The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	SB 1168
INTRODUCER:	Senator Steube
SUBJECT:	Insurance
DATE:	January 12, 2018
REVISED:	1/22/2018

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Billmeier	Knudson	BI	**Pre-meeting**
2.			JU	
3.			RC	

I. Summary:

SB 1168 creates new requirements for assignment of post-loss benefits from personal residential property insurance policies. The bill does not allow personal lines residential or commercial residential property insurance policies to prohibit the post-loss assignment of benefits. It provides, however, that an agreement to assign post-loss benefits is not valid unless the agreement:

- Is in writing;
- Is limited to claims for work performed or work to be performed by the assignee;
- Contains an accurate and up-to-date statement of the scope of work to be performed;
- Allows the insured to rescind the assignment within 7 days after execution;
- Provides that the insured may be responsible for payment for any work performed before the rescission of the assignment; and
- Contains a notice provision informing the homeowner of certain rights and obligations.

The bill requires the assignee to:

- Provide a copy of the assignment agreement to the insurer within a specified time;
- Provide the insurer with a written estimate of the work to be done; and
- Provide specified notice to the insurer no later than 30 days before initiating litigation against an insurer.

The bill allows the insurer to inspect the property at any time. It provides the acceptance by an assignee of a valid assignment agreement constitutes a waiver by the assignee of any claims, with specified exceptions, against named insureds for payment arising from the loss. This waiver is valid even if the assignment agreement is determined to be invalid.

The bill provides that in a civil action relating to a residential homeowner's property insurance claim under a policy in which an assignment agreement was executed, a proposal for settlement may be made by any party no earlier than 30 days after the civil action has commenced.

The bill requires each insurer to report specified data on each residential property claim paid pursuant to an assignment agreement in the prior calendar year to the Office of Insurance Regulation (OIR).

The bill restricts an insurer's ability to deny claims or rescind a policy based on misrepresentations on insurance applications.

The bill amends s. 627.062, F.S., to provide that attorney fees paid pursuant to s. 627.428, F.S., may not be included in the insurer's rate base and may not be used to justify a rate or rate change. These provisions will bar the use of attorney fees paid pursuant to s. 627.428, F.S., in rate making in property, casualty, surety, motor vehicle, employer liability, title, wet marine, credit life or credit disability, and health insurance.

II. Present Situation:

Insurance Rates (Section 1 of the bill)

Section 627.062, F.S., specifies the rate filing process for property and casualty insurers and provides rating standards for these insurers. The rating law applies to property, casualty and surety insurance and prohibits rates that are excessive, inadequate, or unfairly discriminatory. At the same time, an insurer is allowed a reasonable rate of return. The Office of Insurance Regulation (OIR) regulates insurer rate and form filing.

A rate is excessive if:
- It is likely to produce a profit from Florida business that is unreasonably high in relation to the risk involved or if expenses are unreasonably high in relation to the services rendered.
- The rate structure established by a stock insurance company provides for replenishment of surpluses from premiums, when the replacement is attributable to investment losses.[1]

A rate is inadequate if:
- It is clearly insufficient, together with the investment income attributable to them to sustain projected losses and expenses in the class of business to which it applies.
- If discounts or credits are allowed that exceed a reasonable reflection of expense savings and reasonably expected loss experience from the risk or group of risks.[2]

A rate is unfairly discriminatory if:
- The rating plan, including discounts, credits, or surcharges fails to clearly and equitably reflect consideration of the policyholder's participation in a risk management program pursuant to s. 627.0625, F.S.

[1] ss. 627.062(2)(e)1. and 2., F.S.
[2] ss. 627.062(2)(e)3. and 5., F.S.

- As to a risk or group of risks, the application of premium discounts, credits, or surcharges among the risks does not bear a reasonable relationship to the expected loss and expense experience among the various risks.[3]

Section 627.0651, F.S., is the rating law for motor vehicle insurance. It is similar to the law for property. Rates must not be excessive, inadequate, or unfairly discriminatory. At the same time, an insurer is allowed a reasonable rate of return. Workers' compensation insurance rate filings must meet the requirements of ss. 627.062, F.S., and 627.072, F.S.[4] Section 627.410, F.S., governs health insurance filings and rates. The OIR reviews health insurance filings to determine the reasonableness of benefits in relation to premiums charged.

Attorney Fees in Insurance Litigation

Section 627.428, F.S., provides, in part:

> Upon the rendition of a judgment or decree by any of the courts of this state against an insurer and in favor of any named or omnibus insured or the named beneficiary under a policy or contract executed by the insurer, the trial court or, in the event of an appeal in which the insured or beneficiary prevails, the appellate court shall adjudge or decree against the insurer and in favor of the insured or beneficiary a reasonable sum as fees or compensation for the insured's or beneficiary's attorney prosecuting the suit in which the recovery is had.

This statute allows the insured or the insured's assignee[5] to recover attorney's fees if the insured or assignee prevails in an action against an insurer. Florida courts have interpreted the statute broadly to allow recovery of fees when the insurer ultimately settles the case before trial.[6] Fees are awarded pursuant to the statute even if the insurer does not act in bad faith.[7] The Florida Supreme Court recently explained the purpose of the statute:

> The need for fee and cost reimbursement in the realm of insurance litigation is deeply rooted in public policy. Namely, the Legislature recognized that it was essential to "level the playing field" between the economically-advantaged and sophisticated insurance companies and the individual citizen. Most assuredly, the average policyholder has neither the finances nor the expertise to single-handedly take on an insurance carrier. Without the funds necessary to compete with an insurance carrier, often a concerned policyholder's only means to take protective action is to hire that expertise in the form of legal counsel… For this reason, the Legislature recognized that an insured is not made whole when an insurer simply

[3] ss. 627.062(2)(e)4. and 6., F.S.
[4] s. 627.151, F.S.
[5] *All Ways Reliable Bldg. Maintenance, Inc. v. Moore*, 261 So.2d 131 (Fla. 1972).
[6] *Johnson v. Omega Ins. Co.*, 200 So.3d 1207, 1215 (Fla. 2016)(noting that "it is well settled that the payment of a previously denied claim following the initiation of an action for recovery, but prior to the issuance of a final judgment, constitutes the functional equivalent of a confession of judgment").
[7] *Johnson v. Omega Ins. Co.*, 200 So.3d 1207, 1216 (Fla. 2016)(noting "the insurer's intentions do not factor into a policyholder's recovery of fees; it is the fact that the denial of benefits was ultimately incorrect that triggers the statute"); *Ins. Co. of N. Am. v.* Lexow, 602 So.2d 928, 531 (Fla. 1992)("INA's good faith in bringing this suit is irrelevant. If the dispute is within the scope of s. 627.428, F.S., and the insurer loses, the insurer is always obligated for attorney's fees").

> grants the previously denied benefits without fees. The reality is that once the benefits have been denied and the plaintiff retains counsel to dispute that denial, additional costs that require relief have been incurred. Section 627.428, F.S., takes these additional costs into consideration and levels the scales of justice for policyholders by providing that the insurer pay the attorney's fees resulting from incorrectly denied benefits.[8]

Attorney Fees in Insurance Rates

Generally, attorney fees, including those paid pursuant to s. 627.428, F.S., are expenses that insurers can use to justify a rate.[9] However, motor vehicle insurers cannot use attorney fees to justify a rate or rate change if those fees are related to bad faith or punitive damages.[10] Medical malpractice insurers are likewise prohibited from using attorney fees related to bad faith to justify a rate or rate change.[11]

Section 627.062(10), F.S., provides that an insurer cannot include interest paid to a policyholder when an insurer does not act on a claim within statutory time limits.

Misrepresentations in Insurance Applications (Section 2 of the bill)

Section 627.409, F.S., provides that 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,*[12] an insurer refused to pay a claim for a stolen automobile because the insureds did not disclose a previous bankruptcy filing. In *Kieser v. Old Line Insurance Company of America,*[13] 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,*[14] an insurance company refused to pay a property insurance claim because the insureds failed to disclose prior criminal

[8] *Johnson v. Omega Ins. Co.*, 200 So.3d 1207, 1215-1216 (Fla. 2016)(internal citations omitted).
[9] *See, e.g.*, s. 627.062(2)(b), F.S. (requiring the OIR to consider expenses when reviewing a rate filing).
[10] s. 627.0651(12), F.S.
[11] s. 627.062(7)(a), F.S.
[12] 725 So.2d 1141 (Fla. 2d DCA 1998).
[13] 712 So.2d 1261 (Fla. 1st DCA 1998).
[14] 114 So.3d 1031 (Fla. 1st DCA 2013).

history. A misrepresentation from or an omission in an insurance application need not be intentional in order for the insurance company to deny recovery.[15]

A misrepresentation does not need to have a causal connection to the claim in order for the misrepresentation to be material.[16] One commenter explained the rationale for the general rule:

> There is a very sound reason for not requiring a causal connection: such a requirement may encourage fraud. If a loss is caused by something other than the fact misrepresented, there will be coverage. If the cause of loss is connected to the misrepresented fact, the insured has lost nothing, because he wouldn't have had coverage anyway. If the cause of loss is not connected, he has coverage he otherwise couldn't have obtained. Thus, he had nothing to lose by misrepresenting.[17]

Assignment of Benefits (Sections 3 and 4 of the bill)

Background on Assignment of Benefits

An assignment is the voluntary transfer of the rights of one party under a contract to another party. Current law generally allows an insurance policyholder to assign the benefits of the policy, such as the right to be paid, to another party. Once an assignment is made, the assignee can take action to enforce the contract. Accordingly, if the benefits are assigned and the insurer refuses to pay, the assignee may file a lawsuit against the insurer to recover the insurance benefits.

Section 627.422, F.S., governs assignability of insurance contracts and provides that a policy may or may not be assignable according to its terms. In *Lexington Insurance Company v. Simkins Industries*,[18] the court held that a provision in an insurance contract prohibiting assignment of the policy was enforceable under the plain language of s. 627.422, F.S. The court explained that the purpose of a provision prohibiting assignment was to protect an insurer against unbargained-for risks.[19] However, an assignment made after the loss is valid even if the contract states otherwise.[20] In *Continental Casualty Company v. Ryan Incorporated*,[21] the court noted that it is a "well-settled rule that [anti-assignment provisions do] not apply to an assignment after loss." A court explained that a rationale for post-loss assignments is that "assignment of the policy, or rights under the policy, before the loss is incurred transfers the insurer's contractual relationship to a party with whom it never intended to contract, but an assignment after loss is

[15] *Universal Property and Casualty Insurance Company*, 114 So.3d at 1035.
[16] John Dwight Ingram, *Misrepresentations in Applications for Insurance*, University of Miami Business Law Review, 14:103 (2005) at p. 111 ("In most jurisdictions, a misrepresentation is considered material and sufficient grounds for rescission or denial of a claim regardless of whether the fact represented has any causal connection with the death or loss involved in the claim").
[17] *Id*. at 111.
[18] 704 So.2d 1384 (Fla. 1998).
[19] *Id*. at 1386.
[20] *West Fla. Grocery Co. v. Teutonia Fire Ins. Co*., 74 Fla. 220, 77 So. 209 (1917); *Gisela Inv., N.V. v. Liberty Mut. Ins. Co.*, 452 So.2d 1056 (Fla. 3d DCA 1984).
[21] 974 So.2d 368, 377 n. 7 (Fla. 2000).

simply the transfer of the right to a claim for money" and "has no effect upon the insurer's duty under the policy."[22]

Assignments have been prohibited by contract in other insurance contexts. In *Kohl v. Blue Cross Blue Shield of Florida, Inc.*,[23] the court found anti-assignment language was sufficiently clear and upheld language prohibiting the assignment of a health insurance claim. The court explained that anti-assignment clauses "prohibiting an insured's assignments to out-of-network medical providers are valuable tools in persuading health [care] providers to keep their costs down and as such override the general policy favoring the free alienability of choses in action."[24]

Section 627.428, F.S., provides, in part:

> Upon the rendition of a judgment or decree by any of the courts of this state against an insurer and in favor of any named or omnibus insured or the named beneficiary under a policy or contract executed by the insurer, the trial court or, in the event of an appeal in which the insured or beneficiary prevails, the appellate court shall adjudge or decree against the insurer and in favor of the insured or beneficiary a reasonable sum as fees or compensation for the insured's or beneficiary's attorney prosecuting the suit in which the recovery is had.

This statute allows the insured to recover attorney's fees if the insured prevails in an action against an insurer. A person who takes an assignment of benefits is entitled to attorney's fees if that assignee prevails in an action against an insurer.[25]

Assignment of Benefits in Property Insurance Cases

In recent years, insurers have complained of abuse of the assignment of benefits process. An insurance company described the issue in a court filing:

> The typical scenario surrounding the use of an "assignment of benefits" involved vendors and contractors, mostly water remediation companies, who were called by an insured immediately after a loss to perform emergency remediation services, such as water extraction. The vendor came to the insured's home and, before performing any work, required the insured to sign an "assignment of benefits" – when the insured would be most vulnerable to fraud and price gouging. Vendors advised the insured, "We'll take care of everything for you." The vendor then submitted its bill to the insurer that was, on average, nearly 30 percent higher than comparative estimates from vendors without an assignment of benefits. Some vendors added to the invoice an additional 20 percent for "overhead and profit," even though a general contractor would not be required or hired to oversee the work. Vendors used these inflated invoices to extract higher

[22] *Wehr Constructors, Inc. v. Assurance Company of America*, 384 S.W.3d 680, 683 (Ky. 2012).
[23] 955 So.2d 1140 (Fla. 4th DCA 2007).
[24] *Id*. at 1144-1145.
[25] *All Ways Reliable Bldg. Maint., Inc. v. Moore*, 261 So.2d 131 (Fla. 1972); *Allstate Insurance Co. v. Regar*, 942 So.2d 969 (Fla.2d DCA 2006).

> settlements from insurers. This, in turn, significantly increases litigation over the vendors' invoices.[26]

In a court filing in a different case, a company that provides emergency repair and construction services explained the rationale behind assignments of insurance benefits:

> As a practical matter, a homeowner often will not be able to afford or hire a contractor immediately following a loss unless the contractor accepts an assignment of benefits to ensure payment. A homeowner may be unable to comply with the … provision requiring the homeowner to protect and repair the premises unless the remediation contractor accepts an assignment of benefits, however, contractors will become unwilling to accept payments by assignment if court decisions render the assignments unenforceable …
>
> Whether the repair invoice is routed through the insured or submitted by the service provider directly by assignment, the service provider's repair invoice is submitted to the insurer for coverage and reviewed by an adjuster. The only difference an assignment makes is that, if an insurance company wishes to partially deny coverage or contest an invoice as unreasonable, the insured policyholder is not mired in litigation in which he or she has no stake.[27]

There have been a number of cases in recent years where courts have held that post-loss benefits are assignable.[28]

Data and Recommendations for Reform

According to the Department of Financial Services, the number of lawsuits related to water claims where the claimant is an assignee has increased in recent years. In 2006, there were 8 lawsuits and in 2010, there were 483. The numbers increased in subsequent years:

2011 – 989
2012 – 1,603
2013 – 2,083
2014 – 2,786
2015 – 5,328
2016 – 8,488
2017 through September 30 – 5,968[29]

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[26] *Security First Insurance Company v. State of Florida, Office of Insurance Regulation*, Case No. 1D14-1864 (Fla. 1st DCA), Appellant's Initial Brief at pp. 3-4 (appellate record citations omitted).
[27] *One Call Property Services, Inc. v. Security First Insurance Company*, Case No. 4D14-0424 (Fla. 4th DCA), Appellant's Initial Brief at 46-48.
[28] *See, e.g., Security First Ins. Co. v. State of Florida Office of Insurance Regulation*, 177 So.3d 627, *rehearing denied* (Fla. 1st DCA 2015); *Bioscience W., Inc. v. Gulfstream Prop. & Cas. Ins. Co.*, 185 So.2d 638 (Fla.2d DCA 2016); *One Call Property Services, Inc. v. Security First Ins. Co.*, 165 So.3d 749 (Fla. 4th DCA 2015); *Accident Cleaners, Inc. v. Universal Ins. Co.*, 186 So.3d 1 (Fla. 5th DCA 2015).
[29] Information provided by the DFS to Committee staff (on file with the Committee).

In 2015, the Office of Insurance Regulation (OIR) did a data call to attempt to determine the effect of assignment of benefits in the insurance market.[30] The OIR found that water losses alone could require rate increases of 10 percent per year.[31] One company reported that, in 2015, the claim cost of a claim with an assignment of benefits was 141 percent greater than the claim cost of a claim without an assignment of benefits.[32] The company reported 90 cases of suspected insurance fraud to the Department of Financial Services in 2015 and part of 2016.

Citizens Property Insurance Company reported that the percentage of claims litigated with an assignment of benefits increased from 9.6 percent in 2012 to 46.9 percent in 2015.[33] It projects that the average premium will increase in Miami-Dade County from $2,926 to $4,712 by 2022, and in Broward County from $2,390 to $3,850 by 2022.[34] Citizens reports that water claims, including those that do not involve an assignment of benefits, have been increasing:

> 8,097 new lawsuits were filed against Citizens between January and November 2016, a 30 percent increase from the same period in 2015. Meanwhile, Citizens' policy count dropped by 26.3 percent between January 2015 and November 2016.[35]

Citizens noted that factors other than assignment of benefits contribute to the increase in the number of lawsuits. It noted that in many cases, it is made aware of a loss only after repairs are made or the policyholder has hired an attorney or a public adjuster.[36]

Citizens reported 16,150 closed non-weather water claims between January 1, 2016, and June 30, 2017:

	Number of Claims	**Severity**
Attorney Involved and AOB	5,042	$29,889
Attorney Involved, No AOB	4,644	$21,289
No Attorney Involved and AOB	636	$ 9,530
No Attorney Involved, No AOB	5,828	$ 4,430[37]

In a presentation to the Florida Cabinet on February 7, 2017, the State Insurance Commissioner explained that the frequency of water claims rose by 46 percent from 2010 to 2015 and the

[30] http://www.floir.com/Sections/PandC/AssignmentofBenefits.aspx (last accessed January 8, 2018).
[31] Office of Insurance Regulation, *2015 Report on Review of the 2015 Assignment of Benefits Data Call* (February 8, 2016) at p. 8.
[32] Security First Insurance, *Troubled Water: An Analysis of Water Damage Claims and the Impact on Homeowner's Insurance Premiums in Florida* (July 20, 2016) at p. 13.
[33] Citizens Property Insurance Corporation, *Non-Catastrophic Homeowners Water Claims* (January 2016) at p. 3. The report can be found here: https://www.citizensfla.com/documents/20702/1335431/20160121+White+Paper+Non-Catastrophic+Homeowners+Water+Claims.pdf/f66d4f43-e4cf-4e6e-b857-d457d761f5d6 (last accessed January 8, 2018).
[34] Citizens Property Insurance Company, AOB Reform Makes Pocket Sense (on file with the Committee on Banking and Insurance).
[35] https://www.citizensfla.com/-/20161207_bog-press-release (last accessed January 8, 2018).
[36] *Id*.
[37] Citizens Property Insurance Corporation, *President's Report*, December 13, 2017 at p 14 (on file with the Committee).

amount the insurers pay on those claims has increased 28 percent.[38] Data gathered in a data call by the OIR showed that the use of assignments of benefits has increased from 5.7 percent of the claims in 2010 to 15.9 percent of the claims in 2015.[39] The Commissioner continued:

> Absent any other type of reform, absent any other type of coverage or other expense that might be present on an insurance policy, were these trends to continue unchecked, policyholders would expect to see about a 10 percent rate increase going forward just to keep up with the water trends that are covering their policy.[40]

The Commissioner recommended various reforms:

- Amending s. 627.428, F.S., to apply to insureds only and not to assignees;
- Consumer protections so that consumers are not left "holding the bag" if there is a dispute between the insurance company and a contractor; and
- Notice requirements so the insurer is aware of the assignment and can participate in the claims adjustment process.[41]

On January 12, 2018, the OIR released a report on a 2017 data call.[42] The frequency of water claims per 1,000 policies has increased 44 percent since 2015 and the average severity of claims has increased 11.4 percent on annualized basis since 2018.[43] The number of water claims with an AOB has increased to 17 percent in 2017 from 14.9 percent in 2016.[44] The report also showed a claim with at least one AOB was generally a more severe claim than a claim without an AOB.[45]

The First District Court of Appeal recently noted:

> [W]e are not unmindful of the concerns that Security First expressed in support of [limiting assignment of benefits], providing evidence that inflated or fraudulent post-loss claims filed by remediation companies exceeded by thirty percent comparable services; that policyholders may sign away their rights without understanding the implications; and that a "cottage industry" of "vendors, contractors, and attorneys" exists that use the "assignments of benefits and the threat of litigation" to "extract higher payments from insurers." These concerns, however, are matters of policy that we are ill-suited to address.[46]

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[38] Transcript of the Meeting of the Governor and Cabinet, February 7, 2017, at p. 11. The transcript can be found at http://www.myflorida.com/myflorida/cabinet/agenda17/0207/transcript.pdf (last accessed January 8, 2018).
[39] Office of Insurance Regulation, *2015 Report on Review of the 2015 Assignment of Benefits Data Call* (February 8, 2016) at p. 6 and 11.
[40] *Id*. at 11-12.
[41] *Id*. at 16-18.
[42] Office of Insurance Regulation, *Report of the 2017 Assignment of Benefits Data Call*, January 12, 2018. The report can be found at https://www.floir.com/siteDocuments/AssignmentBenefitsDataCallReport02082017.pdf (last visited January 22, 2018).
[43] *Id*. at 3.
[44] *Id*. at 9.
[45] *Id*. at 8. The OIR noted that the reason for higher severity cannot be determined from the information gathered in the data call.
[46] *Security First Ins. Co. v. State of Florida Office of Insurance Regulation*, 177 So.3d 627, 628, *rehearing denied* (Fla. 1st DCA 2015).

The Fourth District Court of Appeal explained the competing policy arguments raised by the assignment of benefits issue:

> Turning to the practical implications of this case, we note that this issue boils down to two competing public policy considerations. On the one side, the insurance industry argues that assignments of benefits allow contractors to unilaterally set the value of a claim and demand payment for fraudulent or inflated invoices. On the other side, contractors argue that assignments of benefits allow homeowners to hire contractors for emergency repairs immediately after a loss, particularly in situations where the homeowners cannot afford to pay the contractors up front.[47]

The court noted that if "studies show that these assignments are inviting fraud and abuse, then the legislature is in the best position to investigate and undertake comprehensive reform."[48]

Proposals for Settlement (Lines 173-177 of the bill)

The "offer of judgment" provided by s. 768.79, F.S., awards attorney's fees to:

- A defendant in any civil action for damage whose proposal for settlement is rejected where the judgment is 75 percent or less than the defendant's offer (including where the plaintiff is awarded nothing or there is a finding of no liability); or
- A plaintiff whose proposal for settlement is rejected where the judgment is at least 25 percent more than the plaintiff's offer.

Section 768.79, F.S., does not provide a time for making settlement proposals. However, Florida Rule of Civil Procedure 1.442(b) provides:

> A proposal to a defendant shall be served no earlier than 90 days after service of process on the defendant; a proposal to the plaintiff shall be serviced no earlier than 90 days after the action has been commenced.

III. Effect of Proposed Changes:

Insurance Rates (Section 1 of the bill)

The bill amends s. 627.062, F.S., to provide that attorney fees paid pursuant to s. 627.428, F.S., may not be included in the insurer's rate base and may not be used to justify a rate or rate change. These provisions will bar the use of attorney fees paid pursuant to s. 627.428, F.S., in rate making in property, casualty, surety, motor vehicle, employer liability, title, wet marine, credit life or credit disability, and health insurance.

Misrepresentations in Insurance Applications (Section 2 of the bill)

The bill amends s. 627.409, F.S., to provide that a misrepresentation, omission, concealment of fact or incorrect statement on an insurance application may prevent recovery only if the

[47] *One Call Property Services, Inc. v. Security First Ins. Co.*, 165 So.3d 749, 755 (Fla. 4th DCA 2015).
[48] *Id*.

misrepresentation, omission, concealment of fact, or incorrect statement directly relates to the cause of the claim. If the misrepresentation, omission, concealment of fact or incorrect statement directly relates to the cause of the claim, one of the following must apply:

(1) The misrepresentation, omission, concealment, or statement is fraudulent or is material to the acceptance of the risk or to the hazard assumed by the insurer; or
(2) If the true facts relative to the loss claimed had been known to the insurer pursuant to a policy requirement or other requirement, the insurer in good faith would not have:
    - Issued the policy or contract;
    - Issued the policy or contract at a premium rate at least 20 percent higher than the rate actually charged;
    - Issued a policy or contract in as large an amount; or
    - Provided coverage with respect to the hazard resulting in the loss.

Assignment of Benefits

Section 3 of the bill amends s. 627.422, F.S., to provide that a personal lines residential property insurance policy or a commercial residential property insurance policy may not restrict the assignment of post-loss benefits. This provision is a restatement of case law that prohibits the restriction of post-loss assignments.

Section 4 of the bill creates s. 627.7152, F.S., to provide requirements for the valid execution of an assignment of post-loss benefits of a residential homeowner's property insurance policy, create requirements regarding litigation involving such assignments, and require insurers to report data to the OIR regarding homeowner's insurance claims involving post-loss assignments.

The bill in s. 627.7152(1), F.S., provides that an agreement to assign post-loss benefits of a residential homeowner's property insurance policy is not valid unless the agreement:

- Is in writing;
- Is limited to claims for work performed or work to be performed by the assignee;
- Contains an accurate and up-to-date statement of the scope of work to be performed;
- Allows the insured to rescind the assignment within 7 days after the execution of the assignment;
- Provides that the insured may be responsible for payment for any work performed before the rescission of the assignment; and
- Contains a provision, in 14-point boldfaced type, which allows the insured to rescind the agreement within 7 days after execution of the assignment, and with a notice that if the assignment is rescinded, the homeowner is responsible to pay for the work done up to the date of the rescission and that the homeowner is not otherwise responsible to pay for the work covered by the assignment.

The bill in s. 627.7152(2), F.S., requires the assignee to provide a copy of the assignment agreement to the insurer within the earlier of 7 days after execution of the agreement, or 48 hours after beginning nonemergency work if the insurer has a facsimile number and e-mail address on its website designated for the delivery of such documents. The notice[49] must be accompanied by a written estimate of the work to be done, with unit prices indicated where appropriate, and the

[49] The bill uses "notice" although the assignee is required to provide the entire "agreement" to the insurer.

basis for calculating lump sum fees if unit prices are inappropriate. The estimate must be timely updated if conditions require a change in scope. The failure to comply with this requirement constitutes a defense to any payment obligation under the policy or the assignment, if the insurer can establish prejudice resulting from the failure.

The bill allows the insurer to inspect the property at any time. If the insurer fails to attempt in good faith to inspect the property within 7 days after learning of the loss and promptly deliver to the assignee written notice of any perceived deficiency in the assignee's notice or the work being performed, the failure may be raised to estop the insurer from asserting that work done was not reasonably necessary or that the notice was insufficient.

The bill in s. 627.7152(3), F.S., provides that notwithstanding any other law, the acceptance by an assignee of a valid assignment agreement constitutes a waiver by the assignee or transferee, and any subcontractor of the assignee or transferee, of any and all claims against named insureds for payment arising from the specified loss. However, all named insureds remain responsible for:

- The payment of any deductible amount provided for by the terms of the insurance policy;
- The payment for work performed before the rescission of the assignment agreement, if there is a rescission;
- The cost of any betterment specifically authorized by the insured in a writing that identifies the work as betterment for which the insured will be liable; and
- A misrepresentation of the existence of homeowner's coverage by the homeowner.

This waiver is valid even if the assignment agreement is determined to be invalid.

Under s. 627.7152(7), F.S., the bill's requirements relating to assignment agreements do not apply to:

- An assignment, transfer, or conveyance granted to a subsequent purchaser of the property with an insurable interest in the property following a loss; or
- A power of attorney under ch. 709, F.S., which grants to a management company, family member, guardian, or similarly situated person of an insured the authority to act on behalf of an insured as it relates to a property insurance claim.

Presuit Notice

The bill in s. 627.7152(4), F.S., requires an assignee to provide the insurer an invoice for all work that has been performed and a current estimate of work remaining to be performed no later than 30 days before an assignee initiates litigation against an insurer relating to a residential homeowner's property insurance claim.

Proposals for Settlement

The bill in s. 627.7152(5), F.S., provides that in a civil action relating to a residential homeowner's property insurance claim under a policy in which an assignment agreement was executed, an offer of settlement under s. 768.79, F.S., by any party may be made no earlier than 30 days after the civil action has commenced.

Required Reports to the Office of Insurance Regulation

The bill in s. 627.7152(6), F.S., requires each insurer to report data on each residential property claim paid pursuant to an assignment agreement in the prior calendar year. The data must include specific data about claims adjustment and settlement timeframes and trends grouped by whether litigated or not litigated, by loss adjustment expenses, and by the amount and type of attorney fees incurred or paid. The bill provides that the office may adopt rules to administer these provisions.

The required information must be reported by January 30, 2021, and each year thereafter.

Section 5 provides that the bill takes effect July 1, 2018.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

Court Rulemaking

Lines 173-177 of the bill allow either party to make a proposal for settlement no earlier than 30 days after the civil action has commenced. Florida Rule of Civil Procedure 1.442(b) provides that a proposal for settlement to a defendant shall be served no earlier than 90 days after service of process on that defendant. A proposal to a plaintiff shall be served no earlier than 90 days after the action has been commenced. Florida Rule of Civil Procedure 1.442(a) provides that the rule applies to all proposals for settlement and "supersedes all other provisions of the rules and statutes that may be inconsistent with this rule."

Article V, section 2(a), of the Florida Constitution provides, in relevant part:

> The supreme court shall adopt rules for the practice and procedure in all courts including the time for seeking appellate review, the administrative supervision of all courts, the transfer to the court having jurisdiction of any proceeding when the jurisdiction of another court has been improvidently invoked, and a requirement that no cause shall be dismissed because an improper remedy has been sought.

Article II, section 3 of the Florida Constitution, reads:

> The powers of the state government shall be divided into legislative, executive and judicial branches. No person belonging to one branch shall exercise any powers appertaining to either of the other branches unless expressly provided herein.

These provisions have been interpreted to give the Florida Supreme Court exclusive jurisdiction over procedural matters while the Legislature has exclusive jurisdiction over substantive law.

The issue created by the bill is whether the Legislature has the constitutional power to set a time for service of proposals for settlement which conflicts with the time set in court rule. The Florida Rules of Civil Procedure are rules of procedure adopted by the Florida Supreme Court. If the timing of service of proposals for settlement is deemed procedural, then the Florida Supreme Court has exclusive jurisdiction to set the time. If it is substantive, then the Legislature can set the time by general law.

The Florida Supreme Court has not specifically addressed the issue. If the statute were to be challenged, the court would have a number of options. In *Timmons v. Coombs*,[50] the court found that s. 768.79, F.S., contained procedural portions and adopted those as rules of court without explaining which portions of the law were procedural and which portions were substantive. If the court were to find the time for service is procedural, it would strike down the statute and require parties to follow rule 1.442.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Section 1 of this bill is similar to a provision in CS/SB 1684 filed during the 2017 session. In its analysis of that bill, the OIR expressed concerns that if insurers are not allowed to use attorney fees as part of the ratemaking process, the OIR might be forced to approve rates that are insufficient. The OIR was also concerned that insurers may pay many more claims to avoid paying attorney fees and that this could lead to rate increases.[51]

C. Government Sector Impact:

None.

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[50] 608 So.2d 1 (1992).

[51] Office of Insurance Regulation, *Analysis of SB 1684* (March 28, 2017)(on file with the Committee on Banking and Insurance).

VI. Technical Deficiencies:

Line 186 provides rulemaking authority to the OIR. Section 20.121(3)(c), F.S., provides that the Financial Services Commission is the agency head for purposes of ch. 120 rulemaking.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 627.062, 627.409, 627.422, and 627.7152.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.