LAAIA 2018 Legislative Session Summary

CS/HB 29 - Military and Veterans Affairs – 2018
By Ponder, Renner
CoSponsors: Abruzzo, Ahern, Altman, Burgess, Byrd, Clemons, Cortes
(B), Cruz, Duran, Eagle, Fant, Fischer, Gonzalez, Grant
(M), Killebrew, Magar, McClain, Mercado, Metz, Moskowitz, Nunez, Payne, Peters, Pigman, Porter, Roth, Silvers, Spano, Trumbull, Watson (C), Willhite, Williamson, Yarborough, Toledo
CS Sponsors: Commerce Committee

HB 29 provides allowances for military members, veterans, and their spouses by expanding or creating fee waivers and select regulatory waivers for certain military-related professional licensees.

The Department of Financial Services (DFS) is the state agency responsible for regulation and licensure of professions related to insurance, fire safety, and funeral and cemetery services. There are a number of allowances in statute for veterans and their spouses regarding many types of insurance licenses. However, there are no similar allowances in statute for other types of licenses regulated by DFS, such as bail bonds, fire safety, and funeral and cemetery services.
The existing allowances administered by DFS are:

- Waiver of application fees – Application fees are waived for applicants seeking licensure as an agent, customer representative, adjuster, service representative, managing general agent, or reinsurance intermediary for military members, recent military retirees (within 24 months of retirement), and their spouses.
- Temporary licensure – A temporary general lines agent license may be issued to an employee, a family member, a business associate, or a personal representative of a licensed general lines agent for the purpose of continuing or winding up the business affairs of the agent or agency in the event the licensed agent has become unable to perform his or her

duties because of military service.

- Exception to additional license examination requirement – Reexamination of the agent is required if they have not received an appointment within 48 months of licensure. DFS may waive this requirement if the circumstance is due to military service (limited to circumstances where the veteran's service did not exceed 3 years and the exception does not apply if 6 years have passed from their licensure date).
- Relief from continuing education requirements – Licensees who are unable to comply with the continuing education requirements due to active duty in the military may submit a written request for a waiver to DFS.
- Licensing and appointment of a non-resident – A natural person, not a resident of this state, may be licensed and appointed to represent an authorized life insurer domiciled in this state or an authorized foreign life insurer which maintains a regional home office in this state, provided such person represents such insurer exclusively at a United States military installation located in a foreign country.
- Reappointment after military service – DFS may, without requiring a further written examination, issue an appointment as an adjuster to a formerly licensed and appointed adjuster of this state who held a current adjuster's appointment at the time of entering service in the U.S. Armed Forces, subject to certain conditions (limited to circumstances where the veteran's service did not exceed 3 years, the application and fee is filed within 12 months of honorable discharge, and the new appointment is of the same type and class).

The bill provides:

- An expansion of the waiver of application fees for insurance profession licenses. Currently the waiver applies to members of the U.S. Armed Forces, their spouses, and veterans who have retired within 24 months before application. The bill replaces the term "retired" with the term "separated," which allows veterans who have less than 20 years of military service to receive the allowance.
- For the elimination of pre-licensure course requirements for members and honorably discharged veterans of the U.S. Armed Forces, and their spouses, if the applicant is subject to a licensing exam.

Effective Date: July 1, 2018
Approved by Governor: March 13, 2018

CS/CS/SB 376 - Workers' Compensation Benefits for First Responders – 2018
by Book
CoSponsors: Campbell, Hukill, Montford, Rader, Stewart, Taddeo, Torres, Jr., Young
CS Sponsors: Appropriations, Banking and Insurance

Florida Workers' Compensation System
Employers are required to pay compensation or furnish benefits that are required under ch. 440, F.S., if an employee suffers an accidental compensable injury or death arising out of work performed in the course and the scope of the employment. Generally, employers may secure coverage from an authorized carrier, qualify as a self-insurer, or purchase coverage from the Workers' Compensation Joint Underwriting Association, the insurer of last resort.

Workers' compensation is the injured employee's remedy for "compensable" workplace injuries. An accidental compensable injury must be the major contributing cause of any resulting injury, meaning that the cause must be more than 50 percent responsible for the injury as compared to all other causes combined, as demonstrated by medical evidence only. An injury or disease caused by a toxic substance is not an injury by accident arising out of employment unless there is clear and convincing evidence establishing that exposure to the specific substance caused the injury or diseases sustained by the employee.

General Compensability for Mental or Nervous Injuries

Section 440.093, F.S., sets forth the conditions under which a mental or nervous injury is compensable. A mental or nervous injury due to only stress, fright, or excitement is not an injury by accident arising out of the employment. Mental or nervous injuries without an accompanying physical injury requiring medical treatment are not compensable. In addition, a physical injury resulting from a mental or nervous injury unaccompanied by a physical trauma requiring medical treatment is not compensable.

Further, s. 440.093, F.S., provides that mental or nervous injuries occurring as a manifestation of an injury compensable under ch. 440, F.S., must be demonstrated by clear and convincing medical evidence. The compensable physical injury must be the major contributing cause of the mental or nervous injury. The law also limits the duration of temporary benefits for a compensable mental or nervous injury to no more than six months after the employee reaches maximum medical improvement.

Injured workers are entitled to receive all medically necessary remedial treatment, care, and attendance, including medications, medical supplies, durable medical equipment, and prosthetics, for as long as the nature of the injury and process of recovery requires.

Indemnity benefits only become payable to employees who are disabled for at least eight days due to a compensable workplace injury. These benefits are generally payable at 66 2/3 percent of the employee's average weekly wage (AWW), up to the maximum weekly benefit established by law. Indemnity benefits fall into one of four categories: temporary partial disability, temporary total disability, permanent partial disability, and permanent total disability.

- Temporary partial disability and temporary total disability benefits are payable for up to a combined total of 260 weeks.
- Permanent partial disability benefits are payable as impairment income benefits that are provided for a variable number of weeks depending upon the value of the injured worker's permanent impairment rating pursuant to a statutory formula.
- Permanent total disability benefits are payable until the age of 75, unless the work-related accident occurs after the worker's 70th birthday, then the benefit is paid for five years.

Section 440.15(3), F.S., provides that permanent impairment benefits are limited for a permanent psychiatric impairment to one percent permanent impairment.

First Responders' Compensability for Mental or Nervous Injuries

In 2007, the Legislature enacted significant changes in workers' compensation benefits for first

responders that provide benefits and standards for determining benefits for employment-related accidents and injuries of first responders. A "first responder" is a law enforcement officer, as defined in s. 943.10, F.S., a firefighter as defined in s. 633.102, F.S., or an emergency medical technician or paramedic as defined in s. 401.23, F.S., employed by state or local government. Further, a volunteer law enforcement officer, firefighter, or emergency medical technician or paramedic engaged by the state or a local government is considered a first responder of the state or local government.

In regards to compensability for a mental or nervous injury involving a first responder, s. 112.1815, F.S.:

- Requires that a mental or nervous injury occurring as a manifestation of a compensable injury must be demonstrated by clear and convincing evidence;
- Authorizes the payment of only medical benefits in employment-related cases involving a mental or nervous injury without an accompanying physical injury requiring medical treatment;
- Prohibits the payment of indemnity benefits unless a physical injury arising out of injury as a first responder accompanies the mental or nervous injury; and
- Provides that benefits for first responders are not subject to any limitation on temporary benefits under s. 440.93, F.S., or the one percent limitation on permanent psychiatric impairments benefits under s. 440.15, F.S.

State Survey of Compensability Laws for Workers' Compensation Mental Injuries

Often stress-related injuries do not result from a physical injury. These types of injuries are referred to as "mental-mental" injuries because they are caused by a purely mental stimulus that leads to a mental impairment, such as depression or post-traumatic stress disorder (PTSD). This stimulus could be witnessing, but not being physically injured by, a particularly horrific accident, workplace incident, or crime scene.

In 2017, the National Council on Compensation Insurance (NCCI) issued a report summarizing compensability for injuries in the United States. Highlights of the study include:

- ***Compensability for Mental-Mental Injuries:*** 27 jurisdictions, including Florida, have statutory language expressly allowing compensation for nonphysical mental (mental-mental) injuries or stress in limited circumstances.
- ***Mental-Mental and Mental-Physical Exclusions:*** Montana is the only state that specially denies compensability for both mental-physical and mental-mental injuries.
- ***Personnel Actions:*** 21 states specify that stress arising out of a personnel action is not compensable.

Post-Traumatic Stress Disorder (PTSD)

The American Psychiatric Association provides diagnostic criteria for mental disorders, including PTSD, in its *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (*DSM-5). PTSD is a psychiatric disorder that can occur in people who have experienced or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war, combat, rape, or other violent personal assault. A diagnosis of PTSD requires exposure to an upsetting traumatic event. However,

exposure could be indirect rather than first hand. Symptoms generally begin within the first three months after the trauma, although there may be a delay of months or even years before the criteria for the diagnosis are met.

Prevalence Rate

The exact prevalence rate for PTSD is difficult to ascertain. According to the National Center for PTSD, about seven or eight percent of the population will have PTSD at some point in their lives. About eight million adults will have PTSD during a given year. About 10 percent of females develop PTSD during their lives compared with about four percent of males. The number of veterans with PTSD varies by service era. For example, about 15 percent of Vietnam veterans are diagnosed with PTSD at the time of the most recent study conducted in the late 1980s. It is estimated that 30 percent of Vietnam veterans have had PTSD in their lifetime. In contrast, about 12 percent of Gulf War veterans have PTSD in a given year.

The DSM-5 estimates approximately 8.7 percent of the U.S. population will develop PTSD in their lifetime. Twelve-month prevalence among U.S. adults is approximately 3.5 percent. The PTSD rates are higher among veterans and others whose employment increases the risk of traumatic exposure, such as police, firefighters, and emergency medical personnel. The highest rates (ranging from one-third to more than one-half of those exposed) are found among survivors of rape, military combat and captivity, and ethnically or politically motivated internment and genocide.

Although estimates vary across occupations and the general population, some studies indicate that first responders and other professionals who are exposed to potentially traumatic events in their workplace are four to five times more likely to develop PTSD compared to the general population. A 2016 report estimated 20 percent of firefighters and paramedics had PTSD. Preexisting mental health conditions may be exacerbated and new mental health conditions may occur due to extremely emotionally and physically demanding working conditions.

A 2015 survey of 4,000 first responders found that 6.6 percent had attempted suicide, which is more than 10 times the rate in the general population. Concern has been expressed that first responders may underreport mental health conditions as a result of stigma associated with seeking treatment for those conditions.

Prognosis

The onset of PTSD symptoms is usually in the first month after the traumatic event; however, in about 15 percent of the cases, there may be a delay of months or years before symptoms appear. Further, although a high proportion of trauma survivors will initially develop symptoms of PTSD, a substantial number of these individuals recover without treatment in the following years, with a steep decline in PTSD rates occurring in the first year. However, at least a third of the individuals who initially develop PTSD remain symptomatic for three years or longer, and are at risk of secondary problems such as substance abuse.

2016 Pulse Shooting in Orlando, Florida

On June 12, 2016, 49 people were killed and at least 68 others were injured at a shooting at the Pulse nightclub in Orlando, Florida. The shooting has been characterized as one of the deadliest

mass shootings in modern U.S. history. One recently profiled police officer was diagnosed with post-traumatic stress disorder and has been out of work since shortly after the shooting. The article noted that, while the City of Orlando Police Department was paying his full salary, Florida law did not require the employer to pay because workers' compensation compensability for PTSD must be accompanied by a physical injury, which the officer did not have.

Florida Retirement System

The Florida Retirement System (FRS) offers members a choice between the Pension Plan (a defined benefit plan) and the Investment Plan (a defined contribution plan). Generally, FRS membership is compulsory for employees filling a regularly established position in a state agency, county agency, state university, state college, or district school board with some limited exceptions. Participation by cities, municipalities, special districts, charter schools, and metropolitan planning organizations, although optional, is generally irrevocable after the election to participate is made. The five classes of membership are Regular Class, Senior Management Service Class, Special Risk Class, Special Risk Administrative Support Class, and Elected Officers' Class.

Special Risk Class of the FRS

The Special Risk Class of the FRS consists of state and local government employees who meet the criteria for special risk membership. The class covers persons employed in law enforcement, firefighting, criminal detention, and emergency medical care who meet statutory criteria for membership set for in s. 121.0515, F.S. A person who is a member in the Special Risk Class may retire at an earlier age and is eligible to receive higher disability and death benefits than Regular Class members. In creating the Special Risk Class of membership within the FRS, the Legislature recognized that certain employees, as an essential function of their positions, must perform work that is physically demanding or that requires extraordinary agility and mental acuity. The Legislature further found that, as persons in such positions age, they may not be able to continue performing their duties without posing a risk to the health and safety of themselves, the public and their coworkers.

Disability Benefits for Members of the FRS

The FRS provides disability benefits for its active members who are permanently, totally disabled from useful employment. The level of disability benefits to which an eligible disabled member is minimally entitled depends upon membership class, and whether the disabling injury or illness was job related. For Special Risk Class members retiring on or after July 1, 2000, the minimum in-line-of-duty disability benefit is 65 percent of average final compensation (AFC) as of the member's disability retirement date.

Section 121.091(4), F.S., provides that any FRS member who is totally and permanently disabled due to a condition or impairment of health caused by an injury or illness (including tuberculosis, heart disease, or hypertension) is entitled to disability benefits. The disabling injury or illness must have occurred before the member terminated employment. If the injury or illness arises out of and in the actual performance of duty required by his or her job, the member is entitled to in-line-of-duty disability benefits.

There are several important differences in the laws applicable to disability benefits, depending on

whether the disability is found to be due to an injury or illness "suffered in the line of duty":

- *Eligibility* — A FRS member is eligible for in-line-of-duty disability benefits from his/her first day on the job. In contrast, the member must have eight years of creditable service before becoming disabled in order to receive disability retirement benefits for any disability occurring other than in the line of duty.
- *Burden of Proof* — Proof of disability is required, including certification by two Florida-licensed physicians that the member's disability is total and permanent (i.e., that the member is prevented by reason of a medically determinable physical or mental impairment from engaging in gainful employment of any type). It is the responsibility of the applicant to provide such proof. Unless a legal presumption applies such as the one provided under s. 112.18, F.S., to qualify to receive the higher in-line-of-duty disability benefits, the member must also show by competent evidence that the disability occurred in the line of duty.
- *Chapter 175, F.S., plans* — Pension plans for firefighters established pursuant to ch. 175, F.S., must provide a minimum line of duty benefit equal to the firefighter's accrued retirement benefit, but no less than 42 percent of his or her average monthly salary at the time of disability. Disability occurs when an injured plan member is wholly prevented from rendering useful and efficient service as a firefighter and is likely to remain so in the opinion of the board of trustees, after the member has been examined by a duly qualified doctor selected by the board. Local law plans may have enacted disability benefits that exceed the minimum requirements.

Existing In-Line-of-Duty Disability Presumptions

Section 112.18, F.S., establishes a presumption for state and local firefighters, law enforcement, correctional, and correctional probation officers regarding determinations of job-related disability. This statute provides that certain diseases (tuberculosis, heart disease, and hypertension) acquired by these officers are presumed to have been suffered in the line of duty. This presumption in law has the effect of shifting from the employee to the employer the burden of proving by competent evidence that the disabling disease was not related to the person's employment.

Section 175.231, F.S., provides a similar presumption for firefighters in any municipality, special fire control district, chapter plan, local law municipality, local law special fire control district, or local law plan under ch. 175, F.S., whose death or disability is the result of tuberculosis, heart disease, or hypertension. Section 185.34, F.S., provides a similar presumption for municipal police officers' pension plans.

Section 112.181, F.S., provides a presumption applicable to any emergency rescue or public safety worker, including a firefighter, that such employee qualifies for in the line of duty disability or death benefits if such disability or death is due to hepatitis, meningococcal meningitis, or tuberculosis.

Absent one of the existing presumptions, the FRS member has the burden of proof when claiming in-line-of-duty disability or death benefits. The employee must show by competent evidence that the death or disability occurred in the line of duty in order to receive the higher benefits. If the employee or the employee's survivors cannot meet the burden of proof, the employee or the employee's survivors are entitled only to the lesser benefits available under regular death or

disability benefits.

Death Benefits Available for FRS Members

The FRS currently provides death benefits for surviving spouses and/or eligible dependents of active members. Under s. 121.091(7), F.S., death benefits may be paid for an active member of the FRS Pension Plan who dies before retirement due to an injury or illness (including tuberculosis, heart disease, or hypertension). If the injury or illness arises out of and in the actual performance of duty required by the job, the member's surviving spouse and/or eligible dependent(s) are entitled to in-line-of-duty death benefits. There are important differences in the laws applicable to death benefits, depending on whether the death is found to be due to an injury or illness "suffered in the line of duty."

From the first day on the job, an FRS Pension Plan member is eligible for in-line-of-duty death benefits that will pay a minimum monthly benefit to a survivor equal to half the member's last monthly salary. If the deceased member would have been entitled to a higher retirement benefit based on service credit, the higher benefit would be payable to his/her spouse or eligible dependent(s). The survivor benefit for Special Risk Class members killed in the line of duty is 100 percent of the member's base pay at the time of death if the member's death occurs on or after July 1, 2013. Unless a legal presumption applies such as those provided under s. 112.18, F.S., the eligible beneficiary must show by competent evidence that the death occurred in the line of duty to qualify to receive the higher in-line-of-duty death benefits.

Local Government Pension Plans

Chapters 175 and 185, F.S., provide funding mechanisms for pension plans of municipal firefighters and police officers, respectively. Both chapters provide a uniform retirement system for firefighters and police officers and set standards for operating and funding of pension systems through a trust fund supported by a tax on insurance premiums. Most Florida firefighters and local law enforcement officers participate in these plans. To be considered totally and permanently disabled, charter plan employees must only be found disabled from rendering useful and efficient service as a firefighter or police officer. Under local law plans, the standards may vary for determining eligibility for disability retirement, death benefits, and the benefits paid, although all plans must abide by minimum standards established under ss. 175.351 and 185.35, F.S., respectively.

Effect of the Bill

Amends s. 112.1815, F.S., to revise the standards for determining compensability of employment-related post-traumatic stress disorder (PTSD) under workers' compensation for first responders, which includes volunteers or employees engaged as law enforcement officers, firefighters, emergency medical technicians, and paramedics. The section creates an exception to the current prohibition on the payment of indemnity benefits unless a physical injury accompanies the mental or nervous injury by authorizing indemnity benefits for PTSD if certain conditions are met. A first responder is entitled to medical and indemnity benefits for PTSD, as an occupational disease, the PTSD resulted from the first responder acting within the course and scope of employment and is diagnosed by a licensed psychiatrist who is an authorized treating physician under ch. 440, F.S. The PTSD must be due to one of the following qualifying events relating to minors or others:

- Seeing for oneself a deceased minor;

- Witnessing directly the death of a minor;
- Witnessing directly the injury to a minor who subsequently died prior to, or upon arrival at a hospital emergency department, participating in the physical treatment of, or manually transporting an injured minor who subsequently died before or upon arrival at a hospital emergency department;
- Seeing for oneself a decedent who died due to grievous bodily harm of a nature that shocks the conscience;
- Witnessing directly a death, including suicide, due to grievous bodily harm; or homicide, including murder, mass killings, manslaughter, self-defense, misadventure, and negligence; or
- Participating in the physical treatment of an injury, including attempted suicide, or manually transporting an injured person who suffered grievous bodily harm, if the injured person subsequently died prior to or upon arrival at a hospital emergency department.

Such medical and indemnity benefits for a first responder's PTSD are due:

- If the PTSD is proven by clear and convincing evidence;
- Regardless of whether the first responder incurred a physical injury;
- Without apportionment due to a preexisting PTSD;
- Without any limitation, thus the one percent on permanent psychiatric impairment benefits does not apply; and
- Without any limitation on temporary benefits under s. 440.093, F.S.

The first responder must file a first notice of injury with their employer or carrier within 90 days of the qualifying event, or manifestation of the PTSD. However, the claim is barred if the notice is not filed within 52 weeks after the qualifying event. The section defines the terms, "directly witnessing," "manually transporting," and "minor." The section also directs the Department of Financial Services to adopt rules specifying injuries qualifying as grievous bodily harm of a nature that shocks the conscience.

Lastly, the section requires an employing agency of a first responder, including volunteer first responders, to provide educational training related to mental health awareness, prevention, mitigation, and treatment.

Current law provides that only medical benefits are payable for a mental or nervous injury of a first responder that is unaccompanied by a physical injury. Indemnity benefits are available only if the mental or nervous injury is accompanied by a physical injury.

Provides that the Legislature declares that this act fulfills an important state interest.

According to the NCCI, the implementation of CS/SB 376 may result in an indeterminate increase in Florida's workers' compensation system costs for law enforcement officer, firefighter, emergency medical technician, and paramedic classifications in Florida. However, the overall impact on workers' compensation costs was expected to be minimal, since the data reported to the NCCI show that first responders represent approximately 2.2 percent of statewide losses in Florida. The

2.2 percent may be an underestimate for the total population of Florida workers, as many entities that employ law enforcement officers, firefighters, and emergency medical technicians are self-insured and do not report data to the NCCI.

The ultimate system cost impact would be realized through future loss experience and reflected in subsequent NCCI rate filings in Florida. A minimal impact in this context is defined as an impact on overall system costs of less than 0.2 percent or approximately $7 million.

The NCCI is unable to quantify the expected increase in the number of post-traumatic stress disorder (PTSD)-related claims that would be entitled to indemnity benefits under CS/SB 376. According to the NCCI, the 2015 average total claim severity for an indemnity or lost-time claim in Florida was $60,700 ($19,100 average indemnity claim severity plus $41,600 average medical claim severity). However, due to the high prevalence of PTSD among first responders, the NCCI estimates that the increase in compensable PTSD-related claims could be significant for these occupational classifications. The bill could potentially result in increased litigation related to the confirmation of a PTSD diagnosis and the determination of whether the PTSD arose out of an activity performed within the course of employment. Any costs associated with increased litigation would be expected to exert upward pressure on overall workers' compensation system costs.

Approved by Governor 3/27/18
Effective Date: 10/1/2018

CS/CS/HB 465 - Insurance - 2018
By Santiago, Hager
CS Sponsors: Commerce Committee, Insurance & Banking Subcommittee

This bill makes the following changes regarding insurance:

Foreign Insurer Stock Valuation
Chapter 625, F.S., regulates the financial dealings of insurers admitted to do insurance business in this state and empowers OIR to regulate and oversee their financial conduct. Among other things, the law provides for the valuation of a variety of assets held by the insurer, which contribute to the insurer's financial stability and, in the event of troubled assets, possible instability or insolvency.

Assets held in the form of stock in a subsidiary corporation are subject to maximum percentages of investments by the insurer, as follows:

- If the insurer's surplus, including investments in subsidiaries, does not exceed $100 million, the maximum percentage of investment in the subsidiaries may not exceed the lesser of:
  - 10 percent of admitted assets; or
  - 50 percent of the surplus in excess of minimum required surplus.
- If the insurer's surplus, including investments in subsidiaries, is $100 million, or more, the maximum percentage investment in the subsidiaries may not exceed:
  - 25 percent of admitted assets.

The valuation of the stock held in the subsidiary may not exceed the net value established using only the assets of the subsidiary eligible under part II of ch. 625, F.S. The valuation of stocks and securities must be consistent with methods published by the National Association of Insurance Commissioners (NAIC).

Part II of ch. 625, F.S., regulates the valuation of investments by domestic insurers and commercially domiciled insurers. However, the law also provides that "[t]he investment portfolio of a foreign or alien insurer shall be as permitted by the laws of its domicile if of a quality substantially as high as that required under [ch. 625, F.S.] for similar funds of like domestic insurers."

There are multiple private organizations that engage in the evaluation and rating of insurance companies for the purposes of identifying the financial strength of insurers. These financial strength ratings allow potential investors to make informed decisions regarding possible investment in the rated insurer. The rating companies use similar terminology, but each has a proprietary method to establish their rating results. While the rating results are similar, it is necessary to review the rating organization's own explanation of its approach and methods to understand the subtle differences that occur when a particular insurer is rated by multiple rating organizations. A.M. Best's Financial Strength Rating is divided between "Secure," with ratings between A++ and B+, or "Vulnerable," with ratings of B or lower. Among the "Secure" ratings, A++ and A+ are described as "Superior," A and A- are described as "Excellent," and B++ and B+ are described as "Good" in terms of A.M. Best's opinion of the company's ability to meet financial obligations.

Effect of the Bill

The bill provides that the stock of a subsidiary corporation or related entity of a foreign insurer is exempt from the limitations on valuation and investment requirements of ss. 625.151(3) and 625.325, F.S., for solvency evaluation purposes. The exemption applies if the investment is allowed under the laws of the insurer's domicile state provided that state is a member of NAIC. In addition, the subsidiary's stock must be valued by NAIC's Securities Valuation Office (SVO) with a rating of 1, 2, or 3 or be exempt from NAIC filing and carry a rating assigned by a nationally recognized statistical rating organization that is equivalent to SVO's rating.

Exemptions to Adjuster Examination Requirement

An adjuster is "an individual employed by a property/casualty insurer to evaluate losses and settle policyholder claims." An adjuster may be licensed as either an "all-lines adjuster" or a "public adjuster." An all-lines adjuster "is a person who, for money, commission, or any other thing of value, directly or indirectly undertakes on behalf of a public adjuster or an insurer to ascertain and determine the amount of any claim, loss, or damage payable under an insurance contract or undertakes to effect settlement of such claim, loss, or damage." Subject to certain exceptions, a public adjuster is someone that is paid by an insured to prepare and file a claim against their insurer. Adjusters are commonly understood as an insurer's representative in an insurance claim. The public is not generally aware of the role of a public adjuster, but access to their services becomes competitive following natural disasters or other mass loss/claim events (e.g., hurricanes, tornadoes, floods, and fires).

Among other requirements, an applicant must pass an examination to obtain an adjuster's license; however, the examination requirement is waived if they have attained certain professional designations that document their successful completion of professional education coursework. This is true for applicants for life and health agents, general lines agents, adjusters, resident or nonresident all- lines adjusters, and non-resident agents. An examination is not required for all-lines adjuster applicants with the following professional designations:

- Accredited Claims Adjuster (ACA) from a regionally accredited postsecondary institution in this state;
- Associate in Claims (AIC) from the Insurance Institute of America;
- Professional Claims Adjuster (PCA) from the Professional Career Institute;
- Professional Property Insurance Adjuster (PPIA) from the HurriClaim Training Academy;
- Certified Adjuster (CA) from ALL LINES Training;
- Certified Claims Adjuster (CCA) from AE21 Incorporated; or
- Universal Claims Certification (UCC) from Claims and Litigation Management Alliance (CLM).

DFS must approve the curriculum, which must include comprehensive analysis of basic property and casualty lines of insurance and testing at least equal to that of standard department testing for the all-lines adjuster license. The curriculum must include 40 hours of instruction covering all of the topics in the all-lines adjuster Examination Content Outline adopted by DFS. DFS only approves curriculum related to adjuster licensing for designations listed in s. 626.221(2)(j), F.S.

WebCE, Inc., is a national provider of professional and continuing educational courses. They provide education related to multiple professions, including: insurance, financial planning, accounting, and tax. Participants can obtain the following professional designations from WebCE: Certified Financial Planner (CFP), Certified Investment Management Analyst (CIMA), Certified Private Wealth Advisor (CPWA), and Certified Fraud Examiner (CFE). WebCE provides continuing education to insurance professionals with courses in subjects of life and health, property and casualty, adjuster, and limited lines.

Effect of the Bill

The bill provides an exemption to the all-lines adjuster licensing exam requirements to individuals who receive a Claims Adjuster Certified Professional (CACP) designation from WebCE, Inc.

Surplus Lines Insurer Eligibility

Surplus lines insurance refers to a category of insurance for which the admitted market is unable or unwilling to provide coverage. There are three basic categories of surplus lines risks:

- Specialty risks that have unusual underwriting characteristics or underwriting characteristics that admitted insurers view as undesirable;
- Niche risks for which admitted carriers do not have a filed policy form or rate; and
- Capacity risks that are risks where an insured needs higher coverage limits than those that are available in the admitted market.

Surplus lines insurers are not "authorized" insurers as defined in the Insurance Code, which means they do not obtain a certificate of authority from OIR to transact insurance in Florida. Rather,

surplus lines insurers are “unauthorized” insurers, but may transact surplus lines insurance if they are made eligible by OIR.

The Florida Surplus Lines Service Office (FSLSO) must file a written request with OIR in order for a surplus lines insurer to become eligible to underwrite insurance risks in Florida. Subsequent to the adoption of this requirement, Congress passed the Nonadmitted and Reinsurance Reform Act of 2010 (NRRA). The NRRA requires the eligibility of surplus lines insurers to be determined in compliance with its criteria, unless the state has adopted nationwide uniform eligibility requirements. OIR has implemented such eligibility determination standards that may be accessed directly by interested surplus lines insurers. Accordingly, surplus lines insurers apply directly to OIR rather than having FSLSO make the written request. The statute requiring such a written request by FSLSO has become superfluous because it conflicts with NRRA and is no longer implemented.

Effect of the Bill
The bill repeals the requirement that FSLSO submit written requests to OIR for eligibility purposes.

Personal Financial and Health Information Privacy
DFS and the Financial Services Commission (Commission) are required to adopt rules governing the use of a consumer’s non-public personal financial and health information by regulated entities. Florida law provides that the rules must be consistent with and not more restrictive than the requirements of Title V of the federal Gramm-Leach-Bliley Act of 1999. However, in December 2015, the Gramm- Leach-Bliley Act was amended by the Fixing America's Surface Transportation (FAST) Act. The law governing DFS and Commission rules on privacy of consumer’s non-public personal financial and health information does not yet incorporate this change. FAST added the following exception to the annual notice requirement found in Section 503 of the Gramm-Leach-Bliley Act:

> (f) Exception to Annual Notice Requirement.--A financial institution that--
> (1) provides nonpublic personal information only in accordance with the provisions of subsection (b)(2) or (e) of section 502 or regulations prescribed under section 504(b), and
>
> (2) has not changed its policies and practices with regard to disclosing nonpublic personal information from the policies and practices that were disclosed in the most recent disclosure sent to consumers in accordance with this section,
>
> shall not be required to provide an annual disclosure under this section until such time as the financial institution fails to comply with any criteria described in paragraph (1) or (2).

Effect of the Bill
The bill incorporates FAST’s amendment of the Gramm-Leach-Bliley Act for purposes of privacy standards applicable to rules adopted by DFS and the Commission. This nullifies any existing rules and prohibits any new rules that would require an annual notice that would be exempted by FAST.

Execution of Insurance Policies

Part II of ch. 627, F.S., specifies numerous requirements applicable to insurance contracts. These requirements apply to all aspects of the insurance transaction from the initial application to the cancellation, non-renewal, or lapse of the policy. This includes requirements concerning the execution of the policy. The policy must be executed in the name of and on behalf of the insurer by its officer, attorney in fact, employee, or representative duly authorized by the insurer. A facsimile signature of one of the specified persons is acceptable and the policy cannot be made invalid because the facsimile signature is that of an individual who did not have the authority to execute the policy on the date of issuance.

Effect of the Bill

The bill provides that an insurer may elect to issue an insurance policy without being executed by one of the specified insurer representatives. If such a policy is issued, it is not invalid despite not being executed.

Notice of Policy Change

An insurer is prohibited from changing policy terms at renewal, unless they issue a notice of change in policy terms. A change in policy terms includes, the modification, addition, or deletion of any term, coverage, duty, or condition from the previous policy, not including typographical or scrivener's errors or the application of mandated legislative changes. The notice may not be used to add optional coverages that increase premium, unless the policyholder affirmatively accepts the optional coverage.

The policyholder must receive advance written notice of the change. If the insurer fails to issue the notice, coverage continues until the next renewal occurs (with proper service of notice) or replacement coverage is obtained. The notice is required to be titled a "Notice of Change in Policy Terms." However, there is no explicit requirement for any other specific content of the notice. OIR has not adopted a rule interpreting the applicable statute.

Section 627.43141(7), F.S., states that the intent of the law is to:

- Allow an insurer to make a change in policy terms without nonrenewing those policyholders that the insurer wishes to continue insuring;
- Alleviate concern and confusion to the policyholder caused by the required policy nonrenewal for the limited issue if an insurer intends to renew the insurance policy, but the new policy contains a change in policy terms; and
- Encourage policyholders to discuss their coverages with their insurance agents.

Despite the stated intent, it is arguable that a bare notice with the title "Notice of Change in Policy Terms" and containing no meaningful explanation of the change in policy terms complies with the law.

Effect of the Bill

The bill requires that an insurer summarize policy changes on the required notice upon renewal, rather than merely issuing a properly titled notice (i.e., requires content more informative than merely the phrase "Notice of Change in Policy Terms").

Property Insurance Claim Mediation

DFS administers alternative dispute resolution programs for various types of insurance. DFS has mediation programs for property insurance and automobile insurance claims. DFS has a neutral evaluation program, similar to mediation, for sinkhole insurance claims. DFS approves mediators used in the two mediation programs and certifies the neutral evaluators used in neutral evaluations for sinkhole insurance claims.

For property insurance claims involving personal lines and commercial residential claims, only the policyholder, as a first-party claimant, or the insurer may request mediation under DFS' program. This means that third parties cannot utilize the program. This is true even if the policyholder assigns their policy benefit rights to the third party. The insurer must notify the policyholder of the right to mediation under the program upon receipt of the claim. The mediation costs are generally the responsibility of the insurer.

Effect of the Bill

The bill provides that a third party who receives rights to policy benefits through an assignment may request mediation of a property insurance claim; except, an insurer is not required to participate in a mediation requested by the third-party assignee. It also conforms terminology in the applicable section of law to change the term "insured" to the term "policyholder." The terms are currently used interchangeably in the statute. This makes it clear that the purchaser of the policy is the one with mediation rights, except as provided by the bill.

Proof of Mailing

When cancelling or non-renewing a policy, motor vehicle insurers are required to mail the cancellation or non-renewal to the first named insured on the policy and the applicable insurance agent at least 45 days prior to the effective date of the cancellation or non-renewal. In the case of non-payment of premium, only a 10-day notice is required. A policy that has been in effect for less than 60 days cannot be cancelled. The reason for the cancellation must be included in the notice. The insurer may also transfer the policy to an insurer under the same ownership or management upon proper notice. For each of these required notices the insurer must use United States postal proof of mailing, certified mail, or registered mail.

Effect of the Bill

The bill permits use of the Intelligent Mail barcode, or similar method approved by the United States Postal Service, to be used to establish proof that required motor vehicle insurance notices of cancellation, non-renewal, or transfer of insurer were mailed.

Filing Exception for Specialty Insurers

In 2014, the Legislature passed CS/CS/SB 1308, which implemented new elements of NAIC Model Acts related to risk-based capital, holding company systems, standard valuation, and actuarial opinions and memorandum. This was primarily in response to the financial crisis of 2008. The financial crisis was affected by the impact of common ownership and control of insurance and financial services companies, such that when one company became financially troubled or insolvent, the value and solvency of related companies also became affected. This led regulators to have an interest in knowing and understanding the web of controlling interests among related companies. This legislation created a presumption of control in certain interests and acquisitions

among related companies.

While not a portion of a model act, the 2014 bill allowed insurers to overcome the presumption of control by either filing a disclaimer of control on a form prescribed by OIR or by providing a copy of the applicable Schedule 13G on file with the federal Securities and Exchange Commission (SEC). After a disclaimer is filed, the insurer is relieved of any further duty to register or report under s. 628.461, F.S., unless OIR disallows the disclaimer. Specialty insurers must meet similar requirements addressing solvency and organizational risk controls as those created for insurers; however, they do not have the option of filing their SEC Schedule 13G to rebut the presumption of control.

Specialty insurers are defined as:

- Motor vehicle service agreement companies;
- Home warranty associations;
- Service warranty associations;
- Prepaid limited health service organizations;
- Authorized health maintenance organizations;
- Authorized prepaid health clinics;
- Legal expense insurance corporations;
- Providers licensed to operate a facility that undertakes to provide continuing care;
- Multiple-employer welfare arrangements;
- Premium finance companies; and
- Corporations authorized to accept donor annuity agreements.

Effect of the Bill

The bill adds viatical settlement providers to the list of specialty insurers and allows any specialty insurer to overcome the presumption of control by filing with OIR a disclaimer of control on an OIR form or a copy of their SEC Schedule 13G.

Confidentiality of Documents Submitted to the Office of Insurance Regulation

In 2011, as part of NAIC's Solvency Modernization Initiative, NAIC adopted a new insurance regulatory tool: the Own Risk and Solvency Assessment (ORSA). ORSA requires insurance companies to issue their own assessment of their current and future risk through an internal risk self-assessment process and allows regulators to form an enhanced view of an insurer's ability to withstand financial stress, particularly on a holding company's level. In essence, an ORSA is an internal process undertaken by an insurer or insurance group to assess the adequacy of its risk management and current and prospective solvency positions under normal and severe stress scenarios. An ORSA requires insurers to analyze all reasonably foreseeable and relevant material risks (i.e., underwriting, credit, market, operational, liquidity risks, etc.) that could have an impact on an insurer's ability to meet its policyholder obligations.

Insurers and insurance groups are required to articulate their own judgment about risk management and the adequacy of their capital position. This is meant to encourage management to anticipate potential capital needs and to take action proactively, and serves as an early warning

mechanism for insurance regulators. ORSA is not a one-off exercise - it is a continuous evolving process and should be a component of an insurer's enterprise risk-management framework. Moreover, there is no mechanical way of conducting an ORSA; how to conduct the ORSA is left to each insurer to decide, and actual results and contents of an ORSA report will vary from company to company. The output is a set of documents that demonstrate the results of management's self-assessment.

Effective January 1, 2018, ORSA is an NAIC accreditation standard for state insurance regulators. During the 2016 Regular Session, the Legislature passed CS/CS/HB 1422 and CS/CS/HB 1416 adopting ORSA requirements for Florida regulated insurers and providing a public record exemption for information provided to OIR in required ORSA filings, respectively.

The law requires insurers or insurance groups to:

- Maintain a risk management framework for identifying, assessing, monitoring, managing, and reporting on its material, relevant risks;
  - This requirement may be satisfied by being a member of an insurance group with a risk management framework applicable to the insurer's operations.
- Conduct an ORSA at least annually (and whenever there have been significant changes to the risk profile of the insurer or the insurance group), consistent with and comparable to the process in the ORSA Guidance Manual; and
- File an ORSA summary report, based on the ORSA Guidance Manual with their domestic regulator or lead state (for an insurance group), beginning in 2017, which must:
  - Be submitted once every calendar year;
  - Include notification to OIR of its proposed annual submission date by December 1, 2016;
  - Initial ORSA summary report must be submitted by December 31, 2017;
  - Include a brief description of material changes and updates from the prior year's report;
  - Be signed by the chief risk officer or chief executive officer responsible for overseeing the enterprise risk management process; provide a copy to the board of directors or appropriate board committee; and
  - Be prepared in accordance with the ORSA Guidance Manual; the insurer must maintain and make documentation and supporting information available for OIR examination.

The law provides that an ORSA summary report and certain other related information are confidential and exempt from the public records law. In addition, that information in required ORSA filings is privileged, may not be produced by OIR in response to a subpoena or discovery request directed to OIR, and, if such information is obtained from OIR, it is not admissible in evidence in any private civil action.

Effect of the Bill

The bill expands the confidentiality of documents submitted to OIR under ORSA requirements to prohibit these documents from being admitted as evidence in a private civil action regardless of the source of the ORSA documents, rather than only when they are obtained from OIR. This change relates to use of these documents while in private hands and not to public record information held by the state.

Reciprocal Insurer Reserve Requirements

Reciprocal insurance is a risk-pooling alternative to stock or mutual insurance. Reciprocal insurance involves an exchange of reciprocal agreements of indemnity among participants who are known as "subscribers." The subscribers generally have something in common. There are currently four companies active in Florida and licensed as reciprocal insurers under s. 629.401, F.S.

The agreements of indemnity are exchanged through an attorney-in-fact, whose powers are set forth by the subscribers. "In general, the attorney in fact manages the reciprocal's finances and handles underwriting, claims administration and investments."

Twenty-five or more persons domiciled in Florida may organize a domestic reciprocal insurer and apply to OIR for authority to transact insurance. Reciprocal insurers may transact any kind of insurance other than life or title.

Reciprocal insurers offering property insurance are required to maintain an unearned premium reserve consistent with the requirement generally applicable to property insurers under the Insurance Code. This reserve requirement ensures the availability of funds for transfer to loss reserves when losses are incurred during the policy period or refunds that become due before the premium is earned, among other things. Premiums ceded to reinsurers for the purchase of reinsurance may be deducted from unearned premiums.

Insurers are allowed to calculate unearned premium reserves on monthly or more frequent pro rata basis. In other words, the insurer may reduce unearned premium reserves on a one-year policy at the rate of 1/12 per month or, for a two-year policy at 1/24 per month, and so on. Reciprocal insurers must calculate unearned premium reserves on a monthly or more frequent basis.

NAIC has developed a model act for regulation of reciprocals. Section 7., Reserves, of NAIC Model Act 356, Model Indemnity Contracts Act, provides for an unearned premium reserve, as follows:

> There shall at all times be maintained as a reserve a sum in cash or convertible securities equal to fifty percent (50%) of the net annual deposits collected and credited to the accounts of the subscribers on policies having one year or less to run and pro rata on those for longer periods. Net annual deposits shall be construed to mean the advance payments of subscribers after deducting the amounts specifically provided in the subscribers' agreements, for expenses. The sum shall at no time be less than $25,000, and if at any time fifty percent (50%) of the deposits so collected and credited shall not equal that amount, then the subscribers, or their attorney for them, shall make up any deficiency.

Effect of the Bill

The bill revises the unearned premium reserve requirement that must be met by a reciprocal insurer, regardless of the line of insurance underwritten. The reciprocal insurer must retain 50 percent of "net written premiums" on policies having a policy period of one year or less. "Net written premiums" means premium payments made or due from subscribers after deducting

expenses specified in the subscriber's agreement, including reinsurance costs and subscriber fees. To take the deduction from "net written premiums" for subscriber fees, the power of attorney agreement must contain an explicit provision to return subscriber fees on a pro rata basis for cancelled policies. The bill requires an unearned premium reserve of $100,000, at all times, and provides a mechanism to return the reserve to that amount if it is not maintained at the required amount.

Delivery of Policies by Motor Vehicle Service Agreement Companies and Health Maintenance Organizations

The law requires every insurance policy to be mailed or delivered to the insured (policyholder) within 60 days after the insurance takes effect. Insurance policies are typically only delivered when the policy is issued and are not delivered each time the policy is renewed.

Insurers are allowed to post certain insurance policies not containing policyholder personal identifiable information for certain types of insurance on the insurer's website instead of mailing or delivering the policy to the insured. Only policies for property and casualty insurance are allowed to be posted online. Casualty insurance includes automobile policies, workers' compensation policies, liability policies, and malpractice policies, among others. Property insurance policies include homeowner's, tenant's, condominium unit owner's, mobile home owner's, condominium association, and commercial business property insurance policies. The policy information posted online is general in nature.

The policy declarations page, which contains personal information about the policyholder, is provided to the policyholder in another manner, usually by mail. The declarations page must also identify the exact policy form purchased by the policyholder so the policyholder can find the policy on the insurer's website.

If an insurer opts to post an insurance policy online instead of mailing it, the policy must be easily accessible on the insurer's website and posted in a format that allows the policy to be printed by the policyholder free of charge. Insurers posting policies on their website must notify each policyholder of their right to request and obtain a paper or electronic copy of the policy without charge, but policyholder consent is not required for an insurer to post an insurance policy online. Insurers must also notify policyholders of this right if the insurer changes a policy. Insurers posting policies online must archive expired policies for five years on the insurer's website and archived policies must be available to policyholders at their request.

Effect of the Bill

The bill requires motor vehicle service agreement companies and health maintenance organizations (HMO) to deliver motor vehicle service agreements and HMO contracts in compliance with the standards applicable to insurers. This changes the timeline for delivery of a motor vehicle service agreement from 45 days to 60 days and for HMO contracts from ten days from enrollment to 60 days. It also allows posting of the non-personal portions of agreements and contracts, as applicable, on a website in the manner allowed for policies by insurers. The personal portions of these documents would be delivered by other allowable means, usually mailing.

Approved by Governor 3/30/18
Effective Date: upon becoming a law

CS/CS/HB 483 — Unfair Insurance Trade Practices - 2018
by Yarborough
CoSponsors: Edwards-Walpole
CS Sponsors: Commerce Committee, Insurance & Banking Subcommittee

The Unfair Insurance Trade Practices Act, among other things, defines unfair methods of competition and unfair or deceptive acts in the business of insurance. It provides an extensive list of prohibited methods and acts. Among these are prohibitions on certain inducements to the purchase of insurance, including rebates, dividends, stock, and contracts that promise to return profits to the prospective insurance purchaser. The law also describes prohibited discrimination. However, there are also many exceptions to the prohibitions defined by law.

Among the exceptions is authorization for insurers and their agents to offer and make gifts of merchandise up to $25 per gift to an insured, prospective insured, or any person for the purpose of advertising. There are several similar limitations on advertising gifts under the Florida Insurance Code related to the advertising practices of public adjusters, group and individual health benefit plans, and motor vehicle service agreement companies. This exception restricts the value of the advertising gift, but it does not limit the frequency of giving or the aggregate value of gifts given. The $25 limit has been in place since 1989.

The Florida Insurance Code does not define the term “merchandise,” nor has the Department of Financial Services or the Office of Insurance Regulation defined this term in rules implementing their duties and obligations under the Florida Insurance Code. The common definition of “merchandise” is “commodities or goods that are bought and sold in business.” Therefore, insurers and agents are allowed to give saleable items valued at $25 or less to others for advertising purposes.

The bill expands the exception to allow gifting of goods, wares, store gift cards, gift certificates, event tickets, anti-fraud or loss mitigation services, and other items, in addition to merchandise. It removes the requirement that the gift be given for advertising purposes. The bill increases the allowed maximum value of the item given from $25 to $100 per insured or prospective insured. It also applies the value limit per insured or prospective insured over one calendar year, rather than per gift without an annual limit.

In relation to advertising gifts by title insurance agents, agencies, and insurers, the bill maintains the existing gift limit applicable to them (i.e., limits them to an aggregate $25 gift value with no annual aggregate limitation).

Approved by Governor 4/06/18
Effective Date: July 1, 2018

CS/HB 533 - Unfair Insurance Trade Practices - 2018

by Hager
CoSponsors: Stark
CS Sponsors: Insurance & Banking Subcommittee

The Unfair Insurance Trade Practices Act, among other things, defines unfair methods of competition and unfair or deceptive acts in the business of insurance. It provides an extensive list of prohibited methods and acts. Among these are prohibitions on an insurer refusing to insure anyone solely because of the following reasons:

- The insured's race, color, creed, marital status, sex, or national origin;
- The residence, age, or lawful occupation of the individual or the location of the risk, unless there is a reasonable relationship between the residence, age, or lawful occupation of the individual or the location of the risk and the coverage issued or to be issued;
- The insured's or applicant's failure to agree to place collateral business with any insurer, unless the coverage applied for would provide liability coverage which is excess over that provided in policies maintained on property or motor vehicles;
- The insured's or applicant's failure to purchase noninsurance services or commodities, including automobile services;
- The fact that the insured or applicant is a public official; or
- The fact that the insured or applicant had been previously refused insurance coverage by any insurer, when such refusal to insure or continue to insure for this reason occurs with such frequency as to indicate a general business practice.

Effective October 1, 1982, the Legislature exempted automobile clubs from insurance regulation for the provision of "automobile services" related to motor vehicles. Accordingly, the provision of the following services related to the ownership, operation, use, or maintenance of a motor vehicle are not subject to the Insurance Code:

- Towing service;
- Procuring group coverage from an insurer for bail and arrest bonds or for accidental death and dismemberment;
- Emergency service;
- Procuring prepaid legal services, or providing reimbursement for legal services;
- Offering assistance in locating or recovering stolen or missing motor vehicles; or
- Paying emergency living and transportation expenses of the owner of a motor vehicle related to a damaged motor vehicle.

Section 626.9541(1)(x), F.S., provides that an insurer may not refuse to insure or refuse to continue to insure anyone for their failure to purchase "automobile services as defined in s. 624.124." However, s. 624.124, F.S., does not define "automobile services"; rather, it establishes that providers of the specified "motor vehicle services" are exempt from regulation as an insurer.

Effect of the Bill

The bill allows a property and casualty insurer to condition the sale of insurance on the purchase of motor vehicle services if the following conditions are met:

- The motor vehicle services are purchased from a membership organization affiliated with

the property and casualty insurer; and,
- The property and casualty insurer and its affiliated membership organization must have been affiliated on January 1, 2018.

It is unknown which or how many Florida property and casualty insurers are affiliated with a qualifying membership organization since such membership information is generally withheld by the membership organization for proprietary and trade secrecy purposes. Proponents of the bill assert that the Auto Club Group, operating in Florida as "AAA," meets these conditions. The Office of Insurance Regulation will be responsible for approving changes to required company filings by property and casualty insurers that wish to condition their sale of insurance on the purchase of motor vehicle services and auditing property and casualty insurers for qualification to do so and their subsequent compliance with applicable law.

The bill also corrects language used in a cross-reference. It replaces the term "automobile services" with the term "motor vehicle services" to conform to the terminology of the target statute of the cross- reference, i.e., s. 624.124, F.S.

Approved by Governor 4/06/18
Effective Date: July 1, 2018

HB 1011 - Homeowners' Insurance Policy Disclosures - 2018
by Cruz
CoSponsors: Fine
CS Sponsors: Commerce Committee, Insurance & Banking Subcommittee

Insurance Policy Form and Content Requirements
The Insurance Code requires that insurance policies, depending on the type of coverage, include specific content to provide consumers with important information or ensure consistency and readability of insurance contracts from different insurers. Such provisions may establish requirements regarding content, print type or size, and appearance (e.g., bold type or all capitalized text). Examples include the following:
- Structured settlement transfers must include a disclosure statement in no less than 14-point type with specified elements;
- Life insurance policies and health insurance policies must be in a light faced type of a style in general use in a uniform size of at least 10-point type with a lowercase alphabet spacing of not less than 120 points.
- Sinkhole policies must include the following statement in bold 14-point type:

  "YOUR POLICY PROVIDES COVERAGE FOR A CATASTROPHIC GROUND COVER COLLAPSE THAT RESULTS IN THE PROPERTY BEING CONDEMNED AND UNINHABITABLE. OTHERWISE, YOUR POLICY DOES NOT PROVIDE COVERAGE FOR SINKHOLE LOSSES. YOU MAY PURCHASE ADDITIONAL COVERAGE FOR SINKHOLE LOSSES FOR AN ADDITIONAL PREMIUM."

- Homeowner's property insurance policies must include the following statement in bold 18-point type:

"LAW AND ORDINANCE COVERAGE IS AN IMPORTANT COVERAGE THAT YOU MAY WISH TO PURCHASE. YOU MAY ALSO NEED TO CONSIDER THE PURCHASE OF FLOOD INSURANCE FROM THE NATIONAL FLOOD INSURANCE PROGRAM. WITHOUT THIS COVERAGE, YOU MAY HAVE UNCOVERED LOSSES. PLEASE DISCUSS THESE COVERAGES WITH YOUR INSURANCE AGENT."

If the policy includes a separate hurricane deductible, it must include the following in bold 18-point type:

"THIS POLICY CONTAINS A SEPARATE DEDUCTIBLE FOR HURRICANE LOSSES, WHICH MAY RESULT IN HIGH OUT-OF-POCKET EXPENSES TO YOU."

If the policy contains a hurricane coinsurance provision, it must include the following in bold 18- point type:

"THIS POLICY CONTAINS A CO-PAY PROVISION THAT MAY RESULT IN HIGH OUT- OF-POCKET EXPENSES TO YOU."

- Motor vehicle policies must include the following statement in bold 12-point type, depending on whether or how much uninsured motorist coverage is purchased:

  "You are electing not to purchase certain valuable coverage which protects you and your family or you are purchasing uninsured motorist limits less than your bodily injury liability limits when you sign this form. Please read carefully."

- Premium finance agreements must include the following in bold 10-point type:

  "PREMIUM FINANCE AGREEMENT"

  In addition, such agreements must also include the following in bold 8-point type:

  "NOTICE:
  1. Do not sign this agreement before you read it or if it contains any blank space.
  2. You are entitled to a completely filled-in copy of this agreement.
  3. Under the law, you have the right to pay off in advance the full amount due and under certain conditions to obtain a partial refund of the service charge."

Flood Insurance

The National Flood Insurance Program (NFIP) was created by the passage of the National Flood Insurance Act of 1968 to offer federally subsidized flood insurance to property owners and to promote land-use controls in floodplains. The Federal Emergency Management Agency (FEMA) administers the NFIP. The federal government makes flood insurance available within a community, if that community adopts and enforces a floodplain management ordinance to reduce future flood risk related to new construction in floodplains.

Nationally, the NFIP insured almost $1.29 trillion in assets in 2014 and $1.27 trillion in assets in 2015. Total earned premium for NFIP coverage for 2014 was $3.56 billion and for 2015 was $3.45 billion.

Private Market Flood Insurance in Florida
In response to changes to the NFIP, the 2014 Legislature created a law governing the sale of personal lines residential flood insurance. For the purposes of Florida law, "flood" is defined as a general and temporary condition of partial or complete inundation of two or more acres of normally dry land area or of two or more properties from:

- Overflow of inland or tidal waters;
- Unusual and rapid accumulation or runoff of surface waters from any source;
- Mudflow; or
- Collapse or subsidence of land along the shore of a lake or similar body of water as a result of erosion or undermining caused by waves or currents of water exceeding anticipated cyclical levels that result in a flood as defined above.

The Legislature amended the law in 2015 and 2017. Flood insurance is a separate line of insurance from homeowner's property insurance and is not included in the base coverage of such a policy, though it may be added through an addendum. In the case of flood damage occurring during the course of a hurricane, the windstorm portion of the homeowner's property insurance policy does not cover the flood damage. If the homeowner does not specifically purchase flood insurance through the NFIP or an authorized Florida flood insurer, such losses will be uninsured.

Effect of the Bill
The bill revises the current notice applicable to homeowner's property insurance policies to require the following statement on initial policies and every renewal issued after January 1, 2019:

> "LAW AND ORDINANCE: LAW AND ORDINANCE COVERAGE IS AN IMPORTANT COVERAGE THAT YOU MAY WISH TO PURCHASE. PLEASE DISCUSS WITH YOUR INSURANCE AGENT."
>
> "FLOOD INSURANCE: YOU MAY ALSO NEED TO CONSIDER THE PURCHASE OF FLOOD INSURANCE. YOUR HOMEOWNER'S INSURANCE POLICY DOES NOT INCLUDE COVERAGE FOR DAMAGE RESULTING FROM FLOOD EVEN IF HURRICANE WINDS AND RAIN CAUSED THE FLOOD TO OCCUR. WITHOUT SEPARATE FLOOD INSURANCE COVERAGE, YOU MAY HAVE UNCOVERED LOSSES CAUSED BY FLOOD. PLEASE DISCUSS THE NEED TO PURCHASE SEPARATE FLOOD INSURANCE COVERAGE WITH YOUR INSURANCE AGENT."

Approved by Governor on 3/21/18
Effective Date: January 1, 2019

CS/CS/CS/HB 1073 - Department of Financial Services - 2018
by Hager
CS Sponsors: Commerce Committee, Government Operations & Technology Appropriations Subcommittee, Insurance & Banking Subcommittee

Reproductions of Certain Warrants, Records, and Documents
Current law authorizes the Division of Treasury to reproduce documents and deems photographs, microphotographs, or reproductions on film of documents to be original records. Use of these mediums is an obsolete method for fulfilling warrant image requests.

Effect of the bill
The bill deems electronic images of warrants, vouchers, or checks to be original records for all purposes. It also replaces the applicable medium from film or print to electronic, in provisions relating to copies and reproductions of records and documents of the division.

Financial Literacy for Foster Youth
Foster care transition plans must be developed during the 180-day period after a child reaches 17 years of age. The transition plan must be developed by the child, with assistance from the Department of Children and Families (DCF) and the community-based care provider, in collaboration with the caregiver and any other individual the child would like to include. The transition plan is in addition to standard case management requirements and must address specific options for the child to use in obtaining services, including housing, health insurance, education, a driver license, and workforce support and employment services.

The Road-to-Independence Program (Program) provides young adults, who were previously living in licensed care, an opportunity to receive postsecondary education services and support if certain conditions are met. Among other conditions, the young adult must have earned a high school diploma, been admitted to a postsecondary educational institution, have reached 18 years of age but is not yet 23 years old, applied for any available scholarship and grants, submitted a Free Application for Federal Student Aid, and signed an agreement to allow DCF to access his or her school records. The Program also makes aftercare services available to young adults who were previously living in licensed care and are currently not receiving funds available under s. 409.1451(2), F.S., to pursue postsecondary education. Aftercare services include mentoring and tutoring, various skills trainings, mental health and substance abuse counseling, temporary financial assistance for necessities, and financial literacy skills training.

Effect of the bill
The bill adds a requirement that the transition plan also address financial literacy. It also requires that DCF and the community-based provider provide information for the financial literacy curriculum for foster youth offered by DFS.

Additionally, the bill provides that the financial literacy skills training available under aftercare services shall be the curriculum offered by DFS.

Local Government Reporting
Local government entities that are determined to be reporting entities and independent special districts must submit to DFS a copy of its annual financial report for the previous fiscal year. Annual financial reports must be submitted in a format prescribed by DFS. Each local government entity must also provide a link on their website to view the annual financial report submitted to DFS.

Currently, local governments and independent special districts must file their annual financial reports using the Local Government Electronic Reporting (LOGER) program.

Effect of the Bill
The bill states that it is the intent of the Legislature to create the Florida Open Financial Statement System, which would be an interactive repository for governmental financial statements. It also states that the Legislature finds a proper and legitimate state purpose is served when governmental financial statement data is transparent and readily accessible to the public. Therefore, this act fulfills an important state interest.

The bill allows the Chief Financial Officer (CFO) to consult with stakeholders, including DFS, the Auditor General, a representative of a municipality or county, a representative of a special district, a municipal bond investor, and an information technology professional employed in the private sector for input on the design and implementation of the system.
The bill states that the CFO may choose contractors to build one or more eXtensible Business Reporting Language (XBRL) taxonomies suitable for state, county, municipal, and special district financial filings and to create a software tool that enables financial statement filers to easily create XBRL documents consistent with the taxonomy or taxonomies. XBRL is an international standard for digital reporting and exchanging business information.

The bill requires the CFO to recruit and select contractors through an open request for proposals process pursuant to ch. 287, F.S., and requires that all work be completed by December 31, 2021. If the CFO deems the work products adequate, all local governmental financial statements pertaining to fiscal years ending on or after September 1, 2022, must be filed in XBRL format and must meet the validation requirements of the relevant taxonomy.

The bill also provides for a nonrecurring, $500,000, appropriation to DFS. The appropriation is to be used to competitively procure a contract for the enhancement of the LOGER program, including the development of XBRL taxonomies for state, county, municipal, and special district financial filings.

Division of Risk Management
The Division of Risk Management (DRM) is responsible for the management of claims reported by or against state agencies and universities for coverage under the self-insurance fund known as the "State Risk Management Trust Fund."

Under current law, the head of each department of state government, except the Legislature, must designate a safety coordinator and DFS must provide the appropriate training to the safety coordinators. Currently, there is no requirement that safety coordinators attend the training provided by DFS.

In accordance with s. 284.50(3), F.S., DFS and all agencies employing more than 3,000 full-time employees must maintain return-to-work programs for employees receiving workers' compensation benefits. DFS is required to submit an annual report on the state insurance program, including agency return-to-work programs; however, there is currently no requirement that

agencies with return-to-work programs report any program information to DFS. According to DFS, several do not voluntarily provide return-to-work program information, and therefore DFS is not able to provide a complete and accurate report.

Additionally, under s. 284.50(4), F.S., DRM is required to evaluate each agency's risk management programs at least once every five years. There is currently no statutory requirement that agencies provide the information DRM needs to perform such evaluation.

DRM routinely sends agencies reports of their claims and losses for review and notifies agencies of any unsafe conditions, trends, incidents, etc., that may lead to accidents or claims involving the state. Currently, agencies are not required to notify DRM of any discrepancies between the reports and their records nor are they required to respond to communications from DRM identifying conditions or trends that may lead to claims involving the state.

In 2017, HB 1107 was passed, creating s. 440.1851, F.S., to restrict DFS's sharing of personal identifying information on workers' compensation claims by making the information confidential and exempt from public record disclosure requirements. This change had the unintended consequence of restricting the information that DRM can share with its contracted vendors to perform its duty of administering state employee workers' compensation claims. Under s. 440.1851, F.S., DRM's data sharing agreements with vendors, such as Insurance Services Office/Verisk Analytics, may be prohibited and, thus, is keeping DRM from sharing such information with the vendors. This hinders DRM in its efforts to obtain an accurate history of preexisting conditions, investigate compensability, and prevent fraud.

Effect of the bill

The bill makes the following changes to the state's safety management programs:

- Makes it mandatory that the safety coordinators complete the safety coordinator training offered by DFS within one year of being appointed to his or her position;
- Requires agencies employing more than 3,000 full-time employees to report return-to-work information to DFS to assist in their mandatory reporting requirement under s. 284.42(1)(b), F.S.;
- Requires each agency to provide risk management program information to DRM in support of DRM's requirement to evaluate and report on agency risk management programs as mandated in s. 284.50(4), F.S.;
- Requires each agency to review information provided by DRM on claims and losses and identify and report any discrepancies between the agency's records and DRM's records;
- Requires each agency to respond to communications from DRM identifying conditions or trends that may lead to claims involving the state; and
- Allows DRM to participate in data sharing agreements with its contracted vendors when administering workers' compensation claims.

Division of Agent and Agency Services

The Division of Agent and Agency Services (A&A) regulates and manages the licensure of insurance agents, adjusters, limited surety (bail bond) agents, and other insurance-related entities.

Managing General Agent Licensure

A managing general agent (MGA) is defined as any person managing all or part of the insurance business of an insurer, including the management of a separate division, department, or underwriting office. In addition, an MGA, is a person acting as an agent for the insurer, who, with or without authority, separately or together with affiliates, produces directly or indirectly, or underwrites an amount of gross direct written premium equal to or more than five percent of the policyholder surplus as reported in the last annual statement of the insurer in any single quarter or year. The definition also includes that an MGA adjusts or pays claims and/or negotiates reinsurance on behalf of the insurer.

A&A currently licenses approximately 150 new MGA licensees per year. To be an MGA requires an MGA license but this license type has no prelicensing requirements or formal examination to determine eligibility. To obtain this license, the only requirements are to complete the application, be eligible to work in the United States, and submit fingerprints for a background evaluation.

Under s. 626.731, F.S., a general lines agent may not hold an MGA license. A general lines agent is one who sells one or more of the following lines of insurance: property; casualty, including commercial liability insurance underwritten by a risk retention group, a commercial self-insurance fund, or a workers' compensation self-insurance fund; surety; health; or, marine. This is inconsistent with the National Association of Insurance Commissioners' Model Act MDL-225, Managing General Agents Act; because the Act states that, a person shall not be an MGA without being a licensed agent in the state.

Effect of the bill

The bill eliminates the MGA license, but not the role of an MGA. It requires an MGA to be a licensed agent and have an MGA appointment. These changes will clarify some of the inconsistency in the MGA statutes. The bill makes technical changes throughout ch. 626, F.S., to conform terminology to these changes.

Fingerprinting Requirements

Current law requires a submission of fingerprints and a fingerprint-processing fee of $50 with each application for an insurance license and each application for licensure as a bail bonds agent. A&A currently tracks its licensees against the Florida Clerk's database to identify existing licensees convicted or pleading to felony charges. According to DFS, the fingerprinting requirement is unnecessary for those already licensed because it informs A&A of information they already knew through the Florida Clerk's database.

Effect of the bill

Under the bill, an individual who is currently licensed under ch. 626, F.S., or ch. 648, F.S., and has submitted fingerprints in the past 48 months is not required to resubmit fingerprints or pay the fingerprint processing fee when applying for an additional license.

All-lines Adjuster Examination Requirements

Under s. 626.221, F.S., DFS may not issue any license as an agent or adjuster to any individual who has not taken and passed a written examination. However, there are exemptions from

examination, including for applicants who have certain professional designations or certificates.

Effect of the bill
The bill adds Claims Adjuster Certified Professional from WebCE, Inc. to the list of professional designations that exempt an applicant from the all-lines adjuster licensure exam requirement.

Credit and Character Reports
Credit and character reports must be secured from an established and reputable independent reporting service. They must be secured and kept on file by the appointing insurer or employer for first-time applicants as agents, services representatives, customer representatives, or managing general agents, in the state. If a credit and character report is requested by DFS, it must be submitted on a form furnished by DFS.

Effect of the bill
The bill clarifies language and changes the time at which a credit and character report must be completed to before appointment rather than before licensure because the licensure process does not involve appointing entities.

The bill removes the requirement that a credit and character report requested by DFS be submitted on a form furnished by DFS. It also removes the requirement that the credit and character report be done by an "established and reputable independent reporting service" because there are no standards to determine "established and reputable independent reporting service;" hence, it is unenforceable. Additionally, the appointing insurer or employer is required to certify to DFS that the licensee is of good moral character and reputation, and is fit to engage in the insurance business. The bill also adds that the requirements for credit and character reports do not apply to licensees who self-appoint pursuant to s. 624.501, F.S.

Exchange of Business
Under current "exchange of business" or "excess or rejected business" laws, brokering agents are permitted to write up to 24 policies for an insurer each year without being appointed by the insurer. Once an agent has written more than 24 policies, the insurer must report them to DFS under the exchange of business appointment type. This appointment type costs $30 per year. Under s. 626.451(3), F.S., an appointment of an agent by an insurer is a certification to DFS that the insurer is willing to be bound by the acts of the agent, within the scope of the licensee's employment or appointment.

Brokering agents are required to maintain a "bound journal" to record chronologically numbered insurance transactions.

Effect of the bill
The bill changes the requirement from "bound journal" to "permanent record of" to allow for electronic recordkeeping.

The bill reduces the number of policies that can be written each year by a brokering agent from 24 to four. The change in statute will allow DFS to protect consumers by increasing the number of

policies written by agents that have been appointed by an insurer and are therefore bound by the acts of the agent.

Life Agent as Beneficiary; Prohibitions
Current law prohibits a life agent from placing life insurance coverage with the life agent, where the life agent or a family member of the life agent is the named beneficiary under the life insurance policy. A life agent or a family member of a life agent also may not be designated as a trustee or guardian or be granted power of attorney unless he or she is a family member of the insured or is a bank or trust company duly authorized to act as a fiduciary.

Effect of the bill
The bill prohibits a life agent from modifying a life insurance contract to name the life agent or a family member of the life agent as the beneficiary unless the life agent has an insurable interest in the life of such person. The bill modifies the circumstances under which a life agent may serve as a trustee or guardian or accept authority to act under a power of attorney to include a life agent who is:

- Acting as a fiduciary;
- Licensed as a certified public accountant under s. 473.308, F.S.; and
- Registered as an investment advisor, or a representative thereof, under federal law or registered as a dealer, investment adviser, or associated person under state law.

Nonresident Public and All-lines Adjuster's Qualifications
Current law requires nonresident public and nonresident all-lines adjusters, wishing to do business in Florida, to submit an affidavit certifying that the licensee is familiar with and understands the insurance code, administrative rules of the state, and the provisions of the contracts negotiated or to be negotiated as a condition precedent to the issuance, continuation, reinstatement, or renewal of appointment. Insurance companies who appoint licensees are already required to certify to A&A that the licensee is of good moral character and is fit to engage in the insurance business.

Effect of the bill
The bill eliminates the affidavit requirement for non-resident public and all-lines adjusters because it is duplicative with the certification of good moral character and fitness by the appointing insurance company.

Division of State Fire Marshall
The Florida State Fire Marshal is dedicated to protecting life, property and the environment from the devastation of fire. Their focus and efforts foster a fire safe environment through engineering, education and enforcement. The Division of State Fire Marshall (SFM) is comprised of the Bureau of Fire Prevention and the Bureau of Fire Standards and Training.

Anti-Fraud Reward Program
The Anti-Fraud Reward Program authorizes DFS to pay rewards of up to $25,000 to persons providing information leading to the arrest and conviction of persons committing various crimes relating to insurance fraud. DFS may pay for tips relating to crimes involving, among others, explosives and arson resulting in injury to another.

Effect of the bill
The bill adds that DFS may also utilize the Anti-Fraud Reward Program to pay rewards for tips leading to the arrest and conviction of persons committing the crime of arson.

Florida Fire Safety Board
The Florida Fire Safety Board (Board) consists of seven members that act as an advisory board for the SFM. They advise on administrative rules, codes, standards, and training. Currently, the initial term for board members is as follows: one member of the Board must be appointed for a term of one year, one member for a term of two years, two members for a term of three years, and two members for a term of four years.

Effect of the bill
The bill clarifies that each member of the Board shall serve a four-year term and removes language relating to the initial staggered terms. The initial terms are no longer necessary because the board is already established and the change is intended to remove confusing language and add clarity.

Fire Suppression Equipment; License to Install or Maintain
Current law allows a person with a valid fire equipment dealer license to maintain their license in an inactive status for four years or when the license is renewed, whichever comes first. Fire equipment dealer licenses are renewed every two years, making this language contradictory.

Individuals performing the work of servicing, recharging, repairing, hydrotesting, installing, testing, or inspecting fire extinguishers or pre-engineered systems must possess a valid and subsisting permit. These permittees must be employees of a fire equipment dealer licensee. Current law does not allow a franchisee to operate under the license of their parent company; the franchisee is required to obtain its own license.

Fire equipment dealers and fire protection system contractors are required to submit to the SFM proof of insurance providing coverage for comprehensive general liability for bodily injury and property damage, products liability, completed operations, and contractual liability. The SFM may require proof of such insurance on a form provided by the SFM.

Effect of the bill
The bill clarifies ambiguous language to allow inactive fire equipment dealers to maintain their license in an inactive status for up to four years. It clarifies that in order to maintain the license in an inactive status; the inactive licensee must submit proof of continuing education and the inactive status fee every two years. The bill also allows franchisees to operate under the license of their parent company.

The bill also deletes the requirement that fire equipment dealer and fire protection system contractors furnish proof of insurance on a form provided by the SFM. According to DFS, industry practice is to use Accord forms to show proof of insurance and this change reflects that practice.

Firefighter and Volunteer Firefighter Training and Certification

Under current law, the SFM may establish requirements to be issued a Firefighter Certificate of Compliance, a Volunteer Firefighter Certificate of Compliance, and a Special Certificate of Compliance. A Special Certificate of Compliance only authorizes an individual to serve as an administrative and command head of a fire service provider.

Additionally, a fire service provider may not employ an individual unless they have a valid Firefighter Certificate of Compliance.

Effect of the bill

The bill adds the following requirements for the Special Certificate of Compliance:

- Requires that an individual who is employed as a fire chief, coordinator, director, or administrator must obtain certification within one year;
- Prohibits an individual from serving as a command officer or in a position dictating incident outcomes or objectives before achieving certification; and
- Outlines requirements for retaining a Special Certificate of Compliance. The requirements include that every 4 years an individual must:
- Be active as a firefighter;
    - Maintain a current and valid fire service instructor certificate, instruct at least 40 hours during the 4-year period, and provide proof of such instruction to the SFM, which proof must be registered in an electronic database designated by the SFM; or
    - Within 6 months before the 4-year period expires, successfully complete a Firefighter
    - Retention Refresher Course consisting of a minimum of 40 hours of training as prescribed by rule.

Miscellaneous

Effect of the bill

The bill:

- Makes a technical change to fix an incorrect reference to the Department of Economic Opportunity with the Department of Education in a list of entities to which a public assistance recipient may be required to provide written consent for certain investigative inquiries;
- The bill renames the Bureau of Fire and Arson Investigations as the Bureau of Fire, Arson, and Explosives Investigations. It also creates the Bureau of Insurance Fraud and the Bureau of Workers' Compensation Fraud;
- Clarifies terminology related to insurance agents;
- Deletes requirement that law enforcement or the state attorney's office notify DFS of criminal actions against licensees because monthly data matching between DFS and the clerks of courts system has made it unnecessary;
- Makes a technical change to delete a contradiction and no longer applicable qualification for a general lines agent license;
- Clarifies requirements for licensing of surplus lines agents and deletes an examination exemption that is no longer applicable;
- Clarifies that surplus lines agents shall maintain their records in either his or her general lines agency office or managing general agency office;

- Authorizes a fire extinguisher serial number to be affixed rather than stamped on the manufacturer's identification and instruction plate; and
- Deletes the responsibility of the SFM to develop a staffing and funding formula for the Florida State Fire College because it was delegated to Marion County through a memorandum of agreement in 2008.

Approved by Governor on 3/23/18
Effective Date: July 1, 2018