HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 565 Insurance
SPONSOR(S): Regulatory Affairs Committee; Insurance & Banking Subcommittee; Santiago and others
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 1260

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee	13 Y, 0 N, As CS	Callaway	Cooper
2) Government Operations Appropriations Subcommittee	12 Y, 0 N	Keith	Topp
3) Regulatory Affairs Committee	16 Y, 0 N, As CS	Callaway	Hamon

SUMMARY ANALYSIS

The bill contains changes for various types of insurance. Issues addressed include:

- insurance agency licensure;
- the alternative dispute programs administered by the Department of Financial Services (DFS) for property, sinkhole, and automobile insurance claims;
- insurance agent licensing of employees and representatives of rental car businesses;
- appointments to the board of governors for the Florida Surplus Lines Service Office;
- quarterly affidavit required of surplus lines agents related to the sale of surplus lines insurance;
- use of hurricane loss models in property insurance rate filings;
- rate setting in workers' compensation;
- the notification period for property insurance nonrenewals, cancellations, or terminations;
- insurance post-claim underwriting;
- liability insurance coverage statements;
- electronic delivery of insurance policies to policyholders;
- notification to policyholders of a change in the terms of their insurance policy;
- disqualification of an appraisal umpire in residential property insurance;
- the fee schedule used in personal injury protection insurance;
- financial requirements for service warranty associations;
- insurance administrators and exemption from licensure as an insurance administrator for a non-profit corporation administering a risk management consortium for local governments;
- the consumer representative on the Board of Governors of Citizens Property Insurance Corporation (Citizens);
- annual reports relating to Citizens and the Florida Hurricane Catastrophe Fund (FHCF);
- independent verification of mitigation discount forms and Citizens' reinspection of property to verify mitigation;
- preinsurance inspection of private passenger motor vehicles;
- refunds of unearned premiums to credit card holders;
- cancellation of motor vehicle insurance the return of unearned premium;
- zip codes and rating territories for motor vehicle insurance;
- information required with the surrender of life insurance or annuity;
- title insurance;
- acquisition of controlling stock;
- refunds to insureds from the Workers' Compensation Joint Underwriting Association;
- licensing and duties of unaffiliated insurance agents;
- the Florida Life and Health Insurance Guaranty Association; and
- venue for court proceedings relating to transfers of structured settlement payment rights.

The bill has no fiscal impact on local government and an insignificant fiscal impact on state government expenditures. The fiscal impact on the private sector is discussed in the Fiscal Analysis section of the analysis. The bill is effective July 1, 2014, unless otherwise provided in the bill.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

The bill contains changes for various types of insurance. Issues addressed include:

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- the alternative dispute programs administered by the Department of Financial Services (DFS) for property, sinkhole, and automobile insurance claims;
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- the Florida Life and Health Insurance Guaranty Association; and
- venue for court proceedings relating to transfers of structured settlement payment rights.

Insurance Agency Licensure

The bill makes significant changes to the insurance agency licensure law to streamline the licensing process and to better align the regulation of insurance agencies in Florida with other states. DFS is the state agency responsible for licensing insurance agencies in accordance with s. 626.172, F.S. In Florida, insurance agents who are sole proprietors and do not employ other insurance agents must be licensed as both an insurance agent and an insurance agency.[1] According to DFS, no other state requires licensure of an insurance agency when the licensed insurance agent is the sole proprietor of the agency. Furthermore, because insurance agents are vetted by the agent license process by DFS, DFS believes also licensing the agency serves no purpose. The bill eliminates the insurance agency

[1] See s. 626.112(7), F.S.

licensing requirement for agencies owned solely by licensed insurance agents and not employing other insurance licensees.

The bill allows a third party to complete, submit, and sign an application for an insurance agency license. Current law allows only specified persons owning or managing an agency to sign an agency license application. The bill also requires additional information relating to an agency or branch agency to be included on the agency license application and repeals some information required under current law.

Current law also requires each insurance agency location be licensed. Other states do not have a similar licensing requirement for branch locations of agencies. Starting January 1, 2015, the bill eliminates the licensing requirement for insurance agency branch locations if the branch locations meet certain requirements set out in the bill. Although licensing is no longer required, starting January 1, 2015, insurance agencies and each branch agency cannot conduct business without an agent in charge and the agent in charge must be a licensed insurance agent. However, insurance activity can occur at any agency location as long as a licensed agent is present at the location and an agent in charge has been designated and is employed by the agency. This is a new requirement provided in the bill. The bill sets out the requirements of the agent in charge and the effect on an agency license if an agent in charge is not employed.

Licenses for an insurance agency expire every three years under current law.[2] Starting January 1, 2015, the bill eliminates the three year expiration of an agency license. Thus, agency licenses will no longer have a definite expiration date.

According to DFS, when the agency licensing law was created, some existing agencies were given the opportunity to register the agency in lieu of licensing the agency. The primary benefit of registration over licensing is that registrations do not expire whereas licenses expire every three years. DFS indicates Florida is the only state that registers insurance agencies in lieu of licensing them. Thus, insurance agencies registered in Florida cannot be recognized in other states because the states only recognize licensed agencies. As a result, insurance agencies have been turning in their registrations to DFS and applying for a Florida agency license. This allows the agency to also obtain an agency license in other states. DFS asserts the number of registered agencies is steadily declining. Over the past four years an average of 38 registered agencies per month have canceled their registrations. Currently, there are over three times as many licensed insurance agencies as registered ones, with over 40,000 licensed agencies and less than 13,000 registered ones.

Effective January 1, 2015, the bill repeals current law allowing certain insurance agencies to obtain a registration in lieu of a license and makes conforming changes due to this repeal. The bill converts all agency registrations to licenses as of October 1, 2015.

Alternative Dispute Programs for Insurance Claims

Current law provides for alternative dispute programs, administered by DFS for various types of insurance. DFS runs mediation programs for property insurance and automobile insurance claims and a neutral evaluation program, similar to mediation, for sinkhole insurance claims.[3] DFS approves mediators used in the two mediation programs and certifies the neutral evaluators used in neutral evaluations for sinkhole insurance claims.

To qualify as a mediator for the property or automobile mediation programs, a person must meet specific education or experience requirements set out in statute.[4] The person must possess certain masters or doctorate degrees, be a member of the Florida Bar, be a licensed certified public accountant, or be a mediator for four years.

[2] s. 626.382, F.S.
[3] s. 627.7015, F.S., for property insurance claim mediation program; s. 627.7074, F.S., for sinkhole claim mediation program; and s. 627.745, F.S., for automobile insurance claim mediation program.
[4] s. 627.745, F.S.

Also, to qualify as a DFS mediator, a person must successfully complete a training program approved by DFS. According to DFS, the required mediation training program is no longer available from outside vendors due to the low volume of DFS mediators.[5] However, in order to ensure there was a training program available for those who wanted to be DFS mediators, for the past seven or eight years DFS approved the mediator training program offered by the courts.

The bill replaces the DFS mediator education, experience, and training program requirements set out above with new ones. Under the bill, a person with an active certification as a Florida Circuit Court Mediator is qualified to be a mediator for the DFS. Also, a person not certified as a Florida Circuit Court Mediator can be a DFS mediator if the person is an approved DFS mediator on July 1, 2014 and has conducted at least one DFS mediation from July 1, 2010–July 1, 2014. This provision essentially grandfathers in current and active DFS mediators so they can continue to be DFS mediators, even if they are not certified as a Florida Circuit Court Mediator.

According to DFS, 224 of the 379 current DFS mediators are certified as Florida Circuit Court Mediators,[6] so these mediators would still qualify to be a DFS mediator under the new qualifications provided in the bill. The remaining 155 mediators are grandfathered in by the bill and would still qualify to be DFS mediators even though they are not certified as a Florida Circuit Court Mediator. DFS estimates changing the DFS mediator qualifications to allow Florida Circuit Court Mediators will expand the pool of mediators qualified to mediate for DFS to over 3,500 mediators.

The bill also requires DFS to deny an application to be a mediator or neutral evaluator or revoke or suspend a mediator or neutral evaluator in specified circumstances. These circumstances primarily involve the mediator or neutral evaluator committing fraud, violating laws or DFS orders, violating a rule governing mediators certified by the Florida courts, or not being qualified. Additionally, DFS is authorized to inquire and investigate into improper conduct of mediators, neutral evaluators, or navigators. DFS does not have this authority in current law, but does have authority to inquire into and investigate improper conduct of other persons licensed by DFS, such as insurance agents and insurance adjusters. The bill allows DFS to share investigative information with any regulatory agency. Current law only allows the information to be shared with any law enforcement agency.

Neutral Evaluation In Sinkhole Claims

The bill requires an insurer to notify a policyholder of the right to participate in neutral evaluation of a sinkhole claims only if there is sinkhole coverage on the damaged property and if the sinkhole claim was submitted within the statute of limitations period which is two years after the policyholder knew or reasonably should have known about the sinkhole loss. There are no parameters under current law about notification of neutral evaluation. Thus, insurers are required to notify a policyholder about neutral evaluation in cases where there is no sinkhole coverage or when the sinkhole claim is untimely filed.

Insurance Agent Licensing Related to the Sale of Motor Vehicle Rental Insurance

In general, insurance agents transact insurance on behalf of an insurer or insurers. Agents must be licensed by DFS to act as an agent for an insurer, and be appointed (i.e., given the authority by an insurance company to transact business on its behalf) by at least one insurer to act as the agent for that particular appointing insurer or insurers.[7]

Limited lines insurance agents are individuals, or in some cases entities, licensed as insurance agents but limited to selling one or more of the following forms of insurance (each requiring a separate license):

- Motor vehicle physical damage and mechanical breakdown insurance;
- Industrial fire or burglary;
- Travel insurance;
- Motor vehicle rental insurance;

[5] DFS does not provide the training program in house.
[6] Information obtained from the DFS dated February 5, 2014, on file with the Regulatory Affairs Committee.
[7] s. 626.112, F.S.

- Credit insurance;
- Crop hail and multiple-peril crop insurance;
- In-transit and storage personal property insurance; and
- Portable electronics insurance.[8]

A limited lines insurance agent license generally has fewer requirements for licensing than other insurance agents. These licensees must, however, file an application with DFS and be appointed by an insurance company.

The bill makes one change to the limited license statute for motor vehicle rental insurance. Under current law, a limited license to sell motor vehicle rental insurance can be issued to a business that offers motor vehicles for rent or lease. A license issued to a rental business covers each office, branch office, or place of business associated with the rental business. The bill expands this coverage to each employee or authorized representative of the rental business located at branch offices. Thus, all employees would be covered by the rental business' license to sell rental insurance. According to DFS, the agency interprets the current law relating to rental insurance licensing to mean the license for the rental company business covers each branch office and each employee working at the rental business. Thus, the change made by the bill is clarifying and is consistent with the application of the current law by DFS.

Surplus Lines Insurance

Surplus lines insurance refers to a category of insurance for which there is no market available through standard insurance carriers in the admitted market (insurance companies licensed to transact insurance in Florida). There are three basic categories of surplus lines risks:

1. specialty risks that have unusual underwriting characteristics or underwriting characteristics that admitted insurers view as undesirable;
2. niche risks for which admitted carriers do not have a filed policy form or rate; and
3. capacity risks which are risks where an insured needs higher coverage limits than those that are available in the admitted market

Florida Surplus Lines Service Office

The entity to which certain information regarding surplus lines insurance must be provided as well as the entity designated to facilitate compliance and provide assistance and information regarding the Florida surplus lines marketplace is the Florida Surplus Lines Service Office (Service Office). The Service Office is a statutorily mandated, not-for-profit association of all Florida surplus lines agents.[9]

The purposes of the Service Office are to protect consumers seeking insurance in this state; permit surplus lines insurance to be placed with approved surplus lines insurers; establish a self-regulating organization which will promote and permit orderly access to surplus lines insurance in this state; enhance the number and types of insurance products available to consumers in this state; provide a source of advice and counsel concerning the operation of the surplus lines insurance market for consumers, surplus lines agents, insurers and government agencies and protect the revenues of this state.[10] The Service Office is required to receive, record, and review all surplus lines policies or documents, maintain records of the information reported to the Office of Insurance Regulation (OIR), and prepare monthly reports for DFS.

A nine member board of governors oversees the operations of the Service Office. Eight of the board members are appointed by DFS. The other board member is the Insurance Consumer Advocate. Five of the eight board members appointed by DFS must be members of the Florida Surplus Lines Association (Association), a trade association composed generally of surplus lines insurers, excess insurers, surplus lines insurance agents, and reinsurers. The bill requires DFS to make the five Association appointments from nominations by the Association from their membership. Current law does not authorize the Association to nominate members for appointment to the Service Office board.

[8] s. 626.321, F.S.
[9] s. 626.921, F.S.
[10] *Id.*

Surplus Lines Agent Affidavit

Surplus lines insurance is sold by surplus lines insurance agents. Before a surplus lines insurance agent can place insurance in the surplus lines market, section 626.916, F.S., requires the insurance agent to make a diligent effort to procure the desired coverage from admitted insurers. Section 626.914, F.S., defines a diligent effort as seeking and being denied coverage from at least three authorized insurers in the admitted market[11] unless the cost to replace the property insured is $1 million or more. In that case, diligent effort is seeking and being denied coverage from at least one authorized insurer in the admitted market.

Surplus lines insurance agents must report surplus lines insurance transactions to the Service Office within 30 days of the effective date of the transaction, must transmit service fees to the Service Office each month, and must transmit assessment and tax payments to the Service Office quarterly.

Current law also requires a surplus lines agent to file a quarterly affidavit with the Service Office to document all surplus lines insurance transacted in the quarter was submitted to the Service Office. The affidavit also documents the efforts the agent made to place coverage with authorized insurers and the results of the efforts. The bill repeals current law requiring this affidavit. However, surplus lines agents must still file a copy of or information on each surplus lines transaction with the Service Office in accordance with the Service Office's plan of operation.

Hurricane Loss Models

In 1995 the Legislature established the Florida Commission on Hurricane Loss Projection Methodology (Commission) to serve as an independent body within the State Board of Administration.[12] The Commission adopts findings on the accuracy or reliability of the methods, standards, principles, models and other means used to project hurricane losses. Members of the Commission include experts in insurance finance, statistics, computer system design, and meteorology who are full-time faculty members in the State University System and appointed by the state Chief Financial Officer (CFO); an actuary member from the FHCF Advisory Council; an actuary employed with a property and casualty insurer appointed by the CFO; an actuary employed by the OIR; the Executive Director of Citizens; the senior employee responsible for FHCF operations; the Insurance Consumer Advocate; and the Director of Emergency Management. The Commission sets standards for loss projection methodology and examines the methods employed in proprietary hurricane loss models used by private insurers in setting rates to determine whether they meet the Commission's standards.

Only hurricane loss models or methods the Commission deems accurate or reliable can be used by insurers in rate filings to estimate hurricane losses used to set property insurance rates. Additionally, insurers have 60 days after the Commission finds a model accurate and reliable to use the model to predict the insurer's probable maximum loss levels[13] in a rate filing.

The bill allows insurers to average model results if the insurer uses multiple models to project losses in their rate filing for property insurance rates. However, the average must be a straight average, thus a weighted average is not allowed. Current law allows only one model to be used to project loss estimates and does not authorize use of an average of model results. Thus, the sole result of the model used is the only result that can be used in a rate filing. The bill also lengthens the time insurers have to use a model or models in their rate filing from 60 to 180 days after the Commission finds the model reliable and accurate.

Retrospective Rating Plan in Workers' Compensation

Retrospective rating plans[14] may be used by workers' compensation insurers to compete on price. Under such a plan, the final premium paid by the employer is based on the actual loss experience of the employer during the policy, plus insurer expenses and an insurance charge. If the employer

[11] Admitted market is the market of Florida authorized (i.e., licensed) insurance companies.
[12] s. 627.0628, F.S.
[13] Probable maximum loss is an estimate of maximum dollar value that can be lost under realistic situations.
[14] See "2013 Workers' Compensation Annual Report" (December 2013) by the Florida Office of Insurance Regulation. Available at http://www.floir.com (last viewed February 4, 2014).

controls the amount of claims, it pays lower premiums. Before there were large deductible programs, retrospective rating plans were the dominant rating plan for large employers.

The bill authorizes retrospective rating plans that contain a provision that allows for negotiation of a premium between the employer and insurer when the employer has exposure in more than one state, an estimated annual standard premium in Florida of at least $175,000, and an annual estimated countrywide standard premium of $1 million or more for workers' compensation. The retrospective ratings plans authorized by the bill are exempt from s. 627.72(a), F.S., which specifies factors to be used in determining workers' compensation rates. These retrospective rating plans and associated forms must be filed by the National Council on Compensation Insurance and approved by OIR. However, an employer's negotiated premium under an approved retrospective rating plan does not have to be filed with OIR.

Nonrenewal Notice For Property Insurance

Under current law,[15] personal lines or commercial lines residential property insurers must give policyholders a notice of cancellation, nonrenewal, or termination at least 100 days prior to the effective date of the cancellation, nonrenewal, or termination.[16] Further, for any cancellation, nonrenewal, or termination that takes effect between June 1st and November 30th, an insurer must provide at least 100 days written notice, or notice by June 1st, whichever is earlier. The June 1st notice deadline ensures policyholders whose property insurance policies will be cancelled, nonrenewed, or terminated during hurricane season (June 1st – November 30th) will receive notice of the cancellation, nonrenewal, or termination by the start of hurricane season.

The bill repeals the required notice by June 1st for policies being cancelled, nonrenewed, or terminated between June 1st and November 30th. The bill also lengthens the notice time period under current law from 100 days to 120 days. Under the bill, policyholders with a policy renewal date from June 1st to November 30th will receive 120 days' notice before the policy's cancellation, nonrenewal, or termination date. This change means some property insurance policyholders will receive notice of cancellation, nonrenewal, or termination during hurricane season (June 1st–November 30th). Under the bill, policies renewing September 28th–November 30th that are being nonrenewed, cancelled or terminated by the insurer will receive notice of nonrenewal, cancellation or termination during hurricane season.

Policyholders with property insured by the same insurer for five years or more receive 120 days' notice of cancellation, nonrenewal, or termination and the bill does not change the notice period for these policyholders.

Post-Claim Underwriting

Post-claim underwriting is a practice where the underwriting of a policy application is actually done for the first time when a claim is filed. Post-claim underwriting can result in a denial of the claim or cancelation of the policy and is a way insurers implement s. 627.409, F.S., which provides recovery under an insurance policy may be prevented if a misrepresentation, omission, concealment of fact, or incorrect statement on an application for insurance:

1. is fraudulent or is material either to the acceptance of the risk or to the hazard assumed by the insurer or
2. if the true facts had been known to the insurer, the insurer would not have issued the policy, would not have issued it at the same premium rate, would not have issued a policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss.

If an insurer discovers a misrepresentation or omission after issuing the policy, it may deny coverage after a claim is made. In *Nationwide Mutual Fire Insurance Company v. Kramer,*[17] an insurer refused to pay a claim for a stolen automobile because the insureds did not disclose a previous bankruptcy filing.

[15] s. 627.4133(2), F.S.

[16] A 45-day notice of cancellation or nonrenewal, rather than the 100-day or 120-day notice is allowed if the OIR determines early cancellation of some or all of an insurer's property insurance policies is necessary to protect the best interest of the public or the policyholders. (s. 627.4133(2)(b)5., F.S.)

[17] 725 So.2d 1141 (Fla. 2d DCA 1998).

In *Kieser v. Old Line Insurance Company of America,*[18] an insurance company refused to pay a life insurance policy because the insured failed to disclose certain health conditions and failed to disclose that he was shopping for other life insurance policies. In *Universal Property and Casualty Insurance Company v. Johnson,*[19] an insurance company refused to pay a property insurance claim because the insureds failed to disclose prior criminal history. A misrepresentation from or an omission in an insurance application need not be intentional in order for the insurance company to deny recovery.[20]

Section 627.4133(2), F.S., requires notice to the insured before an insurer can cancel, nonrenew, or terminate any personal lines or commercial residential property insurance policy. The timing of the notice ranges from 10 days for nonpayment of premium to 120 days for certain policyholders.[21] After the policy has been in effect for 90 days, such a policy cannot be canceled unless that has been a material misstatement, a nonpayment of premium, a failure to comply with underwriting requirements with 90 days after the date of effectuation of coverage, or a substantial change in the risk covered by the policy.[22]

The bill should curtail cancellation of residential property insurance due to misrepresentations about the policyholder's credit contained on the insurance application that are found during post-claim underwriting. The bill provides that if a residential property insurance policy or contract has been in effect for more than 90 days, a claim filed by the insured cannot be denied based on credit information available in the public record. The bill does not change the law relating to other types of insurance or other types of misrepresentations (such as a misrepresentation regarding health or criminal history). Additionally, under the bill, after a policy or contract has been in effect for more than 90 days, the insurer may not cancel or terminate the policy or contract based on credit information available in public records.

Liability Insurance Coverage Statement

Under current law, only an officer of an insurer or the insurer's claims manager or superintendent can sign statements given to persons making a claim under a liability insurance policy. The statement sets out the name of the insurer, the name of each insured, the limits of liability coverage, and coverage defenses. A copy of the insurance policy is also included in the statement. The bill expands the insurer personnel authorized to sign coverage statements to include licensed company adjusters.

Delivery of Insurance Policies Electronically

Section 627.421, F.S., requires every insurance policy[23] to be mailed or delivered to the insured (policyholder) within 60 days after the insurance takes effect. Insurance policies are typically only delivered when the policy is issued and are not delivered each time the policy is renewed.

The Federal Electronic Signatures in Global and National Commerce Act (E-SIGN) applies to electronic transactions involving interstate commerce.[24] Insurance is specifically included in E-SIGN.[25] E-SIGN provides contracts formed using electronic signatures on electronic records will not be denied legal effect only because they are electronic. However, E-SIGN requires consumer disclosure and consent to electronic records in certain instances before electronic records will be given legal effect. Under E-SIGN, if a statute requires information to be provided or made available to a consumer in writing, the use of an electronic record to provide or make the information available to the consumer will satisfy the statute's requirement of writing if the consumer affirmatively consents to use of an electronic record. The consumer must also be provided with a statement notifying the consumer of the right to have the electronic information made available in a paper format and of the right to withdraw consent to electronic records, among other notifications.

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[18] 712 So.2d 1261 (Fla. 1st DCA 1998).
[19] 114 So.3d 1031 (Fla. 1st DCA 2013).
[20] *Universal Property and Casualty Insurance Company*, 114 So.3d at 1035.
[21] See s. 627.4133(2), F.S.
[22] *Id.*
[23] s. 627.402, F.S., defines policy to include endorsements, riders, and clauses. Reinsurance, wet marine and transportation insurance, title insurance, and credit life or credit disability insurance policies do not have to be mailed or delivered. (see s. 627.401, F.S.)
[24] Section 101, Electronic Signatures in Global and National Commerce Act, Pub. L. no. 106-229, 114 Stat 464 (2000). Many of the provisions of E-SIGN took effective October 1, 2000.
[25] *Id.*

In addition, s. 668.50, F.S., Florida's Uniform Electronic Transaction Act (UETA), is similar to the federal E-SIGN law. UETA specifically applies to insurance and provides a requirement in statute that information that must be delivered in writing to another person can be satisfied by delivering the information electronically if the parties have agreed to conduct a transaction by electronic means.

In 2013, legislation[26] was enacted allowing all insurance policies to be electronically transmitted to the policyholder. The legislation also contained specific electronic delivery parameters for insurance covering commercial risks.

For personal lines insurance, the bill allows insurers to deliver insurance policies by electronic means in lieu of delivery by mail if the policyholder affirmatively elects electronic delivery. The bill does not likely implicate E-SIGN or UETA because it requires the affirmative consent of the policyholder before the electronic delivery of insurance policy documents.

Change of Policy Terms In Insurance Policies

Under current law, to make a change in the terms of a property and casualty insurance contract, the insurer must give the policyholder written Notice of Change in Policy Terms with the policy renewal notice and the policy renewal notice must be provided to the policyholder in accordance with current law, which requires insurers to give notice of renewal 45 days prior to the renewal date.[27] A policyholder is deemed to accept the policy term change if the renewal premium is paid. If the insurer does not provide the Notice of Change in Policy Terms to the policyholder, the terms of the insurance policy are not changed.

The bill allows an insurer to send a Notice of Change of Policy Terms separate from the renewal notice as long as the notice is sent within the policy nonrenewal time limits in current law. Generally, the nonrenewal time limits are notice at least 100 days prior to the effective date of the nonrenewal.[28] And, for any nonrenewal that takes effect between June 1st and November 30th, at least 100 days written notice, or notice by June 1st, whichever is earlier, is required. Furthermore, policyholders with property insured by the same insurer for five years or more receive 120 days' notice of nonrenewal instead of 100 days' notice. Thus, the bill requires a Notice of Change of Policy Terms to be given sooner when it is not included with the renewal notice.

The bill also requires the insurer to provide the policyholder's insurance agent with a sample copy of the Notice of Change of Policy Terms before or at the same time as the Notice is provided to the policyholder.

Disqualification of Appraisal Umpire In Residential Property Claims

An appraisal clause is found in all insurance policies. The purpose of the appraisal clause is to establish a procedure to allow disputed amounts to be resolved by disinterested parties. The appraisal clause is used only to determining disputed values. An appraisal cannot be used to determine what is covered under an insurance policy. Coverage issues are litigated and determined by the courts.

The appraisal process generally works as follows:

- The insurance company and the policyholder each appoint an independent, disinterested appraiser.
- Each appraiser evaluates the loss independently.
- The appraisers negotiate and reach an agreed amount of the damages.
- If the appraisers cannot agree on the amount of damages, they together choose a mutually acceptable umpire.
- Once the umpire has been chosen, the appraisers each present their loss assessment to the umpire.

[26] Ch. 2013-190, L.O.F.
[27] s. 627.43141, F.S.
[28] A 45-day notice of cancellation or nonrenewal, rather than the 100-day or 120-day notice is allowed if the OIR determines early cancellation of some or all of an insurer's property insurance policies is necessary to protect the best interest of the public or the policyholders. (s. 627.4133(2)(b)5., F.S.)

- The umpire will subsequently provide a written decision to both parties.

Because current law does not address disqualification of an umpire due to impartiality, a party wanting to disqualify an umpire must go to Circuit Court and have a judge rule on the umpire's impartiality. In making the ruling, the judge uses his or her judgment about the umpire's impartiality. There are no parameters in current law for a judge's ruling on an umpire's impartiality. The bill provides parameters for the judge's impartiality ruling by adding grounds to current law which the insurer or policyholder in a residential property dispute can use to challenge the impartiality of the umpire in order to disqualify the umpire. The disqualification grounds provided in the bill are the substantially the same as those used to disqualify a neutral evaluator in sinkhole claims under s. 627.7074(7)(a), F.S.

Personal Injury Protection Insurance

House Bill 119, the personal injury protection insurance (PIP) reform bill enacted in 2012,[29] amended s. 627.736(5)(a)2., F.S., by establishing the date on which changes to the Medicare fee schedule or payment limitation are effective. The legislation provides in part that:

> [T]he applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect on March 1 of the year in which the services, supplies, or care is rendered…*and the applicable fee schedule or payment limitation applies throughout the remainder of that year* [italics added for emphasis]…."

The above-emphasized language created uncertainty as to whether the Medicare fee schedule in place on March 1st applied through the calendar year (through December 31st) or whether the March 1st fee schedule applied through the end of February of the following year. On November 6, 2012, the OIR issued Informational Memorandum OIR-12-06M,[30] stating that the plain language of the section requires the fee schedule in place on March 1st to apply throughout the following 365 days, or until the following March 1st. The bill amends s. 627.736(5)(a)2., F.S., to clarify that the fee schedule in place on March 1st applies until the last day of February of the following year.

Service Warranty Associations

Chapter 634, F.S., governs the regulation of warranty associations, which are motor vehicle service agreement companies, home warranty associations and service warranty associations. Motor vehicle service agreements provide vehicle owners with protection when the manufacturer's warranty expires. Home warranty associations indemnify warranty holders against the cost of repairs or replacement of any structural component or appliance in a home. Service warranty contracts for consumer electronics and appliances allow consumers to extend the product protection beyond the manufacturer's warranty terms.

While a warranty is not considered a traditional insurance product, it protects purchasers from future risks and associated costs. In Florida, warranty associations are regulated by the OIR. The OIR's regulatory authority of warranty associations includes approval of forms, investigation of complaints, and monitoring of reserve requirements, among other duties. However, the OIR is not required to approve rates for warranties.

The bill changes one of the financial requirements service warranty associations must have in order to keep its license. Current Florida law allows a service warranty association to demonstrate financial responsibility by securing contractual liability insurance from an authorized insurer which covers the service warranty association's obligations under service warranties sold in Florida. There are two kinds of insurance policies that are permitted:

1. an insurance policy that pays only when the service warranty association fails to pay its obligations under the service warranties; and
2. a policy that pays claims under the association's service warranties from the first dollar.

In addition, Florida law requires service warranty associations to maintain a writing ratio of gross written premiums to net assets of seven-to-one, meaning for every one dollar of net assets held by the

[29] Ch. 2012-151, L.O.F.
[30] Available at http://www.floir.com/Sections/PandC/ProductReview/PIPInfo.aspx (last accessed: February 4, 2014).

association, the association can write seven dollars of premium. Under current Florida law a service warranty association can avoid this minimum writing ratio by securing an insurance policy providing first dollar coverage from an insurer that maintains a minimum capital surplus of $100 million, maintains an "A" or higher rating, and is not affiliated with the service warranty association it insures.[31]

The bill expands the exception to the minimum writing ratio for service warranty associations. Under the bill, associations utilizing an insurance policy that pays only when the service warranty association fails to pay its obligations can avoid the writing ratio as long as the insurer issuing the policy to the association maintains a minimum capital surplus of $200 million and an "A" or higher rating. The surplus requirement for insurers issuing both kinds of insurance policies o service warranty associations helps ensure there is more than adequate capital in the insurance companies to honor all obligations of the insured association under service warranties sold in Florida.

For insurers providing first dollar coverage to service warranty associations, the bill repeals one of the three requirements for these insurers so the service warranty association purchasing insurance from the insurer can be exempt from the writing ratio required by law. The requirement that the insurer providing the first dollar coverage not be affiliated with the service warranty association it insures is repealed. These insurers must still maintain a minimum surplus of $100 million and maintain an "A" or higher rating.

Insurance Administrators

An insurance administrator is defined in s. 626.88(1), F.S., and generally is a person or entity that solicits or effects coverage, collects premiums, or adjusts or settles claims on behalf of a commercial self-insurance fund, a life insurer, or a health insurer. Insurance administrators also provide billing and collection services to health insurers and health maintenance organizations. Part VII of chapter 626, F.S., contains the statutory provisions governing insurance administrators. The bill makes several changes to the law governing these administrators.

Current law requires licensed insurance administrators to file financial statements and audited financial statements with OIR on a calendar year basis. Some administrators, however, do not use a calendar year for financial statements and use a fiscal year instead. For these administrators, the current law requiring reporting on a calendar year basis increases costs and work load to prepare and audit financial statements on a calendar year basis as their typical statements do not coincide with a calendar year. The bill changes the filing date for administrator's financial statements and audited financial statements. Instead of being due March 1 each year, financial statements will now be due within three months after the end of the administrator's fiscal year. Audited financial statements will be due within five months after the end of the administrator's fiscal year, rather than on June 1 each year.

The bill also changes which persons are subject to biographical review by OIR relating to issuance of a certificate of authority for an insurance administrator.

Under current law, insurance administrator operations for administrators that administer benefits for more than 100 certificate holders for an insurer must be reviewed by the insurer at least semiannually. The bill allows an insurer required to conduct this review to contract with a qualified third party to do the review.

Insurance Administrators for Insurance Provided by Local Governments

Section 112.08, F.S., allows local governments[32] to provide, and pay all or part of the premium for, specified types of insurance for its public officers and their dependents and local government employees and their dependents. This statute also outlines the parameters local governments must follow to provide insurance to its public officers, employees, and their dependents.

Local governments are authorized to contract with insurance companies for the insurance provided to public officers, employees, and their dependents. However, for health, accident, and hospitalization

[31] The rating is from A.M. Best Company. However, an equivalent rating by another national rating service acceptable to the OIR is also allowed by statute.

[32] Local governments include: counties, municipalities, community college districts, school boards, special districts, or county officers.

insurance coverage, the local government is also authorized to self-insure[33] or enter into a risk management consortium for coverage. Local governments who choose to self-insure or to provide insurance through a risk management consortium must also contract with an insurance company or insurance administrator to administer their insurance plan providing health, accident, and/or hospitalization coverage. In addition to insurance companies and insurance administrators, the bill allows local governments to contract with a corporation not-for-profit which consists only of local governments for administration of their insurance plan. The bill further exempts the corporation not-for-profit from the insurance administrator statute.[34] Thus, the corporation will not have to be licensed as an insurance administrator, or comply with current law relating to insurance administrators, in order to administer an insurance plan for a local government.

Board of Governors of Citizens Property Insurance Corporation

Citizens Property Insurance Corporation (Citizens or corporation) is a state-created, not-for-profit, tax-exempt governmental entity whose public purpose is to provide property insurance coverage to those unable to find affordable coverage in the voluntary admitted market. It is not a private insurance company.

As of February 12, 2014, Citizens is the largest property insurer in Florida with over one million policies extending approximately $315 billion of property coverage to Floridians.[35] Citizens insures over 383,000 residential and commercial policies in Florida's coastal areas and over 600,000 residential policies in Florida's non-coastal areas. The remaining policies are commercial policies insured in Florida's non-coastal areas.

Citizens operates under the direction of an nine member Board of Governors (Board). The board members are not Citizens' employees and are not paid. The Governor, Chief Financial Officer, Senate President, and Speaker of the House of Representatives each appoint two members of the Board, with one member appointed chair by the Chief Financial Officer. Board members serve three year staggered terms.

At least one of the two board members appointed by each appointing officer must have demonstrated expertise in insurance. By law, board members with the required insurance expertise fall within the exemption in the conflicting employment or contractual relationship statute that applies to public officers and agency employees.[36] Thus, these board members can maintain employment in the private sector in jobs involving business with Citizens without violating the conflict of interest statute because the board member is required by law to have insurance expertise in order to sit on the board.

There is also a consumer representative on the Board that is appointed by the Governor. The bill provides the consumer representative on the Citizens' Board with the same exemption from the conflicting employment or contractual relationship statute for public officers and agency employees as that provided in current law to the board members with insurance expertise.

Annual Report to the Legislature Relating to the Florida Hurricane Catastrophe Fund and Citizens Property Insurance Corporation

Section 627.3519, F.S., requires the Financial Services Commission (FSC)[37] to provide the Legislature, by February 1st each year, a report on the aggregate net probable maximum losses,[38] financing options, and potential assessments of the FHCF and Citizens. The report includes the amount and term of debt needed to be issued by the FHCF and Citizens to support the probable maximum losses required to be reported. The assessment percentage that would be needed to support the debt is also required to be reported. The FSC has provided the required report on to the Legislature each February since 2008.

[33] Self-insure means paying for any loss out of funds set aside in lieu of buying an insurance from a third party to pay for any loss.
[34] There are 19 exemptions from the insurance administrator statute in current law (s. 626.88(1), F.S.).
[35] https://www.citizensfla.com/about/bookofbusiness/ (last viewed March 11, 2014).
[36] Board members of Citizens fall under the definition of "public officer" in s. 112.313(1), F.S., because that definition includes any person appointed to hold office in any agency, including serving on an advisory board. "Agency" is defined in s. 112.312, F.S.
[37] The Financial Services Commission is comprised of the Governor and Cabinet (s. 20.121(3), F.S.).
[38] Probable maximum loss is an estimate of maximum dollar value that can be lost under realistic situations.

Section 627.35191, F.S., enacted in 2013,[39] requires the FHCF and Citizens to prepare an annual report on the same issues and provide it to the Legislature and the FSC. The only difference in the report required by s. 627.3519, F.S., and report required by s. 627.35191, F.S. is who provides the report. The bill repeals s. 627.3519, F.S., the statute requiring the report to be provided by the FSC and retains s. 627.35191, F.S., the statute requiring the report to be done by the FHCF and Citizens. The repeal removes inconsistencies in current law relating to the report.

Mitigation Discount Verification for Citizens Property Insurance Corporation

Since 2003, insurers have been required to provide mitigation credits, discounts, other rate differentials, or reductions in deductibles (mitigation discounts) to reduce residential property insurance premiums for properties with mitigation features.[40] Section 627.711, F.S., requires insurers to clearly notify an applicant for or policyholder of a personal lines residential property insurance policy of the availability and range of each premium discount, credit, other rate differential, or reduction in deductibles, for wind mitigation. The notice must be provided when the policy is issued and renewed.

Typically, policyholders are responsible for substantiating to their insurers the insured property has mitigation features. Policyholders submit a completed uniform mitigation verification inspection form to the insurer to substantiate mitigation features. Insurers must accept mitigation forms prepared by home inspectors, building code inspectors, contractors, engineers, and architects and may accept forms prepared by persons determined to be qualified by the insurer to prepare the form.

Insurers can require mitigation forms provided to the insurer by mitigation inspectors or a mitigation inspection company be independently verified for quality assurance purposes before accepting the mitigation form as valid. The insurer must pay for the independent verification.[41] At their expense, insurers can also independently verify, for quality assurance purposes, mitigation forms submitted by policyholders or insurance agents.

The bill provides an exception to the mitigation form independent verification process for Citizens only. The bill does not allow independent verification of mitigation discount forms submitted to Citizens if a quality assurance program approved by Citizens reviewed and verified the form when it was submitted. Similarly, the bill allows insurers, including Citizens, to exempt from verification mitigation discount forms from a mitigation inspector or inspection company with a quality assurance program. In addition, Citizens is not allowed to reinspect a property to confirm mitigation features if the mitigation form was reviewed and verified by a quality assurance program approved by them.

Preinsurance Inspection of Private Passenger Motor Vehicles

Section 627.744, F.S., requires preinsurance inspections of private passenger motor vehicles, but lists various exemptions, including for new, unused motor vehicles "purchased" from a licensed motor vehicle dealer or leasing company when the insurer is provided with the bill of sale, buyer's order, or copy of the title and certain other documentation. Despite the exemptions, an insurer may require a preinsurance inspection of any motor vehicle as a condition of issuance of physical damage coverage. Applicants for insurance may be required to pay the cost of the preinsurance inspection, not to exceed five dollars.

The bill also exempts from preinsurance inspection new, unused motor vehicles that are leased from a licensed motor vehicle dealer or leasing company. It provides insurers discretion whether to require persons who purchase or less a new, unused motor vehicle to submit certain documents to be exempt from preinsurance inspection of the vehicle. Persons who do not submit a requested document at the time the policy is issued are required to submit the document before any physical damage loss is payable under the policy. The bill amends the list of documents that an insurer may require. However, physical damage coverage may not be suspended during the policy period due to the applicant's failure to provide or the insurer's option not to require documents.

[39] Section 11, Ch. 2013-60, L.O.F.
[40] s. 627.0629(1)(a), F.S. Mitigation features are construction techniques used or items purchased and installed by a property owner to protect a structure against windstorm damage and loss. (e.g., hurricane shutters, hip roof, specified roof covering).
[41] s. 627.711(8), F.S.

Refunds of Unearned Premiums to Credit Card Holders

Florida law permits licensed agents or insurers to transact insurance through the use of a credit card facility or organization under certain conditions, including that refunds of unearned premiums be made directly to the credit card holder. The bill deletes the requirement that such refunds be made directly to the credit card holder and allows refunds of unearned premiums to be made to the credit card holder by mail or electronic transfer.

Cancellation of Motor Vehicle Insurance and Return of Unearned Premium

When a motor vehicle insurance policy is canceled, either by the insurer or policyholder, the insurer is required to return any unearned portion of the premium to the policyholder by mail. The bill allows insurers to also return these unearned premiums by electronic transfer.

Zip Codes and Rating Territories for Motor Vehicle Insurance

Section 627.062, F.S., is Florida's rating law. Among other requirements, it provides that insurance rates cannot be excessive, inadequate, or unfairly discriminatory. Insurer rate filings that comply with the law and are adequately supported by actuarial justification must be accepted by the OIR.

Pursuant to s. 627.0651, F.S., the use of a single zip code as a rating territory for motor vehicle insurance rates is deemed unfairly discriminatory and is thus prohibited. OIR informs that this provision was most likely enacted as an anti-redlining measure, and at that time it was probably considered unlikely that defining a territory consisting of less than two zip codes had a legitimate purpose. However, OIR notes that given the increasing role of "big data" in rating insurance, it may become more common for models including demographic data and insurance data to be used in the determination of rating territory boundaries in the future.[42]

The bill amends s. 627.0651, F.S., deeming motor vehicle rating territories that are based on a single zip code to be unfairly discriminatory, unless submitted to OIR for review prior to use and the proposed rating territory has sufficient actual or expected loss and loss adjustment expense experience to be actuarially measurable and credible.

Information Required With the Surrender of Life Insurance or Annuity

The bill creates s. 627.4553. F.S., to require insurance agents, insurers, or persons performing insurance agent activities under an exemption from licensure, who recommend that a consumer surrender an annuity or life insurance policy with a cash value, but who do not recommend that another such policy be purchased with the proceeds from the surrender, to provide the consumer with information on the product to be surrendered before execution of the surrender. The information is to be provided on a form that complies with the DFS rule, and must provide information on the product to be surrendered, including the amount of any: surrender charge; tax consequences resulting from the surrender; or forfeited death benefit. The consumer must also be informed about the loss of any minimum interest guarantees and the value of any other investment performance guarantees that will be forfeited as a result of the surrender.

Title Insurance

In Florida, title insurers operate on a monoline basis, meaning that the insurer can only transact title insurance and cannot transact any other type of insurance. Pursuant to s. 627.782, F.S., the FSC is mandated to adopt a rule specifying the premium to be charged by title insurers for the respective types of title insurance contracts and, for policies issued through agents or agencies, the percentage of such premium required to be retained by the title insurer, which shall not be less than 30 percent. The FSC must review the premium not less than once every three years. Title insurers and title insurance agencies are required to submit to the Office of Insurance Regulation (OIR), on or before March 31st of each year, revenue, loss, and expense data for the most recently concluded year that are determined necessary to assist in the analysis of premium rates, title search costs, and the condition of the Florida title insurance industry.

[42] Correspondence from OIR dated February 7, 2014, on file with the Regulatory Affairs Committee.

The bill extends the date by which title insurers and title insurance agencies must annually submit data on the title insurance industry to the OIR for the most recently concluded year from March 31st to May 31st.

Acquisition of Controlling Stock

OIR Accreditation by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. The membership consists of the state government officials, who along with their departments and staff, regulate the conduct of insurance companies and agents in their respective state or territory. The mission of the NAIC is to assist state insurance regulators, individually and collectively, in serving the public interest and achieving the following fundamental insurance regulatory goals in a responsive, efficient and cost-effective manner, consistent with the wishes of its members:

- Protect the public interest;
- Promote competitive markets;
- Facilitate the fair and equitable treatment of insurance consumers;
- Promote the reliability, solvency and financial solidity of insurance institutions; and
- Support and improve state regulation of insurance.[43]

As a member of the NAIC, the OIR is required to participate in the organization's Financial Regulation Standards and Accreditation Program.[44] NAIC accreditation is a certification that legal, regulatory, and organizational oversight standards and practices are being fulfilled by a state insurance department. The accreditation program is designed to allow for interstate cooperation and reduces regulatory redundancies. For example, the OIR's examinations may be recognized by other member states, thereby avoiding the need to have a Florida domestic insurer examined by multiple states. All 50 states, the District of Columbia, and Puerto Rico are accredited by the NAIC. Once accredited, a state is subject to a full accreditation review every five years, as well as interim reviews. The OIR's most recent accreditation review took place in the fall of 2013.

The NAIC also periodically reviews its solvency standards as set forth in its model acts,[45] and revises accreditation requirements to adapt to evolving industry practices. The OIR has identified elements of several NAIC model acts that are not in the current Insurance Code,[46] and must be implemented in order for the OIR to maintain its accreditation.

Model Holding Company Act and Regulations

For years, the OIR's financial oversight authority has included a review of transactions among affiliates and members of insurance holding companies by adopting the NAIC's Model Insurance Holding Company Act.[47]

In response to the recent financial crisis, the NAIC's Solvency Modernization Initiative (SMI)[48] studied key group supervision issues for insurance holding company systems. In light of the 2008 liquidity crisis and collapse of American International Group, Inc., the SMI's efforts focused on the risks and activities of non-insurance entities within insurance holding companies, concluded there was a corresponding regulatory need to obtain affiliates' financial information, such as enterprise risk. The NAIC model act defines "enterprise risk" as:

> [A]ny activity, circumstance, event, or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer of its insurance company as a whole, including, but

[43] About the NAIC, http://www.naic.org/index_about.htm (last viewed February 27, 2013).
[44] NAIC Financial Regulation Standards and Accreditation Committee: http://www.naic.org/committees_f.htm
[45] NAIC Model Laws, Regulations and Guidelines: http://www.naic.org/store_model_laws.htm
[46] The Insurance Code consists of chs. 624, 632, 634, 635, 636, 641, 642, 648, and 651, F.S.
[47] Bill analysis by the OIR (received March 9, 2013), on file with the Regulatory Affairs Committee.
[48] NAIC Solvency Modernization Initiative (last viewed February 3, 2014), at http://www.naic.org/index_smi.htm

not limited to, anything that would cause the insurer's risk-based capital as set forth in [state requirement] or would cause the insurer to be in a hazardous financial condition.[49]

As a result, the NAIC adopted revisions to its *Model Insurance Holding Company System Regulatory Act and Regulations* in December 2010**,** which states must adopt as an accreditation component.[50] These revisions include:

- expansions to regulators' ability to evaluate any entity within an insurance holding company system;
- enhancements to the regulator's rights to access books and records and to compel production of information;
- establishment of expectation of funding with regard to regulator participation in supervisory colleges;
- enhancements in corporate governance, such as board of directors and senior management responsibilities;
- the inclusion of financial statements as part of an affiliate's registration requirements; and
- enterprise risk reporting requirements.[51]

Current Situation

Currently, s. 628.461, F.S., provides that a person or affiliated person[52] must file a letter of notification and a statement for the OIR's approval before concluding a tender offer to acquire 5% or more of a domestic stock insurer or of a controlling company. The statute also sets forth the information required to be disclosed in the statement, which includes criminal and regulatory history information. Alternatively, a party acquiring less than 10% of the outstanding voting securities of an insurer may file a disclaimer of affiliation of control, and such disclaimer must fully disclose all material relationships and affiliation with the insurer, as well as the reason for such disclaimer (this disclaimer is mandatory for acquisitions of more than 10%).

During the pendency of the OIR's review of an acquisition filing, the insurer is not permitted to make a "material change" to its operation or management, unless the OIR has approved or been notified, respectively. A "material change" consists of a disposal or obligation of 5% or more of the insurer's capital and surplus, or a change in management involving a person who has the authority to dispose or obligate 5% of the insurer's capital and surplus.

Effect of the Bill on Acquisition of Controlling Stock

The bill amends s. 628.461, F.S. (acquisition of controlling stock), with the following changes. The bill appears identical or substantially similar to the Model Act disclaimer, with one exception at lines 1785-1793 (bolded below).

- Increases the ownership threshold (which triggers the notification and statement requirements) from 5% to 10% or more of the outstanding voting securities of a domestic stock insurer or of a controlling company.
- Deletes the provision stating "in lieu of filing an acquisition statement, a party acquiring less than 10% of the outstanding voting securities of an insurer, may file a disclaimer of affiliation and control."
- Adds a provision that the presumption of control may be rebutted by filing a disclaimer of control on a form prescribed by the office or **by providing a copy of a Schedule 13G on file with the SEC**. After a disclaimer is filed, the insurer is relieved of any further duty to register or report under s. 628.461, F.S., unless the OIR disallows the disclaimer.

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[49] Section 1(F) of the NAIC Model Insurance Holding Company System Regulatory Act.

[50] According to the NAIC, 20 states have adopted the December 2010 revisions to the Holding Company act and many others are currently in their respective legislative processes. E-mail from the NAIC (received February 3, 2014), on file with Insurance & Banking Subcommittee staff. The NAIC's 2010 revisions to the Model Holding Company Act have an accreditation deadline of January 1, 2016. See NAIC Financial Regulation and Accreditation Committee: http://www.naic.org/committees_f.htm

[51] NAIC Group Supervision, http://www.naic.org/cipr_topics/topic_group_supervision.htm (last viewed February 27, 2013).

[52] Currently, "affiliated person" is defined in s. 628.461(12)(a), F.S., to include spouses, parents and lineal descendants, and persons affiliated through 5% ownership, common control, or management.

- Deletes the definition of "affiliated person."[53]
- Deletes the definition of "controlling company," which means any corporation, trust, or association that owns 25% or more of the voting securities of one or more domestic stock insurance companies.[54]

SEC filings
The federal Securities and Exchange Act of 1934 (15 U.S.C. § 78a *et seq*, as amended), and Regulation 13D-G (17 CFR Part 240.13d), require certain investment advisers and brokers to file acquisition and beneficial ownership reports with the SEC when they directly or indirectly acquire more than 5% of any issuer's outstanding "Section 13" or "equity securities," which is measured at the end of each calendar year.

A "Section 13" "equity security" means any voting, equity security that is:
1. of a class that is registered pursuant to Section 12 of the Exchange Act (which includes all exchange-traded and NASDAQ-listed securities);
2. issued by an insurance company,[55] which security would have been required to be registered under Section 12 of the Exchange Act but for the exemption contained in Section 12(g)(2)(G) of the Exchange Act; or
3. issued by a closed-end investment company registered under the Investment Company Act of 1940, as amended ("Investment Company Act").[56]

An ownership level above 10% triggers some additional amendatory filing obligations.

Schedule 13G has generally been described as a more streamlined and passive reporting form than Schedule 13D, and may be used by the following:
- qualified institutional investors, which include insurance companies;
- exempt investors, and
- passive investors).
    - A passive investor loses this status at any time it acquires 20% or more of a Section 13 security; at that point, it must file a Schedule 13D unless it can qualify to submit a Schedule 13G as a qualified institutional investor.

It is noted that Schedule 13G only requires the following disclosures (compare with the disclosures required in the s. 628.461 statement):
- Names and types of reporting persons
- Address
- Title of class of securities and CUSIP number
- Citizenship or place of organization
- Aggregated amount beneficially owned by each reporting person
- Identification and classification of members of a reporting group
- Certification and signature

Refunds to Insureds from the Workers' Compensation Joint Underwriting Association
The Florida Workers' Compensation Joint Underwriting Association (FWCJUA)[57] is the market of last resort for workers' compensation and employers liability coverage. Only employers that cannot find

[53] In CS/HB 1271, the definition of "affiliated person" is moved to s. 624.085, F.S., and modified slightly (changed controlling stock threshold from 5% to 10%).
[54] In CS/HB 1271, the definition of "controlling company" is moved to s. 624.085, and now shows a 10% threshold instead of 25%.
[55] 15 U.S.C. 77B(a)(13) defines "insurance company" as "a company which is organized as an insurance company, whose primary and predominant business activity is the writing of insurance or the reinsuring of risks underwritten by insurance companies, and which is subject to supervision by the insurance commissioner, or a similar official or agency, of a State or territory or the District of Columbia; or any receiver or similar official or any liquidating agent for such company, in his capacity as such."
[56] 17 C.F.R. §240.13d-1(i).
[57] The Florida Workers' Compensation Insurance Plan (FWCIP) was the residual market for Florida until the FWCJUA was created on January 1, 1994.

coverage in the voluntary market are eligible for coverage in the FWCJUA. At the end of October 2013, the FWCJUA had 1,636 policies with corresponding premiums of $29.4 million.[58]

The FWCJUA has a three-tier rating plan. As a brief overview, Tier 1 is for employers with good loss experience; Tier 2 is for employers with moderate loss experience and non-rated new employers; and Tier 3 is for employers not eligible for Tiers 1 or 2.[59] As of January 1, 2014, the premium for Tier 1 is 5 percent above voluntary rates, Tier 2 is 20 percent above voluntary rates, and Tier 3[60] is 75 percent above voluntary rates, Additionally, all three tiers have a flat surcharge of $475. Tier 3 policies are also subject to assessment if premiums are not sufficient to cover losses and expenses.

The bill authorizes the FWCJUA to retain for future use any dividends that cannot be paid to former insureds of the FWCJUA because they cannot reasonably be located. Currently, the FWCJUA reports the property[61] and owner's name, last known address, and other information to the Department of Financial Services, Bureau of Unclaimed Property. The owner can claim her or his property at no cost, any time, regardless of the amount.[62] The bill eliminates the ability of a person to recover unclaimed property that is left in possession of the FWCJUA at any time in the future. The FWCJUA will not report unclaimed property to the DFS and will ultimately use the unclaimed funds in its possession.

Unaffiliated Insurance Agent

The bill creates a new type of insurance agent, an unaffiliated insurance agent. The bill defines this type of agent as a licensed insurance agent that is not appointed by or affiliated with any insurer, but is self-appointed. This agent acts as an independent consultant analyzing insurance policies, providing insurance advice, or comparing insurance products. The bill prohibits an unaffiliated insurance agent from holding an appointment with an insurer, but allows the agent to receive commissions on sales made for an insurer the agent was previously appointed by, as long as the agent properly discloses the receipt of commissions to the client.

The bill requires unaffiliated insurance agents to pay the same agent appointment fees required under current law for agents appointed by insurers.

Florida Life and Health Insurance Guaranty Association

Statutory provisions relating to Florida Life and Health Insurance Guaranty Association (FLAHIGA), which was created in 1979, are contained in part III of chapter 631, F.S. FLAHIGA is governed by a board of directors composed of nine insurance companies and is a nonprofit corporation. All insurance companies (with limited exceptions) licensed to write life and health insurance or annuities in Florida are required, as a condition of doing business in Florida, to be a member of FLAHIGA.

By law, FLAHIGA is divided into three accounts:

- the health insurance account;
- the life insurance account; and
- the annuity account.

In the event a member insurer is found to be insolvent and is ordered to be liquidated by a court, FLAHIGA provides protection (up to the limits spelled out in the statute) to Florida residents who are holders of life and health insurance policies and certain annuities with the insolvent insurer.[63]

[58] *See* "2013 Workers' Compensation Annual Report," Florida Office of Insurance Regulation (December 31, 2013). Available at: http://www.floir.com/search/search.aspx#2013 workers compensation annual report (last viewed February 5, 2014).
[59] For further specifics, see the FWCJUA's website: http://www.fwcjua.com/.
[60] In addition, an Assigned Risk Adjustment Program (ARAP) surcharge applies for Tier 3.
[61] Over the past five years, the FWCJUA has reported unclaimed property totaling $279,499.06 to the DFS. The amount for each year follows: $16,388.32 (2009); $87,813.27 (2010); $63,552.52 (2011); $73,631.27 (2012); $38,113.68 (2013). Correspondence from the FWCJUA dated February 7, 2014, on file with the Regulatory Affairs Committee.
[62] *See* chap. 717, F.S. (the Florida Disposition of Unclaimed Property Act) and information on unclaimed property on the website of the Florida Department of Financial Services: http://www.myfloridacfo.com.
[63] Non-residents of Florida and beneficiaries of covered persons are covered by FLAHIGA under limited circumstances (s. 631.713(2), F.S.).

Generally, direct individual or direct group life and health insurance policies, as well as individual and allocated annuity contracts issued by FLAHIGA's member insurers, are covered by FLAHIGA.[64]

When a FLAHIGA member insurer is found to be insolvent and is ordered liquidated, a receiver takes over the insurer under court supervision and processes the assets and liabilities through liquidation. Upon liquidation, FLAHIGA automatically becomes liable for the policy obligations the liquidated insurer owed to its Florida policyholders.[65] FLAHIGA services the policies, collects premiums and pays valid claims under the policies. FLAHIGA's rights under the policies are those that applied to the insurer prior to liquidation. FLAHIGA may cancel the policy if the insurer could have done so, but normally FLAHIGA continues the policies until the association can transfer (or substitute) the policies to a new, stable insurer with approval of the State.

Current law specifies life and health policies and annuity contracts from non-licensed insurers are not covered by FLAHIGA.[66] In addition, s. 631.713(3), F.S., excludes all of the following from coverage by FLAHIGA:

- any portion or part of a variable life insurance contract or a variable annuity contract that is not guaranteed by a licensed insurer;
- any portion or part of any policy or contract under which the risk is borne by the policyholder;
- any policy or contract or part thereof assumed by the failed insurer under a contract of reinsurance, unless assumption certificates were issued;
- fraternal benefit society products;
- health maintenance insurance;
- dental service plan insurance;
- pharmaceutical service plan insurance;
- optometric service plan insurance;
- ambulance service association insurance;
- preneed funeral merchandise or service contract insurance;
- prepaid health clinic insurance;
- certain federal employees group policies;
- any annuity contract or group annuity contract that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed directly and not through an intermediary to an individual by an insurer under such contract or certificate.

In 2011, legislation[67] was enacted specifying that the immunity FLAHIGA had from bad faith lawsuits did not affect the FLAHIGA's obligation to pay valid insurance policy or contract claims if warranted after its independent de novo review of the policies, contracts, and claims presented to it, whether domestic or foreign, after a Florida domestic rehabilitation or liquidation. The bill primarily transfers the placement of the 2011 legislation from one statute in the law governing FLAHIGA to another statute in the governing law. The placement of this authority in the new statute which pertains to FLAHIGA's duty to review claims involving covered policies, rather than the statute providing the powers and duties of FLAHIGA, should resolve issues as to whether the current law applies to foreign rehabilitations and liquidations in other states.

Transfers of Structured Settlement Payment Rights

Structured settlements are arrangements for periodic payments of damages for personal injuries established by settlement or judgment in resolution of a claim.[68] It is an arrangement to satisfy a legal liability, and generally involves one party paying a lump-sum premium to an insurance company to purchase an annuity in the name of the injured victim (payee). The premium varies depending on the number and length of payments. The insurance company then makes periodic payments to the payee

[64] Allocated annuity contracts are directly issued to and owned by individuals or annuities that directly guarantee benefits to individuals by the insurer.
[65] Generally, FLAHIGA covers only policyholders and certificate holders that were valid Florida residents on the date that a member insurer is declared insolvent and liquidated. However, non-residents of Florida and beneficiaries of covered persons are covered by FLAHIGA under limited circumstances (s. 631.713(2), F.S.).
[66] s. 631.713, F.S.
[67] Ch. 2011-226, F.S.
[68] Section 626.99296(2)(m), F.S.

for the negotiated period of time, which also provides federal tax benefits for the insurance company and for the payee. Structured settlements provide long-term financial protection and income, which may be necessary for claimants with dependents and long-term medical needs.

However, over time and as a payee's personal situation may change, liquidity needs may arise for payees. As an alternative to continuing to receive these long-term payments, some individuals may assign or sell their payment rights to factoring companies (also known as specialty finance companies) for lump-sum payments at a discount. Many of these factoring transactions involved high discount rates, leaving significantly reduced net payments to payees, raising consumer protection concerns that these high discount rates were undermining the long term financial needs of injured persons. According to one study of 506 individual transactions, the average discount rate charged to injury victims was 19.64%.[69]

In 2001, the Florida Legislature enacted s. 626.99296, F.S., to protect recipients of structured settlements (payees) who seek to transfer their payment rights in exchange for a discounted lump-sum payment.[70] This statute requires that a proposed transfer of those payment rights must be approved by a court of competent jurisdiction after consideration of several preconditions, including whether the proposed transfer is in the best interest of the payee.

Recently, it has been discovered that some factoring companies have persuaded payees (including individuals not domiciled in Florida) to file transfer petitions in certain Florida counties where the courts have historically ruled favorably for factoring companies, particularly in terms of the proposed discount rates. This practice, known as "forum shopping," has raised concerns that the structured-settlement transfer act's intent is undermined.[71]

The bill amends s. 626.99296(3)(a), F.S., to clarify that the final order authorizing a proposed transfer of structured settlement payment rights must be made by a court of competent jurisdiction in the county in which the payee resides.

B. SECTION DIRECTORY:

Section 1: Amends s. 112.08, F.S., relating to group insurance for public officers, employees, and certain volunteers; physical examination.

Section 2: Amends s. 624.501, F.S., relating to filing, licensing, appointment, and miscellaneous fees.

Section 3: Amends s. 626.015, F.S., relating to definitions.

Section 4: Effective January 1, 2015, amends s. 626.0428, F.S., relating to agency personnel powers, duties, and limitations.

Section 5: Effective January 1, 2015, amends s. 626.112, F.S., relating to license and appointment required; agents, customer representatives, adjusters, insurance agencies, service representatives, managing general agents.

Section 6: Amends s. 626.172, F.S., relating to application for insurance agency license.

Section 7: Amends s. 626.311, F.S., relating to scope of license.

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[69] Envoy Insurance Group, "An Introduction to Enhanced Disability Protections," on file with the Regulatory Affairs Committee.

[70] Section 626.99296(1), F.S.; chs. 2001-207 and 2001-247, L.O.F. "Payee" is defined in s. 626.99296(2)(j), F.S., as an individual who is receiving tax-free damage payments under a structured settlement and proposes to make a transfer of payment rights under the structured settlement. "Transferee" is defined in subsection (2)(t) as a person who is receiving or who will receive structured settlement payment rights resulting from a transfer.

[71] If a cause of action arises from the breach of the transfer agreement, current law requires if the payee is domiciled in Florida, the payee's domicile state is the proper venue only to adjudicate the cause of action (s. 626.99296(a)6., F.S.). However, the statute is silent as to the proper venue for the original petition to transfer structured-settlement payment rights.

Section 8: Amends s. 626.321, F.S., relating to limited licenses.

Section 9: Effective January 1, 2015, amends s. 626.382, F.S., relating to continuation, expiration of license; insurance agencies.

Section 10: Amends s. 626.601, F.S., relating to improper conduct; inquiry; fingerprinting.

Section 11: Effective January 1, 2015, repeals s. 626.747, F.S., relating to branch agencies.

Section 12: Effective January 1, 2015, amends s. 626.8411, F.S., relating to application of Florida Insurance Code provisions to title insurance agents or agencies.

Section 13: Amends s. 626.88, F.S., relating to definitions.

Section 14: Amends s. 626.8805, F.S., relating to certificate of authority to act as administrator.

Section 15: Amends s. 626.8817, F.S., relating to responsibilities of insurance company with respect to administration of coverage insured.

Section 16: Amends s. 626.882, F.S., relating to agreement between administrator and insurer; required provisions; maintenance of records.

Section 17: Amends s. 626.883, F.S., relating to administrator as intermediary; collections held in fiduciary capacity; establishment of account; disbursement; payments on behalf of insurer.

Section 18: Amends s. 626.884, F.S., relating to maintenance of records by administrator; access; confidentiality.

Section 19: Amends s. 626.89, F.S., relating to annual financial statement and filing fee; notice of change of ownership.

Section 20: Amends s. 626.921, F.S.; relating to Florida Surplus Lines Service Office.

Section 21: Amends s. 626.931, F.S., relating to insurer reporting requirements.

Section 22: Amends s. 626.932, F.S., relating to surplus lines tax.

Section 23: Amends s. 626.935, F.S., relating to suspension, revocation, or refusal of surplus lines agent's license.

Section 24: Amends s. 626.936, F.S., relating to failure to file reports or pay tax or service fee; administrative penalty.

Section 25: Amends s. 626.9541, F.S., relating to unfair methods of competition and unfair or deceptive acts or practices defined.

Section 26: Amends s. 626.99296, F.S., relating to transfers of structured settlement payment rights.

Section 27: Amends s. 627.062, F.S., relating to rate standards.

Section 28: Amends s. 627.0628, F.S., relating to Florida Commission on Hurricane Loss Projection Methodology; public records exemption; public meetings exemption.

Section 29: Amends s. 627.0651, F.S., relating to making and use of rates for motor vehicle insurance.

Section 30: Amends s. 627.072, relating to making and use of rates.

Section 31: Amends s. 627.281, F.S., relating to appeal from rating organization; workers' compensation and employer's liability insurance filings.

Section 32: Amends s. 627.311, F.S., relating to joint underwriters and joint reinsurers; public records and public meetings exemption.

Section 33: Amends s. 627.351, F.S., relating to insurance risk apportionment plans.

Section 34: Amends s. 627.3518, F.S., relating to Citizens Property Insurance Corporation policyholder eligibility clearinghouse program to correct a cross reference.

Section 35: Repeals s. 627.3519, F.S., relating to annual report of aggregate net probable maximum losses, financing options, and potential assessments.

Section 36: Amends s. 627.409, F.S., relating to representations in applications; warranties.

Section 37: Amends s. 627.4133, F.S., relating to notice of cancellation, nonrenewal, or renewal premium.

Section 38: Amends s. 627.4137, F.S., relating to disclosure of certain information required.

Section 39: Amends s. 627.421, F.S., relating to delivery of policy.

Section 40: Amends s. 627.43141, F.S., relating to notice of change in policy terms.

Section 41: Creates s. 627.4553, F.S., relating to recommendations to surrender.

Section 42: Amends s. 627.7015, F.S., relating to alternative procedure for resolution of disputed property insurance claims.

Section 43: Creates s. 627.70151, F.S., relating to appraisal; conflicts of interest.

Section 44: Amends s. 627.706, F.S., relating to sinkhole insurance; catastrophic ground cover collapse; definitions.

Section 45: Amends s. 627.7074, F.S., relating to alternative procedure for resolution of disputed sinkhole insurance claims.

Section 46: Amends s. 627.711, F.S., relating to notice of premium discounts for hurricane loss mitigation; uniform mitigation verification inspection forms.

Section 47: Amends s. 627.7283, F.S., relating to cancellation; return of premium.

Section 48: Amends s. 627.736, F.S., relating to required personal injury protection benefits; exclusions; priority; claims.

Section 49: Amends s. 627.744, F.S., relating to required preinsurance inspection of private passenger motor vehicles.

Section 50: Amends s. 627.745, F.S., relating to mediation of claims.

Section 51: Amends s. 627.782, F.S., relating to adoption of rates.

Section 52: Amends s. 628.461, F.S., relating to acquisition of controlling stock.

Section 53: Amends s. 631.717, F.S., relating to powers and duties of the Florida Life and Health Insurance Guaranty Association.

Section 54: Amends s. 631.737, F.S., relating to rescission and review generally.

Section 55: Amends s. 634.406, F.S., relating to financial requirements.

Section 56: Provides an effective date of July 1, 2014, unless otherwise provided.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   According to DFS, the bill will require changes to the current licensure system relating to unaffiliated agents and insurance agency licensure. However, DFS confirms that any technology changes as a result of this legislation will be insignificant and can be implemented and absorbed within current resources.[72]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The changes made by the bill to the use of retrospective rating in workers' compensation may reduce workers' compensation premiums for some employers.

Insurers emailing policies will save costs associated with printing and mailing insurance policies to policyholders. The exact amount of savings cannot be calculated as it is unknown how many insurers will opt to deliver their policies by email and how many policyholders will choose to obtain their policies by email rather than by mail. However, any savings realized by insurers should be passed through to policyholders.

Allowing insurers to electronically transfer unearned premium refunds for motor vehicle insurance, rather than mailing the refunds, could decrease costs to insurers.

Property and casualty insurers who choose to provide a Notice of Change of Policy Terms separate from the renewal notice will incur additional costs associated with printing and mailing this Notice. Additionally, the insurers will incur costs associated with providing a copy of the Notice to the policyholder's insurance agent.

The provision in the bill relating to venue for court proceedings relating to transfers of structured settlement payment rights may be beneficial to payees by requiring that any order authorizing structured settlement transfers must be issued by a court of competent jurisdiction in the county of the payee's residence, instead of specific judicial circuits that may favor high discount rates.

[72] Email correspondence with the Department of Financial Services (February 20, 2014) on file with the Government Operations Appropriations Subcommittee.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to: require counties or municipalities to spend funds or take an action requiring the expenditure of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill requires DFS to adopt rules relating to the certification of sinkhole neutral evaluators.

The bill gives DFS authority to adopt rules to administer the authority given DFS under the bill to deny an application, or suspend or revoke approval of a mediator or certification of a sinkhole neutral evaluator for specific grounds.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 11, 2014, the Insurance & Banking Subcommittee considered the bill, adopted a strike all amendment and an amendment to the strike all amendment and reported the bill favorably with a committee substitute. The amendments:

- Clarified appointment fees apply to unaffiliated agents self-appointed for all types of insurance.
- Delayed the effective date of changes in the bill requiring insurance agencies to have an agent in charge from July 1, 2014 to January 1, 2015.
- Delayed the effective date of changes in the bill exempting insurance agencies owned by a single licensed agent from having an insurance agency license from July 1, 2014 to January 1, 2015.
- Delayed the conversion of registrations for insurance agencies to licenses from October 1, 2014 until October 1, 2015. Delays repeal of current laws relating to the registration of insurance agencies from July 1, 2014 until January 1, 2015.
- Terminated issuance of new limited customer representative licenses by the DFS as of October 1, 2014.
- Changed information required to be on an application for an insurance agency license, who must sign an agency license application, and who has to submit fingerprints for the license.
- Delayed the effective date of the elimination of the expiration of an agency license from July 1, 2014 until January 1, 2015.
- Restored rulemaking authority for DFS relating to nonresident agency licenses.
- Revised the provision relating to the disclosure required for the surrender of life insurance and annuities to require the insurance agent to provide the disclosure info on a form that complies with the DFS rule.
- Added provisions specifying the grounds DFS has to deny an application of a neutral evaluator or suspend or revoke its prior certification of the evaluator.
- Required DFS to adopt rules relating to the certification of neutral evaluators.

- Added a provision changing a funding requirement for members to join a corporation not for profit self-insurance fund. Current law requires each member of the fund to receive at least 75% of its funding from governmental sources and the amendment keeps this requirement but alternatively allows a member of the fund to be a publicly supported organization with specific requirements in the Internal Revenue Code.
- Added a provision allowing insurers to exempt mitigation verification forms from independent verification when there is a quality assurance program.
- Specified insurers who want to use an average of results from hurricane models in a property insurance rate filing must use a straight average.
- Allowed employees and authorized representatives of an automobile rental or leasing entity to offer or sell rental car insurance under the entity's insurance agent license.
- Changed the post-claim underwriting provision in the bill to prohibit insurers from canceling or terminating property insurance based on credit information in public records if the policy has been in effect for more than 90 days.
- Allowed the WCJUA to retain dividends, but not premium refunds, owed to former insureds when they cannot be located.
- Regarding acquisition of controlling stock of an insurer, allowed a person to rebut the presumption of control by filing either the OIR's disclaimer of control or the Schedule 13G to the OIR. It also removes the automatic disclaimer language that was in the bill as filed, so that the OIR could still review and disallow the disclaimer.
- Removed the provision in the bill relating to annual reports required of Citizens and the FHCF on probable maximum loss and assessments and repeals the law. Current law (s. 627.35191, F.S) already requires the reports to be submitted by Citizens and the FHCF, so the provision in the bill is duplicative of current law.

On March 20, 2014, the Regulatory Affairs Committee considered the bill, adopted 21 amendments, and reported the bill favorably with a committee substitute. The amendments made the following changes to the bill:

- For health, accident and hospitalization insurance coverage, allowed a non-profit corporation comprised only of local governments to administer a risk management consortium for insurance without being approved by the OIR as an insurance administrator.
- Removed the boiler inspector provisions from the bill.
- Removed the provision in the bill changing a funding requirement for members to join a corporation not for profit self-insurance fund.
- Required an agent in charge of an insurance agency to be accountable only for misconduct or violations of the Insurance Code committed by a licensee under the agent's supervision rather than being accountable for wrongful acts, misconduct, or violations of the Code.
- Changed the deadline for insurance administrators to file a statement of financial condition, transactions, and affairs with the OIR from April 1st to three months after the administrator's fiscal year. Changed the deadline to file an audited financial statement with the OIR from July 1st to five months after the fiscal year.
- Required the DFS to pick board members for the Florida Surplus Lines Service Office from nominations made by the Florida Surplus Lines Association from their membership.
- Allowed refunds of unearned premiums for insurance policies sold by licensed agents or insurers through a credit card facility to be made to the credit card holder by mail or electronic funds transfer.
- Clarified that a final order authorizing a transfer of structured settlement rights must be authorized by a court of competent jurisdiction in the county in which the payee (the individual receiving structured settlement payments and is seeking to transfer those rights) resides.
- Removed duplicative language in the provision in the bill allowing insurers to use straight averages of hurricane loss models in property insurance rate filings.
- Changed the provision relating to rating auto insurance by zip code. The change deems motor vehicle rating territories that are based on a single zip code to be unfairly discriminatory, unless submitted to the OIR for review prior to use and the proposed rating territory has sufficient loss experience to be actuarially measurable and credible.

- Exempted retrospective rating plans authorizing negotiated premiums from the requirement that specified factors be used in determining workers' compensation rates. Required such plans and associated forms to be filed by the National Council on Compensation Insurance and approved by OIR. Provided that an individual employer's premium negotiated under an approved retrospective rating plan does not have to be filed with OIR.
- Provided the Citizens board member representing consumers falls within the exemption in the conflicting employment or contractual relationship statute that applies to public officers and agency employees.
- Reworded the provisions in the bill relating to independent verification of mitigation forms to clarify the provisions and make them consistent with verbiage used in current law.
- Authorized insurers to return unearned premiums on canceled motor vehicle insurance policies via electronic funds transfer.
- Allowed insurers discretion whether to require persons who purchase or lease a new, unused motor vehicle to submit certain documents to be exempt from preinsurance inspection of the vehicle.
- Removed the provision in the bill allowing a $15 fee for insurance premium payments made by credit or debit cards or electronic funds transfer which are declined or not processed due to insufficient funds.
- Removed the requirements for an acquirer of controlling stock to submit an agreement to file an annual report and to report enterprise risk to the OIR.
- Removed the requirement for a person seeking to divest control to file a confidential notice with the OIR prior to such divestiture.
- Added provisions to the bill relating to FLAHIGA.
- Removed an obsolete reference in the warranty association provision in the bill to quarterly reports filed by these associations with the OIR. Quarterly reports were previously repealed, but one reference to quarterly reports was inadvertently left in statute and is thus repealed.

The staff analysis was updated to reflect the committee substitute.