employed by the plan as of January 1, 2007, regardless of the
4 date of hire, and who subsequently retires or terminates
5 employment is prohibited from representing another person or
6 entity before the plan for 2 years after retirement or
7 termination of employment from the plan.
8 (p) No part of the income of the plan may inure to the
9 benefit of any private person.
10 (q) Notwithstanding ss. 112.3148 and 112.3149 or other
11 provision of law, an employee or board member may not
12 knowingly accept, directly or indirectly, any expenditure from
13 a lobbyist or his or her principal. An employee or board
14 member that fails to comply with this paragraph is subject to
15 penalties provided under ss. 112.317 and 112.3173.
16 (r) Nothing contained in this section shall be
17 construed as barring the plan from providing insurance
18 coverage to any employer with whom a former employee of the
19 plan is affiliated or employing or reemploying any former
20 employee of the plan in a part-time, full-time, temporary, or
21 permanent capacity, so long as such employment does not
22 violate any provision of part III of chapter 112.
23 (s)~~(o)~~ Neither the plan nor any member of the board of
24 governors is liable for monetary damages to any person for any
25 statement, vote, decision, or failure to act, regarding the
26 management or policies of the plan, unless:
27 1. The member breached or failed to perform her or his
28 duties as a member; and
29 2. The member's breach of, or failure to perform,
30 duties constitutes:
31 a. A violation of the criminal law, unless the member

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

597-2015-06

1 1. The spouse of such other natural person;
2 2. Any person who directly or indirectly owns or
3 controls, or holds with the power to vote, 5 percent or more
4 of the outstanding voting securities of such other person;
5 3. Any person who directly or indirectly owns 5
6 percent or more of the outstanding voting securities that are
7 directly or indirectly owned or controlled, or held with the
8 power to vote, by such other person;
9 4. Any person or group of persons who directly or
10 indirectly control, are controlled by, or are under common
11 control with such other person;
12 5. Any officer, director, trustee, partner, owner,
13 manager, joint venturer, or employee, or other person
14 performing duties similar to persons in those positions, of
15 such other persons; or
16 6. Any person who has an officer, director, trustee,
17 partner, or joint venturer in common with such other person.
18 (u)~~(q)~~ Effective July 1, 2004, the plan is exempt from
19 the premium tax under s. 624.509 and any assessments under ss.
20 440.49 and 440.51.
21 (v) The Office of Insurance Regulation shall perform a
22 comprehensive market conduct examination of the plan
23 periodically to determine compliance with its plan of
24 operation and internal operating policies and procedures.
25 (w) Upon dissolution, the assets of the plan shall be
26 applied first to pay all debts, liabilities, and obligations
27 of the plan, including the establishment of reasonable
28 reserves for any contingent liabilities or obligations, and
29 all remaining assets of the plan shall become property of the
30 state and shall be deposited in the Workers' Compensation
31 Administration Trust Fund. However, dissolution shall not take

effect as long as the plan has financial obligations outstanding unless adequate provision has been made for the payment of financial obligations pursuant to the documents authorizing the financial obligations.

(6) 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 created under subsection (5) is a political subdivision of the state and is exempt from the corporate income tax.

(7) 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.

(8)~~(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

1 other lending document. Collateral protection insurance is not
2 residential coverage.
3 (9)~~(7)~~(a) The Florida Automobile Joint Underwriting
4 Association created under this section shall be deemed to have
5 appointed its general manager as its agent to receive service
6 of all legal process issued against the association in any
7 civil action or proceeding in this state. Process so served
8 shall be valid and binding upon the insurer.
9 (b) Service of process upon the association's general
10 manager as the association's agent pursuant to such an
11 appointment shall be the sole method of service of process
12 upon the association.
13 Section 2. Section 2 of chapter 2004-266, Laws of
14 Florida, appearing as a footnote to section 627.311, Florida
15 Statutes, is amended to read:
16 Notwithstanding the provisions of ss. 440.50 and
17 440.51, Florida Statutes, subject to the following procedures
18 and approval, the Department of Financial Services may request
19 transfer funds from the Workers' Compensation Administration
20 Trust Fund within the Department of Financial Services to the
21 workers' compensation joint underwriting plan provided in s.
22 627.311(5), Florida Statutes.
23 (1) The department shall establish a contingency
24 reserve within the Workers' Compensation Administration Trust
25 Fund, from which the department is authorized to expend funds
26 as provided in the subsection, in an amount not to exceed $15
27 million to be released only upon the approval of a budget
28 amendment presented to the Legislative Budget Commission. For
29 actuarial deficits projected for policyholders, based on
30 actuarial best estimates, covered in subplan ~~"~~D~~"~~ prior to July
31 1, 2004, and upon verification by the Office of Insurance

1 Regulation, the plan is authorized to request and the
2 department is authorized to submit a budget amendment in an
3 amount not to exceed $15 million for the purpose of funding
4 deficits in subplan ~~"~~D~~"~~.
5 (2) After the contingency reserve is established,
6 whenever the board determines subplan ~~"~~D~~"~~ does not have a
7 sufficient cash basis to meet a 6-month period ~~3 months~~ of
8 projected cash needs due to any deficit in subplan ~~"~~D~~,"~~
9 remaining after accessing any policyholder surplus
10 attributable to former subplan C, the board is authorized to
11 request the department to transfer funds from the contingency
12 reserve fund within the Workers' Compensation Administration
13 Trust Fund to the plan in an amount sufficient to fund the
14 difference between the amount available and the amount needed
15 to meet subplan ~~"~~D~~"~~'s projected cash need for the subsequent
16 6-month ~~3-month~~ period. The board and the office must first
17 certify to the Department of Financial Services that there is
18 not sufficient cash within subplan ~~"~~D~~"~~ to meet the projected
19 cash needs in subplan ~~"~~D~~"~~ within the subsequent 6-month period
20 ~~3 months~~. The amount requested for transfer to subplan ~~"~~D~~"~~ may
21 not exceed the difference between the amount available within
22 subplan ~~"~~D~~"~~ and the amount needed to meet subplan ~~"~~D~~"~~'s
23 projected cash need for the subsequent 6-month ~~3-month~~ period,
24 as jointly certified by the board and the Office of Insurance
25 Regulation to the Department of Financial Services,
26 attributable to the former subplan ~~"~~D~~"~~ policyholders. The
27 Department of Financial Services may submit a budget amendment
28 to request release of funds from the Workers' Compensation
29 Administration Trust Fund, subject to the approval of the
30 Legislative Budget Commission. The board will provide, for
31 review of the Legislative Budget Commission, information on

1 the reasonableness of the plan's administration, including,
2 but not limited to, the plan of operations and costs, claims
3 costs, claims administration costs, overhead costs, claims
4 reserves, and the latest report submitted on administration
5 cost reduction alternatives as required in s.
6 627.311(5)(c)17., Florida Statutes.
7 (3) This section expires July 1, 2011 ~~2007~~.
8 Section 3. No later than January 1, 2007, the plan
9 shall submit a request to the Internal Revenue Service for a
10 letter ruling or determination on the plan's eligibility as a
11 section 501(c)(3) tax-exempt organization.
12 Section 4. Except as otherwise expressly provided in
13 this act, this act shall take effect July 1, 2006.
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