2010 INSURANCE LEGISLATION

Summary & Analysis with Comments

compiled by the

FLORIDA ASSOCIATION OF INSURANCE AGENTS

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CONTENTS

Page numbers refer to pages in the enrolled bill. Section (§) numbers refer to Florida Statutes.

** Bills without effective dates become law when signed by the Governor, or 15 days after the Governor receives the bill if he does not sign it.*

SUBJECT, BILL PAGES AND/OR STATUTE #	FINAL PROVISION	COMMENTS

PROPERTY INSURANCE

Property Insurance, CS/CS/SB 2044

Carrier & Rating Law Issues

Surplus Requirements
p. 13, §624.408

1. Increases the minimum surplus requirements for current residential property insurers from $4 million to $5 million and increases the minimum surplus requirements for new residential property insurers admitted after July 1, 2015 from $5 million to $10 million and $15 million after July 1, 2020.

Given the current property market, this provision was included to provide additional consumer protection.

Rate Standards
p. 36, §627.062

2. Extends the prohibition on "use and file" rate filings from Dec. 31, 2010, to Dec. 31, 2011.

VETOED

3. Clarifies current law that the OIR shall not prohibit an insurer from paying the full amount of acquisition costs in a rate filing. The bill says, "The office shall not, directly or indirectly, impede, abridge, or otherwise compromise an insurer's right to acquire policyholders, advertise, or appoint agents, including the calculation, manner, or amount of such agent commissions, if any."

This provision was FAIA's number one priority for the 2010 session. Over the last couple of years, the OIR has been pressuring companies to reduce their agent commissions to ultimately reduce rate increases. This provision should curtail that from happening in the future.

4. Amends the expedited rate filing statute to allow for the inclusion of an "inflation trend factor" to be published by the OIR to allow "expenses and profit load" to be included in the expedited rate filing, and removes onerous restrictions regarding other company rate filings.

This was another FAIA priority. As HB 1495 passed in 2009, it precluded companies from including expenses and profit load in their expedited rate filings. As a result, those rate increases became non-commissionable. This fixes that glitch.

5. The OIR, beginning January 1, 2011, will publish one or more inflation trend factors in an annual informational memorandum.

6. Instructs the OIR to develop or contract with a private entity to develop a comprehensive program for providing consumers with all available information necessary to make an informed purchase of the insurance product that best serves their individual needs.

The hope is that the website will function much more efficiently than shopandcompare.com. This was seen as a needed consumer protection and a priority of several legislators.

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	7. Clarifies that if an insurer provides the OIR additional or supplementary information with regards to a pending rate filing at the request of the OIR that information falls within the scope of the original insurer rate filing certification.	
Rate Standards Mitigation **p. 55, §627.0629**	8. Clarified legislative intent to say that the implementation of mitigation discounts should not result in a loss of income to the insurer issuing the discounts, so that the aggregate of mitigation discounts should not exceed the aggregate if the expected reduction in loss that is attributable to the mitigation efforts. It also allows carriers to debit a policy to reflect accurate pricing.	*The amount of the mitigation credits mandated by the OIR is one of the primary reasons many carriers are currently experiencing underwriting losses with no storms. This provision should allow those carriers the rating flexibility they need to address mitigation losses.*
	9. Deletes the requirement that the OIR, by February 1, 2011, implement a method for insurers to establish uniform discounts.	
	10. Allows carriers to include any expense or profit load in filings to replace TICL coverage. However, the total annual base rate change may not exceed 10 percent.	*This was another FAIA priority. As HB 1495 passed in 2009, it precluded companies from including expenses and profit load in their expedited rate filings. As a result those rate increases became non-commissionable. This fixes that glitch.*
Notice of Cancellation **p. 91, §627.4133**	11. Allows for the 45-day cancellation of a Citizens policy for the purposes of a takeout.	*This is a cancellation notice to allow faster depopulation. It does not change a policyholder's ability to stay in Citizens.*
	12. Allows a voluntary market insurer to cancel or nonrenew policies with 45 days notice if the OIR finds that it is necessary to protect the best interests of the public or policyholders. The OIR may base such a finding upon the financial condition of the insurer, lack of adequate reinsurance coverage for hurricane risk, or other relevant factors. The OIR may condition its finding on the consent of the insurer to be placed in administrative supervision pursuant to §624.81, F.S., or consent to the appointment of a receiver under Chapter 631.	*While the 45 days in this provision is considerably less than the 100 or 180 days that is currently provided for in Florida Statutes, it is more than the 30 days that would be available to move a policy if a carrier was placed in liquidation. This provision was the number one priority of the OIR.*
Notice of Change in Policy Terms **p. 97, §627.43141**	13. Creates a new section in Florida Statutes that defines "change in policy terms."	*The intent of this section is to allow an insurer to make a change in policy terms without nonrenewing 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 when an*
	14. "Change in policy terms" means the modification, addition, or deletion of any term, coverage, duty, or condition from the previous policy. The cor-	

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	rection of typographical or scrivener's errors or the application of mandated legislative changes is not a change in policy terms.	*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 agent.*
	15. "Policy" means a written contract of personal lines property insurance or a written agreement for insurance, or the certificate of such insurance by whatever name called, and includes all clauses, riders, endorsements, and papers that are a part of such policy. The term does not include a binder as defined in §627.420, F.S., unless the duration of the binder period exceeds 60 days.	
	16. A renewal policy may contain a change in policy terms. If a renewal policy contains a change in policy terms, the insurer shall give the named insured a written notice of the change in policy terms, which must be enclosed along with the written notice of renewal premium required by §627.4133, F.S., and §627.728, F.S. Such notice should be entitled "Notice of Change in Policy Terms."	
Homeowners Policies, Replacement Cost Coverage **p. 99, §627.7011**	17. In the event of a loss for which a dwelling is insured on the basis of replacement cost, the insurer initially must pay at least the actual cash value of the insured loss, less any applicable deductible. An insured shall subsequently enter into a contract for the performance of building and structural repairs. The insurer shall pay any remaining amounts incurred to perform such repairs as the work is performed. With the exception of incidental expenses to mitigate further damage, the insurer or any contractor or subcontractor may not require the policyholder to advance payment for such repairs or expenses. The insurer may waive the requirement for a contract as provided in this paragraph. An insured shall have a period of one year after the date the insurer pays actual cash value to make a claim for replacement cost. If a total loss of a dwelling occurs, the insurer shall pay the replacement cost coverage without reservation or holdback of any depreciation in value, pursuant to §627.702, F.S.	*Lack of a holdback provision is generally regarded as the number one reason for a spike in non-catastrophe claims.* *While this is an improvement, many carriers believe more needs to be done.*
Insurer's Duty to Acknowledge Claims **p. 103, §627.70131**	18. Clarifies that supplemental claims must be paid within 90 days. The same provision currently applies to the initial claim.	

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Notice of Premium Discounts/Mitigation Verification Forms **p. 104, §627.711**	19. Provides that an insurer must accept a mitigation verification form only if it is signed by specified categories of inspectors, which under the bill will include a new category for licensed home inspectors who have completed at least three hours of hurricane mitigation training (which includes training on hurricane mitigation techniques and compliance with the uniform mitigation verification form) and completion of a proficiency exam. Thereafter, these licensed home inspectors must complete at least two hours of continuing education on this subject as part of their license renewal requirements each year. 20. Requires that a person who is authorized to sign a mitigation verification form must inspect the structures personally and not through employees or other persons, and must certify and attest to this on the form. 21. Specifies what constitutes misconduct on the part of an inspector and provides for disciplinary action by licensing boards and the OIR's Division of Insurance Fraud. 22. Authorizes an insurer, at its own expense, to require that any uniform mitigation verification form provided by an authorized mitigation inspector be independently verified by an inspector, inspection company, or an independent third-party quality assurance provider before accepting the form as valid.	*The language in these provisions (paragraphs 45–48) also passed in CS/CS/CS/CS/HB 663.* *Current law provides that the following are the specified categories of inspectors who may sign a mitigation verification form that must be acceptable to insurers: certified building code inspectors; licensed general, building or residential contractors; licensed professional engineers; and licensed professional architects.* *The bill provides certain specified exemptions to this requirement for employees of professional engineers and licensed contractors who have the requisite skill, knowledge and experience to conduct a mitigation verification inspection, but insurers have the right to ask for qualifications of these employees before accepting the form.*
Insurer Affiliates **p. 109, §628.252**	23. Creates a new section in the Florida Statutes that states that every domestic property insurer shall notify the OIR of its intention to enter into with affiliates all management agreements, service contracts, and cost-sharing arrangements. A domestic property insurer may not enter into such an agreement, contract, or arrangement unless the insurer has provided the OIR with at least 30 days' written notice of its intention to enter into such agreement, contract, or arrangement, or such shorter period as the OIR, in its discretion, may permit and the OIR has not disapproved such agreement, contract, or arrangement within such period. This section does not limit any existing authority of the OIR.	

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Risk-Based Capital Requirements p. 15, §624.4085	24. Defines "surplus action level" as a loss of surplus on any quarterly or annual filing that exceeds 15 percent, or which cumulatively for a calendar year exceeds 15 percent as of the most recently filed report. 25. Codifies a current OIR rule as it relates to the OIR's right to examine insurer affiliates. 26. Provides additional regulation for affiliates of property insurance companies. 27. Gives the OIR the ability to examine all managing general agents (MGAs) to the same extent it is allowed to examine insurance companies, provides that insurers must notify OIR of their intentions to enter into agreements with affiliated entities, and requires insurers to submit detailed reports about relationships with affiliates when solvency is in question.	*During the Legislative Session, there were a number of media reports regarding the practice of using MGAs. As a result this became one of the most contentious provisions of the bill. This language reflects the compromise that was struck between the OIR and the carriers.*
Managing General Agents p. 23, §626.7452	28. Removes the examination exemptions from managing general agents who solely represent a single domestic insurer.	
	Public Adjusters	
p. 23, §626.854	29. Clarifies that public adjuster compensation for reopened or supplemental claims may not exceed 20 percent of a reopened or supplemental claim payment. 30. Clarifies that fees on original claims are capped at 10 percent.	*The public adjuster reforms were viewed by most domestic carriers and the OIR as the most important provision in the bill to curb the "cost drivers" in homeowner's rates.*
Public Adjuster Prohibitions p. 24, §626.854	31. Prohibits fraudulent and misleading communications by public adjusters. 32. Ensures that the insurer has all of the appropriate information and access to the property needed to handle the claim. 33. Prohibits a public adjuster from advertising to a policyholder that there is "no risk" to file a claim, or to induce a reopened claim when an initial claim was handled properly. 34. Prohibits using a logo implying the public adjuster is affiliated with a state agency.	

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	35. Requires a disclosure on public adjuster ads that says "this is a solicitation for business; if you are satisfied with your insurer's claim you can disregard this ad."	
Public Adjuster Apprentice Licenses p. 32, §626.8651	36. Requires additional continuing education for public adjuster apprentices, including a minimum of eight hours of continuing education with two hours of ethics, in order to qualify for public adjuster licensure.	
Public Adjuster Contracts p. 32, §626.8796	37. Clearly defines every provision that must be included in a public adjuster's contract with an insured: adjuster's full name, adjuster's address, adjuster's license number, firm name, insured's full name, insured's address, and a brief description of the claim. It must also include the percentage compensation, type of claim, signatures of the adjuster and insureds, and the date. An unaltered copy must be provided to the insurer within 30 days of the execution date.	
Duty to File a Windstorm Claim p. 33, §626.70132	38. Clarifies that a claim, supplemental claim, or reopened claim under an insurance policy that provides personal lines residential coverage for loss or damage caused by the peril of windstorm or hurricane is barred unless notice of the claim, supplemental claim, or reopened claim was given to the insurer in accordance with the terms of the policy within three years after the hurricane first made landfall or the windstorm caused the covered damage.	*Currently, policyholders have five years to file a windstorm claim. It is estimated that over $2.5 billion in Hurricane Wilma claims have been filed since 2008 by public adjusters. The Cat Fund just had to bond over $700 million to pay for those claims. This provision is meant to shorten the amount of time public adjusters can bring claims and thus reduce the number of fraudulent claims.*
	Citizens Property Insurance Corporation	
p. 61, §627.351	39. Changes the name of the High Risk Account (HRA) to Coastal.	*It was argued that the words "High Risk" impaired negotiations with reinsurers, financial markets, bond markets, etc.*
	40. Clarifies that a Citizens' policyholder surcharge is payable upon cancellation, termination, renewal, or issuance of a new policy by Citizens within the first 12 months after the date of the levy.	
	41. States that Citizens may not levy a regular assessment on the voluntary market until it has first levied the Citizens' policyholder surcharge.	

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	42. Clarifies that Citizens' board members who have demonstrated insurance expertise can serve on the board and are deemed to be within the scope of Florida's ethics laws.	*The current statutory language mandates that each appointing officer must appoint a board member who has demonstrated insurance expertise. Citizens had a concern that the language did not clearly allow for service without conflict. This provision clarifies that.*
	43. Sets forth a procedure for board members to declare conflicts of interest and abstain from voting.	
p. 91	44. Directs the Division of Statutory Revision to prepare a reviser's bill for introduction at the next regular session of the Legislature to change the term "high-risk account" to "coastal account" to conform the Florida Statutes to the amendment to §627.351(6)(b)2.a.(III), F.S., made by this act.	
	Miscellaneous	
Annual Statement p. 20, §624.424	45. Reduces the number of years, from seven to five, that an insurance company can consecutively use the same accountant to prepare financial reports.	*This provision is meant to protect against a carrier and accountant from conspiring to file false financial reports.*
Premiums Written, Restrictions/Crop Ins. p. 19, §624.4095	46. Will allow financially sound multi-peril crop insurers to meet the statutorily-required capital and surplus for admission into the state of Florida. It also addresses a technical accounting issue relating to how surplus is calculated.	
Examination Requirements p. 20, §626.221	47. Adds a designation to the current list that allows someone to exempt the state examination for customer representative.	*This provision also passed in CS/CS/SB 2176.*
Revenue Bonds p. 9, §215.555	48. Extends the Cat Fund emergency assessment exemption for medical malpractice until May 31, 2013.	
Appropriation p. 109	49. Provides $263,200 of nonrecurring funds and $47,500 in recurring funds from the Insurance Regulatory Trust Fund to design, develop, and operate the consumer website.	
Insurance Consumer Advocate p. 34, §627.613	50. Makes changes to the insurer report card statute. The consumer advocate must objectively grade insurers and grades must be based on "valid consumer complaints." The term "valid consumer complaint" is	

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		defined as "a written communication, or oral communication that is subsequently converted to a written form, from a consumer that expresses dissatisfaction involving a personal residential insurance policy with a specific personal residential property insurer." However, a valid complaint does not arise if in the disposition thereof by the department, the insurer or agent position is upheld, the policy provision is upheld, the coverage is explained, additional information is provided, the complaint is withdrawn, the complaint is referred outside the department, or if an inquiry has missing or insufficient information, is not within the jurisdiction of the department, or requests mediation of a claim that is not eligible for mediation. Veto date: June 1, 2010.	

Condominium Insurance, CS/CS/CS/SB 1196

p. 11, §627.714 pp. 14–21, 718.111(11)	1.	Revises and clarifies the property insurance requirements of condominium associations and condominium unit owners under Chapter 718, F.S., known as the Condominium Act.	*This bill was known as the "condominium insurance glitch bill" because it corrects inconsistencies with terms used under the Florida Insurance Code. These inconsistencies were created in HB 601, a bill that passed during the 2008 legislative session. During the 2009 session, the first condominium insurance glitch bill passed, SB 714, but it was vetoed by the governor due to provisions in the bill regarding fire sprinkler safety systems. This bill is very similar to the 2009 legislation with regard to the condominium insurance provisions, but it does not contain the same controversial provisions regarding fire sprinkler safety systems.*
p. 11, §627.714 p. 17, §718.111(11)(g)	2.	Creates a new provision under the Insurance Code (§627.714, F.S.) to require that residential condominium unit owner policies issued or renewed on or after July 1, 2010, must include loss assessment coverage of $2,000 for all assessments made as a result of the same direct loss to the property. Authorizes insurers to apply a deductible of no more than $250 per direct property loss, except that if a deductible was or will be applied to the other property loss sustained by the unit owner resulting	*The bill deletes similar language from §718.111, F.S., and instead provides in §718.111(11)(g), F.S., that all condominium unit owners' policies shall conform to the requirements of the new §627.714, F.S.*

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		from the same direct loss to the property, no deductible shall apply to the loss assessment coverage. Also provides that the maximum amount that any unit owner's loss assessment coverage can be assessed for any loss is the amount equal to that unit owner's loss assessment coverage limit in effect one day before the date of the occurrence.	
p. 12, §627.714 p. 17, §718.111(11)(g)	3.	The new §627.714, F.S., also requires that every property insurance policy issued or renewed to a unit owner contain a provision stating that the coverage is excess coverage over the amount recoverable under any other policy covering the same property.	*Again, the bill deletes similar language from §718.111, F.S., and instead provides in §718.111(11)(g) , F.S., that all condominium unit owners' policies shall conform to the requirements of the new §627.714, F.S.*
p. 17, §718.111(11)(g)	4.	Deletes the provision prohibiting the unit owner's policy from providing rights of subrogation against the condominium association operating the condominium in which the individual unit is located.	
p. 17, §718.111(11)(f)	5.	Clarifies that the property that is the responsibility of the unit owner and covered by the unit owner's property insurance policy must be located within the boundaries of the unit and service only such unit.	*The property covered by the unit owner's policy and excluded by the association's policy is the same as it is under current law (the 2008 legislation):* *"…all personal property within the unit or limited common elements, and floor, wall, and ceiling coverings, electrical fixtures, appliances, water heaters, water filters, built-in cabinets and countertops, and window treatments, including curtains, drapes, blinds, hardware, and similar window treatment components, or replacements of any of the foregoing…"* *You may recall that the 2008 legislation removed HVAC equipment from the list of excluded property under the association policy. This bill makes no change in that regard.*
p. 18, §718.111(11)(g)	6.	Deletes the requirement that all improvements or additions to the condominium property that benefit fewer than all unit owners be insured by the unit owner or owners having the use thereof, or may be insured by the association at the cost and expense of the unit owners having such use.	

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p. 18, §718.111(11)(g)	7.	Removes the provision that the association must require owners to provide evidence of hazard and liability insurance upon written request, and, should the owner fail to provide such proof of insurance, the association may purchase a policy on the owner's behalf for which the owner is responsible for the cost.	
p. 19, §718.111(11)(g)	8.	Deletes the requirement that the association be an additional named insured and loss payee on all casualty insurance policies issued to unit owners in the condominium operated by the association.	
pp. 14–21, §718.111(11)	9.	Clarifies throughout the bill that adequate "property" insurance, as opposed to "hazard" or "casualty" insurance, be provided by the condominium association and condominium unit owner.	
p. 14, §718.111(11)(a)	10.	Clarifies that adequate property insurance be based upon the replacement cost of the insured property, which must be determined at least once every 36 months.	*Current law provides that "full insurable value" be determined at least once every 36 months.*
p. 16, §718.111(11)(c)	11.	Deletes the requirement that notices of association board meetings contain specified provisions relating to establishing deductibles for the association policy and that such meetings may be held in conjunction with budget meetings.	
p. 3, §633.0215(13)	12.	Adds a new subsection to the Florida Fire Prevention Code, §633.0215(13), F.S., which provides that a condominium that is one or two stories in height and has an exterior means of egress corridor is exempt from installing a manual fire alarm system as required by the Florida Fire Prevention Code.	
pp. 11–23, §718.112	13.	Amends various provisions of §718.112, F.S., regarding condominium association bylaws.	
p. 23, §553.509	14.	Repeals subsection (2) of §553.509, F.S., regarding the requirement that certain residential multi-family dwellings have at least one public elevator that is capable of operating on an alternate power source for emergency purposes.	
pp. 10, 12, 39–41, §399.02, §633.0215, and §718.112	15.	Provides that certain low-rise condominium buildings with exterior corridors need not install a central fire alarm system; it amends provisions relating to sprinklers and engineered lifesafety systems; it provides for	

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	additional forms of bulk communications contracts; it allows associations to waive the requirement to provide alternative power supplies to elevators and alarms during emergencies; and it delays retrofitting requirements related to the elevators.	
	16. Allows all associations to forever waive retrofitting with sprinklers and engineered lifesafety systems. As to associations who do not vote to forego retrofitting, full compliance with retrofitting requirements is moved from 2014 to 2019, and such associations must complete planning and permitting by 2016.	*Current law requires older residential structures to retrofit units and common areas with sprinklers and engineered lifesafety systems by 2012. Current law also allows condominium and cooperative associations (by unit owner vote) to forever waive retrofitting of sprinklers in unit interiors, forever waive retrofitting of common areas in shorter buildings, and delay retrofitting of common areas in high-rise buildings until 2014.*
pp. 65–75, §718.701–§718.708	17. As to delinquent assessments owed to a condominium association at the time of foreclosure, the bill provides that the foreclosing lender is only liable for the lesser of 12 months or one percent of the original mortgage balance. The bill also provides a means by which a bulk buyer may purchase units owned by a financially troubled developer without having to assume all of the liabilities of such developer.	*Current law provides that the foreclosing lender is only liable for the lesser of six months or one percent of the original mortgage balance.*
pp. 76–103, various sections of Chapters 718, 719, and 720	18. Amends all association laws to expand the list of records exempt from disclosure to members to include certain records containing personal identification information; it allows an association to collect delinquent fees from a tenant (who deducts such payment from the rent owed to the delinquent unit or parcel owner); and it allows an association to suspend common area use rights and suspend voting rights of delinquent owners.	
pp. 95–103, §720.304–§720.315	19. Amends homeowners' association law to allow a homeowners association the ability to direct where a flagpole may be erected and whether the flag may be lighted; it allows a homeowners' association to purchase recreational facilities that are not located next to the neighborhood; it limits compensation of directors of an association; and it creates an absentee voting procedure. Effective date: July 1, 2010. Chapter No. 2010-174, LOF.	

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Residential Property Sales, HB 545			
p.1, §689.262 VETOED	1.	Repeals §689.262, F.S., which would have required on January 1, 2011, that sellers of any home in the wind-borne debris region disclose to the buyers the home's windstorm mitigation rating. Consequently, sellers of homes located in the wind-borne debris region will not be required, beginning January 2011, to disclose the home's windstorm mitigation rating. Veto date: June 1, 2010.	*Pursuant to current law, in November 2007 the Financial Services Commission (FSC) adopted a uniform home grading scale to grade the ability of a home to withstand the wind load from a tropical storm or hurricane. The rating system scores homes on a scale of 1 to 100. In 2008, the Legislature passed a law that established a two-part phase-in of a requirement that sellers of homes located in the state's wind-borne debris region disclose the home's windstorm mitigation rating based on the grading scale:* ♦ *The first part of the phase-in was to begin January 2010 and would have required sellers of homes insured by Citizens Property Insurance Corporation (Citizens) for $500,000 or more to disclose the home's windstorm mitigation rating to buyers. However, in 2009, before it took effect, this disclosure requirement was repealed.* ♦ *The second part of the phase-in, which remains law today and is scheduled to begin January 2011, will require sellers of any home in the wind-borne debris region to disclose the home's rating.*
Wind Mitigation Inspectors/Verification Forms, CS/CS/CS/CS/HB 663			
pp. 69–71, §627.711(2)	1.	The bill provides that an insurer must accept a mitigation verification form only if it is signed by specified categories of inspectors, which under the bill will include a new category for licensed home inspectors who have completed at least three hours of hurricane mitigation training (which includes training on hurricane mitigation techniques and compliance with the uniform mitigation verification form) and completion of a proficiency exam. Thereafter, these licensed home inspectors must	*Current law provides that the following are the specified categories of inspectors who may sign a mitigation verification form that must be acceptable to insurers: certified building code inspectors; licensed general, building, or residential contractors; licensed professional engineers; and licensed professional architects.*

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		complete at least two hours of continuing education on this subject as part of their license renewal requirements each year.	
pp.71–72, §627.711(3)	2.	The bill requires that a person who is authorized to sign a mitigation verification form must inspect the structures personally and not through employees or other persons, and must certify and attest to this on the form.	*The bill provides certain specified exemptions to this requirement for employees of professional engineers and licensed contractors who have the requisite skill, knowledge, and experience to conduct a mitigation verification inspection, but insurers have the right to ask for qualifications of these employees before accepting the form.*
pp.72–74, §627.711(4)–(5)	3.	The bill specifies what constitutes misconduct on the part of an inspector and provides for disciplinary action by licensing boards and the OIR's Division of Insurance Fraud.	
p.74, §627.711(8)	4.	The bill authorizes an insurer, at its own expense, to require that any uniform mitigation verification form provided by an authorized mitigation inspector be independently verified by an inspector, inspection company, or an independent third-party quality assurance provider before accepting the form as valid. Effective date: April 9, 2010. Chapter No. 2010-176, LOF.	

Florida Hurricane Catastrophe Fund, CS/SB 1460

pp. 1–17, §215.555	1.	Returns the contract year for the Cat Fund to June 1–May 31 (starting June 1, 2010) in order to remedy the negative financial impact of the transitional contract year, which was created during the 2009 legislative session.	*The Cat Fund generally operates on a contract year. Historically, the Cat Fund's contract year has run from June 1 to May 31 of the next calendar year. However, 2009 legislation changed the Cat Fund's contract year to a calendar year starting January 1, 2011. In order to provide for a transition from a contract year ending on May 31 to one ending on December 31, the legislation created a seven-month transitional contract year from June 1, 2010, to December 31, 2010. The transitional contract year has created unintended consequences for insurers due to the way in which the cost of reinsurance is amortized (allocated as a cost) on insurers' financial*

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		statements. In 2010, an insurer's financial statements will show a larger expense associated with Cat Fund reinsurance than historically shown because of the transitional contract year in 2010. The statement will show an expense equal to five months of Cat Fund reinsurance costs from January 1, 2010, to May 31, 2010. And, the statements will also show an expense equal to 12 months of Cat Fund reinsurance costs over the seven-month period from June 1, 2010, to December 31, 2010. This reduces a company's pre-tax income and surplus more than what it is historically reduced each year for the purchase of Cat Fund reinsurance. The reduction in income and surplus could impact the financial solvency of some insurance companies and may negatively impact an insurer's rating by the rating agencies. The bill should resolve the financial issues for insurers relating to the amortization of Cat Fund reinsurance.
pp. 15–17, §215.555(18)	2. Also provides legislative intent and findings relating to Cat Fund coverage in order to facilitate insurers' purchase of private reinsurance and provides earlier time frames for the State Board of Administration (SBA) and insurers to effectuate Cat Fund coverage each year.	*Effectuating Cat Fund coverage earlier in the year may result in lower private reinsurance costs for insurers. Lower private reinsurance costs may reduce property insurance rates for policyholders.*
p.6, §215.555(4)(c)	3. Changes the way in which the Cat Fund's capacity for mandatory coverage is calculated each year. Instead of allowing the Cat Fund's capacity to increase each year as the Cat Fund's exposure increases (but limited by the increase in the Cat Fund's cash balance), the bill sets the Cat Fund's capacity at $17 billion for each contract year and does not allow the capacity to increase until the Cat Fund's cash and bonding ability exceeds $34 billion. 4. Does not change the way the Cat Fund's retention is calculated but requires the use of earlier exposure data in its calculation. Effective date: April 9, 2010. Chapter No. 2010-10, LOF.	*Changes related to the Cat Fund's capacity may reduce the likelihood or amount of assessments levied by the Cat Fund on most property and casualty policyholders.*

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WORKERS' COMPENSATION

Employee Leasing Companies, CS/SB 2046

p. 1, §468.5245

1. Makes several changes relating to the regulation of Employee Leasing Organizations (PEO).

p. 2, §468.5245(2)

2. Streamlines the approval process for a change of ownership of a PEO by providing that a purchase or acquisition of a licensed PEO does not require prior licensing board approval if the purchaser is already licensed and vetted as a PEO "controlling person."

Currently, the Board of Employee Leasing Companies within the Department of Business and Professional Regulation must give prior approval for all purchases and acquisitions of PEOs.

p. 3, §468.528

3. Eliminates the requirement that a license becomes automatically void 30 days after a missed renewal date and provides such delinquent license could be subject to other disciplinary action or penalties by the board under §468.432, F.S. Those penalties include, among other things, an administrative fine not to exceed $5,000 for every count or separate offense.

Current law requires that delinquent licenses automatically become void 30 days after the renewal date when the renewal fees are not paid. It can be reinstated during that 30-day period by paying a $300 fine. Voiding the license could be interpreted to take away any possibility of further disciplinary action.

The original draft of the bill amended §468.534, F.S., to provide that being in a PEO did not affect a "client" company's eligibility for local or state tax incentives or other economic benefits. That language was removed on the floor of the Senate, before the bill went to the House. Final staff analysis indicates that the bill still contains that provision, but the official "Enrolled" bill does not.

Effective date: July 1, 2010.
Chapter No. 2010-126, LOF.

SUBJECT, BILL PAGES AND/OR STATUTE #	FINAL PROVISION	COMMENTS

Workers' Compensation Drugs, HB 5603

pp. 6–7, §440.13(12)(c)

VETOED

1. Under §440.13(12)(c), F.S., of the workers' compensation law, reimbursement rates for prescription medications shall be the average wholesale price plus $4.18 for the dispensing fee, except when a carrier has contracted for a lesser amount. The bill amends that section to make it clear that it applies "*…regardless of the location or provider from which the claimant receives the prescription medication.*"

Under Florida law, a state-appointed three-member panel develops a Guide of Maximum Reimbursement Allowances that govern medical cost reimbursement for workers' compensation claimants. It is updated on a periodic basis.

2. Also provides a formula for calculating the reimbursement amount for a drug that has been repackaged or relabeled. It also provides that the maximum price for repackaged or relabeled drugs is the amount that would have been otherwise payable had the drugs not been repackaged or relabeled.

It has been alleged that some providers were purchasing drugs in bulk at a reduced wholesale price. Then they would break them down into smaller amounts, repackage them, and seek reimbursement at a much higher rate. This change will curtail that practice. See the bill for the formula for calculating the reimbursement amount in these instances.

Veto date: May 28, 2010.

AUTOMOBILE INSURANCE

Motor Vehicle Records, HB 5501

pp. 16–17; §322.20(11)

1. Creates two new motor vehicle record (MVR) reports and applicable fees:
   - A report for searching an individual's driver history record when no record is found on file, with a fee of $2; and,
   - A report for searching an individual's driver history to confirm that there has been no change to the record since the last time a search was done, with a fee of one cent.

During the 2009 session, the Legislature adopted significant fee increases for most of the fees collected by the Department of Highway Safety and Motor Vehicles (DHSMV). The fees for MVRs were increased from $2.10 to $8 for a three-year MVR, and from $3.10 to $10 for a seven-year MVR. Although the Legislature was unable to roll back those fee increases this session due to budget constraints, the Legislature did implement two new MVR reports, which will be available and helpful to insurance agents and others at a much lower cost than the traditional reports.

Effective date: July 1, 2010.
Chapter No. 2010-163, LOF.

SUBJECT, BILL PAGES AND/OR STATUTE #		FINAL PROVISION	COMMENTS

LIFE & HEALTH INSURANCE

Life Insurance, CS/CS/HB 885

pp. 1–2, §626.2815(3)(k)	1.	Creates an exemption from the continuing education requirement that mandates life agents to take a three-hour class on the subject of suitability in annuity and life insurance transactions. The exemption from this requirement applies to agents who have not sold individual life insurance policies or annuity contracts during the continuing education compliance cycle in question and who do not have any active individual life insurance policies or annuity contracts.	*This provision also passed in CS/CS/SB 2176.*
pp. 2–3, §627.4605	2.	Creates §627.4605, F.S., which provides that an insurer is not required to send notice of replacement life insurance to the current insurer when the replacement policy is issued by the same insurer or an affiliate of the insurer of the policy that is to be replaced. Specifically, notice of replacement life insurance does not need to be sent to the current insurer for transactions involving: ♦ An application to the current insurer that issued the current policy when a contractual change or conversion privilege is being exercised; ♦ A current policy is being replaced by the same insurer pursuant to a program approved by the OIR; or, ♦ A term conversion privilege is being exercised among corporate affiliates.	*This section is consistent with model standards adopted by the National Association of Insurance Commissioners (NAIC).*
p. 3, §627.464	3.	Bars the sale or transfer of annuities purchased as a part of a Medicare Secondary Payer (MSP) settlement to third parties that are not connected with the settlement.	*42 U.S.C. 1395y(b)(2) sets forth the Medicare secondary payer (MSP) requirements. Annuities may be purchased as part of a settlement to satisfy MSP requirements.*
p. 3, §627.552	4.	Amends §627.552, F.S., regarding employee groups for purposes of group life insurance policies by prohibiting employers from creating a class of employees eligible for such insurance that consists solely of employees covered under the employer's group health plan.	

SUBJECT, BILL PAGES AND/OR STATUTE #		FINAL PROVISION	COMMENTS
p.4, §627.5575	5.	Removes the 50 percent cap, which applies to spouses and children, and allows spouses and dependent children to be insured under a group life insurance policy up to the amount for which the employee is insured. Effective date: May 11, 2010. Chapter No. 2010-61, LOF.	*Thirty-five states have statutory provisions relating to coverage of spouses and dependent children under group life insurance policies. Twenty of these states do not specify a coverage limitation; twelve allow coverage up to the amount for which the employee is insured under the group policy; and three states, including Florida (under current law in §627.5575(3), F.S.) allow coverage of up to 50 percent of the amount for which the employee is insured under the group life insurance policy.*

Health Care Services Constitutional Amendment, CS/CS/HJR 37

pp. 1–3, Section 28, Article I of the Florida Constitution	1.	Proposes the creation of the Health Care Freedom Constitutional Amendment in Section 28, Article I, of the Florida Constitution.	*In response to the passage of Federal Health Care Reform legislation, the Florida Legislature passed this resolution to preserve the freedom of all residents of Florida to provide for their own health care.*
p. 1	2.	Prohibits any person, employer, or health care provider from being compelled to participate in any health care system.	*With respect to an individual or employer mandate, this provision would allow any person or employer to opt-out of mandated insurance coverage and would allow for flexibility in any health care provider's participation in a particular health care system.*
pp. 1–2	3.	Authorizes any person or employer to pay directly for health care services and provides that persons or employers shall not incur a penalty or fine for direct payment. The resolution authorizes a health care provider to accept direct payment and provides that such health care provider will not incur a penalty or fine for accepting direct payment.	*This provision would allow a person or employer to purchase health care services without participation in a health care system or plan.*
p. 2	4.	Prohibits any law or rule that prohibits private health insurance sales or purchases. The bill subjects this prohibition to reasonable and necessary rules that do not substantially limit purchase or sale options.	*This provision would allow the purchase or sale of private insurance to individuals regardless of a mandate requiring individuals to have health insurance coverage.*

SUBJECT, BILL PAGES AND/OR STATUTE #	FINAL PROVISION	COMMENTS
p. 2	5. Directs that its provisions do not affect: ♦ Required performance of services by a health care provider or hospital; ♦ Health care services permitted by law; ♦ Workers' compensation care as provided by general law; ♦ Laws or rules in effect as of March 1, 2010; ♦ Any health care system terms and conditions that do not provide punitive measures against persons, employers, or health care providers for direct payment; and, ♦ Any general law passed by a two-thirds vote of the membership of each house of the Legislature after the effective date of the amendment if the law states with specificity the public necessity that justifies an exception to the amendment.	*However, the amendment may not be construed to prohibit any negotiated provision in any insurance contract, network agreement, or other provider agreement contractually limiting co-payments, coinsurance, deductibles or other patient charges.*
pp. 2–3	6. Provides definitions or usage for the following terms: ♦ "Compel" includes the imposition of penalties or fines. ♦ "Direct payment" or "pay directly" means payment for health care services without the use of a public or third-party, excluding any employers. ♦ "Health care system" means any public or private entity whose function or purpose is the management of; processing of; enrollment of individuals for; or payment, in full or in part for health care services, health care data, or health care information for its participants. ♦ "Lawful health care services" means any health care service offered by legally-authorized persons or businesses, provided that such services are permitted or not prohibited by law or regulation. ♦ "Penalties or fines" mean any civil or criminal penalty or fine, tax, salary, or wage-withholding or surcharge, or any named fee with a similar effect established by law or rule by an agency established, created, or controlled by the government, which is used to punish or discourage the exercise of rights protected under this section. ♦ "Rule by an agency" may not be construed to mean any negotiated provision in any insurance contract, network agreement, or other provider agreement contractually limiting co-payments, coinsurance, deductibles, or other patient charges.	

SUBJECT, BILL PAGES AND/OR STATUTE #		FINAL PROVISION	COMMENTS
pp. 4–5	7.	Provides for a ballot summary that describes the provisions of the constitutional amendment in plain language. Effective date: January 4, 2011. Filed with the Secretary of State on May 20, 2010.	*If adopted by 60 percent of the voters during the 2010 General Election.*

TORT REFORM

Negligence/Slip And Fall, HB 689

p. 1, §789.0755	1.	Amends current law to provide that when a person slips and falls on a transitory foreign substance, such as a banana peel or spilled liquid, it shifts the burden of proof to the injured person to show that the business establishment had actual or constructive knowledge of the dangerous condition and should have taken action to remedy it.	*In the case of Owen v. Publix Supermarkets, Inc., 802 So. 2d. 315 (Fla. 2001), the Florida Supreme Court held that a plaintiff need not demonstrate that the store had constructive knowledge of the substance or object that caused the slip and fall. Instead, the store had to demonstrate that it had used reasonable care, and the mere existence of the substance on the floor created a rebuttable presumption that the store had not maintained the premises in a reasonably safe condition. Despite a subsequent legislative "fix," the Court continued to rule that the plaintiff only had to show that another customer of the store could have conceivably produced the hazardous condition.*
pp. 1 & 2, §768.0755(1)	2.	Constructive knowledge may be proven by circumstantial evidence showing that: ♦ The dangerous condition existed for such a length of time that, in the exercise of ordinary care, the business establishment should have known of the condition; or ♦ The condition occurred with regularity and was therefore foreseeable. Effective date: July 1, 2010. Chapter No. 2010-8, LOF.	*The legislation specifically provides that this new provision does not affect any common law duty of care owed by a person or entity in possession or control of a business premise.*

SUBJECT, BILL PAGES AND/OR STATUTE #	FINAL PROVISION	COMMENTS

Parental Release of Liability, CS/SB 2440

p. 2, §549.09

1. Deals with a natural guardian's ability to sign a valid release of liability for their minor child. The bill dealt directly with the "motorsport" portion of a recent Florida Supreme Court ruling. Specifically, it:

   1. Authorizes a motorsport liability release signed on behalf of a minor participating in a sanctioned motorsport event to be valid to the same extent as other "nonspectators" (i.e. adult participants in the race).

   2. Clarifies that if a minor is participating in an activity at a closed-course motorsports facility, other than a sanctioned motorsports event, then the waiver must comply with additional requirements newly created in §744.301(3), F.S.

In Kirton v. Fields, 2008 WL. 5170602 (Fla. 2008), the Florida Supreme Court addressed the enforceability of a pre-injury release form, signed by a parent that provided a pre-injury waiver of liability for a minor child's participation in a motorcycle event. The Court ruled that natural guardians have no right to sign a pre-injury release from tort liability on behalf of their minor child.

The law currently lists a number of sanctioned motorsports events. However, most motorsports facilities also hold other, non-sanctioned events.

p. 2, §744.301(3)

2. The newly created subsection (3) allows a natural guardian to waive and release, in advance, on behalf of their minor children, any claim or cause of action against a commercial activity provider, or its owners, affiliates, employees, or agents, which would accrue to the minor child for personal injury, including death, and property damage resulting from an inherent risk in the activity.

The Supreme Court's decision in Kirton only dealt with commercial activities. They left unanswered any liability releases in non-commercial activities.

3. "Inherent risk" is defined to mean those dangers or conditions, known and unknown, which are characteristic of, intrinsic to, or an integral part of the activity, and which are not eliminated even if the activity provider acts with due care in a reasonable prudent manner.

It includes, but is not limited to:

- *The failure by the activity provider to warn the natural guardian or minor child of an inherent risk, and*
- *The risk that the natural child or another participant in the activity may act in a negligent or intentional manner and contribute to the injury or death of the minor child.*

A "participant" does not include the activity provider, affiliates, employees, or agents.

4. To be enforceable, the waiver or release must include a specifically-worded statement in uppercase type that is at least five points larger than, and clearly distinguishable from, the text of the waiver or release.

The statement is headed "NOTICE TO THE MINOR CHILD'S NATURAL GUARDIAN" and contains 18 lines of specific legal language. See the bill for details.

SUBJECT, BILL PAGES AND/OR STATUTE #	FINAL PROVISION	COMMENTS
p. 4, §744.301(3)(c)	5. If the waiver or release complies with the above, and waives no more than that which is allowed by statute, then there is a rebuttable presumption that it is valid and that any injury or damage to the minor child arose from the inherent risk involved in the activity.	
	6. To rebut the presumption that the waiver or release was valid, a claimant must demonstrate by a preponderance of the evidence that the waiver or release does not comply with the new law.	
	7. To rebut the presumption that the injury or damage arose from an inherent risk, a claimant must demonstrate by clear and convincing evidence that the conduct, conditions, or other cause resulting in the injury or damage was not an inherent risk of the activity.	*"Clear and convincing" evidence requires a much higher level of proof than the "more than 50-percent" requirement of showing something by the preponderance of evidence.*
p. 5, §744.301(3)(d)	8. Clarifies that natural guardians have the right to waive, in advance, any claim against a *non-commercial* activity provider, or its owners, affiliates, employees, or agents *to the extent authorized by common law*.	*This is the Legislature's attempt to clarify that non-commercial activity providers may still use pre-injury releases to waive negligence. That question was not directly addressed by the Court's decision.*
	Effective date: April 27, 2010. Chapter No. 2010-27, LOF.	

Sovereign Immunity, CS/SB 2060

p. 1, §768.28	1. Increases the sovereign immunity limits for those making tort claims against the state and its political subdivisions.	*The Florida Constitution authorizes the Legislature to enact laws that permit suits against the state and its political subdivisions. The current limit is $100,000 per person, with an aggregate cap of $200,000 per incident.*
p. 1, §768.28 (5)	2. The sovereign immunity limits are increased to $200,000 per person and $300,000 per incident.	*This is the first increase since 1981. Amounts in excess of these limits may be sought through the Legislative claims bill process. Early drafts of this bill had a per person limit of $250,000 and no aggregate cap. Opposition by cities and counties led to this compromise.*
	Effective date: October 1, 2011. Chapter No. 2010-26, LOF.	*This applies to claims arising on or after that date.*

Page numbers refer to pages in the enrolled bill. Section (§) numbers refer to Florida Statutes.
** Bills without effective dates become law when signed by the governor, or 15 days after the governor receives the bill if he does not sign it.*

SUBJECT, BILL PAGES AND/OR STATUTE #	FINAL PROVISION	COMMENTS

MISCELLANEOUS

Miscellaneous Insurance Provisions, CS/CS/SB 2176

Workers' Compensation
p. 9, §30.2905

1. Revises the way sheriffs' deputies and others are treated under workers' compensation in certain circumstances.

Off-duty sheriffs' deputies often provide security services for private businesses. The question often arises as to who covers the cost of injuries to those off-duty deputies: the sheriff or the private business?

p. 10, §30.2905(2)(b)

2. Amends current law to provide that "enforcing the criminal, traffic, or penal laws" shall be interpreted to include, but is not limited to, providing security, patrol, or traffic direction for a private or public employer.

The law currently provides that, when an off-duty sheriff's deputy is injured while enforcing the criminal, traffic, or penal laws, they shall be regarded as working on duty.

3. It also provides that a sheriff may include the sheriff's proportionate costs of workers' compensation premiums for the off-duty deputy sheriffs providing such services.

An earlier version of the bill would have allowed the sheriff to be reimbursed for the total costs incurred because of the injury. Since a seriously injured deputy could cost a self-insured sheriff a significant amount of money, employers expressed concern that the recoupment provision was too broad. It was amended to allow recovery of only the proportionate cost of the premium.

p. 10, §112.18(1)(a)

4. Under current law, firefighters and law enforcement or correctional officers enjoy a presumption that tuberculosis, heart diseases, or hypertension resulting in total or partial disability or death have been suffered in the line of duty if they have successfully passed a physical exam prior to being hired and the exam failed to show evidence of such condition. The bill adds "correctional probation officer" to the list of those covered.

The presumption can be overcome by competent evidence to the contrary.

5. Reverses that presumption and says that it is presumed to <u>not</u> have been suffered in the line of duty for any claim filed by a law enforcement officer, correctional officer, or correctional probation officer on or after July 1, 2010, if such claimant:
   - ♦ Departed in a material way from the prescribed course of treatment of his or her personal physician and the departure is demonstrated to have resulted in a significant aggravation of the disease resulting in disability or increasing the disability or need for medical treatment; or

For claims made on or after July 1, 2010, there does not appear to be a similar provision allowing the presumption to be overcome by competent evidence to the contrary. Also, these restrictions do not apply to firefighters. They retain their current presumption.

SUBJECT, BILL PAGES AND/OR STATUTE #		FINAL PROVISION	COMMENTS
		♦ Was previously compensated under §112.18, F.S., and Ch. 440, F.S., for such disease, and thereafter sustains and reports a new workers' compensation claim, and the claimant has departed in a material fashion from the prescribed course of treatment of an authorized physician for the preexisting workers' compensation claim and the departure is demonstrated to have resulted in a significant aggravation of the disease, resulting in disability or the need for medical treatment.	*It is unclear whether this presumption can be overcome for claims made after July 1, 2010.*
p. 12, §112.18(1)(b)4	6.	A law enforcement officer, correctional officer, or correctional probation officer is not entitled to the presumption provided in §112.18, F.S., unless a claim for benefits is made prior to or within 180 days after leaving employment.	
Commercial Self Insurance Funds p. 13, §624.46223	7.	Creates a new section in the Commercial Self Insurance Fund Act, which prohibits an association, fund, or pool created to form or manage a risk management program or to provide self insurance for a public entity from requiring its members to give more than 60 days notice of the member's intention to withdraw from the association, fund, or pool.	*On pp. 54–55 of the bill, this new section of the law was added to the bill again, but here the reference to the number of days notice was no more than "45 days notice."*
Commercial Insurance Rates pp. 13–14, §627.062(3)	8.	Amends provisions relating to rating requirements for property, casualty, and surety policies and excludes the following types of insurance from the OIR filing and review requirements in §§627.062(2)(a) and (f): ♦ Excess or umbrella. ♦ Surety and fidelity. ♦ Boiler and machinery and leakage and fire-extinguishing equipment. ♦ Errors and omissions. ♦ Directors and officers, employment practices, and management liability. ♦ Intellectual property and patent infringement liability. ♦ Advertising injury and Internet liability. ♦ Property risks rated under a highly protected risks rating plan. ♦ Any other commercial lines categories of insurance or commercial lines risks that the OIR determines should not be subject to the filing and review requirements because of the existence of a competitive market for such insurance, similarity of such insurance to other cat-	*During the session, these provisions were known as the "Commercial Rate Modernization" provisions, and they were supported by the OIR.* *Although the bill excludes these types of insurance from the OIR filing and review requirements in §§627.062(2)(a) and (f), the bill does not remove from the law the current statutory requirement that these types of insurance coverages are subject to §627.062(1), F.S., which requires that rates must not be excessive, inadequate, or unfairly discriminatory.*

SUBJECT, BILL PAGES AND/OR STATUTE #	FINAL PROVISION	COMMENTS
	egories or kinds of insurance not subject to filing and review requirements, or to improve the general operational efficiency of the OIR.	
p. 14, §627.062(3)	9. Requires insurers or rating organizations to establish and use rates, rating schedules, or rating manuals to allow insurers a reasonable rate of return on the types of coverages listed above.	
	10. Requires that an insurer must notify the OIR of any changes in the rates for the types of insurance listed above, no later than 30 days after the effective date of the change in rates. The notice to the OIR must include the following information: ♦ The name of the insurer. ♦ The type of insurance. ♦ The total premium written during the immediately preceding year for that type of insurance. ♦ The average statewide percentage change in rates.	
pp. 14–15, §627.062(3)	11. Underwriting files, premiums, and loss and expense statistics must be maintained by the insurer and are subject to inspection by the OIR. Upon examination, the OIR shall determine if the rates are excessive, inadequate, or unfairly discriminatory. The bill requires that in reviewing the rate, the OIR may require the insurer to provide at the insurer's expense all information necessary to evaluate the condition of the company and the reasonableness of the rate.	
pp. 15–17, §627.0651	12. Creates a new subsection (14) in §627.0651, F.S., relating to rate setting for motor vehicle insurance, and it provides that rates for commercial motor vehicle insurance covering a fleet of 20 or more self-propelled vehicles are exempt from the following provisions: ♦ Section 627.0651(1), F.S., which establishes the procedures required for automobile insurers to file rates, rating schedules and rating manuals. ♦ Section 627.0651(2), F.S., which specifies the factors the OIR must apply to determine whether an automobile insurer's rates are excessive, inadequate, or unfairly discriminatory. ♦ Section 627.0651(2), F.S., which allows the OIR to require information necessary to evaluate the filing. ♦ Section 627.0645, F.S., which requires annual rate filing.	

SUBJECT, BILL PAGES AND/OR STATUTE #	FINAL PROVISION	COMMENTS
p. 16, §627.0651	13. Provides in the new subsection (14) of §627.0651, F.S., that rates for insurance under this section may not be excessive, inadequate, or unfairly discriminatory, and must be set to allow the insurer a reasonable rate of return. Requires an insurer to notify the OIR of any rate changes within 30 days of the effective date of the change. Requires that the notice must include the name of the insurer, the type or kind of insurance subject to rate change, total premium written during the immediately preceding year by the insurer for the type or kind of insurance subject to the rate change, and the average statewide percentage change in rates. Requires that the insurer must maintain underwriting files, premiums, losses, and expense statistics, which are subject to examination by the OIR. Requires that the OIR consider all the factors that are required in current §627.0651(2)(a)–(l), F.S., and §627.0651(3)–(8), F.S. to determine if the rate is excessive, inadequate, or unfairly discriminatory.	
pp. 16–17, §627.0651	14. Provides that a rating organization must also notify the office of any changes to loss cost for insurance and risks within 30 days after the effective date of the change. This notice must include the name of the rating organization, the type or kind of insurance subject to a loss cost change, loss costs during the immediately preceding year, and the average statewide percentage change in loss cost. Requires the rating organization to maintain loss and exposure statistics, which are subject to examination by the OIR. Requires that the OIR consider all the factors that are required in current §627.0651(2)(a)–(l), F.S., and §627.0651(3)–(8), F.S., to determine if the rate is excessive, inadequate, or unfairly discriminatory.	
p. 17, §627.0651	15. Requires that in reviewing the rate, the OIR may require the insurer to provide at the insurer's expense all information necessary to evaluate the condition of the company and the reasonableness of the rate.	
Medicare Supplement Policies p.17, §626.9541	16. Revises provisions related to unfair methods of competition and unfair or deceptive acts to provide that this section does not prohibit a Medicare supplement insurer from providing a premium credit to an insured for using an in-network inpatient facility.	
p. 18, §627.6741	17. Provides that an insurer offering a Medicare supplement policy is not prohibited from entering into an agreement through a network with in-	

SUBJECT, BILL PAGES AND/OR STATUTE #	FINAL PROVISION	COMMENTS
	patient facilities that agrees to waive the Medicare Part A deductible in whole or in part. The insurer's network agreement would not be subject to the approval of the OIR and the insurer would not be required to file a copy of the agreement with OIR.	
p. 18, §627.6745	18. Requires an insurer to factor such a waiver of the Medicare Part A deductible and premium credit into the insurer's loss-ratio calculation and policy premium.	
Warranty Associations pp. 19–53, §634.011–§634.313	19. Reduces much of the regulatory oversight that the OIR currently exercises over warranty associations. Removing the OIR's regulation of warranty companies is balanced by new prohibited acts created by the bill and the addition of criminal penalties to the statutes that regulate warranty companies.	*The provisions in the bill regarding warranty associations take effect upon the bill becoming law, not January 1, 2011, as noted below.*
	20. The major provisions of the bill regarding warranty associations include: ♦ Exempts motor vehicle service agreements sold to non-consumers from the Florida Insurance Code. ♦ Provides that unlicensed activity by warranty associations is a first-degree misdemeanor. ♦ Prohibits false, deceptive, or misleading advertising. ♦ Removes the requirement to submit warranty service agreements to the OIR for approval; however, the bill provides that the OIR may order that a form not be used if it does not meet specified criteria. ♦ Switches from quarterly to annual financial reporting requirements. ♦ Makes periodic OIR examinations discretionary and provides factors to consider in choosing to conduct an examination. ♦ Provides that there is no violation for knowingly overcharging if a motor vehicle service agreement company refunds any excess premium within 45 days. ♦ Makes a failure to provide a complete sample copy of the terms and conditions of a service or warranty agreement prior to sale an unfair practice, but provides that this information may be provided online. ♦ Broadens the definition of home warranty service agreements. ♦ Allows premium increases in renewal home warranty contracts if supported by claims history or claims cost data.	

SUBJECT, BILL PAGES AND/OR STATUTE #	FINAL PROVISION	COMMENTS
	♦ Removes the OIR's ability to require additional regular or special reports from home warranty associations. ♦ Repeals the requirement for home warranty associations and motor vehicle service agreement companies to file rates with the OIR. ♦ Requires that all agreements issued under Chapter 634, F.S., must provide a customer with a sample copy of the terms and conditions of the service agreement upon request from the customer. The service agreement company may comply by providing a written copy of the agreement or by directing the customer to a website that contains the information requested.	
	21. Also repeals §634.313(4), §634.3126, §634.136(2) and (3), and §634.1216, F.S., which are inconsistent with or replaced by the new provisions described above.	
Customer Representatives **pp. 55–56, §626.221**	22. Adds to the list of applicants for customer representative who are exempt from the state examination to include individuals with the designation of Certified Insurance Representative from the National Association of Christian Catastrophe Insurance Adjusters.	*This provision also passed in CS/CS/SB 2044.*
Safeguard Our Seniors Act **pp. 53–65, §624.310, §626.025, §626.2815, §626.621, §626.641, §626.798, §626.9521, §626.99, §627.4554**	23. Makes several changes in the Insurance Code to enhance penalties for unethical annuities sales practices as well as provide certain consumer protections for seniors who purchase annuities contracts.	*Many annuities are complicated and difficult to understand; because of this, uninformed consumers are often targeted by unscrupulous agents employing deceptive sales practices to defraud investors. In the past five years, investigations by the Department of Financial Services (DFS) regarding sales of annuities have increased by approximately 300 percent. These cases are revealing the fact that many of Florida's seniors are being sold deferred annuity contracts, which are not suitable for their financial needs. Further, the producers of these unsuitable contracts are unethical agents who earn large commissions on the sale of these contracts.*
pp. 53–54, §624.310	24. Expands the definition of "affiliated party" with regard to the enforcement of the Insurance Code to include any third-party marketer who aids or abets a licensee in a violation of the Insurance Code relating to the sale of an annuity to a person 65 years of age of older.	

SUBJECT, BILL PAGES AND/OR STATUTE #	FINAL PROVISION	COMMENTS
p. 56, §626.025	25. Prohibits "family members" of the selling life agent from being added as a designated beneficiary to a life insurance policy sold to an individual, other than to a family member under §626.798, F.S.	*Current law prohibits only the agent from designating himself or herself as the beneficiary.*
pp. 56–57, §626.2815(3)(k)	26. Creates an exemption from the continuing education requirement that mandates life agents to take a three-hour class on the subject of suitability in annuity and life insurance transactions. The exemption from this requirement applies to agents who have not sold individual life insurance policies or annuity contracts during the continuing education compliance cycle in question and who do not have any active individual life insurance policies or annuity contracts.	*This provision also passed in CS/CS/HB 885.*
pp. 57–58, §626.621	27. Provides additional grounds for discretionary refusal, suspension, or revocation of an agent's license or appointment when the agent has had prior action taken against his/her license for violations of state or federal securities or commodities law.	
p. 58, §626.941	28. Prohibits an agent who has had his license revoked for violations involving seniors from being eligible for licensure again.	
pp. 58–59, §626.798	29. Provides that a "family member" of an agent placing life insurance coverage cannot be designated as beneficiary on a policy unless the life agent or family member has an insurable interest in the life of such person.	
pp. 59–60, §626.9521	30. Amends the provisions of the Insurance Code pertaining to unfair or deceptive acts or practices with regard to the offenses known as "twisting" and "churning," and increases the maximum administrative fine for violations from $40,000 to $75,000. Also provides that an agent/licensee must make a reasonable effort to discover the age of the consumer at the time the insurance application is completed. Finally, the bill provides that victims over the age of 65 may offer testimony at an administrative proceeding through a video deposition.	*This provision may aid in prosecution due to the fact that some senior victims are unable to appear at hearings due to failing health, physical limitations, or death.*
pp. 60–62, §626.99	31. Amends provisions concerning the disclosures an insurer must provide a prospective purchaser of life insurance to require an insurer to: ♦ Provide a minimum 30-day unconditional refund period to an annuity purchaser who is at least 65 years old. For a fixed annuity contract, the refund includes premiums paid and any contract fees	*The 30-day refund provision for a variable or market value annuity contract does not apply to a prospective*

SUBJECT, BILL PAGES AND/OR STATUTE #	FINAL PROVISION	COMMENTS
	and charges. For a variable or market value annuity contract, the refund includes the cash surrender value provided in the contract and any fees or charges deducted from premiums or imposed under the contract. ♦ Provide a contract summary and a DFS-developed buyer's guide on annuities to each prospective purchaser (regardless of the purchaser's age) prior to accepting any payment for an annuity contract. ♦ Attach a cover page to an annuity policy informing the purchaser (regardless of the purchaser's age) of the unconditional refund period, contact information for the issuing company, the DFS toll-free help line number, and other information required by DFS administrative rule. The cover page is part of the annuity contract and is subject to review by the OIR pursuant to §627.410, F.S.	*owner or an accredited investor as defined in the Security and Exchange Commission's Regulation.*
pp. 62–65, §627.4554	32. Amends §627.4554, F.S., relating to the standards and procedures for recommending annuity products to senior consumers. The bill: ♦ Defines the term "accredited investor;" in the same way as the description of accredited investors who are natural persons in Regulation D adopted by the Securities and Exchange Commission. ♦ Authorizes the DFS to require an insurance agent to provide monetary restitution of penalties and fees incurred by a senior consumer who is harmed by a willful violation of §627.4554, F.S. (annuity investments by seniors). ♦ Requires the DFS to order payment of restitution to a senior consumer who is deprived of money by an insurance agent's misappropriation, conversion, or unlawful withholding of a senior consumer's money in the course of an annuity transaction. Restitution is limited to the amount misappropriated, converted, or unlawfully withheld, and does not preclude the victim from seeking other legal remedies. ♦ Creates a new subsection (9) that prohibits an annuity contract issued to a senior consumer from including a surrender or deferred sales charge for withdrawal of money that exceeds 10 percent, which must be reduced by one percent each year to zero by the end of the tenth policy year. Effective date: January 1, 2011, except as otherwise provided. Chapter No. 2010-175, LOF.	

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Guaranty Associations, CS/CS/CS/HB 159			
Chapter 631	1.	This 18-page bill makes numerous technical and substantive changes to the way guaranty funds are structured and operate in Florida. The following substantive changes are the more important to insurance agents.	*Guaranty associations are non-profit corporations that assume responsibility for settling claims and refunding unearned premiums to policyholders of insolvent and liquidated insurance companies. Insurance companies are required to participate in guaranty associations as a condition of doing business in Florida.*
p. 3, §631.52(14)	2.	Excludes the employer liability coverage under a workers' compensation policy from coverage under Part II of Ch. 631. Workers' compensation itself is already excluded from that part.	*The employer liability coverage's losses will be addressed in §631.904, F.S., discussed below.*
p. 3, §631.55(2)	3.	Combines the two FIGA automobile accounts—the automobile liability account and the automobile physical damage account.	*According to FIGA, combining these accounts will produce greater efficiencies and will align FIGA with the national Model Act and the guaranty funds of other states.*
p. 5, §631.57(3)(c)	4.	Changes the way insurance companies assessed by FIGA for deficits pass the assessment to their policyholders.	*Under current law, FIGA certifies the need for an assessment to the OIR. If the OIR agrees with the calculation, the OIR issues an order for the insurers to pay the assessment amount to FIGA within 30 days. The insurer can recoup the amount from its policyholders, but must submit a rate filing with the OIR to do so.*
p. 9, §631.57(3)(f)	5.	Removes the requirement that an assessed insurance company make a filing with OIR prior to obtaining recoupments from policyholders. Instead, the insurance company can apply a "recoupment factor" to the policyholders' premiums.	*The bill sets forth the method of applying the recoupment's factor, as well as limitations on how much can be recouped in a given year. See the bill for details.*
p. 10, §631.57(3)(g)	6.	Specifies that the amounts recouped are to be considered "premium" for purposes of premium taxes, *but are not subject to fees or commissions*.	
pp. 11–13, §631.713(3)(n)–(p)	7.	Makes several changes to the Florida Life Accident & Health Guaranty Association (FLAHIGA). Most of them are technical in nature, dealing with issues such as the calculations for coverage limits for life insurance cash surrender; coverage limits for deferred annuities; and certain policies providing hospital, medical, or other health care benefits.	*It also deals with "indexed: products and reinsurance issues." Most of it is very technical in nature. See the bill for details.*

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p. 16, §631.735	8.	Provides that licensed insurance agents are not prohibited from furnishing written information that is in a form prepared by FLAHIGA, summarizing the claim, cash value, and annuity cash value limits of FLAHIGA, upon the request of the policyholder or applicant for insurance.	*Current law prohibits advertisement for insurance to use the existence of FLAHIGA for the purpose of the sale of insurance.*
p. 17, §631.904	9.	Amends the Florida Workers' Compensation Insurance Guaranty Association (FWCIGA) to provide for the payment of employer liability claims under a workers' compensation policy up to a limit of $300,000. Effective date: July 1, 2010. Chapter No. 2010-49, LOF.	*The bill remedies FIGA's difficulty administering employer's liability claims due to the insolvency of a workers' compensation insurer by giving FWCIGA responsibility for covering those claims. The $300,000 limit is the same as was in FIGA for these claims. See also, §631.52 (14), F.S., above.*

This summary & analysis was prepared by the

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