

2009 INSURANCE LEGISLATION
Summary & Analysis with Comments
 compiled by the
FLORIDA ASSOCIATION OF INSURANCE AGENTS
June 2009 (updated)

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SUBJECT, BILL PAGES AND/OR STATUTE #	FINAL PROVISION	COMMENTS
PROPERTY INSURANCE		
Property Insurance, CS/CS/CS/HB 1495		
Citizens pp. 71, §627.351	1. Implements a rate “glide path” capped at 10 percent per year for Citizens’ policyholders until rates are actuarially sound.	<i>The filing will be made by July 15, 2009, to be implemented on or after January 1, 2010.</i>
p. 72, §627.351	2. Allows Citizens to increase its rates to pay the Cat Fund’s “cash build up” program for five years.	<i>The estimated rate impact should be less than one percent.</i>
p. 59, §627.351	3. Staggers the terms of office for members of the Board of Governors.	<i>FAIA-suggested language to solve the problem of all the Citizens board members rolling off at the same time.</i>
p. 77, §627.712	4. Insurers may offer ex-wind policies to homeowners with homes located within the HRA (High Risk Account) boundaries who do not qualify for Citizens because they own \$2+ million properties or \$750,000+ properties without shutters.	
p. 53, §627.351	5. Deletes the provision that required on January 1, 2010, a seller of a home, which is insured by Citizens and located in the wind-borne debris region, with an insured value of \$500,000 or more, to disclose in writing to the prospective purchaser its windstorm mitigation rating based on the uniform home grading scale, prior to sale.	
p. 73, §627.351	6. Extends to Dec. 2010 (10 months), the implementation of the requirement that Citizens reduce its HRA area boundaries in order to lower its 100-year probable maximum loss (PML).	
CAT Fund pp. 73–76, §627.3512	7. Changes recoupment by insurers for Citizens’ assessments, eliminating the need to receive OIR approval prior to recouping costs from policyholders. Instead, the OIR would review the final accounting report of the recoupment after it has been completed.	
pp. 19–25, §215.555	8. Implements provisions to reduce the Cat Fund’s exposure by phasing out the Temporary Increase in Coverage Limit (TICL) layer of coverage over a six-year period at a rate of \$2 billion per year.	<i>TICL was scheduled to expire in 2010, but there was not enough private reinsurance available to cover the entire \$12 billion. By phasing TICL out over six years, it lessens the sticker shock to consumers.</i>

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pp. 19–25, §215.555	9. Increases the price of the TICL layer by an additional multiple each year until TICL is eliminated in six years.	
p. 16, §215.555	10. Authorizes the Cat Fund to implement a “cash build up” factor based on increased reimbursement premiums phased in over a five year period.	
pp. 9–10, §215.555	11. Allows small insurers to purchase an additional amount of FHCF reimbursement coverage up to \$10 million through December 2011. Specifies that the optional coverage retention as specified in the reimbursement contract shall be accessed before the mandatory coverage, but once the limit of coverage selected under this option is exhausted, the insurer's retention under the mandatory coverage shall apply. This coverage shall apply and be paid concurrently with the mandatory coverage.	<i>This is a coverage that is vital to the limited apportionment carriers.</i>
p. 6, §215.555	12. Establishes the contract period for the Cat Fund to be the calendar year (January through December).	<i>This was done to match the contracts in the private re-insurance market and to give carriers time to negotiate prior to hurricane season.</i>
Rating Law pp. 43-45, §627.062	13. Provides that the separate rate filing for insurers be expedited according to specified dates; that insurers purchasing reinsurance do so at a price no higher than would be paid in an “arms-length” transaction; and that costs incurred to pay additional Cat Fund premium be included in the filing. The separate filing is capped at 10 percent per policyholder.	
p. 43, §627.062	14. Extends the prohibition against “use and file” rate filings to December 31, 2010.	
pp. 80–81, §627.0628	15. Authorizes the Florida Hurricane Loss Projection Methodology Commission to study and issue a report on mitigation credits, discounts, and deductibles.	
p. 49, §627.0629	16. Provides that premium discounts resulting from the home grading scale (due in 2011 from the Office of Insurance Regulation (OIR)) will supersede the current mitigation discounts approved by the OIR.	
pp. 46–47, §627.0621	17. Repeals statute that prevents OIR attorneys from asserting attorney-client privilege or work-product confidentiality on certain communications with other OIR personnel.	

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My Safe Florida Home Program p. 31, §215.5586	18. Adds mitigation improvements relating to roof hardening to help facilitate the My Safe Florida Home (MSFH) program to access federal “weatherization” stimulus money and FEMA grant money.	
p. 34–35, §215.5586	19. Clarifies that the MSFH program provides grants rather than a no-interest loan program.	
p. 29, §215.5586	20. Revises the threshold for grant and contract review by the Legislative Budget Commission.	
Public Adjusters p. 37, §626.854	21. Prohibits public adjusters and public adjuster apprentices from accepting referrals of business from any person with whom the public adjuster or apprentice conducts business.	<i>FAIA has consistently advocated reforming the practices of public adjusters. While these provisions do not cure all of the problems associated with public adjusters they are at least steps in the right direction. Most likely the results of the Office of Program Policy Analysis and Government Accountability (OPPAGA) study will provide a template for future legislation.</i>
p. 39, §626.8651	22. Requires public adjuster apprentices to pass a written examination prior to licensure.	
p. 40, §626.8651	23. Limits the number of public adjuster apprentices that are maintained by public adjusting firms.	
p. 80	24. Requires the OPPAGA to review the practices and laws relating to public adjusters and submit a report to the governor, Senate president, speaker of the House, the CFO, and the insurance commissioner by Feb. 2010.	
Agent Issues p. 77, §627.711	25. An individual or entity who knowingly provides or utters a false or fraudulent mitigation verification form with the intent to obtain or receive a discount on an insurance premium to which the individual or entity is not entitled committed misdemeanor of the first degree, punishable as provided in §775.082 or §775.083.	
p. 79, §631.65	26. Allows insurance agents to explain the applicability of FIGA to consumers.	<i>FAIA-suggested language. It does not altogether repeal the statute, but makes it clear agents can explain it. Advertising is still prohibited.</i>
Miscellaneous p. 81, §624.46226	27. Authorizes reinsurers to issue coverage directly to a self-insuring public housing authority.	
p. 37, §627.7011, §627.2702(7)	28. Clarifies an insurer’s right to repair damaged property in compliance with its policy.	
	Effective date: May 27, 2009. Chapter No. 2009-87, LOF.	

SUBJECT, BILL PAGES AND/OR STATUTE #	FINAL PROVISION	COMMENTS
Residential Property Insurance/Rate Deregulation, CS/CS/HB 1171		
pp. 1–2, §627.062	1. The bill adds a new subparagraph (2)(k) to §627.062, F.S., regarding rate standards, and provides that certain residential property insurers that comply with a newly created §627.7031, F.S., may use a rate in excess of the otherwise applicable filed rate. The bill provides that this new rate is not subject to a determination by the OIR that it is excessive.	<i>The OIR can still disapprove this new rate as inadequate or for using a rating factor that is unlawful under §626.9541(1), F.S., regarding unfair methods of competition and unfair or deceptive acts or practices.</i>
pp. 2–3, §627.7031(1)	<p>2. The bill creates §627.7031, F.S., which allows property insurers to offer residential property insurance policies that use a rate in excess of the filed rate (as described above) if the property insurer is authorized to write business in this state, and:</p> <ol style="list-style-type: none"> 1. The insurer has a surplus as to policyholders equal to or greater than \$500 million; 2. The insurer has a surplus as to policyholders equal to or greater than \$200 million and a ratio of net written premium to its surplus not exceeding two to one; or 3. The insurer has a surplus as to policyholders equal to or greater than \$150 million and is an insurer whose primary function is offering insurance as a service or member benefit to members of a nonprofit corporation. 	<p><i>Informally, FAIA believes approximately 20 carriers may qualify with far fewer taking advantage. Others may qualify in the future.</i></p> <p><i>For purposes of calculating net written premium for option two, net written premium shall only consider reinsurance placed in the Florida Hurricane Catastrophe (Cat) Fund or with reinsurers or direct insurers that have been given a superior, excellent, exceptional, or equally comparable financial strength rating by a rating agency that is generally considered accurate or acceptable.</i></p>
p. 3, §627.7031(1)(c) p.5, §627.7031(3)	3. The bill also provides that insurers offering these “unregulated rate” policies cannot purchase reinsurance coverage relating to the Temporary Increase in Coverage Limit (TICL) options under the Cat Fund, and that these “unregulated rate” policies cannot exclude coverage for the perils of windstorm or hurricane.	
p. 3–4, §627.7031(1)(d) p. 5, §627.7031(2)	4. The bill provides that before the issuance or renewal of an unregulated rate policy, the applicant or insured must be given a written disclosure notice, on a separate document, and in 12-point boldfaced type.	

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	<p>5. The disclosure notice must read as follows:</p> <p style="padding-left: 40px;">THE RATE FOR THIS POLICY IS NOT REGULATED BY THE FLORIDA OFFICE OF INSURANCE REGULATION AND MAY BE HIGHER THAN RATES APPROVED BY THAT OFFICE. A RESIDENTIAL PROPERTY POLICY SUBJECT TO FULL RATE REGULATION REQUIREMENTS MAY BE AVAILABLE FROM ANOTHER INSURER OR CITIZENS PROPERTY INSURANCE CORPORATION. PLEASE DISCUSS YOUR POLICY OPTIONS WITH AN INSURANCE AGENT. YOU MAY WISH TO VIEW THE OFFICE OF INSURANCE REGULATION'S WEBSITE WWW.SHOPANDCOMPARERATES.COM FOR MORE INFORMATION ABOUT CHOICES AVAILABLE TO YOU.</p>	
<p>p.4, §627.7031(1)(e)</p>	<p>6. In addition, the bill provides that before issuance of an unregulated rate policy the insured must be given a quote for a policy from Citizens or for a fully rate-regulated policy from an admitted insurer willing to insure the risk, reflecting substantially similar coverages, limits, and deductibles, to the extent available.</p>	<p><i>This language is unclear. It does not require the quote to be in writing. It says "to the extent available" and it conflicts with the acknowledgement form described in paragraph eight below.</i></p>
<p>p. 4–5, §627.7031(1)(e)</p>	<p>7. The bill requires that the insured who purchases an unregulated rate policy must sign an acknowledgement form, which must be retained by the insurer or the agent for at least three years. If the acknowledgement form is signed by the insured, it is presumed that the insured has been informed and understands the form.</p>	<p><i>The presumption language regarding the insured's signature on the acknowledgement form was drafted by FAIA.</i></p>
	<p>8. The acknowledgement form must read:</p> <ol style="list-style-type: none"> 1. I HAVE REVIEWED THE REQUIRED DISCLOSURE AND THE REQUIRED PREMIUM COMPARISON. 2. I UNDERSTAND THAT THE RATE FOR THIS RESIDENTIAL PROPERTY INSURANCE POLICY IS NOT REGULATED BY THE FLORIDA OFFICE OF INSURANCE REGULATION AND MAY BE HIGHER THAN THE RATES APPROVED BY THAT OFFICE. 3. I UNDERSTAND THAT A RESIDENTIAL PROPERTY INSURANCE POLICY SUBJECT TO FULL RATE REGULATION REQUIREMENTS MAY BE AVAILABLE FROM 	

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p. 5, §627.7031(4)	<p>ANOTHER INSURER OR CITIZENS PROPERTY INSURANCE CORPORATION.</p> <p>4. I UNDERSTAND THAT THE FLORIDA OFFICE OF INSURANCE REGULATION'S WEBSITE WWW.SHOPANDCOMPARERATES.COM CONTAINS RESIDENTIAL PROPERTY INSURANCE RATE COMPARISON INFORMATION.</p> <p>5. I UNDERSTAND THAT SHOULD A HURRICANE CAUSE SEVERE DAMAGE IN FLORIDA, A POLICYHOLDER OF CITIZENS PROPERTY INSURANCE CORPORATION MAY BE REQUIRED TO PAY A HIGHER ASSESSMENT THAN THE ASSESSMENT OTHERWISE APPLICABLE TO THIS RESIDENTIAL PROPERTY INSURANCE POLICY.</p> <p>9. Finally, the bill requires that insurers issuing an unregulated rate policy must provide the named insured at least 180 days written notice of cancellation or nonrenewal.</p>	<p><i>The 180-day notice requirement for these unregulated rate policies supersedes all other cancellation and non-renewal notice requirements in §627.4133, F.S.</i></p>
<p>Effective date: Upon becoming law.</p>		

Condominium Insurance, CS/CS/SB 714

VETOED

<p>p. 3, §627.714 p. 7, §718.111(11)(g)</p>	<p>1. This bill revises and clarifies the property insurance requirements of condominium associations and condominium unit owners under Chapter 718, F.S., known as the Condominium Act.</p> <p>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, 2009, must include loss assessment coverage of \$2,000 for all assessments made as a result of the same direct loss to the property. The bill 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 from the same direct loss to the property, no deductible shall apply to the loss assessment coverage.</p>	<p><i>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.</i></p> <p><i>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.</i></p>
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SUBJECT, BILL PAGES AND/OR STATUTE #	FINAL PROVISION	COMMENTS
p. 3, §627.714 p. 7, §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.	<i>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.</i>
pp. 7-8, §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.	<i>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):</i>
p. 7, §718.111(11)(f)	5. Clarifies that the property, which 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.	<p><i>...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...</i></p> <p><i>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.</i></p>
p. 8, §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.	
p.8, §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 which the owner is responsible for the cost.	

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p.9, §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. 4–11, §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. 4, §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.	<i>Current law provides that “full insurable value” be determined at least once every 36 months.</i>
p. 5, §718.111(11)(a)	11. Creates an exception to the provision that allows three or more condominium associations to provide adequate property insurance through a shared limit program with insurance sufficient to cover a 250-year probable maximum loss (PML) as long as the policy or program which is issued or renewed after July 1, 2008, has been approved by the OIR. The exception provides that a property insurance policy or program originally issued before January 1, 2000, which has provided uninterrupted property insurance coverage and has provided coverage for a group of no fewer than three communities is not subject to review and approval by the OIR until renewed after July 1, 2009. In addition, such coverage or program may not exist beyond July 1, 2010.	<i>This exception was created to grandfather in, until July 1, 2010, one group of associations that had been utilizing this type of pooling arrangement since 1999. The language for this exception was carefully crafted by representatives of FAIA, the Florida Bankers Association, and the community associations.</i>
p. 6, §718.111(11)(c)	12. 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)	13. 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	14. Amends various provisions of §718.112, F.S., regarding condominium association bylaws.	

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p. 23, §553.509	<p>15. 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.</p> <p>Effective date: Upon becoming law. Vetoed: June 1, 2009.</p>	
Relating to Sinkhole Losses, CS/SB 742		
pp. 1–2, §627.706	<p>1. Provides that an insurer, offering sinkhole coverage to policyholders, may nonrenew the policies of policyholders maintaining sinkhole coverage in Pasco County or Hernando County at the option of the insurer and provide an offer of coverage to such policyholders, which includes catastrophic ground cover collapse and excludes sinkhole coverage. Insurers availing themselves to this option are subject to the following requirements:</p> <ol style="list-style-type: none"> 1. Policyholders must be notified that a nonrenewal is for purposes of removing sinkhole coverage and that the policyholder is still being offered a policy that provides coverage for catastrophic ground cover collapse. 2. Policyholders must be provided an actuarially reasonable premium credit or discount for the removal of sinkhole coverage and provision of only catastrophic ground cover collapse. 3. The insurer shall provide each policyholder with the opportunity to purchase an endorsement to his or her policy providing sinkhole coverage and may require an inspection of the property before issuance of a sinkhole coverage endorsement. 	
pp. 2–3, §627.7063	<p>2. Mandates the creation of a building code effectiveness grading schedule that evaluates the effectiveness of sinkhole loss prevention ordinances in reducing the number of sinkholes and the severity of sinkhole losses. The grading schedule will:</p>	

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	<ol style="list-style-type: none"> 1. Be adopted by the Financial Services Commission by rule. 2. Be based on the effectiveness of code enforcement in each county and scientific, modeling, and engineering methodologies; and 3. Evaluate ordinances no earlier than four years after the ordinance takes effect. <p>3. The commission must also adopt rules mandating insurance premium discounts or surcharges on personal residential property insurance based on a property's compliance with an ordinance and the grade assigned to the applicable sinkhole loss prevention ordinance.</p>	<p><i>The Financial Services Commission is likely to rely on personnel of the OIR to develop the rule; the OIR does not have rulemaking authority itself.</i></p> <p><i>The four-year time period is designed to allow for the gathering of data regarding the frequency and severity of sinkhole damage to structures that are required to be compliant with the sinkhole prevention ordinance in question.</i></p>
	<p>Effective date: January 1, 2010.</p>	

SURPLUS LINES

Surplus Lines Insurers, [CS/HB 853](#)

<p>p. 2, §626.913</p>	<ol style="list-style-type: none"> 1. <i>The bill amends §626.913, F.S., regarding the surplus lines law, to clarify that the provisions of Chapter 627, F.S., do not apply to surplus lines insurers, unless specifically stated to apply.</i> 	<p><i>Historically, surplus lines insurers have not been subject to the insurance regulatory requirements in Chapter 627, F.S., nor has the OIR ever regulated surplus lines insurers as to rate, form, or other requirements under Chapter 627. However, two recent court rulings (<u>Essex v. Zota</u>, by the Florida Supreme Court, and <u>CNL Hotels v. Twin City Fire Insurance</u> by a federal district appellate court in Florida) have altered the manner in which surplus lines insurers have been regulated. These rulings essentially require that surplus lines policy forms must now be filed,</i></p>
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pp. 1–2, §626.924	<p>2. The bill requires surplus lines insurers to include on the face of any policy issued on or after October 1, 2009, a statement that surplus lines insurers' policy rates and forms are not approved by any Florida regulatory agency.</p>	<p><i>reviewed, and approved by the OIR. The purpose of this bill is to reverse the effect of those court rulings on the regulation of surplus lines insurers.</i></p> <p><i>The bill imposes certain other requirements on surplus lines insurers, beginning October 1, 2009, which are similar to some of the provisions governing admitted insurers in Chapter 627, F.S.</i></p>
pp. 3–4, §626.9371	<p>3. The bill creates §626.9371, F.S., which relates to payment of premiums and claims for surplus lines policies. The bill specifies that the premiums for surplus lines insurance contracts issued on or after October 1, 2009, must be paid in cash consisting of coins, currency, checks, or money orders, or by using a debit card, credit card, automatic electronic funds transfer, or payroll deduction plan.</p>	<p><i>The provisions in this section of the bill are almost identical to the payment of premiums and claims provisions applicable to admitted insurers in Chapter 627, F.S. However, the bill does not include similar provisions from §627.4035(1), F.S., that allow for the option of payment plans establishing quarterly and semiannual payment of premiums for certain policyholders or provisions exempting certain agreements and loans from these provisions.</i></p>
pp. 4–5, §626.9372	<p>4. The bill creates §626.9372, F.S., which relates to required disclosure statements of certain information in liability claims. The bill provides that each surplus lines insurer that provides or may provide liability insurance coverage to pay all or a portion of any claim under a policy issued on or after October 1, 2009, must provide, within 60 days after the written request of the claimant, a statement of the corporate officer or the insurer's claims manager or superintendent setting forth certain information regarding each known policy of insurance.</p> <p>5. In addition to this requirement, the insured or his or her insurance agent must disclose the name and coverage of each known insurer to the claimant upon request. The insured or agent must forward the request for information to all affected insurers. The insurer has 60 days from receipt of the request to comply with the request for information. If the insurer discovers facts requiring an amendment to the information provided, it must provide an amended statement within 60 days of discovery of those facts.</p>	<p><i>These provisions differ slightly from the disclosures required of admitted insurers under §627.4137(1), F.S. Under Chapter 627, F.S., admitted insurers are required to submit the same information to a claimant within 30 days (not 60 days) of request. In addition, the statement must be made under oath. While surplus lines insurers are afforded 60 days to provide amended statements to claimants under the bill, admitted insurers must immediately provide an amended statement upon discovery of facts necessitating an amendment.</i></p>

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p.5, §626.9373	<p>6. The bill creates §626.9373, F.S., to provide for an award of attorney's fees against insurers in certain cases. Under the bill, if a state court or appellate court awards a judgment or decree against a surplus lines insurer and in favor of any named or omnibus insured or the named beneficiary under a policy or contract executed by the insurer on or after October 1, 2009, the trial or appellate court is authorized to award reasonable attorney's fees. If attorney's fees are awarded, the award must be included in the judgment or decree rendered in the case.</p>	<p><i>Although the attorney's fee provision governing admitted insurers in §627.428, F.S., includes an exclusion of attorney's fee awards in certain life insurance policies and annuity contracts, which are not applicable in the surplus lines context, the attorney's fee provision in the bill is virtually identical to the provision in Chapter 627, F.S.</i></p>
pp. 6–7, §626.9374	<p>7. The bill creates §626.9374, F.S., to provide for notices to insureds regarding certain liability assumed with deductibles and coinsurance. For instance, the bill provides that a surplus lines personal lines residential property insurance policy issued on or after October 1, 2009, that contains a separate hurricane or wind deductible must place the following language in 14-point font on the face of the policy:</p> <p style="text-align: center;">THIS POLICY CONTAINS A SEPARATE DEDUCTIBLE FOR HURRICANE OR WIND LOSSES, WHICH MAY RESULT IN HIGH OUT-OF-POCKET EXPENSES TO YOU.</p> <p>8. Similarly, any surplus lines personal lines residential property insurance policy issued on or after October 1, 2009, containing a coinsurance provision applicable to hurricane or wind losses must include the following language on the face of the policy in 14-point font:</p> <p style="text-align: center;">THIS POLICY CONTAINS A CO-PAY PROVISION THAT MAY RESULT IN HIGH OUT-OF-POCKET EXPENSES TO YOU.</p>	<p><i>Although these provisions are almost identical to the provisions included in §627.701(4), F.S., relating to admitted insurers, Chapter 627, F.S., provides some additional requirements for insurers. For example, existing law requires admitted insurers to display the actual dollar value of the hurricane deductible on the declarations page of the policy and on the renewal declarations page for personal lines residential property insurance policies. For any personal lines residential property insurance policy containing an inflation guard rider, the admitted insurer must notify the policyholder of the possibility that the hurricane deductible may be higher than indicated when loss occurs due to application of the inflation guard rider. Finally, other detailed provisions governing hurricane deductibles for admitted policies covering a risk valued at less than \$500,000 are included in Chapter 627, F.S.</i></p>
p. 6	<p>9. The bill provides that the amendments to §626.913, F.S., in this bill (the clarification above that Chapter 627, F.S., does not apply to surplus lines insurers) are remedial in nature and operate retroactively to the regulation of surplus lines insurers from October 1, 1988, except with respect to lawsuits that are filed on or before May 15, 2009.</p>	<p><i>October 1, 1988, was chosen for the retroactivity date because that was the effective date of the law that originally added the surplus lines exemption to Chapter 627, F.S.</i></p> <p><i>FAIA lobbyists worked with other insurance industry lobbyists to advocate the passage of this bill with a retroactivity clause which would also operate to stop existing and future class action lawsuits regarding surplus lines coverages. However, the Legislature forced a compro-</i></p>

SUBJECT, BILL PAGES AND/OR STATUTE #	FINAL PROVISION	COMMENTS
p. 6	<p>10. This bill provides that if any provision of the bill or the application of the bill is held invalid, the invalidity will not affect other provisions or applications of the bill, and the other provisions can be given effect without the invalid provision or application.</p> <p>Effective date: June 11, 2009, except as otherwise provided. Chapter No. 2009-166, LOF.</p>	<p><i>mise between the insurance industry and the trial lawyers, which resulted in several “new” statutory sections being made applicable to surplus lines insurers beginning October 1, 2009, and which allowed existing lawsuits and those filed by May 15, 2009 to continue.</i></p> <p><i>This is the bill’s severability clause which was included in the bill in the event a court later declares that the retroactivity clause in the bill is unconstitutional.</i></p>

WORKERS' COMPENSATION

Workers' Compensation Attorney Fees, CS/HB 903

p. 1, §440.34(1)	<p>1. To put this issue in historic perspective, in 2003, the Florida Legislature enacted SB 50A, a comprehensive reform of Florida’s workers’ compensation system. A key part of that reform package was restrictions on plaintiff’s attorney fees based on benefits secured by the attorney’s efforts. Under the 2003 reforms, those fees were limited to:</p> <ul style="list-style-type: none"> ◆ 20 percent of the first \$5,000 of benefits secured; ◆ 15 percent of the next \$5,000 of benefits secured; ◆ 10 percent of the remaining benefits secured during the first 10 years after the claim is filed; and, ◆ Five percent of the benefits secured after 10 years. <p>2. In October 2008, the Florida Supreme Court decided the case of <u>Murray v. Mariner Health and ACE USA</u>. In that decision, the high court ruled that, when the fee schedule was read together with a provision that entitles certain prevailing claimants to a “reasonable attorney’s fee,” it created an ambiguity as to whether the fee schedule was the sole basis for determining a reasonable attorney’s fee. In deciding for the plaintiff, the</p>	<p><i>As a result of the reform package, Florida’s WC system went from being one of the most expensive in the nation, to one of the best.</i></p> <p><i>Since the enactment of SB 50A, the OIR has approved six consecutive rate decreases, resulting in a cumulative decrease of the overall statewide average rate by more than 60 percent.</i></p> <p><i>As a direct result of that decision, the OIR granted a rate increase of 6.4 percent, effective April 1, 2009, with the National Council on Compensation Insurance (NCCI) predicting the need for another double-digit increase starting January 1, 2010.</i></p>
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SUBJECT, BILL PAGES AND/OR STATUTE #	FINAL PROVISION	COMMENTS
p.3, §440.34(2)	<p>Court applied what is known as the <u>Lee Engineering</u> standards, which take into account factors such as the number of hours in prosecuting the claim and degree of difficulty of the case, just to name a few.</p> <p>3. The bill clarifies that the Legislature really intended for the attorney fee schedule to be the sole provision to be used in awarding a reasonable attorney fee. The only exception will be medical-only claims, in which case the Judge of Compensation claims may approve an alternative attorney's fee not to exceed \$1,500, only once per accident, based on a maximum hourly rate of \$150 per hour. Under the bill, the attorney's fees in WC cases will be calculated in the manner that they had been from the effective date of the 2003 reform up to the decision in <u>Murray</u>.</p> <p>Effective date: July 1, 2009. Chapter No. 2009-94, LOF.</p>	<p><i>The NCCI has indicated that as soon as the bill becomes effective, they will lower the rate by the same amount as the <u>Murray</u> decision increased it and will not file for the additional <u>Murray</u>-indicated increase for next year.</i></p> <p><i>Some carriers have expressed concern that, if the rate increase is reversed and the Supreme Court in a later case finds the fee schedule unconstitutional, then the system could be exposed to years of unfunded losses. However, proponents of the change expressed confidence that the law is constitutional and that there would be no unfunded losses. Only time will tell which side is correct.</i></p>

Workers' Compensation Self-Insurance, CS/CS/HB 845

p. 2, §624.4626	<p>1. This bill creates a new §624.4626, F.S., allowing two or more electric cooperatives organized pursuant to Chapter 425 to operate a self-insurance fund for the purpose of pooling and spreading liabilities of its group members for WC.</p> <p>2. A self-insurance fund formed under this new chapter must:</p> <ul style="list-style-type: none"> ◆ Require that every member of the fund be jointly and severally liable for the obligations of the fund. ◆ Maintain a continuing program of excess insurance coverage and reserve evaluation to protect the financial stability of the fund in an amount and manner determined by a qualified and independent actuary. ◆ Subscribe to, or be a member of, a rating organization as prescribed in §627.231, F.S. 	<p><i>Under current law, there are eight types of self-insurance funds, ranging from commercial self-insurance funds to hospital alliances. They have varying degrees of governmental oversight and regulation.</i></p>
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SUBJECT, BILL PAGES AND/OR STATUTE #	FINAL PROVISION	COMMENTS
	<ul style="list-style-type: none"> ◆ Employ an independent CPA to do year-end financial statements. ◆ Have a governing body made up of a representative from each fund member. ◆ Limit the membership of the fund to Florida electric cooperatives, their subsidiaries, and the current members of the Florida Rural Electric Self-Insurer's Fund. ◆ At renewal, provide the members of the Fund with a disclosure that the fund is not regulated by the OIR. 	
p. 3, §624.4626(2)	<p>3. A self-insurance fund that meets the requirements of the above is subject to the assessments of the WC Administrative Trust Fund and the Special Disability Trust Fund, but <u>is not</u> subject to any of the other provisions of §624.4621, F.S., and <u>is not</u> required to file any report with the OIR under §440.38(2)(b), F.S., which is uniquely required of group self-insurers qualified under §624.4621, F.S.</p>	<p><i>This takes them out from under regulation by the OIR. They must, however, still pay premium taxes, but at a reduced 1.6 percent rate, rather than the 1.75 percent rate required of carriers.</i></p>
p. 3, §626.89	<p>4. It specifies the qualifications of an authorized self-insurance fund administrator and changes the reporting period for the administrator's audited financial statement.</p>	<p><i>The bill changes the reporting period for insurance administrators of a governmental self-insurance program or of a university from calendar year to a fiscal year.</i></p>
p. 5, §631.904	<p>5. The bill excludes independent educational institution self-insurance entities and electric cooperatives from the definition of those who participate in the Florida Workers' Compensation Insurance Guaranty Association.</p>	
p. 1, §624.4621(1)	<p>6. As to group self-insurance funds established under §624.4621, F.S., each of their applications for WC coverage must contain, in boldface and in not less than 10-point type, the following statement:</p> <p style="padding-left: 40px;">This is a fully assessable policy. If the fund is unable to pay its obligations, the policyholders must contribute, on a pro rata basis, the money necessary to meet any unfilled obligations.</p>	<p><i>The original draft of this legislation required the disclosure to be in a "color contrasting font." Group self-insurance funds are required by §440.585, F.S., to use contrasting color to explain their contingent liability obligations when joining the fund. In today's age of doing business electronically, this requirement of a two-color application for WC coverage was impractical because funds could not email or fax applications to insureds. The change in CS/ HB 845 allows group funds to use boldface instead of contrasting color, preserving the disclaimer while allowing increased ease of transacting business for the fund, the agent, and the client.</i></p>

SUBJECT, BILL PAGES AND/OR STATUTE #	FINAL PROVISION	COMMENTS
p. 2, §624.4621(1)(a)	<p>7. In an effort from keeping the fund members from later denying that they understood that they could be liable for assessment, the bill provides that, if the application is signed by the applicant, the applicant is deemed to have made an informed, knowing acceptance of the assessment liability that exists as a result of participation in the fund.</p> <p>Effective date: July 1, 2009. Chapter No. 2009-116, LOF.</p>	

MOTOR VEHICLE INSURANCE

Dori Slosberg and Katie Marchetti Safety Belt Law, CS/SB 344

pp. 1–2, §316.614	<p>1. This bill amends the Florida Safety Belt Law to provide for primary enforcement of the safety belt law for operators and front seat passengers.</p> <p>2. The bill will allow law enforcement officers to stop motorists solely for not using their safety belts.</p> <p>3. The bill also removes from the list of exemptions to the safety belt law front seat passengers of a pickup truck in excess of the number of safety belts installed.</p> <p>Effective date: June 30, 2009. Chapter No. 2009-32, LOF.</p>	<p><i>Current law provides for secondary enforcement for operators and front seat passengers and primary enforcement for all passengers under 18 years of age.</i></p>
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Motor Vehicle Records, CS/CS/SB 1778

<p>MVR Fees p. 40, §321.23</p>	<p>1. The cost of obtaining a crash report from the state was increased from \$2 to \$10.</p> <p>2. The cost of obtaining a three-year driver's record was increased from \$2.10 to \$8 and the cost for a seven-year record went from \$3.10 to \$10.</p>	<p><i>As part of the Legislature's attempt to balance the budget without raising taxes, there were a host of "fee" increases, some of which could affect insurance agents.</i></p> <p><i>Current law, §627.7295(5)(b), F.S., allows an agent to charge the client for the actual cost of obtaining these reports. However, if the client is just "shopping" for cov-</i></p>
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SUBJECT, BILL PAGES AND/OR STATUTE #	FINAL PROVISION	COMMENTS
		<i>erage, the agent obtains the report as part of making a quote, and the driver decides not to purchase the coverage through that agent, it may be difficult to collect the expense, unless collected up front.</i>
	<p>Effective date: September 1, 2009. Chapter No. 2009-71, LOF.</p>	

Fees for First Responder Services, CS/SB 2282

pp. 1–2, §125.01045, §166.0446	<ol style="list-style-type: none"> 1. The bill creates a new section in Chapter 125, F.S., and a new section in Chapter 166, F.S., which prohibits counties and municipalities from imposing a fee or seeking reimbursement for costs incurred for services provided by first responders in response to a motor vehicle accident. 2. The bill excludes from the prohibited first responder fees costs to contain or clean up certain hazardous materials and costs for transportation and treatment provided by ambulance services licensed pursuant to current law. 3. The bill defines “first responder” as a law enforcement officer, firefighter, or an emergency medical technician or paramedic, including volunteer first responders. 	<p><i>This bill, supported by the major property and casualty insurance companies, was labeled by many as the “ban the crash tax bill.”</i></p> <p><i>“Ambulance services” includes both ground and air transportation.</i></p>
	<p>Effective date: July 1, 2009.</p>	

MISCELLANEOUS

Financial Instruments, CS/CS/CS/HB 569

FHCF Reimbursement Contracts pp. 5–7, §215.555	<ol style="list-style-type: none"> 1. Allows small insurers to purchase an additional amount of Florida Hurricane Catastrophe Fund (FHCF) reimbursement coverage up to \$10 million through December 2011. 	<i>This provision also passed in CS/CS/CS/HB 1495 (Property Insurance).</i>
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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
	<p>2. Specifies that the optional coverage retention as specified in the reimbursement contract shall be accessed before the mandatory coverage, but once the limit of coverage selected under this option is exhausted, the insurer's retention under the mandatory coverage shall apply.</p> <p>3. This coverage shall apply and be paid concurrently with the mandatory coverage.</p> <p>Effective date: July 1, 2009. Chapter No. 2009-140, LOF.</p>	

Premium Financing, HB 741

<p>§627.902</p>	<p>1. The bill specifies that paid in full discounts provided to a policyholder when premium payment is made in full at the beginning of the policy term is not prohibited by the premium financing statutes and is not premium financing as long as the discount is included in an insurance company's rate filing and is determined to be actuarially justified by the OIR in their rate filing review. Accordingly, valid paid in full discounts cannot be included in the calculation of premium finance charges under the premium financing statutes. The bill applies to paid in full discounts given by an insurance company or subsidiary for any line of insurance.</p> <p>Effective date: July 1, 2009. Chapter No. 2009-84, LOF.</p>	<p><i>Some insurance companies give insurance premium discounts to their policyholders that pay their insurance premium in full at the beginning of the policy term. If a paid in full discount is given, the policyholder receives the discount as a lower insurance rate; the discount is not a line item reduction in premium on the policyholder's insurance bill. Insurers providing paid in full discounts submit the details about the discount in the rate filing submitted to the OIR for approval of the company's insurance rates. In order for the discounts to be approved for use by the OIR, the discounts must be based on loss experience of the insurance company and be actuarially supported.</i></p> <p><i>Some policyholders have argued a paid in full discount should be included in the calculation of the premium finance charge. In cases where the premium difference for those policyholders who pay in installments and those who pay in full and receive a paid in full discount plus the premium financing charges charged by the insurer equal more than the premium financing statutes allow for charges, policyholders allege the insurer is charging an excessive premium finance charge not allowed by law.</i></p>
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SUBJECT, BILL PAGES AND/OR STATUTE #	FINAL PROVISION	COMMENTS
Professional Employee Leasing Organizations, CS/CS/SB 1062		
p. 1	1. The bill creates the “Accurate Employment Statistics Enhancement Act.”	<i>There are 127 professional employee leasing organizations (PEO) in Florida. They are one of the largest employers in the state, co-employing close to 700,000 employees and serving over 50,000 companies. It is critical that they keep and report accurate employment statistics to both the state and their insurers.</i>
p. 1, §443.036	2. The bill provides that it is the responsibility of the PEO to produce quarterly reports concerning the clients of the PEO and internal staff of the PEO itself.	<i>Currently, PEOs must report statistics twice a year to the state.</i>
p. 3, §443.1216	3. The bill requires that, in addition to other reports required by law, PEOs shall also report the following information for each client establishment and each establishment of the PEO: <ul style="list-style-type: none"> ◆ The trade or establishment name; ◆ The former unemployment compensation (UC) account number, if available; ◆ The former federal employer’s identification number (FEIN), if available; ◆ A description of the client’s primary business activity in order to verify or assign an industry code; ◆ The address of the physical location; ◆ The number of full-time and part-time employees who worked during, or received pay that was subject to UC taxes for, the pay period during the 12th of the month for each month of the quarter; ◆ The total wages subject to UC taxes paid during the calendar quarter; ◆ An internal ID code to uniquely identify each establishment of each client; ◆ The month and year that the client entered into the contract for service; and, ◆ The month and year that the client terminated the contract for services. 	<i>The reports go to the Labor Market Statistics Center within the Agency for Workforce Innovation and the data must match the data supplied to the state for unemployment compensation purposes.</i> <i>A report is not required for any calendar quarter preceding the third calendar quarter of 2010.</i> <i>While many of these items are currently being reported twice a year, the more comprehensive quarterly reports will give a better picture of what is happening in this labor force. Also, the requirement that these reports match the UC reports should lessen any manipulation of data.</i>
<p>Effective date: October 1, 2009. Chapter No. 2009-101, LOF.</p>		

SUBJECT, BILL PAGES AND/OR STATUTE #	FINAL PROVISION	COMMENTS
Health Insurance, CS/SB 1122		
p. 1, §627.638(2)	<ol style="list-style-type: none"> 1. Under current Florida law, a health insurance policy that insures against loss of expense due to hospital confinement or due to medical and related services shall, when assignment is made by the insured, pay benefits directly to recognized hospital, licensed ambulance provider, doctor, or other person who provided the health care services, <u>unless otherwise provided in</u> the insurance contract. 2. Current law also provides that payment to a medical provider from an insurer may not be more than the payment due to an insured when an assignment of benefits is not made. 3. The bill <u>requires</u> insurers to make payments to <u>any provider</u> whether under contract with the insurer or not, if the insured makes a written assignment of benefits. Payment may not be more than would have been paid to a provider under contract with the insurer. 	<p><i>Under current law, direct payment by an insurer is only <u>required</u> for emergency services and care, and many policies prohibit the assignment of benefits to other out-of-network providers. Generally, an insurer will permit the policyholder to make an assignment of benefits for direct payment to providers with whom the insurer has contracted to be part of a network such as a preferred provider organization (PPO), but for services by providers outside of the network, the insurer will pay the benefits directly to the policyholder and the provider must seek payment from them.</i></p> <p><i>Current law does not prohibit an out-of-network provider from balance billing the insured the difference in the amount paid by the insurer and the amount charged by the out-of-network provider.</i></p> <p><i>Health care insurers contend that this bill will take away their ability to negotiate reduced rates for in-network providers and will cause overall health care insurance costs to increase.</i></p>
p. 2	<ol style="list-style-type: none"> 4. Recognizing that there is the potential for increased costs, the bill provides for a study to be performed by the Office of Policy Analysis and Government Accountability and presented to the speaker of the House and Senate president by March 1, 2012. If the study shows that these amendments have caused the third-party administrator of the state group plan to suffer a net loss of physicians from its preferred provider plan network and, as a direct result, caused an increase in costs to the state group plan, then this new law stands repealed effective July 1, 2012. 	<p><i>Opponents to the change, primarily Blue Cross/Blue Shield who acts as third-party administrator for the state group health plan, contend that if a physician can get the same level of reimbursement whether or not they are in the network, then there will be no incentive on the physician's part to join the network and provide services at a lower rate. According to them, this would drive up the cost of the state group plan.</i></p>
<p>Effective date: July 1, 2009 Chapter No. 2009-124, LOF.</p>		

SUBJECT, BILL PAGES AND/OR STATUTE #	FINAL PROVISION	COMMENTS
Professional Liability Insurance, CS/CS/SB 2252		
p. 2, §627.912(1)	1. The bill changes the criteria under which a claim against professional liability insurance must be reported to the state.	<i>Under current law, insurers providing professional liability insurance are required to report to the OIR whenever a “claim or action” against one of their insured is made and the claim results in: (1) a final judgment in any amount; (2) a settlement in any amount; or, (3) a final disposition of a medical malpractice claim resulting in no indemnity payment on behalf of the insured. The reporting under current law has been the subject of controversy, because there was no clear definition of what exactly was a claim.</i>
	2. The new criteria require a report be submitted if any of the following occur: <ol style="list-style-type: none"> <li data-bbox="464 800 1304 889">1. Entry of any judgment against the provider for which all appeals as a matter of right have been exhausted or for which the period for filing such an appeal has expired; 	
p. 3	2. The execution of an agreement to settle damages allegedly arising from the provision of professional services. The agreement must pay at least \$1. If applicable statutes require court approval before the agreement becomes final, the duty to report does not arise until approval is given.	
p. 3	3. The final payment of any indemnity money on behalf of the provider for damages alleged in the provision of professional services.	
p. 3	4. Final disposition of a claim for which no indemnity was made on behalf of the insured, but for which there were loss adjustment expenses paid in excess of \$5,000. “Final disposition” is defined to mean the insurer has brought down all reserves and closed its files.	<i>Earlier drafts of the bill had a \$2,500 threshold.</i>

SUBJECT, BILL PAGES AND/OR STATUTE #	FINAL PROVISION	COMMENTS
p. 4	3. After any calendar year in which no claim or action for damages was closed, the entity shall file a “no claim submission” report.	<i>It shall be filed with the OIR by April 1 of each calendar year in which there was no action in the prior year.</i>
p. 4	4. If a claim is initially opened and then closed, and is subsequently reopened, the reopened claim shall be treated as a new claim and reported like any other new claim.	
p. 4	5. An insurer is not required to file a new or amended report on a claim more than one year after submitting an initial report.	
	Effective date: October 1, 2009.	

This summary & analysis was prepared by the

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