HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 465 Insurance
SPONSOR(S): Insurance & Banking Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Insurance & Banking Subcommittee		Lloyd	Luczynski

SUMMARY ANALYSIS

The bill makes the following changes regarding insurance:

- **Consumer Complaint Ratio Calculation** – specifies that third-party vendors, as an assignee of policy benefits, are not insurance consumers and will not be used for purposes of calculating complaint ratios.
- **Foreign Insurer Stock Valuation** – provides that the stock of a subsidiary corporation or related entity of a foreign insurer is exempt from certain limitations on valuation and investment requirements for solvency evaluation purposes in certain circumstances, including permissibility in the insurer's domicile state.
- **Surplus Lines Export Eligibility** – lowers the home value threshold from $1,000,000 to $700,000 for exporting a homeowner's property insurance for a residential dwelling to a surplus lines insurer following a single coverage rejection.
- **Personal Financial and Health Information Privacy** – incorporates a recent amendment of the Gramm-Leach-Bliley Act for purposes of privacy standards applicable certain notices required by rules adopted by the Department of Financial Services and the Financial Services Commission.
- **Execution of Insurance Policies** – provides that an insurer may elect to issue an insurance policy without being executed by one of several specified insurer representatives and the policy is not invalid despite not being executed.
- **Notice of Policy Change** – requires that a property and casualty insurer summarize policy changes on the required Notice of Change in Policy Terms that is issued at policy renewal, rather than merely issuing a notice (i.e., requires content more informative than merely the phrase "Notice of Change in Policy Terms").
- **Property Insurance Claim Mediation** – provides that a third-party assignee may request mediation of a property insurance claim; except, an insurer is not required to participate in a mediation requested by the third-party assignee.
- **Proof of Mailing** – permits motor vehicle insurers to use the Intelligent Mail barcode, or similar method approved by the United States Postal Service, to document proof of mailing of certain required notices.
- **Transportation Network Company Related Automobile Liability Insurance Exclusions** – allows private passenger motor vehicle insurers to generally exclude coverage of transportation network services provided by a named insured, rather than limiting the exclusion to specific motor vehicles.
- **Confidentiality of Documents Submitted to the Office of Insurance Regulation** – expands the confidentiality of documents submitted to the Office of Insurance Regulation (OIR) under Own-Risk and Solvency Assessment requirements to make them inadmissible as evidence in any private civil action, regardless of from whom they were obtained, rather than only when they are obtained from OIR.
- **Reciprocal Insurer Reserve Requirements** – revises unearned premium reserve requirements applicable to reciprocal insurers.
- **Exception to Required Insurance Licensure** – expands a licensure exemption that relieves sellers of travel insurance from required health insurance agent licensing to allow anyone to sell such prepaid limited health service contracts without licensure, if the contract only relates to air ambulance coverage.

The bill has no impact on state or local government revenues or expenditures. It has positive and negative impacts on the private sector.

The bill is effective upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Consumer Complaint Ratio Calculation

The Chief Financial Officer (CFO) is an elected member of the Cabinet, serves as the chief fiscal officer of the State of Florida[1] and is designated as the State Fire Marshal.[2] The CFO is the head of the Department of Financial Services (DFS). Effective January 2003, the Department of Insurance, Treasury, State Fire Marshal and the Department of Banking and Finance merged into DFS. DFS consists of many divisions and several specialized offices.[3] Among these is the Division of Consumer Services (Division). The division deals with consumer issues and complaints related to the jurisdiction of DFS and the Office of Insurance Regulation (OIR). The division:

- Receives insurance inquiries and complaints from consumers;
- Prepares and disseminates information as DFS deems appropriate to inform or assist consumers;
- Provides direct assistance and advocacy for consumers;
- Reports potential violations of law or applicable rules by a person or entity licensed by DFS or OIR to the appropriate division within DFS or OIR, as appropriate; and
- Designates an employee of the division as the primary contact for consumers on issues relating to sinkholes.[4]

Any person licensed by DFS or OIR, including insurance companies, are required to respond to the division within 20 days after written receipt of a request for information relevant to a consumer complaint. The response must address the issues and allegations raised in the consumer complaint. The licensee is subject to the following administrative fines for failure to comply with the response requirement:

- For licensed entities (e.g., insurers):
  - Up to $2,500, per violation.
- For individuals licensees:
  - $250, for the first violation;
  - $500, for the second violation; and
  - $1,000, for the third or subsequent violation.

Among other reporting requirements, OIR is required to publish a complaint ratio each year for the top 10 insurers according to market share in each line of insurance based upon information provided to OIR by DFS.[5]

Generally, an agreement assigning contract benefits allows a third party to collect and enforce collection of insurance proceeds owed to the policyholder directly from the insurance company. Consequently, the proceeds are not paid to the policyholder. Assignment agreements are commonly used in health insurance and personal injury protection insurance. In health insurance, a policyholder typically assigns his or her benefits for a covered medical service to the health care provider. Thus, the treating physician is paid directly from the insurer. Assignment agreements are becoming more common in property insurance claims, particularly in water damage claims where a homeowner assigns his or her benefits from the property insurance policy to a contractor, water remediation company, or roofer who repairs the damaged property. These assignees are “third-party vendors.”

[1] FLA. CONST. art. IV, s. 4.
[2] s. 633.104(1), F.S.
[3] s. 20.121, F.S.
[4] s. 624.307(10)(a), F.S.
[5] s. 624.313(1)(i), F.S.

Assignment agreements used by some vendors attempt to transfer broad rights under the policy and combine the assignment with authorization to perform services described only in general terms.[6] "When a party assigns a contract, the party assigns all equitable and legal interest in the contract to the assignee. The assignee thereafter stands in the shoes of the assignor and may enforce the contract against the original obligor in the assignee's own name." [7] Thus, assignment of the right to receive payment under an insurance contract necessarily assigns the right to enforce payment.

Effect of the Bill

The bill specifies that third-party vendors, as assignees of policy benefits, are not insurance consumers and will not be used for purposes of calculating complaint ratios.

Foreign Insurer Stock Valuation

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

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

- If the insurer's surplus, including investments in subsidiaries, does not exceed $100 million, the maximum percentage of investment in the subsidiaries may not exceed the lesser of:
  - 10 percent of admitted assets;[8] or,
  - 50 percent of the surplus in excess of minimum required surplus.[9]
- If the insurer's surplus, including investments in subsidiaries, is $100 million, or more, the maximum percentage investment in the subsidiaries may not exceed:
  - 25 percent of admitted assets.

The valuation of the stock held in the subsidiary may not exceed the net value established using only the assets of the subsidiary eligible under part II of ch. 625, F.S. The valuation of stocks and securities must be consistent with methods published by the National Association of Insurance Commissioners (NAIC).[10]

Part II of ch. 625, F.S., regulates the valuation of investments by domestic insurers and commercially domiciled insurers.[11] However, the law also provides that "[t]he investment portfolio of a foreign or alien insurer shall be as permitted by the laws of its domicile if of a quality substantially as high as that required under [ch. 625, F.S.] for similar funds of like domestic insurers."[12]

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[6] *See, e.g.*, ERICKSON'S, *Contract for Services, Assignment of Benefits*, http://ericksonsdrying.com/contact-us/contract-for-services-assignment-of-benefits/ (last visited Jan. 14, 2018) (assigning "any and all insurance rights, benefits, and proceeds under applicable insurance policies …; authorizing release of any and all information requested by Erickson's its representative, or its attorney to [sic] the direct purpose of obtaining actual benefits to be paid …; waiv[ing] privacy rights …; appointing Erickson's as attorney-in-fact, authorizing Erickson's to endorse [insured's] name, and to deposit insurance checks ….").

[7] 3A Fla. Jur 2d *Assignments* § 34 (Nov. 2015).

[8] "Admitted assets" are "assets recognized and accepted by state insurance laws in determining the solvency of insurers and reinsurers. To make it easier to assess an insurance company's financial position, state statutory accounting rules do not permit certain assets to be included on the balance sheet. Only assets that can be easily sold in the event of liquidation or borrowed against, and receivables for which payment can be reasonably anticipated, are included in admitted assets." https://www.iii.org/resource-center/iii-glossary/A (last visited Jan. 15, 2018).

[9] s. 625.151(3)(a), F.S.

[10] s. 625.151(4), F.S.

[11] s. 625.301, F.S

[12] s. 625.340, F.S.

There are multiple private organizations that engage in the evaluation and rating of insurance companies for the purposes of identifying the financial strength of insurers.[13] These financial strength ratings allow potential investors to make informed decisions regarding possible investment in the rated insurer. The rating companies use similar terminology, but each has a proprietary method to establish their rating results. While the rating results are similar, it is necessary to review the rating organization's own explanation of its approach and methods to understand the subtle differences that occur when a particular insurer is rated by multiple rating organizations. A.M. Best's Financial Strength Rating is divided between "Secure," with ratings between A++ and B+, or "Vulnerable," with ratings of B or lower. Among the "Secure" ratings, A++ and A+ are described as "Superior," A and A- are described as "Excellent," and B++ and B+ are described as "Good" in terms of A.M. Best's opinion of the company's ability to meet financial obligations.[14]

Effect of the Bill

The bill provides that the stock of a subsidiary corporation or related entity of a foreign insurer are exempt from the limitations on valuation and investment requirements ss. 625.151(3) and 625.325, F.S., for solvency evaluation purposes. The exemption applies if the investment is allowed under the laws of the insurer's domicile state if that state is a member of NAIC. In addition, the subsidiary's stock must be valued by NAIC's Securities Valuation Office (SVO)[15] with a rating of 1, 2, or 3 or be exempt from NAIC filing and carry a rating assigned by a nationally recognized statistical rating organization that is equivalent to SVO's rating.[16]

Surplus Lines Export Eligibility

Surplus lines insurance refers to a category of insurance for which the admitted market is unable or unwilling to provide coverage.[17] There are three basic categories of surplus lines risks:

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

Surplus lines insurers are not "authorized" insurers as defined in the Insurance Code,[18] which means they do not obtain a certificate of authority from OIR to transact insurance in Florida.[19] Rather, surplus lines insurers are "unauthorized" insurers,[20] but may transact surplus lines insurance if they are made eligible by OIR.

"To export" a policy means to place it with an unauthorized insurer under the Surplus Lines Law.[21] Unless an exception applies, before an insurance agent can place insurance in the surplus lines market, the insurance agent must make a diligent effort to procure the desired coverage from admitted insurers.[22] "Diligent effort" means seeking and coverage being rejected from at least three authorized insurers in the admitted market; however, if the cost to replace a residential dwelling is $1,000,000 or

[13] Financial strength rating organizations include: A.M. Best (www.ambest.com), Fitch (www.fitchratings.com), Moody's Investor Services (www.moodys.com), Standard & Poor's (www.standardandpoors.com), and Demotech (www.demotech.com).
[14] See A.M. BEST COMPANY, Guide to Best's Financial Strength Ratings, http://www.ambest.com/ratings/guide.pdf (Last visited Jan. 15, 2018).
[15] http://www.naic.org/svo.htm (last visited Jan. 14, 2018).
[16] NAIC has published tables of equivalent ratings comparing SVO ratings to ratings published by nationally recognized statistical rating organizations. http://www.naic.org/documents/svo_naic_aro.pdf (last visited Jan. 14, 2018).
[17] The admitted market is comprised of insurance companies licensed to transact insurance in Florida. The administration of surplus lines insurance business is managed by the Florida Surplus Lines Service Office. s. 626.921, F.S.
[18] The Insurance Code is chapters 624-632, 634, 635, 636, 641, 642, 648, and 651, F.S. s. 624.01, F.S.
[19] s. 624.09(1), F.S.
[20] s. 624.09(2), F.S.
[21] s. 626.914(3), F.S.
[22] s. 626.916(1)(a), F.S.

more, then only one coverage rejection is needed prior to export. In that case, diligent effort is seeking and being denied coverage from at least one authorized insurer in the admitted market.[23] The law further specifies that:[24]

- The premium rate for policies written by a surplus lines insurer cannot be less than the premium rate used by a majority of authorized insurers for the same coverage on similar risks;
- The policy exported cannot provide coverage or rates that are more favorable than those that are used by the majority of authorized insurers actually writing similar coverages on similar risks;
- The deductibles must be the same as those used by one or more authorized insurers, unless the coverage is for fire or windstorm; and
- For personal residential property risks, [25] the policyholder must be advised in writing that coverage may be available and less expensive from Citizens Property Insurance Corporation (Citizens).

As of January 1, 2017, Citizens decreased the maximum coverage limit for dwellings from $1,000,000 to $700,000 statewide, except for Miami-Dade and Monroe counties.[26]

Effect of the Bill

The bill allows homeowner's property insurance for a residential dwelling with a replacement cost of $700,000 or more to be exported to a surplus lines insurer following a single coverage rejection. This reduces, from three to one, the number of coverage rejections required prior to exportation for homes valued between $700,000 and $1,000,000.

Personal Financial and Health Information Privacy

DFS and the Financial Services Commission (Commission) are required to adopt rules governing the use of a consumer's non-public personal financial and health information by regulated entities.[27] The rules must be consistent with and not more restrictive than the requirements of Title V of the Gramm-Leach-Bliley Act of 1999. However, in December 2015, the Gramm-Leach-Bliley Act was amended by the Fixing America's Surface Transportation (FAST) Act.[28] The law governing DFS and Commission rules on privacy of consumer's non-public personal financial and health information does not yet incorporate this change. FAST added the following exception to the annual notice requirement found in Section 503 of the Gramm-Leach-Bliley Act:[29]

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

[23] s. 626.914(4), F.S.
[24] s. 626.916(1), F.S.
[25] Personal residential policies include homeowners, mobile homeowners, dwelling fire, tenants, condominium unit owners, and similar policies.
[26] https://www.citizensfla.com/-/20160726-maximum-coverage-limit-decreased (last visited Jan. 14, 2018).
[27] s. 626.9651, F.S.
[28] https://www.congress.gov/bill/114th-congress/house-bill/22/text (last visited Jan. 14, 2018).
[29] 15 U.S.C. §6803.

Effect of the Bill

The bill incorporates FAST's amendment of the Gramm-Leach-Bliley Act for purposes of privacy standards applicable to rules adopted by DFS and the Commission. This makes ineffectual and prohibits any rule that would require an annual notice that would be exempted by FAST.

Execution of Insurance Policies

Part II of ch. 627, F.S., specifies numerous requirements applicable to insurance contracts.[30] These requirements apply to all aspects of the insurance transaction from the initial application to the cancellation, non-renewal, or lapse of the policy. This includes requirements concerning the execution of the policy.[31] The policy must be executed in the name of and on behalf of the insurer by its officer, attorney in fact, employee, or representative duly authorized by the insurer. A facsimile signature of one of the specified persons is acceptable and the policy cannot be made invalid because the facsimile signature is that of an individual who did not have the authority to execute the policy on the date of issuance.

Effect of the Bill

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

Notice of Policy Change

An insurer is prohibited from changing policy terms at renewal, unless they issue a notice of change in policy terms.[32] A change in policy terms includes, the modification, addition, or deletion of any term, coverage, duty, or condition from the previous policy, not including typographical or scrivener's errors or the application of mandated legislative changes. The notice may not be used to add optional coverages that increase premium, unless the policyholder affirmatively accepts the optional coverage.

The policyholder must receive advance written notice of the change.[33] If the insurer fails to issue the notice, coverage continues until the next renewal occurs (with proper service of notice) or replacement coverage is obtained. The notice is required to be titled a "Notice of Change in Policy Terms." However, there is no explicit requirement for any other specific content of the notice. OIR has not adopted a rule interpreting the applicable statute.

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

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

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

[30] Section 627.401, F.S., provides limited exceptions to the applicability of part II of ch. 627, F.S.
[31] s. 627.416, F.S.
[32] s. 627.43141(2), F.S.
[33] The written notice may be issued with the notice of renewal premium or consistent with the timeline for issuing a notice of non-renewal provided by law. *Id.*

Effect of the Bill

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

Property Insurance Claim Mediation

DFS administers alternative dispute resolution programs for various types of insurance. DFS has mediation programs for property insurance[34] and automobile insurance[35] claims. DFS has a neutral evaluation program, similar to mediation, for sinkhole insurance claims.[36] DFS approves mediators used in the two mediation programs and certifies the neutral evaluators used in neutral evaluations for sinkhole insurance claims.[37]

For property insurance claims[38] involving personal lines and commercial residential claims, only the policyholder, as a first-party claimant, or the insurer may request mediation under DFS' program.[39] This means that third parties cannot utilize the program. This is true even if the policyholder assigns their policy benefit rights to the third party.[40] The insurer must notify the policyholder of the right to mediation under the program upon receipt of the claim. The mediation costs are generally the responsibility of the insurer.

Effect of the Bill

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

Proof of Mailing

When cancelling or non-renewing a policy, motor vehicle insurers are required to mail the cancellation or non-renewal to the first named insured on the policy and the applicable insurance agent at least 45 days prior to the effective date of the cancellation or non-renewal. In the case of non-payment of premium, only a 10-day notice is required. A policy that has been in effect for less than 60 days cannot be cancelled. The reason for the cancellation must be included in the notice. The insurer may also transfer the policy to an insurer under the same ownership or management upon proper notice. For each of these required notices the insurer must use United States postal proof of mailing, certified mail, or registered mail.[41]

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[34] s. 627.7015, F.S.
[35] s. 626.745, F.S.
[36] s. 627.7074, F.S.
[37] ss. 627.7015, 627.7074, and 627.745, F.S.
[38] An eligible claim is one that does not involve: suspected fraud; there is no coverage under the policy; one where the insurer reasonably believes the policyholder has made material misrepresentations relevant to the claim and request for payment has been denied for that reason; one for less than $500 (unless agreed to by the parties); or, windstorm or hurricane loss if the required notice of claim was not issued in compliance with law. s. 627.7015(9), F.S.
[39] Policyholders may have the assistance of legal counsel during the mediation process. Litigants in the county and circuit court may be referred to the program. Commercial coverages, private passenger motor vehicle coverages, and liability coverages of property insurance policies are not eligible for the property insurance mediation program. s. 627.7015(1), F.S.
[40] s. 627.7015(1), F.S.
[41] s. 627.728, F.S. While certified mail and registered mail are both services currently offered by the United States Postal Service (USPS), "proof of mailing" is not a service offered. https://www.usps.com/ship/insurance-extra-services.htm (last visited Jan. 14, 2018). However, "certificate of mailing" is a service offered that documents presentment of the item to USPS.

Effect of the Bill

The bill permits use of the Intelligent Mail barcode,[42] or similar method approved by the United States Postal Service, to be used to establish proof that required motor vehicle insurance notices of cancellation, non-renewal, or transfer of insurer were mailed.

Transportation Network Company Related Automobile Liability Insurance Exclusions

While a transportation network company (TNC) driver[43] is logged on to the TNC's digital network but is not engaged in a prearranged ride, a TNC[44] (i.e., a ridesharing company like Uber, Lyft, and Sidecar) or TNC driver must have automobile insurance that provides:

- Primary automobile liability coverage of at least $50,000 for death and bodily injury per person, $100,000 for death and bodily injury per incident, and $25,000 for property damage; and
- Personal injury protection benefits that meet the minimum coverage amounts required under the Florida Motor Vehicle No-Fault Law.[45] The amount of insurance required is $10,000 for emergency medical disability, $2,500 non-emergency medical, and $5,000 for death.[46]

A TNC driver is required to secure coverage while they are logged on to the TNC's digital network, but if the driver fails to do so, the TNC is required to provide coverage for the driver and vehicle. An insurer that provides an automobile liability insurance policy under part XI of ch. 627, F.S.,[47] may exclude any and all coverage afforded under the policy issued to an owner or operator of a TNC vehicle for any loss or injury that occurs while a TNC driver is logged on to a digital network or while a TNC driver provides a prearranged ride.[48] This right to exclude all coverage may apply to any coverage included in an automobile insurance policy, including, but not limited to:

- Liability coverage for bodily injury and property damage;
- Uninsured and underinsured motorist coverage;
- Medical payments coverage;
- Comprehensive physical damage coverage;
- Collision physical damage coverage; and
- Personal injury protection.

The exclusions apply notwithstanding any requirement under the Financial Responsibility Law of 1955.[49] An automobile insurer that excludes the coverage described above does not have a duty to defend or indemnify any claim expressly excluded thereunder. Some insurers offer policy addendums for the driver to purchase coverage of TNC activities.

Automobile liability insurance policies cover automobiles identified on the policy and the policyholder when operating other motor vehicles. However, s. 627.728(8)(b)1., F.S., arguably limits TNC related exclusions to specific motor vehicles. It uses the specific term "that vehicle" rather than a general term

[42] https://postalpro.usps.com/ (last visited Jan. 14, 2018).
[43] A "TNC driver" means an individual who: 1. Receives connections to potential riders and related services from a transportation network company; and 2. In return for compensation, uses a TNC vehicle to offer or provide a prearranged ride to a rider upon connection through a digital network. s. 627.728(1)(f), F.S.
[44] "Transportation network company" or "TNC" means an entity operating in this state pursuant to this section using a digital network to connect a rider to a TNC driver, who provides prearranged rides. A TNC is not deemed to own, control, operate, direct, or manage the TNC vehicles or TNC drivers that connect to its digital network, except where agreed to by written contract, and is not a taxicab association or for-hire vehicle owner. An individual, corporation, partnership, sole proprietorship, or other entity that arranges medical transportation for individuals qualifying for Medicaid or Medicare pursuant to a contract with the state or a managed care organization is not a TNC. This section does not prohibit a TNC from providing prearranged rides to individuals who qualify for Medicaid or Medicare if it meets the requirements of this section. s. 627.728(1)(e), F.S.
[45] ss. 627.730-627.7405, F.S.
[46] s. 627.736, F.S.
[47] Part XI of Ch. 627, F.S., relates to motor vehicle and casualty insurance contracts.
[48] s. 627.728(8)(b), F.S.
[49] ch. 324, F.S.

like “a vehicle.” Arguably, current law allows a coverage exclusion applicable to a particular vehicle during use its as a TNC vehicle, but it does not explicitly allow a coverage exclusion applicable to the named insured(s) when operating as TNC driver using another vehicle, which is not listed on policy. In other words, a question arises over the coverage exclusion applies to a vehicle that the insured borrows and uses as a TNC vehicle.

Effect of the Bill

The bill allows private passenger motor vehicle liability insurers to generally exclude coverage of TNC related activities provided by a named insured, rather than limiting the exclusion to a specific motor vehicle.

Confidentiality of Documents Submitted to the Office of Insurance Regulation

In 2011, as part of NAIC’s Solvency Modernization Initiative, NAIC adopted a new insurance regulatory tool: the U.S. Own Risk and Solvency Assessment (ORSA). ORSA requires insurance companies to issue their own assessment of their current and future risk through an internal risk self-assessment process and allows regulators to form an enhanced view of an insurer’s ability to withstand financial stress, particularly on a holding company’s level.[50] In essence, an ORSA is an internal process undertaken by an insurer or insurance group to assess the adequacy of its risk management and current and prospective solvency positions under normal and severe stress scenarios. An ORSA requires insurers to analyze all reasonably foreseeable and relevant material risks (i.e., underwriting, credit, market, operational, liquidity risks, etc.) that could have an impact on an insurer’s ability to meet its policyholder obligations.

The “O” in ORSA represents the insurer’s “own” assessment of their current and future risks. Insurers and insurance groups are required to articulate their own judgment about risk management and the adequacy of their capital position. This is meant to encourage management to anticipate potential capital needs and to take action proactively, and serves as an early warning mechanism for insurance regulators. ORSA is not a one-off exercise - it is a continuous evolving process and should be a component of an insurer’s enterprise risk-management framework. Moreover, there is no mechanical way of conducting an ORSA; how to conduct the ORSA is left to each insurer to decide, and actual results and contents of an ORSA report will vary from company to company. The output is a set of documents that demonstrate the results of management’s self-assessment.

Effective January 1, 2018, ORSA is an NAIC accreditation standard for state insurance regulators. During the 2016 Regular Session, the Legislature passed CS/CS/HB 1422[51] and CS/CS/HB 1416[52] adopting ORSA requirements for Florida regulated insurers and providing a public record exemption for information produced to OIR in required ORSA filings, respectively.

The law requires insurers or insurance groups to:

- Maintain a risk management framework for identifying, assessing, monitoring, managing, and reporting on its material, relevant risks;
    - This requirement may be satisfied by being a member of an insurance group with a risk management framework applicable to the insurer’s operations.
- Conduct an ORSA at least annually (and whenever there have been significant changes to the risk profile of the insurer or the insurance group), consistent with and comparable to the process in the ORSA Guidance Manual;[53] and

[50] NAIC, *Own Risk and Solvency Assessment (ORSA)*, at http://www.naic.org/cipr_topics/topic_own_risk_solvency_assessment.htm (last visited Jan. 15, 2018).
[51] Ch. 2016-206, Laws of Fla.
[52] Ch. 2016-205, Laws of Fla.
[53] The bill defines “ORSA guidance manual” as the ORSA manual developed and adopted by NAIC. *See* NAIC, *ORSA Guidance Manual* (Jul. 2014), at http://www.naic.org/store/free/ORSA_manual.pdf (last visited Jan. 15, 2018).

- File an ORSA summary report, based on the ORSA Guidance Manual with their domestic regulator or lead state (for an insurance group), beginning in 2017, which must:
  - Be submitted once every calendar year;
  - Include notification to OIR of its proposed annual submission date by December 1, 2016; initial ORSA summary report must be submitted by December 31, 2017;
  - Include a brief description of material changes and updates from the prior year's report;
  - Be signed by the chief risk officer or chief executive officer responsible for overseeing the enterprise risk management process; provide a copy to the board of directors or appropriate board committee; and
  - Be prepared in accordance with the ORSA Guidance Manual; the insurer must maintain and make documentation and supporting information available for OIR examination.

The law provides that an ORSA summary report and certain other related information are confidential and exempt public record information. In addition, that information in required ORSA filings is privileged, may not be produced by OIR in response to a subpoena or discovery request directed to OIR, and, if such information is obtained from OIR, it is not admissible in evidence in any private civil action.[54]

Effect of the Bill

The bill expands the confidentiality of documents submitted to OIR under ORSA requirements to prohibit these documents from being admitted as evidence in a private civil action regardless of the source of the ORSA documents, rather than only when they are obtained from OIR.

Reciprocal Insurer Reserve Requirements

Reciprocal insurance is a risk-pooling alternative to stock or mutual insurance.[55] Reciprocal insurance involves an exchange of reciprocal agreements of indemnity among participants who are known as "subscribers."[56] The subscribers generally have something in common; for example, USAA is a well-known reciprocal insurer for U.S. military service members and their families.[57]

The agreements of indemnity are exchanged through an attorney-in-fact, whose powers are set forth by the subscribers.[58] "In general, the attorney in fact manages the reciprocal's finances and handles underwriting, claims administration and investments."[59]

Twenty-five or more persons domiciled in Florida may organize a domestic reciprocal insurer and apply to OIR for authority to transact insurance.[60] Reciprocal insurers may transact any kind of insurance other than life or title.[61]

Reciprocal insurers offering property insurance are required to maintain an unearned premium[62] reserve consistent with the requirement generally applicable to property insurers under the Insurance Code.[63] This reserve requirement ensures the availability of funds for transfer to loss reserves when losses are incurred during the policy period or refunds that become due before the premium is earned,

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[54] s. 628.8015(4), F.S.
[55] *See* Kevin Moriarty, *Twenty Things You'd Always Wanted to Know about Reciprocals (But May Not Have Thought to Ask)*, THE RISK RETENTION REPORTER, July 2003.
[56] ss. 629.011 and 629.021, F.S.
[57] *See* USAA, https://www.usaa.com/inet/pages/g_old_PC_Insurance_index (last visited Jan. 13, 2018).
[58] ss. 629.011 and 629.101, F.S.
[59] Moriarty, *supra* note 55.
[60] s. 629.081(1), F.S.
[61] s. 629.041(1), F.S.
[62] "Unearned premium" is the portion of a premium already received by the insurer under which protection has not yet been provided. The entire premium is not earned until the policy period expires, even though premiums are typically paid in advance. https://www.iii.org/resource-center/iii-glossary (last visited Jan. 13, 2018).
[63] s. 625.051, F.S. This section does not apply to title insurers. s. 625.051(5), F.S.

among other things. Premiums ceded to reinsurers for the purchase of reinsurance may be deducted from unearned premiums.

Property insurers are required to retain unearned premiums on reserve in the following proportions based upon the length of the policy period, as follows:

Policy Term	Proportion Required to be Reserved	
1 year or less		1/2
2 years	1st year	3/4
	2nd year	1/4
3 years	1st year	5/6
	2nd year	1/2
	3rd year	1/6
4 years	1st year	7/8
	2nd year	5/8
	3rd year	3/8
	4th year	1/8
5 years	1st year	9/10
	2nd year	7/10
	3rd year	1/2
	4th year	3/10
	5th year	1/10
Over 5 years		pro rata

In the alternative, insurers are allowed to calculate unearned premium reserves on monthly or more frequent pro rata basis. In other words, the insurer may reduce unearned premium reserves on a one-year policy at the rate of 1/12 per month or, for a two-year policy at 1/24 per month, and so on. Reciprocal insurers must calculate unearned premium reserves on a monthly or more frequent basis.[64]

NAIC has developed a model act for regulation of reciprocals. Section 7., Reserves, of NAIC Model Act 356, Model Indemnity Contracts Act,[65] provides for an unearned premium reserve, as follows:

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

Effect of the Bill

The bill revises the unearned premium reserve requirement that must be met by a reciprocal insurer, regardless of the line of insurance underwritten. The reciprocal insurer must retain 50 percent of “net

[64] s. 629.401(6)(b)24., F.S. OIR may require reciprocal insurers to calculate unearned premium reserves on a different time basis. Marine and transportation risk premiums are not earned until the trip is completed.
[65] http://www.naic.org/store/free/MDL-356.pdf (last visited Jan. 13, 2018).

written premiums" on policies having a policy period of one year or less. "Net written premiums" means premium payments made or due from subscribers after deducting subscriber fees. To take the deduction from "net written premiums" for subscriber fees, the power of attorney agreement must contain an explicit provision to return subscriber fees on a pro rata basis for cancelled policies. The bill requires an unearned premium reserve of $100,000, at all times, and provides a mechanism to return the reserve to that amount if it is not maintained at the required amount.

Exception to Required Insurance Licensure

Part I of ch. 636, F.S., requires OIR to license and regulate prepaid limited health service organizations (PLHSOs). These organizations are similar to health maintenance organizations (HMOs), but are limited to providing the following services: ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services, and pharmaceutical services.[66] A PLHSO may not offer inpatient or surgical hospital services or emergency services, except as such services are incidental to a limited health service. PLHSO enrollees are under a prepayment arrangement (i.e., either a prepaid per capita sum or a prepaid aggregate fixed sum) and receive services from an exclusive panel of providers such as physicians, dentists, health providers or other persons or institutions that are licensed in Florida to deliver limited health services.[67]

There are 23 authorized prepaid limited health service organizations which have received a certificate of authority to operate in Florida.[68] Only licensed and appointed health insurance agents may sell PLHSO contracts.[69]

The Department of Agriculture and Consumer Services (DACS) is responsible for registering "sellers of travel," which is any resident or nonresident who offers for sale, at wholesale or retail, prearranged travel or tour-guide services for individuals or groups.[70] Sellers of travel must annually register with DACS, pay a fee of $50, and receive a certificate evidencing proof of registration. If the seller of travel offers vacation certificates, the seller must obtain a performance bond in the amount specified in s. 559.929, F.S.

Air ambulance services are regulated by the Department of Health (DOH).[71] An "air ambulance" is any fixed-wing or rotary-wing aircraft used for transporting sick or injured persons requiring, or likely to require, medical attention during transport.[72] An "air ambulance service" is a publicly or privately owned service, licensed by DOH, which operates air ambulances to transport persons requiring medical attention during transport.[73] To be licensed, an air ambulance service must apply to DOH, pay fees, meet specified standards and obtain insurance. To be permitted by DOH, each transport vehicle is required to meet specified safety standards, have an appropriate communication system, and be furnished with essential medical supplies and equipment.

The United States Center for Disease Control and Prevention estimates that between 22 percent and 64 percent of U.S. travelers heading to developing countries will experience some kind of health problem.[74] International medical evacuation and air ambulance cost anywhere between $30,000 and $150,000, per incident.[75] Air ambulances are sometimes the only way to transport a patient safely. The

[66] s. 636.003(5), F.S.
[67] s. 636.003(7), F.S.
[68] https://www.floir.com/CompanySearch/ (last visited Jan. 14, 2018). Select *Pre-paid Limited Health Service Organization* under *Company Type*.
[69] s. 636.044, F.S.
[70] s. 559.928, F.S.
[71] part III, ch. 401, F.S.
[72] s. 401.23(3), F.S.
[73] s. 401.23(4), F.S.
[74] https://wwwnc.cdc.gov/travel/yellowbook/2018/post-travel-evaluation/general-approach-to-the-returned-traveler (last visited Jan. 14, 2018).
[75] https://medjetassist.com (last visited Jan. 14, 2018).

aircraft are "specially equipped for a patient that requires extensive or urgent medical assistance and a fast and safe method of transport of a distance of 100 miles or more."[76]

Law provides that a person registered as a seller of travel may engage in the solicitation and sale of prepaid limited health service contracts covering the cost of transportation by an air ambulance when that air ambulance service is licensed under s. 401.251, F.S.[77] However, the contract for such coverage is subject to all applicable provisions pertaining to prepaid limited health service organizations under ch. 636, F.S. This allows any travel agent to sell a prepaid limited health service contract to any person to cover the cost of transportation provided by an air ambulance service without being licensed as a health insurance agent.

Effect of the Bill

The bill expands a licensure exemption that relieves sellers of travel insurance from required health insurance agent licensing to allow anyone to sell prepaid limited health service contracts without licensure, if the contract only relates to air ambulance coverage. The contract remains regulated by law.

B. SECTION DIRECTORY:

Section 1. Amends s. 624.307, F.S., relating to general powers; duties.

Section 2. Amends s. 625.151, F.S., relating to valuation of other securities.

Section 3. Amends s. 625.325, F.S., relating to investments in subsidiaries and related corporations.

Section 4. Amends s. 626.914, F.S., relating to definitions.

Section 5. Amends s. 626.9651, F.S., relating to privacy.

Section 6. Amend s. 627.416, F.S., relating to execution of policies.

Section 7. Amend s. 627.43141, F.S., relating to notice of change in policy terms.

Section 8. Amends s. 627.7015, F.S., relating to alternative procedure for resolution of disputed property insurance claims.

Section 9. Amends s. 627.728, F.S., relating to cancellations; nonrenewals.

Section 10. Amends s. 627.748, F.S., relating to transportation network companies.

Section 11. Amends s. 628.8015, F.S., relating to own-risk and solvency assessment; corporate governance annual disclosure.

Section 12. Amends s. 629.401, F.S., relating to insurance exchange.

Section 13. Amends s. 636.044, F.S., relating to agent licensing.

Section 14. Provides an effective date of upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

[76] www.usairambulance.net
[77] s. 636.044(5), F.S.

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Reducing the number of coverage rejections required prior to exportation of a residential dwelling valued between $700,000 and $1,000,000 to the surplus lines market may remove some of these risks from the admitted market in the state. Owners in this home value range may find it easier to obtain coverage at a price acceptable to them.

Changes to the proof of mailing requirements may create savings for insurers.

Allowing private passenger motor vehicle insurers to generally exclude motor vehicles used to provide transportation network services will reduce losses incurred by the insurer. Since the transportation network company is required to provide coverage when the driver fails to do so, a general exclusion applicable to the driver's policy may increase losses incurred by the company's insurer.

Exempting certain monies from a reciprocal insurer's reserve requirements will reduce the amount of funds that must be retained in reserves and allow it to be utilized by the reciprocal insurer for other purposes. However, drafting issues discussed in Section III.C., Drafting Comments, may require increases in net unearned premium reserves, which would reduce usable capital for the time that it is retained in the required reserve.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill neither authorizes nor requires administrative rulemaking.

C. DRAFTING ISSUES OR OTHER COMMENTS:

There may be an unintended consequence regarding reciprocal insurers and the change in unearned premium reserves made to s. 629.401, F.S. (section 12 of the bill). Currently, reciprocal insurers carrying property risks are required to maintain unearned premium reserves consistent with the general

requirements of s. 625.051, F.S. The only modification to this general requirement relates to the calculation of the proportion of the unearned premium to be kept by the reciprocal in reserve. The general requirement is calculated annually. Section 629.401(6)(b)24., F.S., provides a specific requirement applicable to reciprocal insurers without limitation based on the lines underwritten. A reciprocal insurer must calculate the unearned premium reserve on a monthly or more frequent basis, unless modified in the discretion of OIR.

Section 625.051, F.S., also provides a general provision allowing the deduction of reinsurance from the premiums subject to the reserve requirement. The bill expands s. 629.401(6)(b)24., F.S., to provide more specific requirements. In particular, the bill specifies what can be deducted from unearned premiums for the purposes of the reserve requirement. This provision only allows deduction of subscriber fees from “net written premiums.” These premiums form the only basis for the reciprocal’s unearned premium reserves. “Net written premiums” under the provided definition does not reference s. 625.051, F.S., or reinsurance.” “Net written premiums” is not otherwise defined by the Insurance Code.

For policies with a period of one year or less, the specific provisions of the amendment to s. 629.401(6)(b)24., F.S., may predominate over the general requirements of s. 625.051, F.S., to the exclusion of any deductions from “unearned premiums” or “net written premiums” such that premiums ceded to reinsurers for the purchase of reinsurance may not be deducted when calculating the unearned premium reserve.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES