CHAPTER 2004-266

House Bill No. 1251

An act relating to a joint underwriting plan of insurers; amending s. 627.311, F.S.; revising provisions requiring the Office of Insurance Regulation to approve a joint underwriting plan for workers' compensation and employer's liability insurers; requiring plan rates to be noncompetitive with the voluntary market for certain purposes; deleting authorization for insureds to select certain alternative coverages; requiring the plan of operation to establish three tiers for eligible employers; specifying criteria and rates for each tier; deleting provisions requiring establishment of certain subplans; providing criteria for minimum premium policies; providing requirements for premiums under such tiers; revising criteria, requirements, and limitations for a required depopulation program to reduce numbers of insureds under the tiers; providing an application fee for administration and fraud prevention; revising certain tier notice requirements; providing for funding of the plan through deficit funding; providing for transferring an appropriation in an amount not to exceed $10 million from the Workers' Compensation Administration Trust Fund to the workers' compensation joint underwriting plan for certain purposes; providing procedures and requirements; providing for establishing a contingency reserve for certain purposes; providing for transfers of funds from the contingency reserve in an amount not to exceed $15 million to the plan for purposes of funding certain deficits; providing limitations; providing for review of the reasonableness of the plan's administration; providing a sunset date for deficit funding; providing a mechanism for collecting deficit assessments; providing duties of the office; providing requirements, procedures, and limitations for collecting and enforcing deficit assessments; providing for transfers of funds from the Workers' Compensation Administration Trust Fund to the plan under certain circumstances; providing an exclusion for deficit assessments from certain taxes; specifying that deficit assessments are plan funds when collected; providing notice requirements for certain policies; providing for liability of certain insureds for certain additional deficit assessments; specifying venue for proceedings to enforce or collect assessments; expanding a prohibition against providing certain persons with workers' compensation and employers' liability insurance; providing an exclusion for the plan from certain taxes and assessments; requiring the Auditor General to conduct an operational audit of the association; providing audit requirements; requiring the association to comply with the Florida Single Audit Act, if certain conditions are met; requiring a report; providing appropriations; providing an exception from certain deficit funding assessment provisions; providing a procedure for a transition period; providing application; providing an effective date.

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

Section 1. Paragraphs (a), (c), (d), (e), (g), and (p) of subsection (5) of section 627.311, Florida Statutes, are amended, and paragraph (q) is added to said subsection, 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 procure ~~purchase~~ such insurance through the voluntary market. Except as provided herein, the plan must have actuarially sound rates that ensure ~~assure~~ that the plan is self-supporting.

(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. 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. ~~Establish four subplans as follows:~~

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.

(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.

(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. ~~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. 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.

(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. ~~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. 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.

(II) Rates.—The board shall establish, subject to paragraph (e), and the plan shall charge, actuarially sound rates for Tier Three insureds. ~~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 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.~~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 inforce 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 ~~plus, for the first 2 years, the surcharge as~~ 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. ~~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. ~~The plan must be funded through actuarially sound premiums charged to insureds of the plan.~~

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 any of the plan's former subplans and that the deficit cannot be funded without the use of deficit assessments, the board shall request the office 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 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. ~~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.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 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 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 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 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 3 months of projected cash needs. ~~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, 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.

(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, through the use of assessments as provided in subparagraph (d)2., and through assessments on ~~insureds in the plan if the plan uses~~ assessable policies as provided in subparagraph (d)3.

(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.

(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 the sum of $10 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 such funds to the plan no later than July 31, 2004.

[The previous paragraph was vetoed by the Governor.]

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

(1) The department shall establish a contingency reserve within the Workers' Compensation Administration Trust Fund, from which the department is authorized to expend funds as provided in the subsection, 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 is authorized to request and the department is authorized to submit a budget amendment in an amount not to exceed $15 million for the purpose of funding deficits in subplan "D".

(2) After the contingency reserve is established, whenever the board determines subplan "D" does not have a sufficient cash basis to meet 3 months of projected cash needs due to any deficit in subplan "D," the board is authorized to request the department to 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 need for the subsequent 3-month period. The board and the office must first certify to the Department of Financial Services that there is not sufficient cash within subplan "D" to meet the projected cash needs in subplan "D" within the subsequent 3 months. The amount requested for transfer to subplan "D" may not exceed the difference between the amount available within subplan "D" and the amount needed to meet subplan "D"'s projected cash need for the subsequent 3-month period, as jointly certified by the board and the Office of Insurance Regulation to the Department of Financial Services, attributable to the former subplan "D" policyholders. The Department of Financial Services 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 will provide, for review of the Legislative Budget Commission, information on 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., Florida Statutes.

(3) This section expires July 1, 2007.

Section 3. The Auditor General shall perform an operational audit, as defined in s. 11.45(1), Florida Statutes, of the Workers' Compensation Joint Underwriting Association created under s. 627.311(5), Florida Statutes. The scope of the audit shall also include:

(1) An analysis of the adequacy and appropriateness of the rates and reserves of the association. The Auditor General shall engage an independent consulting actuary who is a member of the American Academy of Actuaries or the Casualty Actuarial Society to evaluate the rates and the reserves of the association.

(2) An evaluation of costs associated with the administration and servicing of the policies issued by the association to determine alternatives by which costs can be reduced.

The Auditor General shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December 31, 2004.

Section 4. The Workers' Compensation Joint Underwriting Association is subject to the Florida Single Audit Act, as provided in s. 215.97, Florida Statutes, if the association expends a total amount of state financial assistance equal to or in excess of $300,000 in any fiscal year. Such audit reports shall be submitted to the President of the Senate, the Speaker of the House of Representatives, and the Governor pursuant to s. 215.97, Florida Statutes.

Section 5. The sum of $50,000 in nonrecurring funds is appropriated from the Worker's Compensation Administration Trust Fund to the Office of the Auditor General for the purpose of engaging an actuary to evaluate the rates and reserves of the Florida Workers' compensation Joint Underwriting Association as required in section 3.

Section 6. Transitional provisions.—Effective upon this act becoming a law:

(1) Notwithstanding s. 627.311(5), Florida Statutes, 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's 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 s. 627.311(5), Florida Statutes, as amended, effective July 1, 2004, and shall be subject to the premiums and charges provided for in that section as amended.

Section 7. Except as otherwise provided herein, this act shall take effect July 1, 2004.

Approved by the Governor May 28, 2004.

Filed in Office Secretary of State May 28, 2004.