Committee on Banking and Insurance

CS/CS/SB 54 — Motor Vehicle Insurance

by Judiciary Committee; Banking and Insurance Committee; and Senators Burgess and Rouson

Motor Vehicle Financial Responsibility Requirements

CS/CS/SB 54 repeals the Florida Motor Vehicle No-Fault Law (No-Fault Law), which requires every owner and registrant of a motor vehicle in this state to maintain Personal Injury Protection (PIP) coverage. The bill enacts, effective January 1, 2022, financial responsibility requirements for liability for motor vehicle ownership or operation, as follows:

- For bodily injury (BI) or death of one person in any one crash, $25,000, and
- Subject to that limit for one person, $50,000 for BI or death of two or more people in any one crash.

The bill retains the existing $10,000 financial responsibility requirement for property damage (PD).

The bill increases required coverage amounts for garage liability and commercial motor vehicle insurance. It also increases the cash deposit amount required for a certificate of self-insurance establishing financial responsibility for owners and operators of motor vehicles that are not for-hire vehicles.

Mandatory Offer of Medical Payments Coverage

The bill requires insurers to offer medical payments coverage (MedPay), which protects the named insured, resident relatives, vehicle operators, vehicle passengers, and pedestrians struck by a motor vehicle to a limit of at least $5,000 for medical expenses incurred due to bodily injury, sickness, or disease arising out of the ownership, maintenance, or use of a motor vehicle. Coverage must be offered at limits of both $5,000 and $10,000. Insurers may also offer other policy limits that exceed $5,000. Insurers must offer a zero deductible option for MedPay, and may also offer deductibles of up to $500. MedPay must provide an additional death benefit of at least $5,000. MedPay coverage to a limit of $10,000 with no deductible is presumed to be contained in the policy unless a named insured signs a form declining the coverage or selects a different coverage limit or a deductible. Insurers must reserve $5,000 of MedPay benefits for 30 days to pay physicians or dentists who provide emergency services and care or hospital inpatient care.

The repeal of the No-Fault Law eliminates the limitations on recovering pain and suffering damages from PIP insureds, which currently requires bodily injury that causes death or significant and permanent injury. Because this limitation is repealed, the bill also specifies that legal liability of an uninsured motorist insurer includes damages in tort for pain, suffering, disability or physical impairment, disfigurement, mental anguish, inconvenience, and the loss of past and future capacity for the enjoyment of life.

Mandatory Death Benefit

The bill requires that each motor vehicle insurance policy issued to meet the financial responsibility requirements established by the bill must also provide a first-party death benefit of $5,000 per deceased individual. As with MedPay, the death benefit covers the named insured, resident relatives, vehicle operators, vehicle passengers, and pedestrians struck by a motor vehicle. The benefit is payable when the death arises out of the ownership, maintenance, or use of a motor vehicle.

Actions Against Motor Vehicle Insurers for Bad Faith Failure to Settle Third-Party Claims

The bill creates a new framework governing all actions against motor vehicle insurers for bad faith failure to settle a third-party claim. The bill requires motor vehicle insurers to follow claims handling best practices standards based on long-established good faith duties related to claim handling, claim investigation, defense of the insured, and settlement negotiations. The bill also specifies an insured's duty to cooperate with their insurer in attempting to settle third-party claims, and specifies conditions in which an insurer may terminate its defense because of the insured's failure to cooperate. The bill prohibits the trier of fact in a bad faith action from attributing the insurer's failure to settle a covered claim to the claimant's lack of communication when the claimant makes certain communications to the insurer.

The bill defines "bad faith failure to settle" as an insurer's violation of a best practice, which is a proximate cause of the insurer not settling a third-party claim when, under all the circumstances, the insurer could and should have done so, had it acted fairly and honestly toward its insured and with due regard for the insured's interests. The party bringing the bad faith action has the burden to prove both elements.

The bill creates "safe harbors" to provide insurers a reasonable opportunity to investigate and evaluate a claim. The safe harbors specify that an insurer that follows the best practices does not act in bad faith when the insurer:

- Does not initiate settlement negotiations by tendering applicable policy limits in exchange for a general release of the insured within 45 days after receiving actual notice of the loss.
- Does not accept a settlement offer within 45 days after receiving actual notice of the loss if:
  - The settlement offer provides the insurer fewer than 15 days for acceptance; or
  - The settlement offer provides the insurer fewer than 30 days for acceptance where the offer contains conditions for acceptance other than the insurer's disclosure of its policy limits.

The best practices require that an insurer must initiate settlement negotiations after the expiration of the foregoing safe harbor periods by tendering its policy limits to the claimant in exchange for a general release of the insured, if the facts available to the insurer indicate the insured's liability is likely to exceed the policy limits.

The bill specifies that the damages in a bad faith action are the amount of the excess judgment and court costs. If the party bringing the bad faith action is the insured or an assignee of the insured, the damages also include reasonable attorney fees incurred by the party bringing the action. Punitive damages may not be awarded.

Setoff on Noneconomic Damages

The bill provides the defendant a $10,000 setoff on noneconomic damages for injuries suffered by a person who operated a motor vehicle that lacked the minimum required motor vehicle insurance under the financial responsibility law while such operator was not in compliance with financial responsibility requirements for more than 30 days immediately preceding the crash. The setoff on noneconomic damages does not apply if the person who is liable for the injury was driving under the influence; acted intentionally, recklessly, or with gross negligence; fled from the scene of the crash; or was acting in furtherance of, or immediate flight from, a felony.

The setoff on noneconomic damages does not apply to wrongful death claims.

Other Provisions

The bill also:

- Requires motor vehicle insurers to notify policyholders by September 1, 2021, of the new financial responsibility requirements and to allow policyholders to change their existing coverage to meet the new financial responsibility requirements.
- Specifies that any policy issued before January 1, 2022, in compliance with the Florida Motor Vehicle No-Fault Law, is deemed to comply with the financial responsibility requirements established by the bill until the end of the policy term.
- Increases required coverage amounts for garage liability and commercial motor vehicle insurance.
- Provides that if a motor vehicle insurer fails to timely provide information related to liability insurance coverage as required by s. 627.4137, F.S., the claimant may file an action to enforce the section, and is entitled to an award of reasonable attorney fees and costs to be paid by the insurer.
- Allows policyholders to obtain motor vehicle insurance that excludes specified coverages for claims or suits resulting from the operation of a motor vehicle by an identified individual who is specifically excluded by name.

If approved by the Governor, these provisions take effect January 1, 2022, except where otherwise provided.
Vote: Senate 37-3; House 100-16

Committee on Banking and Insurance

CS/CS/CS/SB 76 — Property Insurance

by Rules Committee; Judiciary Committee; Banking and Insurance Committee; and Senators Boyd and Brandes

Prohibited Property Insurance Practices by Contractors

The bill prohibits contractors, and persons acting on behalf of contractors, from:

- Soliciting residential property owners through prohibited advertisements, which are communications to a consumer that encourage, instruct, or induce a consumer to contact a contractor to file an insurance claim for roof damage;
- Offering the residential property owner consideration to perform a roof inspection or file an insurance claim;
- Offering or receiving consideration for referrals when property insurance proceeds are payable;
- Unlicensed public adjusting; and
- Providing an authorization agreement to the insured without providing a good faith estimate.

The above acts are subject to license discipline by the Department of Business and Professional Regulation and a $10,000 fine per violation. The bill provides that the residential property owner may void the contract with the contractor within 10 days of its execution if the contractor fails to provide notice to the residential property owner of the contractor's prohibited practices.

The bill prohibits licensed contractors and subcontractors from advertising, soliciting, offering to handle, handling, or performing public adjuster (PA) services without a license. The prohibition does not prohibit the contractor from recommending that the consumer consider contacting his or her insurer to determine if the proposed repair is covered by insurance.

The bill prohibits a PA, PA apprentice, or person acting on behalf of a PA or PA apprentice, from offering financial inducements for allowing a roof inspection of residential property or making an insurance claim for roof damage. The bill also prohibits them from offering or accepting consideration for referring services related to a roof claim. Each violation subjects the PA or PA licensee to up to a $10,000 fine. Unlicensed persons not otherwise exempted from PA licensure commit the unlicensed practice of public adjusting when they do these prohibited acts, and are subject to a $10,000 fine per act and the criminal penalty for unlicensed activity.

Regulatory Oversight of Property Insurers

The bill requires insurers to annually file, with the Office of Insurance Regulation (OIR), specified data on residential and commercial property insurance closed claims.

The bill requires that any fee, commission, or consideration paid to an affiliate must be fair and reasonable. In determining whether the consideration is "fair and reasonable," the OIR must

consider the actual cost of the service being provided and may consider other factors. Companies that pay affiliates must provide to OIR any information the office deems necessary.

The bill removes the underwriting exemption for a contract between an insurer and a managing general agent (MGA) when the MGA is controlled by, or a controlling person of, an insurer with which it contracts. The bill removes the examination exemption for an MGA that represents a single domestic insurer, allowing the OIR to examine such MGA as if the MGA were the insurer.

The bill specifies that when OIR examines an insurer that is part of an insurance holding company, the insurer must pay the expense of examination and the OIR may retain at the insurer's expense attorneys, actuaries, accountants, and other experts reasonably necessary to assist in the examination. The OIR may require such insurers to produce records, books, and other information in the possession of the insurer or its affiliates as are reasonably necessary. The OIR may examine the insurer's affiliates to obtain reasonably necessary information; however, such examination may not extend to the passive investors of affiliates in the holding company system which do not provide services to, or have relationships with, the insurer.

Citizens Property Insurance Corporation

The bill provides that a personal lines residential risk seeking to be newly insured by Citizens Property Insurance Corporation (Citizens) is ineligible for coverage if it receives an offer of comparable coverage from an authorized insurer that is not more than 20 percent higher than the Citizens premium, rather than the current 15 percent eligibility threshold for new policyholders.

The bill increases the 10 percent cap (the "glide path") on Citizens rate increases by 1 percent annually beginning in 2022, until the cap reaches 15 percent in 2026.The bill specifies that Citizens' rate calculations must include the cost of reinsurance to cover its projected 100-year probable maximum loss, even when Citizens does not purchase reinsurance.

The bill requires that Citizens' budget allocations for employee compensation and all proposed raises for an employee exceeding 10 percent of their current salary must be approved by the Citizens board of governors. The bill requires Citizens to have an overall employee compensation plan approved by the board of governors.

Notice of Property Insurance Claims

The bill specifies a property insurance claim or reopened claim must be provided to the authorized or surplus lines insurer within 2 years of the date of loss. A supplemental claim is barred unless notice is provided to the insurer within 3 years after the date of loss. The bill clarifies that the date of loss for claims resulting from hurricanes, tornadoes, windstorms, severe rain, or weather-related events is the date a hurricane makes landfall or when the tornado, windstorm, severe rain, or another type of weather-related event is verified by the National Oceanic and Atmospheric Administration (NOAA).

Lawsuits Arising Under Property Insurance Policies

The bill creates a framework for all suits not brought by an assignee arising under a residential or commercial property insurance policy, including surplus lines policies.

A claimant must provide DFS with written notice of intent to initiate litigation at least 10 business days before filing suit. The notification must be made on a form provided by DFS and may not be given before the earlier of the insurer's denial of coverage or the expiration of the 90-day period to adjust a claim under s. 627.70131, F.S. The notice must detail the alleged acts or omissions of the insurer giving rise to the suit. If the insurer denied coverage, the notice must include an estimate of damages. If the insurer did not deny coverage, notice must include a presuit settlement demand that itemizes damages, attorney fees, costs, and the disputed amount. The notice may include supporting documents. The notice and supporting documents are admissible only in a proceeding regarding attorney fees. A court must dismiss without prejudice any claimant's suit if the claimant has not complied with the requirement to provide 10 business days' notice of intent to initiate litigation.

The insurer must respond in writing within 10 business days after receiving notice of intent to initiate litigation. If the insurer denied coverage, the insurer must either accept coverage, deny coverage, or assert the right to re-inspect the property within 14 business days. If the notice alleges the insurer did an act other than denying coverage, the insurer must respond by making a settlement offer or requiring the claimant to participate in an appraisal or another method of alternative dispute resolution (ADR). If appraisal or ADR is not concluded within 90 days after the 10-day notice of intent to initiate litigation, the claimant may immediately file suit.

The bill provides that, for lawsuits under surplus lines and authorized residential and commercial property insurance policies not brought by an assignee, attorney fees may only be awarded using the methodology created by the bill or when the court imposes sanctions under s. 57.105, F.S. Accordingly, claimants may no longer obtain attorney fees under s. 627.428, F.S., or s. 626.9373, F.S., nor may insurers recover attorney fees using an offer of judgment under s. 768.79, F.S.

Attorney fees and costs are awarded based on a formula that compares the amount obtained by the claimant in excess of the insurer's presuit settlement offer (exclusive of attorney fees and costs) with the disputed amount between the two parties (the difference between the claimant's presuit settlement demand and the insurer's presuit settlement offer, also exclusive of attorney fees and costs). If the amount obtained by the claimant in excess of the insurer's presuit settlement offer is:

- Less than 20 percent of the disputed amount, each party pays its own attorney fees and costs.
- At least 20 percent but less than 50 percent of the disputed amount, the insurer pays the claimant's attorney fees equal to the percentage of the disputed amount obtained times the total attorney fees and costs.
- At least 50 percent of the disputed amount, the insurer pays the claimant's full attorney fees and costs.

Consolidation of Multiple Residential Property Suits

The bill requires each party that is aware of ongoing multiple actions, based upon coverage provided under the same residential property insurance policy for the same property and owners, must provide written notice to the court of the multiple actions. Once the court receives notice, it may order that the actions be consolidated and transferred to the court having jurisdiction based on the total amount in controversy of all consolidated claims. If multiple cases are pending in circuit courts, the cases may be consolidated based on the date the first case was filed.

If approved by the Governor, these provisions take effect July 1, 2021.
Vote: Senate 35-5; House 75-41

Committee on Banking and Insurance

CS/SB 420 — Motor Vehicle Insurance Coverage Exclusions

by Judiciary Committee and Senator Hooper

The bill creates s. 627.747, F.S., to authorize a private passenger motor vehicle policy to exclude specified coverages for claims resulting from the operation of a motor vehicle by an identified individual other than the named insured. The bill provides for exclusion of the following coverages under the policy:

- Personal injury protection (PIP) coverages applicable to the identified individual's injuries, lost wages, and death benefits;
- Property damage liability coverage;
- Bodily injury liability coverage, when required by law;
- Uninsured motor coverage for any damages sustained by the excluded individual; and
- Any coverage the named insured is not required by law to purchase.

The bill requires that a valid exclusion include the written consent of the named insured and that the identified individual is named on the declarations page of, of endorsement to, the policy. The bill prohibits a private passenger motor vehicle policy from excluding coverage when:

- The identified individual is injured while not operating a motor vehicle;
- The identified individual is solely excluded on the basis of race, color, religion, sex, national origin, age, handicap, pregnancy, or marital status; or
- The exclusion is inconsistent with the underwriting rules filed by the insurer.

The bill requires that an identified individual excluded from the named insured's policy must separately establish, maintain, and show proof of financial responsibility under ch. 324, F.S., for the purpose of responding to damages out of ownership, maintenance, or use of a motor vehicle, and maintain the required security under s. 627.733, F.S., for the purpose of payment of required benefits.

If approved by the Governor, these provisions take effect July 1, 2021.
Vote: Senate 40-0; House 116-0

Committee on Banking and Insurance

CS/HB 425 — Disposition of Unclaimed Property

by Insurance and Banking Subcommittee and Reps. Clemons, Duggan, and others (CS/SB 1434 by Banking and Insurance Committee and Senator Wright)

CS/HB 425 revises the claims process under the Florida Disposition of Unclaimed Property Act. Specifically, the bill replaces the power of attorney and full disclosure statement process used by claimant representatives as provided in ch. 717, F.S., with a standardized unclaimed property recovery agreement for claimant representatives to use when recovering unclaimed property on behalf of a client claimant. The bill also creates a standardized unclaimed property purchase agreement that must be used by purchasers of unclaimed property held by the Division of Unclaimed Property. The bill directs the Department of Financial Services to create these standardized agreements by rule and provides rulemaking requirements for the development of the agreements. The bill also provides that the total fees and costs that may be charged in a recovery agreement, or the total discount in the case of a purchase agreement, may not exceed 30 percent of the claimed amount and a process for the payment of claims. Finally, the bill also revises s. 717.124(7), F.S., to increase from $1,000 to $2,000 the maximum recovery value for claims submitted electronically that utilize identity verification processes other than government issued photographic identification or a sworn, notarized statement.

In addition to the above revisions relating to the claims process, the bill also creates a new requirement that if a will or trust instrument is included within an unclaimed safe deposit box or other safekeeping repository delivered to DFS, the department must provide a copy of such will or trust instrument (and any codicils or amendments thereto) upon request to a person providing evidence of the death of the testator or settlor.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 40-0; House 118-0

Committee on Banking and Insurance

HB 467 — Insurance Adjuster Examination Requirements

by Reps. DuBose; McCurdy; and others (SB 534 by Senators Gibson and Thurston)

HB 467 amends s. 626.221, F.S., to add a category of persons to the list of individuals who are not required to take the examination to become an all-lines insurance adjuster—namely a person certified as an Accredited Insurance Claims Specialist from Encore Claim Services.

If approved by the Governor, these provisions take effect July 1, 2021.
Vote: Senate 39-0; House 115-0

Committee on Banking and Insurance

CS/CS/SB 566 — Motor Vehicle Rentals

by Appropriations Committee; Banking and Insurance Committee; and Senator Perry

The bill creates taxation, insurance, and operational requirements for peer-to-peer car-sharing programs.

The tax provisions of the bill:

- Clarify that Florida's 6 percent sales tax applies to a peer-to-peer car-sharing program.
- Require the peer-to-peer car-sharing program to collect and remit the sales tax due.
- Impose a $1 per day or any part of the day surcharge on each peer-to-peer car-sharing program agreement. The surcharge applies to the first 30 days of the car sharing period.
- Require the peer-to-peer car-sharing program to collect the surcharge due.
- Require the peer-to-peer car-sharing program to attribute the surcharge revenue to the county corresponding to the car-sharing start time location for purposes of reporting surcharge revenue.

The insurance provisions of the bill:

- Require the peer-to-peer car-sharing program to ensure the shared vehicle owner and shared vehicle driver are insured during each car-sharing period under a motor vehicle insurance policy that provides minimum statutory requirements for property damage liability, bodily injury liability, personal injury protection, and uninsured and underinsured vehicle insurance coverages.
- Specify the peer-to-peer car-sharing program may satisfy compliance with minimum statutory insurance coverages by a motor vehicle insurance policy maintained by the shared vehicle owner, shared vehicle driver, the peer-to-peer car-sharing program, or a combination of all three.
- Specify that the motor vehicle insurance policy used by the peer-to-peer car-sharing program to satisfy minimum statutory insurance coverages is primary in the event of a claim. The insurer or peer-to-peer car-sharing program providing the required coverage assumes primary liability for a claim when a dispute exists over who was in control of the shared vehicle at the time of the loss, or a dispute exists over whether the shared vehicle was returned to the agreed-upon location specified in the peer-to-peer car-sharing programs agreement. The peer-to-peer car-sharing program assumes liability in the event of a coverage lapse by the shared vehicle owner or shared vehicle driver.
- Provides that a peer-to-peer car-sharing program may maintain one or more motor vehicle insurance policies which provide coverage for liabilities assumed by the peer-to-peer car?sharing program under a peer-to-peer car-sharing program agreement, liability of the shared vehicle owner, liability of the shared vehicle driver, damage or loss to the shared motor vehicle, or damage, loss, or injury to persons or property to satisfy minimum statutory requirements for personal injury protection and uninsured and underinsured insurance coverage.
- Specifies the peer-to-peer car-sharing program assumes liability during the car-sharing period of a shared vehicle owner for bodily injury or property damage to a third party or

uninsured and underinsured motor or personal injury losses. The peer-to-peer car-sharing program does not assume liability when a shared vehicle owner makes an intentional or fraudulent material representation or omission before the car-sharing period in which the loss occurs, or the shared vehicle owner acts in concert with shared vehicle driver who fails to return the shared vehicle in accordance with the peer-to-peer car-sharing program agreement.

- Provide that the peer-to-peer car-sharing program and the shared vehicle owner are exempt from vicarious liability consistent with federal law.
- Provide that an authorized motor vehicle insurer may exclude any coverage and the duty to defend or indemnify any claim under a shared vehicle owner's motor vehicle insurance policy.

The operational provisions of the bill:

- Require the peer-to-peer car-sharing program to provide notice to a shared vehicle owner upon registration, that if the shared vehicle has a lien against it, use of the shared vehicle in the peer-to-peer car-sharing program may violate the terms of the contract with the lienholder.
- Require the peer-to-peer car-sharing program to keep and retain specified records relating to the facilitation of claim coverage investigation, settlement, negotiation, or litigation.
- Require the peer-to-peer car-sharing program to provide notice of specified matters to the shared vehicle owner and shared vehicle driver, including the rates of the peer-to-peer car-sharing program contract and the peer-to-peer car-sharing programs' right to seek indemnification and make defenses.
- Require that the shared vehicle driver has a current, valid driver's license or be otherwise authorized to drive.
- Specify the peer-to-peer car-sharing program has sole responsibility for equipment put in or on the shared vehicle for purposes of monitoring or facilitating the peer-to-peer car-sharing transactions.
- Require the peer-to-peer car-sharing program to verify the shared vehicle has been repaired pursuant to any safety recalls, provide notice to the shared vehicle owner of recalls, and remove unrepaired shared vehicles from the peer-to-peer car-sharing program.

If approved by the Governor, these provisions take effect January 1, 2022.
Vote: Senate 28-12; House 101-15

Committee on Banking and Insurance

CS/HB 701 — Behavior Health Care Services Coverage and Access

by Insurance and Banking Subcommittee and Rep. Stevenson and others (CS/CS/SB 1024 by Appropriations Committee; Banking and Insurance Committee; and Senators Brodeur and Rouson)

The bill requires the Department of Financial Services (DFS) to submit a report, by January 31, 2022, to the Legislature and the Governor regarding complaints received from insureds and subscribers about the adequacy of coverage and access to mental health services through their individual or group health insurance policies or health maintenance organization (HMO) contracts.

Further, the bill requires insurers and HMOs to provide insureds and subscribers a direct notice regarding the federal and state coverage requirements for mental health services, as well as contact information for the Division of Consumer Services within the DFS. Insurers and HMOs are also required to make this information available on their website.

If approved by the Governor, these provisions take effect October 1, 2021.
Vote: Senate 40-0; House 117-1

Committee on Banking and Insurance

SB 728 — Credit for Reinsurance

by Senator Broxson

The bill revises provisions relating to the reinsurance statutes of the Florida Insurance Code to incorporate recent changes made by the National Association of Insurance Commissioners (NAIC) to the Credit for Reinsurance Model Law and the Credit for Reinsurance Model Regulation.

The 2017 Bilateral Agreement between the United States and European Union on Prudential Measures Regarding Insurance and Reinsurance (Covered Agreement) reached between the U.S. Department of the Treasury, U.S. Trade Representative, and the European Union (EU), in part, commits the U.S. to phasing-out state-based reinsurance collateral requirements for EU reinsurers by 2022. The covered agreement further exempts EU reinsurers from current U.S. domiciliary requirements for authorized reinsurer status by creating a new, broader classification of jurisdiction called a "reciprocal jurisdiction."

The bill provides insurers with credit for reinsurance and eliminates additional collateral requirements for reinsurers if the reinsurer is domiciled in a "reciprocal jurisdiction" and meets requirements set forth in the bill. The bill defines "reciprocal jurisdiction" to mean:

- A non-U.S. jurisdiction that is subject to an in-force covered agreement with the U.S. or, in the case of a covered agreement between the U.S. and the EU, an EU member state;
- A U.S. jurisdiction that meets the NAIC requirements for accreditation; or
- Any other qualified jurisdiction that meets certain statutory requirements and any additional requirements of the Office of Insurance Regulation set forth in rule.

The requirements the reinsurer must meet include, but are not limited to:

- Minimum capital and surplus requirements;
- Minimum solvency or capital ratios;
- Annual confirmation from the domiciliary supervisory authority stating that the reinsurer meets the capital, surplus, and minimum solvency or capital ratio requirements; and
- Prompt claims payment practices.

The bill also provides insurers with protections against reinsurer failure that include, but are not limited to, requiring the reinsurer to post collateral equal to all outstanding reinsurance liabilities in the event the reinsurer enters into receivership; requiring the reinsurer to consent to the jurisdiction of courts of the State of Florida; and requiring the reinsurer to post collateral equal to all outstanding liabilities if the reinsurer resists enforcement of a court order from a jurisdiction in which it has consented.

If approved by the Governor, these provisions take effect July 1, 2021.
Vote: Senate 38-1; House 118-0

Committee on Banking and Insurance

HB 797 — Florida Life and Health Insurance Guaranty Association

by Representative Robinson, W. (SB 1470 by Senator Boyd)

The bill revises provisions relating to the Florida Life and Health Insurance Guaranty Association (FLAHIGA), the guaranty association for most insurance companies that write life and health insurance or annuities in Florida. The bill incorporates some recent changes made to the National Association of Insurance Commissioners' (NAIC) Life and Health Guaranty Association Model Act and makes additional revisions. The bill:

- Adds a definition for the term "Moody's Corporate Bond Yield Average."
- Amends the definition of "person" to include "limited liability company" and "governmental body or entity."
- Clarifies that, in dealing with an impaired domestic insurer, FLAHIGA may assume or reissue covered policies, in addition to guaranteeing and reinsuring the policies.
- Expressly provides that FLAHIGA has the right to appear or intervene before a court or agency in another state which has jurisdiction over an impaired or insolvent insurer for which FLAHIGA is or may become obligated, or a person or property against whom FLAHIGA may have rights through subrogation or otherwise.
- Provides that, for the purposes of FLAHIGA's standing to appear before any court in this state, FLAHIGA's powers and duties include reissuing or modifying covered policies.
- Provides that FLAHIGA may take legal action to recover payment of improper claims.
- Clarifies that FLAHIGA has the authority to join an organization of other state guaranty associations to further the purposes and to carry out the powers and duties of FLAHIGA.
- As to Class A assessments, which pay FLAHIGA's general administrative expenses, removes the cap of $250, permits the assessment to be made on a pro rata basis, and allows FLAHIGA's board to credit the assessments against future assessment related to insurer insolvencies.
- Provides that, if an insurer's assessment is deferred because the assessment would endanger the insurer's financial solvency, the insurer must pay the assessment once it regains financial strength.
- Removes the reduced assessment cap for nonprofit insurers that issue annuity contracts to education groups, thus making such insurers subject to the assessment cap for all other annuity insurers.
- Directs that FLAHIGA establish a procedure for removing a board member if that member becomes impaired or insolvent, and requires the FLAHIGA board of directors to establish a policy and procedure to address conflicts of interest.

If approved by the Governor, these provisions take effect July 1, 2021.
Vote: Senate 40-0; House 118-0

Committee on Banking and Insurance

CS/CS/CS/HB 1209 — Department of Financial Services

by Commerce Committee; State Administration and Technology Appropriations Subcommittee; Insurance and Banking Subcommittee; and Rep. Fetterhoff and others (CS/SB 1408 by Banking and Insurance Committee and Senator Burgess)

CS/CS/CS/HB 1209 amends sections of Florida Statutes relating to the Department of Financial Services (DFS). The bill:

- Designates the Division of Public Assistance Fraud a criminal justice agency;
- Adds cancer benefits for firefighters (who are employees of a state agency or department covered under s. 284.31, F.S.) into the self-insurance coverages provided by the Division of Risk Management and requires the Department of Management Services to verify and approve payments prior to distribution from the State Risk Management Trust Fund;
- Prohibits employees who fall under the State Risk Management Trust Fund from engaging in retaliatory conduct against a sexual harassment victim and provides that willful and knowing dissemination of the identifying information of a sexual harassment victim, exempt under s. 119.071(2)(n), F.S., is a first degree misdemeanor;
- Amends the Board of Funeral, Cemetery, and Consumer Services composition; clarifies Board member requirements; removes Board term staggering requirements; and clarifies rulemaking responsibilities relating to the Board;
- Prohibits specific unlicensed funeral activity and increases the penalty for such;
- Increases criminal penalties associated with unlicensed Funeral, Cemetery, and Consumer Services activity;
- Allows cemetery companies to sell certain merchandise for use within a cemetery, including cemeteries that the cemetery company selling such items does not own;
- Allows funeral director interns and combination funeral director and embalmer interns, meeting certain educational requirements, to continue acting as such while an application for full licensure is pending, or up to 90 days, whichever is sooner;
- Clarifies that once a preneed funeral contract has been fulfilled, statutory deposit requirements for proceeds do not apply;
- Requires, with a specified exception, that monument retailers must comply with the same inspection and place of business requirements as monument builders;
- Updates the definition of "two-component explosive" to reflect the current market;
- Allows contractors to begin repairs on previously permitted fire alarms after filing a permit application and specifying the repair is not compliant until permitted and approved;
- Amends continuing education requirements for individuals licensed to solicit, sell, or adjust insurance in the state and revises the hours requirement for specified elective insurance agents and adjusters continuing education course;
- Amends provisions regarding appointments to transact insurance or adjust claims on behalf of an insurer or employer, to apply certain deadlines to renewal appointments, and to revise procedures and requirements when an individual was not properly appointed by inadvertent error;

- Adds the designation of "Insurance Customer Service Representative" from "Statewide Insurance Associates LLC" to the list of designations that will qualify a person for licensure as an insurance agent's customer representative;
- Increases the maximum license suspension for title insurance agents and agencies;
- Provides that coverage for deductibles for property insurance may be written on the surplus lines market without first meeting requirements typically necessary before coverage may be written in the surplus lines market, subject to certain conditions;
- Removes a requirement for personal residential property agents to notify an insured regarding coverage from Citizens Property Insurance Corporation before exporting a policy to the surplus lines marketplace;
- Prohibits an insurance agent or agency from giving, or a lender from requiring, a copy of an insurer's proprietary underwriting information as a condition precedent to extending credit secured by real estate and prohibiting an insurance agent or agency from providing such information;
- Allows flood insurance coverage to be exported to a surplus lines insurer without the agent first seeking to place the coverage with an admitted insurer;
- Revises the scope of fire protection system work for persons with certain contractor classifications of the Division of State Fire Marshal;
- Revises entities involved in the Fire and Emergency Incident Information Reporting Program by replacing and revises the composition of the Fire and Emergency Incident Information System Technical Advisory Panel;
- Extends compliance deadlines and revises permit application requirements relating to minimum radio signal strength for fire department communications and two-way radio systems for existing high-rise buildings and existing apartment buildings;
- Prohibits certain influencing of firesafety inspectors to violate applicable law and prohibits a firesafety inspector knowingly and intentionally requesting, soliciting, accepting, or agreeing to accept a bribe;
- Revises the course required to obtain or renew a fire suppression license or permit to require that such course include both written and practical training approved by the State Fire Marshal;
- Revises the composition of the Firefighters Employment, Standards, and Training Council;
- Allows fire service providers to hire volunteer firefighters, and allows them to continue to function in a volunteer firefighter capacity for the first year of employment while they obtain career firefighter certifications;
- Creates a criminal penalty for aiding and abetting a person engaged in unlicensed bail bond agent activity; and
- Expands the applicability of criminal penalties for impersonation of investigators and personnel of the DFS.

If approved by the Governor, these provisions take effect July 1, 2021.
Vote: Senate 39-1; House 119-0

Committee on Banking and Insurance

CS/CS/SB 1598 — Consumer Protection

by Appropriations Committee; Banking and Insurance Committee; and Senator Gruters

The bill amends several insurance-related provisions to provide greater protections for consumers and oversight of public adjusters and residential property insurers.

Public Adjusters

- Prohibits a licensed contractor or subcontractor from advertising, soliciting, offering to handle, handling, or performing public adjuster services, unless licensed and compliant as a public adjuster.
- Specifies that entities must comply with s. 626.8696, F.S., with respect to possessing an adjusting firm license, provides an exception for adjusting firm's branch place of business if certain requirements are met; and authorizes administrative penalties for noncompliance with licensure requirements.
- Increases the cooling-off period from 3 to 10 days during which a consumer may cancel his or her contract with a public adjuster.
- Requires each public adjuster to provide an estimate of the loss to the claimant or insured within 60 days after the execution of the public adjuster contract and specifies that the written estimate of loss of the public adjuster must include an itemized, per-unit estimate of the repairs.
- Prohibits a person other than a licensed public adjuster or attorney from advertising services that require a license as a public adjuster or offering to initiate or negotiate a claim on behalf of an insured.
- Prohibits a public adjustor, public adjustor apprentice, or public adjusting firm that solicits a claim and does not enter into a contract with an insured or third-party claimant, from charging or receiving payment from an insured or a third-party claimant.
- Eliminates the $60 initial licensure fee and renewal fees for an adjusting firm license.

Residential Property Insurers; Surplus Lines Insurers

- Requires a residential property insurer to initiate a claim investigation within 14 days of receiving a proof of loss statement; current law provides 10 business days.
- Directs insurers to provide to policyholders the adjuster's name and state adjuster license number when a claim investigation involves a physical inspection of the property, and to maintain a record of each adjuster who communicates with the policyholder.
- Requires the insurer to provide notices that explain when the insurer is providing a preliminary or partial estimate or making a claim payment that is not the full and final payment for the claim.
- Directs insurers to provide the Homeowner Claims Bill of Rights pursuant to any personal lines residential property insurance claim and adds notice regarding the right to receive interest and the utility of taking video of damages and repairs.
- Expands the definition of sliding, a practice that violates the Unfair Insurance Trade Practices, to include:

- Initiating, effectuating, binding, or otherwise issuing an insurance policy without the prior informed consent of the person who owns the property that will be insured.
- Submitting an invoice for premium payment to a mortgagee or escrow agent in order to institute an insurance policy without the prior informed consent of the owner of the property, with exceptions.

- Requires that, prior to the placement of an insured with a surplus lines insurer, a disclosure must be provided to the insured that the Florida Insurance Guaranty Association (FIGA) does not provide any protections for persons insured by a surplus lines carrier that becomes insolvent.
- Applies the property insurance claim investigation and communication requirements of s. 627.70131, F.S., to surplus lines insurers.

Other Provisions

- Requires an entity regulated by the Department of Financial Services (DFS) or the Office of Insurance Regulation to respond to document requests from the Division of Consumer Services of DFS, and authorizes the department to impose penalties for noncompliance.
- Requires insurance agencies whose name contains the word “Medicare” or "Medicaid," to delete those words from the agency name no later than June 30, 2023.
- Authorizes DFS to suspend, revoke, or refuse to issue the license of an insurance agent, adjuster, customer representative, service representative, or managing general agent that makes a consumer’s personal financial or medical information available to the public, or initiates without the request of a prospective customer in-person or telephone solicitation after 9 p.m. or before 8 a.m. local time of the prospective customer.
- Requires insurers to include information regarding the free financial literacy programs offered by DFS at the time the insurer informs an applicant or insured that a credit report or score is being requested for underwriting or rating purposes.
- Eliminates the $100 deductible an insured must pay to the Florida Insurance Guaranty Association in order to receive payment on their claim through the association.
- Revises the definition of a “covered claim,” for purposes of the Florida Workers’ Compensation Insurance Guaranty Association, to exclude the return of premium resulting from a policy that was not in force on the date of the final order of liquidation.
- Prohibits the sale of industrial life insurance policies, effective July 1, 2021.

If approved by the Governor, these provisions take effect upon becoming law, except where otherwise provided.
Vote: Senate 34-3; House 114-1

Committee on Banking and Insurance

CS/CS/SB 1786 — Florida Birth-Related Neurological Injury Compensation Plan

by Appropriations Committee; Health Policy Committee; and Senators Burgess and Book

In 1988, the Legislature created the Florida Birth-Related Neurological Injury Compensation Plan (plan) to provide limited recovery, irrespective of fault, for infants who have sustained a birth-related neurological injury. If an infant suffers such an injury, and the physician participates in the Florida Birth-Related Neurological Injury Compensation Association (NICA), and delivers obstetrical services in connection with the birth, then an administrative award for a compensable injury is the infant's sole and exclusive remedy for the injury, with exceptions. Compensation under the plan includes actual expenses for medically necessary and reasonable care, including long-term medical care, transportation, special equipment, and other services for the lifetime of the child. The plan is administered by NICA. The bill provides the following changes to the plan and NICA:

Benefits

- Increases the maximum award to parents or legal guardians of an infant who has sustained a birth-related neurological injury from $100,000 to $250,000 for pending petitions or claims filed on or after January 1, 2021. This provision applies retroactively to claims filed before January 1, 2021, to provide a payment to current plan members sufficient to bring the payment up to $250,000 by July 1, 2021. Thereafter, the $250,000 limit on the maximum award increases by three percent annually.
- Increases the death benefit from $10,000 to $50,000. Parents or legal guardians of a child that died since the inception of the plan must receive a retroactive payment in an amount to bring the total award paid to the parents or legal guardian to $50,000 by July 1, 2021.
- Provides up to $10,000 in annual psychotherapeutic services for immediate family members who reside with the plan participant.
- Specifies benefits for transportation, including providing parents or legal guardians with a reliable method of transportation for the care of the child or reimbursing the cost of upgrading an existing vehicle to accommodate the child's needs when it becomes medically necessary for wheelchair transportation. The plan must replace any vans purchased by the plan every 7 years or 150,000 miles, whichever comes first.
- Authorizes housing assistance of up to $100,000 for the life of the child, including home construction and modifications.
- Provides that the parents or legal guardians of a plan participant may file a petition with the Division of Administrative Hearings to dispute the amount of actual expenses reimbursed or a denial of reimbursement.
- Directs NICA to furnish by mail or electronically a list of expenses compensable under the plan to each parent or legal guardian of a plan participant.

Governance of NICA

- Directs NICA to administer the plan in a manner that promotes and protects the health and best interests of children with birth-related neurological injuries.

- Creates code of ethics for specified staff and the board of directors of NICA.
- Increases members on the board of directors from five to seven members by adding a parent or a legal guardian representative of a plan participant and a representative of an advocacy organization for children with disabilities, and authorizes the Chief Financial Officer (CFO) or Governor to remove a director for cause.
- Prohibits the appointment of a participating physician to the board who is named in a pending petition for a claim and prohibits an appointed director who is a participating physician from voting on any board matter related to a claim accepted for an award for compensation if the physician is named in the petition for the claim.
- Limits the term a member of the board may serve to no more than six consecutive years and prohibits the citizen representative on the board from having an affiliation with any one of the groups providing lists of names to the CFO for consideration as a board member.
- Clarifies that board meetings are subject to public meeting requirements of s. 286.011, F.S., and requires advance notice of board meetings, with exceptions, and the posting of information relating to such meetings on NICA's website.

Studies and Reports

- Requires the Auditor General to conduct an operational audit of NICA once every three years. The Auditor General must complete the first audit report by August 15, 2021.
- Requires NICA to report by November 1, 2021, and by November 1 thereafter, to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the CFO regarding claims, reimbursement, and other information.
- Directs NICA to publish an annual report on its website January 1, 2022, and every January 1, thereafter that includes information about the board members and employees, staff compensation, a summary of reimbursement disputes and resolutions, a list of expenses for attorney and lobbying fees, and other expenses to oppose each plan claim.
- Directs the Agency for Health Care Administration (agency) to review its third-party liability functions and rights under Medicaid, relative to the plan, and include in its review the extent and value of liabilities owed by the plan as a third-party benefit provider. Based on its findings, the agency must provide recommendations regarding the development of policies and procedures to ensure implementation of agency functions and rights to the primacy of the plan's third-party benefits payable and recoveries due to the agency under Medicaid. The agency is required to submit a report to the President of the Senate, the Speaker of the House of Representatives, and the CFO of its findings regarding the extent and value of the liabilities owed by the plan by November 1, 2021.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 40-0; House 117-0

Committee on Banking and Insurance

SB 7014 — OSGR/Office of Insurance Regulation

by Banking and Insurance Committee

The bill amends s. 624.4212, F.S., to save from repeal the public records exemption relating to insurer reporting of certain proprietary business and other information that is held by the Office of Insurance Regulation (OIR). This includes proprietary business information and supporting documents contained in an actuarial opinion summary, principle-based valuation report, enterprise risk report, insurance holding company registration, own risk and solvency assessment summary report, and corporate governance annual disclosure. The bill authorizes OIR to disclose such proprietary business information and other information to the Office of Insurance Consumer Advocate within the Department of Financial Services. Currently, the OIR may disclose this confidential and exempt proprietary business information to other states, federal, and international agencies, and other specified entities. This information will continue to be confidential and exempt from public disclosure beyond October 2, 2021.

By saving s. 624.4212, F.S., from repeal, the bill also prevents the repeal of amendments made to ss. 628.8015, F.S., and 628.803, F.S., implementing the following National Association of Insurance Commissioners Model Acts and Regulations:

- Risk Management and Own-risk and Solvency Assessment Model Act.
- Corporate Governance and Disclosure Model Act; and the corresponding Corporate Governance Annual Disclosure Model Regulation.

If approved by the Governor, these provisions take effect October 1, 2021.
Vote: Senate 39-1; House 114-1