Insurance & Banking Subcommittee

Monday, January 25, 2016
12:30 PM
Sumner Hall (404 HOB)

MEETING PACKET

Steve Crisafulli
Speaker

John Wood
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Insurance & Banking Subcommittee

Start Date and Time:	Monday, January 25, 2016 12:30 pm
End Date and Time:	Monday, January 25, 2016 03:30 pm
Location:	Sumner Hall (404 HOB)
Duration:	3.00 hrs

Consideration of the following bill(s):

HB 1163 Insurer Regulatory Reporting by Hager
HB 1165 Pub. Rec./Office of Insurance Regulation by Hager
HB 1233 Federal Home Loan Banks by Stevenson

Consideration of the following proposed committee substitute(s):

PCS for HB 671 -- Prohibited Insurance Practices
PCS for HB 929 -- Peril of Flood
PCS for HB 1097 -- Assignment or Transfer of Property Insurance Rights

Pursuant to rule 7.12, the filing deadline for amendments to bills on the agenda by a member who is not a member of the committee or subcommittee considering the bill is 6:00 p.m., Friday, January 22, 2016.

By request of the Chair, all Insurance & Banking Subcommittee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Friday, January 22, 2016.

NOTICE FINALIZED on 01/21/2016 3:41PM by McCloskey.Michele

The Florida House of Representatives

Regulatory Affairs Committee

Insurance & Banking Subcommittee

Steve Crisafulli
Speaker

John Wood
Chair

AGENDA

January 25, 2016
404 House Office Building
12:30 PM – 3:30 PM

I. Prayer and Pledge of Allegiance

II. Call to Order & Roll Call

III. Consideration of the following bill(s):

A. HB 1163 Insurer Regulatory Reporting by Hager

B. HB 1165 Pub. Rec./Office of Insurance Regulation by Hager

C. HB 1233 Federal Home Loan Banks by Stevenson

D. PCS for HB 671 Prohibited Insurance Practices by Insurance & Banking Subcommittee

E. PCS for HB 929 Peril of Flood by Insurance & Banking Subcommittee

F. PCS for HB 1097 Assignment or Transfer of Property Insurance Rights by Insurance & Banking Subcommittee

IV. Adjournment

303 House Office Building, 402 South Monroe Street, Tallahassee, Florida 32399-1300
(850) 717-4871 Fax: (850) 413-0419

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1163 Insurer Regulatory Reporting
SPONSOR(S): Hager
TIED BILLS: HB 1165 **IDEN./SIM. BILLS:** SB 1422

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee		Bauer GB	Luczynski MZ
2) Government Operations Appropriations Subcommittee			
3) Regulatory Affairs Committee			

SUMMARY ANALYSIS

The Office of Insurance Regulation (OIR) is responsible for all activities concerning insurers and other risk bearing entities, including solvency oversight. Solvency regulation is designed to protect policyholders against the risk that insurers will not be able to meet their financial responsibilities, and includes the initial and ongoing requirements for an insurer's authority to transact insurance in this state, monitoring the financial condition of insurers through examinations and audits, and procedures for the administrative receivership of an insurance company if it is in unsound financial condition or insolvent. Additionally, the OIR is a member of the National Association of Insurance Commissioners (NAIC), an organization consisting of state insurance regulators that establish standards and best practices, conduct peer reviews, and coordinate their regulatory oversight. As a member of the NAIC, the OIR is required to participate in the organization's accreditation program, which is a certification that legal, regulatory, and organizational oversight standards and practices are being fulfilled by a state insurance department.

The OIR has identified two NAIC model acts as critical solvency regulation tools -- the Own Risk Solvency Assessment (ORSA) and the Corporate Governance Annual Disclosure (CGAD):

- *ORSA* requires insurers to analyze all reasonable foreseeable and relevant material risks potentially affecting their ability to meet policyholder obligations. This will provide the OIR with an effective early warning mechanism and provides a group-level perspective on risk and capital. Effective January 1, 2018, ORSA is an NAIC accreditation standard.
- *CGAD* will provide the OIR with a detailed narrative describing governance practices to promote market stability and to deter unethical behavior.

The bill creates s. 628.8015, F.S., to implement the ORSA and CGAD model acts, and:

- Provides criteria for the OIR to exempt certain insurers and insurance groups and to provide waivers of ORSA requirements;
- Provides that ORSA and CGAD filings and related documents are privileged and not subject to subpoena or discovery directly from the OIR;
- Authorizes the OIR to retain third-party consultants to assist in its administration of the bill and specifies requirements for such third-party consultants;
- Authorizes the Financial Services Commission to adopt rules to implement the ORSA and CGAD requirements, and provides that such rules are not subject to rule ratification; and
- Authorizes the OIR to impose sanctions, for failure to submit ORSA summary reports or CGADs.

The bill has no fiscal impact on local government. The bill has an indeterminate impact on state government and the private sector, in that it requires new regulatory reporting duties from insurers and will subject them to third-party consultant regulatory costs and other sanctions for violations. However, these insurer regulatory reports may reduce regulatory redundancies with other states and may enhance the OIR's solvency oversight.

The bill provides a contingent effective date of October 1, 2016, if the linked public records bill (HB 1165) or similar legislation is adopted in the same legislative session or an extension thereof and becomes law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Insurer Solvency Regulation & NAIC Accreditation

The regulatory oversight of insurance companies is generally reserved to the states. In Florida, the Office of Insurance Regulation (OIR) is responsible for all activities concerning insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the insurance code or ch. 636, F.S.[1] Solvency regulation is designed to protect policyholders against the risk that insurers will not be able to meet their financial responsibilities, namely, the payment of claims. Solvency regulations include the initial and maintenance requirements for an insurer's authority to transact insurance in this state,[2] monitoring the financial condition of insurers through examinations and audits, and procedures for the administrative supervision, rehabilitation, or liquidation of an insurance company if it is in unsound financial condition or insolvent.[3]

The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance departments that regulate the conduct and solvency of insurers in their respective states or territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer reviews, and coordinate their regulatory oversight.[4] As a member of the NAIC, the OIR is required to participate in the organization's Financial Regulation Standards and Accreditation Program.[5]

NAIC accreditation is a certification that legal, regulatory, and organizational oversight standards and practices are being fulfilled by a state insurance department to promote sound insurer financial solvency regulation. The accreditation program is also designed to allow for interstate cooperation and reduces regulatory redundancies. For example, the OIR's examinations may be recognized by other member states, thereby avoiding the need to have a Florida domestic insurer examined by multiple states. All fifty states, the District of Columbia, and Puerto Rico are accredited by the NAIC. Once accredited, a state is subject to a full accreditation review every five years, as well as interim reviews. One major component of NAIC accreditation standards is the adequacy of solvency laws and regulations in each accredited state to protect consumers and guaranty funds, through the adoption of model laws.[6] The NAIC also periodically reviews these model solvency standards, and revises accreditation requirements to adapt to evolving industry practices.

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[1] s. 20.121(3)(a)1., F.S. The OIR's commissioner is the agency head for purposes of final agency action, and its rulemaking body is the Financial Services Commission (the Governor and the Cabinet).

[2] Pt. III, ch. 624, F.S.

[3] *Administrative supervision* allows the Department of Financial Services (DFS) to supervise the management of a consenting troubled insurance company in an attempt to cure the company's troubles, rather than close it down. In *rehabilitation*, the DFS is authorized to act as the receiver to conduct all business of the insurer in an attempt to place the insurance company back in sound financial condition. In *liquidation*, the DFS is authorized as the receiver to gather an insolvent insurance company's assets, convert them to cash, distribute them to various claimants, and close the company. Ch. 631, F.S., governs these receivership processes for insurance companies, as well as the five guaranty funds to ensure policyholders of liquidated insurers are protected with respect to insurance premiums paid and the settlement of outstanding claims, up to limits provided by law.

[4] NAIC, *About the NAIC*, http://www.naic.org/index_about.htm (last visited Jan. 18, 2016).

[5] NAIC, *Financial Regulation Standards and Accreditation Committee,* at http://www.naic.org/committees_f.htm (last visited Jan. 18, 2016).

[6] All NAIC Model Laws, Regulations and Guidelines are available at: http://www.naic.org/store_model_laws.htm (last accessed Jan. 11, 2016).

In the wake of the 2008 financial crisis, U.S. insurance regulators began to modify their supervisory framework in order to be able to assess the holding company's financial system (as a whole) and its impact on an insurer within the holding company system. The AIG Financial Products unit based in London, a non-insurance component of the AIG holding company system, experienced significant losses from risky investments. The contagion effects experienced by U.S. insurers in the AIG holding company system's near collapse prompted U.S. insurance regulators to reevaluate their group supervisory framework and pay closer attention to the risks created by activities going on outside of those entities as well as the reputational and contagion issues that could exist.[7]

In 2008, the NAIC launched the Solvency Modernization Initiative (SMI) as a critical self-examination to update the U.S. insurance solvency framework. SMI focused on key issues such as capital requirements (including risk-based capital), governance and risk management, group supervision, statutory accounting and financial reporting, and reinsurance. In 2014, the Legislature enacted updates to the Insurance Code to include these new NAIC model elements necessary for the OIR to maintain its accreditation, including the Insurance Holding Company System Model, Risk-Based Capital for Insurers and Health Organization, the Property & Casualty Actuarial Opinion Model Law, and the Standard Valuation Law.[8]

The OIR has identified two model acts that the NAIC adopted as part of its Solvency Modernization Initiative and its Corporate Governance Working Group: the Own Risk and Solvency Assessment Act and the Corporate Governance Disclosure Model Act.

Own Risk and Solvency Assessment (ORSA)

In 2011, as part of the NAIC's Solvency Modernization Initiative, the NAIC adopted a new insurance regulatory tool: the U.S. Own Risk and Solvency Assessment (ORSA), which will require insurance companies to issue their own assessment of their current and future risk through an internal risk self-assessment process, which will allow regulators to form an enhanced view of an insurer's ability to withstand financial stress, particularly on a holding company's level.[9] In essence, an ORSA is an internal process undertaken by an insurer or insurance group to assess the adequacy of its risk management and current and prospective solvency positions under normal and severe stress scenarios. An ORSA will require insurers to analyze all reasonably foreseeable and relevant material risks (i.e., underwriting, credit, market, operational, liquidity risks, etc.) that could have an impact on an insurer's ability to meet its policyholder obligations.

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

Effective January 1, 2018, ORSA is an NAIC accreditation standard for state insurance regulators. As of November 2015, thirty-four states have adopted ORSA.[10]

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[7] NAIC, *Own Risk and Solvency Assessment* (ORSA), http://www.naic.org/cipr_topics/topic_own_risk_solvency_assessment.htm (last visited Jan. 18, 2016).
[8] Ch. 2014-101, Laws of Fla.
[9] NAIC, *Own Risk and Solvency Assessment (ORSA)*, at http://www.naic.org/cipr_topics/topic_own_risk_solvency_assessment.htm (last visited Jan. 18, 2016).
[10] OIR, *Q&A on ORSA and CGAD* (Nov. 15, 2015), on file with the Insurance & Banking Subcommmittee staff.

Corporate Governance Annual Disclosure (CGAD)

Currently, during full-scope financial examinations, the OIR obtains some information on insurer governance structures, processes and practices. However, these examinations are typically limited to domestic insurers and occur only once every five years.[11] In the period between these examinations, the OIR's access to insurer governance practices is more limited. This can mask changes and activities having a substantial bearing on the financial condition of the insurer.[12]

In 2012, the National Association of Insurance Commissioners (NAIC) formed the Corporate Governance Working Group to outline high-level corporate governance principles for use in U.S. insurance regulation and to develop regulatory guidance, including detailed best practices, for the corporate governance of insurers. In 2014, the NAIC adopted the Corporate Governance Annual Disclosure Model Act (CGAD) and supporting Model Regulations.[13]

In the CGAD, insurers must document highly confidential information about their corporate governance framework, including the structure and policies of their boards of directors and key committees, the frequency of their meetings, and procedure for the oversight of critical risk areas and appointment practices, among other things. Insurers must also disclose the policies and practices used by their board of directors for directing senior management on critical areas, including a description of codes of business conduct and ethics, and processes for performance evaluation, compensation practices, corrective action, succession planning and suitability standards. The CGAD will provide regulators with a detailed narrative describing governance practices to promote market stability and to deter unethical behavior.

Upon state adoption of the NAIC models and as early as June 1, 2016, each U.S. insurer or the insurance group in which the insurer is a member, must submit, a Corporate Governance Annual Disclosure (CGAD) to its lead state or domestic regulator on an annual basis.[14] According to the NAIC, five jurisdictions have adopted the CGAD in a substantially similar form.[15]

Effect of the Bill

The bill creates s. 628.8015, F.S., to require insurers or insurance groups (as applicable), to file an ORSA and CGAD with their domestic regulator or lead state, beginning in 2017.

Definitions

In addition to defining "corporate governance annual disclosure," "ORSA," "ORSA guidance manual," and "ORSA summary report," the bill defines the following:

- "Insurer" is defined as the same as in s. 624.03, F.S.,[16] but excludes state and federal agencies, authorities, instrumentalities, possessions, territories, or political subdivisions of a state.
- "Insurance group" is defined to mean insurers and affiliates included within an insurance holding company system.
- "Senior management" is defined to mean any corporate officer responsible for reporting information to the board of directors at regular intervals or providing information to shareholders or regulators. This includes, but is not limited to, a number of executives such as chief executive officer, chief financial officer, and chief risk officer.

[11] s. 624.316(2)(a), F.S.
[12] Office of Insurance Regulation, Agency Analysis of 2016 House Bill 1163, p. 3 (Jan. 22, 2016).
[13] The CGAD Model Act and supporting Model Regulations are currently exposed for public comment until December 31, 2016, and may be considered for adoption as a NAIC accreditation standard in 2017, effective January 2019. See footnote 9, *supra.*
[14] NAIC, *Corporate Governance*, at http://www.naic.org/cipr_topics/topic_corporate_governance.htm (last visited Jan. 7, 2016).
[15] These five states are California, Indiana, Iowa, Louisiana, and Vermont. Office of Insurance Regulation, Agency Analysis of 2016 House Bill 1163, p. 3 (Jan. 22, 2016).
[16] Section 624.03, F.S., defines "insurer" to mean every person engaged as an indemnitor, surety, or contractor in the business of entering into contracts of insurance or of annuity.

ORSA

The bill incorporates the three major components of the ORSA, to require insurers or insurance groups to:

- Maintain a *risk management framework* for identifying, assessing, monitoring, managing, and reporting on its material, relevant risks;
    - This requirement may be satisfied by being a member of an insurance group with a risk management framework applicable to the insurer's operations;
- Conduct an ORSA at least annually (and whenever there have been significant changes to the risk profile of the insurer or the insurance group), consistent with and comparable to the process in the ORSA Guidance Manual;[17]
- File an ORSA summary report, based on the ORSA Guidance Manual with their domestic regulator or lead state (for an insurance group), beginning in 2017, which must:
    - Be submitted once every calendar year;
    - Include notification to the OIR OIR of its proposed annual submission date by December 1, 2016; initial ORSA summary report must be submitted by December 31, 2017;
    - Include a brief description of material changes and updates from the prior year's report;
    - Be signed by the chief risk officer or chief executive officer responsible for overseeing the enterprise risk management process; provide copy to board of directors or appropriate board committee; and
    - Be prepared in accordance with the ORSA guidance manual; insurer must maintain and make available for OIR examination documentation and supporting information.

ORSA Exemption & Waiver

The bill exempts an insurer from the ORSA requirement if:

- Its annual direct written and unaffiliated assumed premium is less than $500 million (excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program), or
- It is a member of an insurance group with an annual direct written and unaffiliated assumed premium of $1 billion or less (excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program).[18]

The bill also sets forth reporting obligations, depending on the exempt status of the insurer and its insurance group. Additionally, the OIR may still require an exempt insurer to maintain a risk management framework, conduct an ORSA and file an ORSA summary report based on certain circumstances, such as risk-based capital that triggers a company action level event,[19] exhibits qualities of an insurer in hazardous financial condition, or is in the best interests of the state.

In addition, the bill allows OIR to grant a waiver to an otherwise non-exempt insurer based on unique circumstances, and specifies criteria for the OIR to consider.

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[17] The bill defines "ORSA guidance manual" as the ORSA manual developed and adopted by the NAIC. *See* NAIC, *ORSA Guidance Manual* (Jul. 2014), at http://www.naic.org/store/free/ORSA_manual.pdf.

[18] According to the OIR, two property and casualty insurer groups and five life and health insurer groups meet the ORSA threshold and have Florida as the lead state. OIR, *Q&A on ORSA and CGAD* (Nov. 15, 2015), on file with the Insurance & Banking Subcommmittee staff. This information is based on 2014 premium data.

[19] Section 624.81(11), F.S., authorizes the OIR to place an insurer under administrative supervision and order corrective action if the insurer is in unsound condition, exceeds its powers granted under its certificate of authority, or its practices are hazardous to the public. Commission rule defines "hazardous financial condition" in accordance with NAIC model regulation. Rule 69O-141.002, F.A.C.

CGAD

The bill requires insurers or insurer members of insurance groups (of which the OIR is the lead state regulator) to submit a CGAD to every June 1, with an initial CGAD to be submitted by December 31, 2017. The CGAD must be signed by the CEO or corporate secretary, and must describe the insurer or insurance group's governance framework and structure, relevant policies and practices, and processes for overseeing critical risk areas affecting business activities.

The bill allows insurers and insurance groups to provide corporate governance information at the ultimate controlling parent level, the intermediate holding company level, or at the individual legal entity level. Additionally, insurers and insurance groups may make their CGAD at levels at which the insurer or insurance group 1) determines risk appetite, 2) oversees or exercises coordinated supervision of earnings, capital, liquidity, operations, and reputation of the insurer, or 3) at which legal liability would be placed for failure of general corporate governance duties. The insurer or insurance group must indicate their level of reporting and explain any subsequent changes, and may meet these requirements by referring other relevant and existing documents, such as the ORSA summary report, Holding Company B or F filings, and Securities and Exchange Commission proxy statements. The lead state may request additional information and must review the CGAD in accordance with the NAIC Financial Handbook. Insurers and insurance groups must report subsequent changes to the CGAD.

Privilege & Confidentiality of ORSA & CGAD

The bill provides that the ORSA and CGAD filings and related documents that are submitted pursuant to this new s. 628.8015, F.S., are privileged and not subject to subpoena or discovery directly from the OIR. The bill prohibits the OIR, or any person acting under the OIR's authority (such as third-party consultants), from testifying as to such filings or related documents in a private civil action. However, the OIR or the Department of Financial Services may use these filings and related documents in any regulatory or legal action it brings against an insurer as part of their official duties. The bill also provides that any applicable claims of privilege as to these filings and related documents are not waived simply because a disclosure to the OIR under this section or under any other provision of the Insurance Code.

Substantially similar privilege language was enacted in 2014 for other insurer regulatory filings:

- Section 628.801(4), F.S., regarding insurance holding company registration statements and annual enterprise risk reports.
- Section 625.1214, F.S., relating to annual actuarial opinions of reserves and supporting memoranda required of life insurers.

Third-Party Consultants

The bill authorizes the OIR to retain third-party consultants at the expense of the insurer or the insurance group for the purpose of assisting the OIR with ORSA and CGAD responsibilities. The bill requires these third-party consultants to adhere to confidentiality and conflict of interest standards through a written agreement with the OIR.

In other areas of the Insurance Code, the OIR has authority to contract with independent external auditors or examiners under the following provisions:

- s. 624.316(2)(e), F.S., OIR general examination authority;
- s. 624.3161(3), F.S., OIR market conduct examination authority;
- s. 624.44(1)(c), F.S., multiple-employer welfare arrangements; and
- s. 641.27(2), F.S., for health maintenance organization examinations.

Sanctions

Currently, s. 628.803, F.S., authorizes the OIR to impose sanctions on insurers and certain affiliated individuals of insurers for certain violations. The 2014 insurer solvency legislation authorizes the OIR to place an insurer under an order of supervision and to disapprove dividends or distributions, if the OIR finds that the insurer violated s. 628.461, F.S., (acquisition of controlling stock requirements) or s. 628.801, F.S., (insurance holding company registration statement and enterprise risk reporting requirements).[20]

Section 2 of the bill amends s. 628.803, F.S., to provide that the OIR may impose these fines for failure to submit an ORSA summary report or CGAD, or may issue an order of supervision and disapprove dividends or distributions if an insurance company violates the new s. 628.8015, F.S. created by this bill.

B. SECTION DIRECTORY:

Section 1. Creates s. 628.8015, F.S., relating to own-risk and solvency assessment; corporate governance annual disclosure.
Section 2. Amends s. 628.803, F.S., relating to sanctions.
Section 3. Provides an effective date of October 1, 2016, if HB 1165 or similar legislation is adopted in the same legislative session or an extension thereof and becomes a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   Indeterminate but positive. The bill applies existing sanctions (for insurers' failure to file a holding company registration statement) to failure to file an ORSA or a CGAD ($100 a day, not to exceed $10,000 total).

2. Expenditures:

   The OIR does not anticipate a significant budgetary impact. While the bill may have an insignificant impact on the OIR's technology systems, the OIR states it can accommodate the collection of additional information through their current systems.[21]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Indeterminate. The bill exposes insurers and insurance groups to additional fines and sanctions and third-party consultant costs incurred by the OIR. However, it may have a positive impact by enhancing the OIR's solvency oversight and thus ultimately benefit policyholders.

[20] s. 628.803(4), F.S.; s. 12, ch. 2014-101, Laws of Fla.
[21] Office of Insurance Regulation, Agency Analysis of 2016 House Bill 1163, pp. 6-7 (Jan. 22, 2016).

According to the OIR, insurers should realize indeterminate cost savings through regulatory efficiencies resulting from adoption of the ORSA Model Act and elimination of regulatory redundancies (i.e., having to make separate filings in each state). Complying with the CGAD is estimated to have only a minimal fiscal impact on insurers and insurance groups, since they currently summarize and describe their corporate governance practices for a number of stakeholders on a regular basis. In addition, the CGAD permits insurers and insurance groups to reference existing documents and filings and simplifies the reporting process for filing changes from the prior year.[22]

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:
The bill authorizes the Financial Services Commission to adopt rules to administer the new s. 628.8015, F.S., and provides that the adoption of such rules is *not* subject to ratification requirements in s. 120.541(3), F.S., for proposed rules whose estimated adverse impacts or regulatory impacts exceed certain statutory criteria in s. 120.541(2), F.S.

C. DRAFTING ISSUES OR OTHER COMMENTS:

- Lines 185-190 appear to duplicate a requirement regarding the ORSA summary report in lines 112-116. It may be clearer to delete lines 185-190, and to move lines 191-195 as a new paragraph s. 628.8015(2)(c)6., F.S.
- An amendment is anticipated to remove the exception from rule ratification required in s. 120.541(3), F.S.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[22] *Id.*

A bill to be entitled

An act relating to insurer regulatory reporting; creating s. 628.8015, F.S.; defining terms; requiring an insurer to maintain a risk management framework; requiring certain insurers and insurance groups to conduct an own-risk and solvency assessment; providing requirements for the preparation and submission of an own-risk and solvency assessment summary report; providing exemptions and waivers; requiring certain insurers and members of an insurance group to prepare and submit a corporate governance annual disclosure; providing disclosure and preparation requirements; specifying privilege requirements and prohibitions for certain filings and related documents; authorizing the Office of Insurance Regulation to retain third-party consultants for certain purposes; authorizing the Financial Services Commission to adopt rules; amending s. 628.803, F.S.; revising provisions relating to penalties to conform to the act; providing a contingent effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 628.8015, Florida Statutes, is created to read:

628.8015 Own-risk and solvency assessment; corporate

governance annual disclosure.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Corporate governance annual disclosure" means a report filed by an insurer or insurance group in accordance with this section.

(b) "Insurance group" means insurers and affiliates included within an insurance holding company system.

(c) "Insurer" has the same meaning as in s. 624.03. However, the term does not include agencies, authorities, instrumentalities, possessions, or territories of the United States, the Commonwealth of Puerto Rico, or the District of Columbia; or agencies, authorities, instrumentalities, or political subdivisions of a state.

(d) "Own-risk and solvency assessment" or "ORSA" means an internal assessment, appropriate to the nature, scale, and complexity of an insurer or insurance group, conducted by that insurer or insurance group, of the material and relevant risks associated with the business plan of an insurer or insurance group and the sufficiency of capital resources to support those risks.

(e) "ORSA guidance manual" means the own-risk and solvency assessment guidance manual developed and adopted by the National Association of Insurance Commissioners.

(f) "ORSA summary report" means a high-level ORSA summary of an insurer or insurance group, consisting of a single report or combination of reports.

(g) "Senior management" means any corporate officer responsible for reporting information to the board of directors at regular intervals or providing information to shareholders or regulators and includes, but is not limited to, the chief executive officer, chief financial officer, chief operations officer, chief risk officer, chief procurement officer, chief legal officer, chief information officer, chief technology officer, chief revenue officer, chief visionary officer, or any other executive performing one or more of these functions.

(2) OWN-RISK AND SOLVENCY ASSESSMENT.—

(a) Risk management framework.—An insurer shall maintain a risk management framework to assist in identifying, assessing, monitoring, managing, and reporting its material and relevant risks. An insurer may satisfy this requirement by being a member of an insurance group with a risk management framework applicable to the operations of the insurer.

(b) ORSA requirement.—Subject to paragraph (c), an insurer, or the insurance group of which the insurer is a member, shall regularly conduct an ORSA consistent with and comparable to the process in the ORSA guidance manual. The ORSA must be conducted at least annually and whenever there have been significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member.

(c) ORSA summary report.—

1.a. A domestic insurer or insurer member of an insurance group of which the office is the lead state, as determined by

the procedures in the most recent National Association of Insurance Commissioners Financial Analysis Handbook, shall:

(I) Submit an ORSA summary report to the office once every calendar year.

(II) Notify the office of its proposed annual submission date by December 1, 2016. The initial ORSA summary report must be submitted by December 31, 2017.

b. An insurer not required to submit an ORSA summary report pursuant to sub-subparagraph a. shall:

(I) Submit an ORSA summary report at the request of the office, but not more than once per calendar year.

(II) Notify the office of the proposed submission date within 30 days after the request of the office.

2. An insurer may comply with sub-subparagraph 1.a. or sub-subparagraph 1.b. by providing the most recent and substantially similar ORSA summary report submitted by the insurer, or another member of an insurance group of which the insurer is a member, to the chief insurance regulatory official of another state or the supervisor or regulator of a foreign jurisdiction. For purposes of this subparagraph, a "substantially similar" ORSA summary report is one that contains information comparable to the information described in the ORSA guidance manual as determined by the commissioner of the office. If the report is in a language other than English, it must be accompanied by an English translation.

3. The chief risk officer or chief executive officer of

the insurer or insurance group responsible for overseeing the enterprise risk management process must sign the ORSA summary report attesting that, to the best of his or her knowledge and belief, the insurer or insurance group applied the enterprise risk management process described in the ORSA summary report and provided a copy of the report to the board of directors or the appropriate board committee.

4. The ORSA summary report must be prepared in accordance with the ORSA guidance manual. Documentation and supporting information must be maintained by the insurer and made available upon examination pursuant to s. 624.316 or upon the request of the office.

5. The ORSA summary report must include a brief description of material changes and updates since the prior year report.

(d) Exemption.—

1. An insurer is exempt from the requirements of this subsection if:

a. The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program, of less than $500 million; or

b. The insurer is a member of an insurance group and the insurance group has annual direct written and unaffiliated assumed premium, including international direct and assumed

premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program, of less than $1 billion.

2. If an insurer is:

a. Exempt under sub-subparagraph 1.a., but the insurance group of which the insurer is a member is not exempt under sub-subparagraph 1.b., the ORSA summary report must include every insurer within the insurance group. The insurer may satisfy this requirement by submitting more than one ORSA summary report for any combination of insurers if any combination of reports includes every insurer within the insurance group.

b. Not exempt under sub-subparagraph 1.a., but the insurance group of which it is a member is exempt under sub-subparagraph 1.b., the insurer must submit to the office the ORSA summary report applicable only to that insurer.

3. The office may require an exempt insurer to maintain a risk management framework, conduct an ORSA, and file an ORSA summary report:

a. Based on unique circumstances, including, but not limited to, the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests;

b. If the insurer has risk-based capital for a company action level event pursuant to s. 624.4085(3), meets one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in rules adopted by the

commission pursuant to s. 624.81(11), or exhibits qualities of an insurer in hazardous financial condition as determined by the office; or

c. If the office determines it is in the best interest of the state.

4. If an exempt insurer becomes disqualified for an exemption because of changes in premium as reported on the most recent annual statement of the insurer or annual statements of the insurers within the insurance group of which the insurer is a member, the insurer must comply with the requirements of this section effective 1 year after the year in which the insurer exceeded the premium thresholds.

(e) Waiver.—An insurer that does not qualify for an exemption under paragraph (d) may request a waiver from the office based upon unique circumstances. If the insurer is part of an insurance group with insurers domiciled in more than one state, the office must coordinate with the lead state and with the other domiciliary regulators in deciding whether to grant a waiver. In deciding whether to grant a waiver, the office may consider:

1. The type and volume of business written by the insurer.

2. The ownership and organizational structure of the insurer.

3. Any other factor the office considers relevant to the insurer or insurance group of which the insurer is a member.

A waiver granted pursuant to this paragraph is valid until withdrawn by the office.

(f) Preparation of the ORSA summary report.—

1. The ORSA summary report must be prepared consistent with the ORSA guidance manual, subject to the requirements of paragraph (b). Documentation and supporting information must be maintained and made available upon examination pursuant to s. 624.316 or upon the request of the office.

2. Office review of the ORSA summary report must be conducted, and any additional requests for information must be made, using procedures similar to those used in the analysis and examination of multistate or global insurers and insurance groups.

(3) CORPORATE GOVERNANCE ANNUAL DISCLOSURE.—

(a) Scope.—This section does not prescribe or impose corporate governance standards and internal procedures beyond those required under applicable state corporate law or to limit the authority of the office, or the rights or obligations of third parties, under s. 624.316.

(b) Disclosure requirement.—

1.a. An insurer, or insurer member of an insurance group, of which the office is the lead state regulator, as determined by the procedures in the most recent National Association of Insurance Commissioners Financial Analysis Handbook, shall submit a corporate governance annual disclosure to the office by June 1 of each calendar year. The initial corporate governance

annual disclosure must be submitted by December 31, 2017.

b. An insurer or insurance group not required to submit a corporate governance annual disclosure under sub-subparagraph 1.a. shall do so at the request of the office, but not more than once per calendar year. The insurer shall notify the office of the proposed submission date within 30 days after the request of the office.

2. The chief executive officer or corporate secretary of the insurer or the insurance group must sign the corporate governance annual disclosure attesting that, to the best of his or her knowledge and belief, the insurer has implemented the corporate governance practices and provided a copy of the disclosure to the board of directors or the appropriate board committee.

3.a. Depending on the structure of its system of corporate governance, the insurer or insurance group may provide corporate governance information at one of the following levels:

(I) The ultimate controlling parent level;

(II) An intermediate holding company level; or

(III) The individual legal entity level.

b. The insurer or insurance group may make the corporate governance annual disclosure at:

(I) The level used to determine the risk appetite of the insurer or insurance group;

(II) The level at which the earnings, capital, liquidity, operations, and reputation of the insurer are collectively

overseen and the supervision of those factors is coordinated and exercised; or

(III) The level at which legal liability for failure of general corporate governance duties would be placed.

An insurer or insurance group must indicate the level of reporting used and explain any subsequent changes in the reporting level.

4. The review of the corporate governance annual disclosure and any additional requests for information shall be made through the lead state as determined by the procedures in the most recent National Association of Insurance Commissioners Financial Analysis Handbook.

5. An insurer or insurance group may comply with this paragraph by cross-referencing other existing relevant and applicable documents, including, but not limited to, the ORSA summary report, Holding Company Form B or F filings, Securities and Exchange Commission proxy statements, or foreign regulatory reporting requirements, if the documents contain information substantially similar to the information described in paragraph (c). The insurer or insurance group shall clearly identify and reference the specific location of the relevant and applicable information within the corporate governance annual disclosure and attach the referenced document if it has not already been filed with, or made available to, the office.

6. Each year following the initial filing of the corporate

governance annual disclosure, the insurer or insurance group shall file an amended version of the previously filed corporate governance annual disclosure indicating changes that have been made. If changes have not been made in the previously filed disclosure, the insurer or insurance group should so indicate.

(c) Preparation of the corporate governance annual disclosure.—

1. The corporate governance annual disclosure must be prepared in a manner consistent with this subsection. Documentation and supporting information must be maintained and made available upon examination pursuant to s. 624.316 or upon the request of the office.

2. The corporate governance annual disclosure must be as descriptive as possible and include any attachments or example documents used in the governance process.

3. The insurer or insurance group has discretion in determining the appropriate format of the corporate governance annual disclosure in communicating the required information and responding to inquiries, provided that the corporate governance annual disclosure includes material and relevant information sufficient to enable the office to understand the corporate governance structure, policies, and practices used by the insurer or insurance group.

4. The corporate governance annual disclosure must describe the:

a. Corporate governance framework and structure of the

insurer or insurance group.

b. Policies and practices of the most senior governing entity and significant committees.

c. Policies and practices for directing senior management.

d. Processes by which the board, its committees, and senior management ensure an appropriate amount of oversight to the critical risk areas that have an impact on the insurer's business activities.

(4) CONFIDENTIALITY.—The filings and related documents submitted pursuant to subsections (2) and (3) are privileged and not subject to subpoena or discovery directly from the office. However, the department or office may use these filings and related documents in the furtherance of any regulatory or legal action brought against an insurer as part of the official duties of the department or office. A waiver of any applicable claim of privilege in these filings and related documents may not occur because of a disclosure to the office under this section, because of any other provision of the Insurance Code, or because of sharing under s. 624.4212. The office or a person receiving these filings and related documents, while acting under the authority of the office, or with whom such filings and related documents are shared pursuant to s. 624.4212, is not permitted or required to testify in any private civil action concerning any such filings or related documents.

(5) USE OF THIRD-PARTY CONSULTANTS.—The office may retain third-party consultants at the expense of the insurer or

insurance group for the purpose of assisting it in the performance of its regulatory responsibilities under this section, including, but not limited to, the risk management framework, the ORSA, the ORSA summary report, and the corporate governance annual disclosure. A third-party consultant must agree, in writing, to:

(a) Adhere to confidentiality standards and requirements applicable to the office governing the sharing and use of such filings and related documents.

(b) Verify to the office, with notice to the insurer, that the consultant is free of any conflict of interest.

(c) Monitor compliance with applicable confidentiality and conflict of interest standards pursuant to a system of internal procedures.

(6) RULE ADOPTION.—The commission may adopt rules to administer this section. The adoption of such rules is not subject to s. 120.541(3).

Section 2. Subsections (1) and (4) of section 628.803, Florida Statutes, are amended to read:

628.803 Sanctions.—

(1) Any company failing, without just cause, to file any registration statement or certificate of exemption required to be filed pursuant to commission rules relating to this part or to submit an ORSA summary report or a corporate governance annual disclosure required pursuant to s. 628.8015 shall, in addition to other penalties prescribed under the Florida

Insurance Code, be subject to pay a penalty of $100 for each day's delay, not to exceed a total of $10,000.

(4) If the office determines that any person violated s. 628.461, ~~or~~ s. 628.801, or s. 628.8015, the violation may serve as an independent basis for disapproving dividends or distributions and for placing the insurer under an order of supervision in accordance with part VI of chapter 624.

Section 3. This act shall take effect October 1, 2016, if HB 1165 or similar legislation is adopted in the same legislative session or an extension thereof and becomes a law.

INSURANCE & BANKING SUBCOMMITTEE

HB 1163 by Rep. Hager
Insurer Regulatory Reporting

AMENDMENT SUMMARY
January 25, 2016

Amendment 1 by Rep. Hager (line 112): Removes language in lines 185-190 relating to preparation of the ORSA summary report that duplicates lines 112-116, and moves lines 191-195 relating to the OIR's review of the ORSA summary report as a new subparagraph under subsection (2)(c) after line 119.

Amendment 2 by Rep. Hager (line 328): Retains rulemaking authority for the Financial Services Commission, but removes the exemption from rule ratification requirements.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 1163 (2016)

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Insurance & Banking Subcommittee

Representative Hager offered the following:

Amendment

Remove lines 112-119 and insert:

4. The ORSA summary report must be prepared in accordance with the ORSA guidance manual, subject to the requirements of paragraph (b). Supporting information must be maintained by the insurer and made available upon examination pursuant to s. 624.316 or upon the request of the office.

5. The ORSA summary report must include a brief description of material changes and updates since the prior year report.

6. Office review of the ORSA summary report must be conducted, and any additional requests for information must be made, using procedures similar to those used in the analysis and

Amendment No. 1

examination of multistate or global insurers and insurance groups.

Remove lines 185-195

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 1163 (2016)

Amendment No. 2

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Insurance & Banking Subcommittee

Representative Hager offered the following:

Amendment

Remove lines 328-329 and insert:

administer this section.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1165 Pub. Rec./Office of Insurance Regulation
SPONSOR(S): Hager
TIED BILLS: HB 1163 **IDEN./SIM. BILLS:** SB 1416

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee		Bauer GB	Luczynski MJ
2) Government Operations Subcommittee			
3) Regulatory Affairs Committee			

SUMMARY ANALYSIS

The bill amends s. 624.4212, F.S., to exempt certain insurer regulatory reports and supporting documents that the linked bill (HB 1163) requires insurers and insurance groups to submit annually to the Office of Insurance Regulation (OIR):

- An Own Risk and Solvency Assessment (ORSA) summary report or a substantially similar ORSA report (submitted to an insurance regulator of another state or foreign jurisdiction),
- A Corporate Governance Annual Disclosure, and
- Supporting documents.

The bill provides for repeal of the exemption on October 2, 2021, unless reviewed and saved from repeal by the Legislature pursuant to the Open Government Sunset Review Act. It also provides a statement of public necessity as required by the State Constitution.

The bill provides that the act shall take effect on the same date that the main bill (HB 1163) or similar legislation is adopted in the same legislative session or an extension thereof and becomes law.

Article I, s. 24(c) of the State Constitution, requires a two-thirds vote of the members present and voting for final passage of a newly created or expanded public record or public meeting exemption. The bill expands public record exemptions for trade secret information; thus, it requires a two-thirds vote for final passage.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Public Records

The Florida Constitution provides every person the right to inspect or copy any public record made or received in connection with the official business of the legislative, executive, or judicial branches of government.[1] The Legislature, however, may by general law exempt records from the constitutional requirements.[2] An exemption must state with specificity the public necessity justifying the exemption and may be no broader than necessary to accomplish the stated purpose of the law.[3] A bill enacting an exemption must pass by a two-thirds vote of the members present and voting.[4]

The Open Government Sunset Review Act (the Act) prescribes a legislative review process for newly-created or substantially-amended public records or open meetings exemptions.[5] A public records or open meetings exemption may be created or maintained only if it serves an identifiable public purpose. An identifiable public purpose is served, if the exemption:

- Allows the state or its political subdivisions to effectively and efficiently administer a government program, which administration would be significantly impaired without the exemption;
- Protects personal identifying information that, if released, would be defamatory or would jeopardize an individual's safety; or
- Protects trade or business secrets.

The Act requires the automatic repeal of an exemption on October 2 of the fifth year after creation or substantial amendment, unless the Legislature reenacts the exemption.[6] The Act directs the Legislature to consider the following as part of the review process:

- What specific records or meetings are affected by the exemption?
- What specific parties does the exemption affect?
- What is the public purpose of the exemption?
- Can the information contained in the records or meetings be readily obtained by alternative means? If so, how?
- Is the record or meeting protected by another exemption?
- Are there multiple exemptions for the same type of record or meeting that it would be appropriate to merge?

Confidential & Exempt Treatment of Insurer Regulatory Reports

The Office of Insurance Regulation (OIR) is a member of the National Association of Insurance Commissioners (NAIC), an organization consisting of state insurance regulators. As a member of the NAIC, the OIR is required to participate in the organization's accreditation program. NAIC accreditation is a certification that legal, regulatory, and organizational oversight standards and practices are being fulfilled by a state insurance department. Once accredited, a member state is subject to a full accreditation review every five years. The NAIC also periodically reviews its solvency standards as set forth in its model acts, and revises accreditation requirements to adapt to evolving industry standards.

[1] FLA. CONST., art. I, s. 24(a).
[2] FLA. CONST., art. I, s. 24(c).
[3] *Id.*
[4] *Id.*.
[5] s. 119.15, F.S.
[6] s. 119.15(3), F.S.

In 2014, the Legislature enacted s. 624.4212, F.S., which makes "proprietary business information" contained in certain insurer regulatory documents held by the OIR confidential and exempt from s. 119.091(1), F. S., and s. 24(a), Art. I, of the State Constitution.[7] Such documents include the principle-based valuation report, the enterprise risk report, and the insurance holding company registration, which are required to be filed with the OIR as part of related legislation enacted in 2014.[8] In some instances, OIR may disclose this confidential and exempt proprietary business information, such as to other state, federal, and international agencies and law enforcement agencies.

"Proprietary business information" means information, regardless of form or characteristics, that is owned or controlled by an insurer, or a person or affiliated person who seeks acquisition of controlling stock in a domestic stock insurer or controlling company, and that:

- Is intended to be and is treated by the insurer or the person as private in that the disclosure of the information would cause harm to the insurer, the person, or the company's business operations and has not been disclosed unless disclosed pursuant to a statutory requirement, an order of a court or administrative body, or a private agreement that provides that the information will not be released to the public;
- Is not otherwise readily ascertainable or publicly available by proper means by other persons from another source in the same configuration as requested by the office; and
- Includes:
    - Trade secrets as defined in s. 688.002, F.S.,[9] and that comply with s. 624.4213, F.S.[10]
    - Information relating to competitive interests the disclosure of which would impair the competitive business of the provider of the information.
    - The source, nature, and amount of the consideration used or to be used in carrying out a merger or other acquisition of control in the ordinary course of business, including the identity of the lender, if the person filing a statement regarding consideration so requests.
    - Information relating to bids or other contractual data the disclosure of which would impair the efforts of the insurer or its affiliates to contract for goods or services on favorable terms.
    - Internal auditing controls and reports of internal auditors.

HB 1163: Insurer Regulatory Reporting

The NAIC has adopted two new insurance model acts that give state insurance regulators like the OIR new solvency regulatory tools – the Own Risk and Solvency Assessment (ORSA) and the Corporate Governance Annual Disclosure (CGAD). Effective January 1, 2018, ORSA is a NAIC accreditation standard. Both model acts require that states must keep these documents confidential.

The related bill, HB 1163, implements the new ORSA and CGAD requirements in the Insurance Code.

Effect of the Bill

The bill amends s. 624.4212, F.S., to provide that ORSA summary reports, substantially similar ORSA reports, CGAD reports, and supporting documents submitted pursuant to a new s. 628.8015, F.S. (created by the main bill, HB 1163), are confidential and exempt from public records disclosure. The bill also makes minor technical revisions to the exemption.

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[7] Ch. 2014-100, Laws of Fla. This public records bill was enacted along with the 2014 OIR insurer solvency bill, ch. 2014-101, Laws of Fla. Passage of several components in these bills were necessary for the OIR to maintain its NAIC accreditation.

[8] Ch. 2014-101, Laws of Fla.

[9] Section 688.002(4), F.S., defines the term "trade secret" to mean information, including a formula, pattern, compilation, program, device, method, technique, or process that derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use; and is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.

[10] Section 624.4213, F.S., contains a process for submitting trade secret documents to the OIR or the Department of Financial Services, including marking each document as a trade secret.

Unlike the other insurer regulatory reports protected by this statute, the bill exempts the ORSA and CGAD documents in their entirety, not just portions of those reports which contain "proprietary business information."

The bill provides a statement of public necessity and provides for repeal of the exemption on October 2, 2021, unless reviewed and saved from repeal by the Legislature.

B. SECTION DIRECTORY:

Section 1. Amends s. 624.4212, F.S., relating to confidentiality of proprietary business and other information.

Section 2. Provides a statement of public necessity as required by the State Constitution.

Section 3. Provides that the bill shall take effect on the same date that HB 1163 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill likely could create a minimal fiscal impact on OIR, because staff responsible for complying with public record requests could require training related to creation of the new public records exemption. The OIR noted the bill is expected to have an insignificant impact on OIR technology systems.[11]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

This public records exemption bill will have an indeterminate positive impact on the private sector by protecting insurers' ORSA summary reports, CGAD reports, and supporting documents, which contain highly sensitive and strategic financial information.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

[11] Office of Insurance Regulation, Agency Analysis of 2016 House Bill 1165, on p. 6 (Jan. 22, 2016).

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

- Vote Requirement
  Article I, s. 24(c) of the State Constitution, requires a two-thirds vote of the members present and voting for final passage of a newly created or expanded public record or public meeting exemption. The bill expands current public record exemptions; thus, it requires a two-thirds vote for final passage.

- Public Necessity Statement
  Article I, s. 24(c) of the State Constitution, requires a public necessity statement for a newly created or expanded public record or public meeting exemption. The bill expands a current public record exemption; thus, it includes a public necessity statement.

- Breadth of Exemption
  Article I, s. 24(c) of the State Constitution, requires a newly created public record or public meeting exemption to be no broader than necessary to accomplish the stated purpose of the law. *See Drafting Issues or Other Comments.*

B. RULE-MAKING AUTHORITY:

None provided by the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

As an alternative to filing the CGAD, lines 248-255 of the main bill (HB 1163) allows an insurer or insurance group to cross-reference "other existing relevant and applicable documents, including, but not limited to, the ORSA summary report, Holding Company B or F filings, Securities and Exchange Commission (SEC) proxy statements, or foreign regulatory reporting requirements, if the documents contain information substantially similar to the information [required to be in the CGAD]." While some of these substantially similar CGAD substitutes may be independently protected from public records disclosure, (such as the ORSA summary report and Holding Company filings), other documents, such as SEC annual proxy statements, are publicly available.[12] However, a SEC proxy statement submitted in lieu of or in addition to a CGAD is arguably considered a "supporting document" that the bill would protect in its entirety.

In order to ensure that the exemption is no broader than necessary to accomplish the stated purpose of the law, the exemption may need to be narrowed to specify that supporting documents are protected, if not otherwise readily ascertainable or publicly available by proper means by other persons from another source in the same configuration as requested by the OIR. This same language appears in the current definition of "proprietary business information."

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[12] Publicly traded companies' annual proxy statements are available on the Securities & Exchange Commission's EDGAR database. *See* U.S. SECURITIES AND EXCHANGE COMMISSION, *EDGAR Company Filings*, at http://www.sec.gov/edgar/searchedgar/companysearch.html (last visited Jan. 20, 2016).

A bill to be entitled

An act relating to public records; amending s. 624.4212, F.S.; providing an exemption from public records requirements for certain reports and documents submitted to the Office of Insurance Regulation related to an own-risk and solvency assessment by an insurer or insurance group; providing an exemption from public records requirements for a corporate governance annual disclosure and supporting documents submitted to the office; revising the actuarial board to which the office may disclose certain information; providing for and revising future legislative review and repeal; providing a statement of public necessity; providing a contingent effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Present subsections (3), (4), and (5) of section 624.4212, Florida Statutes, are redesignated as subsections (4), (5), and (6), respectively, and amended, and a new subsection (3) is added to that section, to read:

624.4212 Confidentiality of proprietary business and other information.—

(3) The following information held by the office is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution:

(a) An ORSA summary report, a substantially similar ORSA report, and supporting documents submitted pursuant to s. 628.8015.

(b) A corporate governance annual disclosure and supporting documents submitted pursuant to s. 628.8015.

(4)~~(3)~~ Information received from the NAIC, a ~~or another~~ governmental entity in this or another state, the Federal Government, or a government of another nation which is confidential or exempt if held by that entity and which is held by the office for use in the ~~office's~~ performance of its duties relating to insurer valuation and solvency is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(5)~~(4)~~ The office may disclose information made confidential and exempt under this section:

(a) If the insurer to which it pertains gives prior written consent;

(b) Pursuant to a court order;

(c) To the Actuarial Board for Counseling and Discipline ~~American Academy of Actuaries~~ upon a request stating that the information is for the purpose of professional disciplinary proceedings and specifying procedures satisfactory to the office for preserving the confidentiality of the information;

(d) To other states, federal and international agencies, the National Association of Insurance Commissioners and its affiliates and subsidiaries, and state, federal, and

international law enforcement authorities, including members of a supervisory college described in s. 628.805 if the recipient agrees in writing to maintain the confidential and exempt status of the document, material, or other information and has certified in writing its legal authority to maintain such confidentiality; or

(e) For the purpose of aggregating information on an industrywide basis and disclosing the information to the public only if the specific identities of the insurers, or persons or affiliated persons, are not revealed.

(6) ~~(5)~~ This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and is repealed on October 2, 2021 ~~2019~~, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. (1) The Legislature finds that it is a public necessity that the own-risk and solvency assessment (ORSA) summary report, a substantially similar ORSA report, and supporting documents submitted to and held by the Office of Insurance Regulation pursuant to s. 628.8015, Florida Statutes, be exempt from public records requirements. In conducting this required internal assessment, an insurer or insurance group identifies and evaluates the material and relevant risks to the insurer or insurance group and the adequacy of capital resources to support these risks. The ORSA summary report, substantially similar ORSA report, and supporting documents contain highly sensitive and strategic financial information about an insurer

or insurer group. Having a comprehensive and unbiased assessment will provide the office with an effective early warning mechanism for preventing insolvencies and protecting policyholders and promote a stable insurance market. Divulging the ORSA summary report, substantially similar ORSA summary report, and supporting documents will injure the insurer or insurance group by providing competitors with detailed insight into their financial position, risk management strategies, business plans, pricing and marketing strategies, management systems, and operational protocols.

(2) The Legislature finds that it is a public necessity that the corporate governance annual disclosure and supporting documents submitted to and held by the office be exempt from public records requirements. The corporate governance annual disclosure describes an insurer's governance structure and the internal practices and procedures used in conducting the business affairs of the company, making strategic operational decisions affecting its competitive position, and managing its financial condition. Broad disclosure will give state regulators a thorough understanding of the corporate governance structure and internal policies and practices used by insurers and promote market integrity. Effective governance mechanisms will enable insurers to take any necessary corrective actions and achieve strategic goals.

Section 3. This act shall take effect on the same date that HB 1163 or similar legislation takes effect, if such

legislation is adopted in the same legislative session or an extension thereof and becomes a law.

INSURANCE & BANKING SUBCOMMITTEE

HB 1165 by Rep. Hager
Public Records/Office of Insurance Regulation

AMENDMENT SUMMARY
January 25, 2016

Amendment 1 by Rep. Hager (line 24): Clarifies that the public records exemption does not apply to information obtained by the OIR that would otherwise be available for public inspection.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 1165 (2016)

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Insurance & Banking Subcommittee

Representative Hager offered the following:

Amendment

Remove line 24 and insert:

(3) Except for information obtained by the office that would otherwise be available for public inspection, the following information held by the office is

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1233 Federal Home Loan Banks
SPONSOR(S): Stevenson
TIED BILLS: **IDEN./SIM. BILLS:** SB 1490

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee		Bauer	Luczynski
2) Government Operations Appropriations Subcommittee			
3) Regulatory Affairs Committee			

SUMMARY ANALYSIS

The Office of Financial Regulation (OFR) charters and regulates entities that engage in financial institution business in Florida, in accordance with the Florida Financial Institutions Codes (Codes). The OFR ensures Florida-chartered financial institutions' compliance with state and federal requirements for safety and soundness through regular examinations. These examinations measure the institutions' financial condition, and culminate in a highly confidential examination report, which in some instances, may result in a corrective or enforcement action. Currently, the Codes generally provide that OFR records related to investigations and reports of examination, operations, or condition are confidential and exempt from public records disclosure, with certain exceptions. One such exception states that the OFR is not prevented or restricted from furnishing records or information to "any other state, federal, or foreign agency responsible for the regulation or supervision of financial institutions, including Federal Home Loan Banks." However, the current statute does not clearly require or mandate that the OFR provide these records or information to those agencies or to the Federal Home Loan Banks (FHLBs). Secondly, the FHLBs are actually not federal financial institution regulators, resulting in some uncertainty regarding the OFR's ability to share confidential supervisory information with the FHLBs. While the OFR currently has information-sharing agreements with other federal financial institution regulators, it does not have any such agreements with the FHLBs.

Congress created FHLB System as a government-sponsored enterprise to provide liquidity support to the housing finance market and to promote community investment at the local level. It is comprised of 11 district FHLBs, which are wholly owned by members (financial institutions who make long-term mortgage loans and meet certain requirements), under the supervision of the Federal Housing Finance Agency (FHFA). In order to be eligible for FHLB membership, federal law requires that the institution agree that state and federal examination reports be provided to the FHLBs in order to determine its financial condition.

Due to this FHLB eligibility requirement and the ambiguity in the Codes, the bill clarifies that the OFR is not prevented or restricted from providing otherwise confidential information to any FHLB *or* any state, federal, or foreign agency responsible for the regulation or supervision of financial institutions. This change correctly reflects the FHLBs' status as not being a federal financial institution regulator. Secondly, the bill requires the OFR to make reports of examination (and other information relating to a FHLB member's condition) available to the FHLB.

The bill has no impact on local governments. It has an indeterminate impact to state government, in that the bill will require indeterminate staff time for redaction and legal review as part of the production process to the FHLBs, in order to comply with existing federal confidentiality restrictions and the OFR's information-sharing agreements with other agencies. It may have a positive impact to the private sector

The bill provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

The U.S. Dual Banking System

The U.S. dual banking system allows commercial banks to become chartered (organized) under either federal or state law.

- *National banks* are chartered under federal law, i.e., the National Bank Act.[1] Their primary federal regulator is the Office of the Comptroller of the Currency (OCC), an independent agency within the U.S. Department of the Treasury.
- *State-chartered banks* are chartered under the laws of the state in which the bank is headquartered.
    - The primary federal regulator for state banks that are members of the Federal Reserve System is the Board of Governors of the Federal Reserve System (FRB).
    - The primary federal regulator for non-FRB member banks is the Federal Deposit Insurance Corporation (FDIC).[2]
- *Credit unions* may also be either state or federally chartered. Their primary federal regulator is the National Credit Union Administration.

In Florida, the Office of Financial Regulation (OFR) charters and regulates entities that engage in financial institution business in Florida, in accordance with the Florida Financial Institutions Codes (Codes) and the Florida Financial Institutions Rules.[3] The OFR does not regulate financial institutions that are nationally chartered or chartered in other states. In addition, the OFR does not regulate institutions that are chartered and regulated by foreign institutions, except to the extent those foreign institutions seek to engage in the business of banking or trust business in Florida.

The OFR ensures Florida-chartered financial institutions' compliance with state and federal requirements for safety and soundness.[4] Like their federal counterparts, the OFR conducts regular examinations of Florida institutions. The Codes require the OFR to conduct examinations of each Florida financial institution during each 18-month period, although it may examine more frequently based on the institution's risk profile, prior exam history, or significant changes in the institution or its operations.[5] The examinations primarily review the institution's condition as to its Capital, Asset Quality, Management, Earnings, Liquidity, and Sensitivity (such as interest rate risk), based on a uniform supervisory rating system (CAMELS) that is used by state and federal financial institution regulators to classify a financial institution's overall condition.[6] Upon completion of the examination, the regulator presents its findings and recommended corrective measures to the institution through a highly confidential examination report.[7]

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[1] The National Bank Act of 1964 (12 U.S.C. § 24 Seventh) gives enumerated powers and "all such incidental powers as shall be necessary to carry on the business of banking" to nationally chartered banks.

[2] 12 U.S.C. §1813(q).

[3] Chs. 655, 657, 658, 660, 663, 665, and 667, F.S.; ch. 69U-100 through 69U-150, F.A.C.

[4] While the Codes do not specifically define "safety and soundness," s. 655.005(1)(y), F.S., defines "unsafe and unsound practice" as: [A]ny practice or conduct found by the office to be contrary to generally accepted standards applicable to a financial institution, or a violation of any prior agreement in writing or order of a state or federal regulatory agency, which practice, conduct, or violation creates the likelihood of loss, insolvency, or dissipation of assets or otherwise prejudices the interest of the financial institution or its depositors or members. In making this determination, the office must consider the size and condition of the financial institution, the gravity of the violation, and the prior conduct of the person or institution involved.

[5] s. 655.045(1), F.S.

[6] CAMELS is based on the Federal Financial Institutions Examination Council's Uniform Financial Institutions Rating System. Institutions are assessed on a 1 (best) to 5 (worst) rating system. *See* FDIC Financial Institution Letter FIL-105-96 (Dec. 26, 1996).

[7] s. 655.057(12)(a), F.S.

Confidentiality of Records and Information Held by the OFR

Currently, s. 655.057, F.S., governs the confidentiality of records and information relating to investigations, informal enforcement actions, trade secrets, and reports of examination, operations, or condition, including working papers of the OFR or any state or federal agency responsible for the regulation or supervision of financial institutions in Florida. It generally provides that OFR records related to investigations and reports of examination, operations, or condition are confidential and exempt from public records disclosure, with certain exceptions, such as publishing reports required by federal law or reporting suspected criminal activity to appropriate law enforcement and prosecutorial agencies.[8]

Another such exception is in subsection (5), which provides that the statute does not prevent or restrict the OFR from "[f]urnishing records or information to any other state, federal, or foreign agency responsible for the regulation or supervision of financial institutions, *including Federal Home Loan Banks*" (emphasis added). However, the current statute does not clearly require or mandate that the OFR provide these records or information to those agencies or to the Federal Home Loan Banks (FHLBs).

The OFR routinely shares confidential supervisory information with other federal and state agencies that are responsible for the regulation and supervision of financial institutions (such as the FDIC, the National Credit Union Administration, or the Financial Crimes Enforcement Network[9]), in accordance with memoranda of understanding (MOUs) that acknowledge the existing framework of federal and state laws and regulations which uniformly respect the confidential treatment that the documents or information would receive under the submitting agency's applicable confidentiality laws.[10] In particular, OFR reports of examination, described above, routinely contain confidential supervisory information obtained from other bank regulators, and the OFR is obligated to protect such information pursuant to federal confidentiality restrictions and these MOUs. Willful release of confidential information is a violation of s. 655.057(13), F.S., a third-degree felony. Similar federal criminal sanctions may also apply if confidential supervisory information owned by federal financial institution regulators is improperly released.

Despite the statute's inclusion of FHLBs as permissive recipients of confidential supervisory information along with other federal bank regulators, the FHLBs are actually *not* federal agencies responsible for the regulation of financial institutions,[11] but are eleven separate corporations owned by eligible financial institution members that collectively make up the FHLB System.[12] As a result, there is some uncertainty regarding the OFR's ability to share information with the FHLBs under s. 655.057, F.S. The OFR does not currently have an MOU with the FHLBs.

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[8] In addition, s. 119.0712(3), F.S., contains an OFR-specific public records exemption for any information received from or jointly developed with other state or federal regulatory, administrative, or criminal justice agencies.

[9] FinCEN is a bureau of the U.S. Department of Treasury that safeguards the U.S. financial system from illicit use, money laundering, and terrorist financing through the collection, analysis, and dissemination of financial intelligence and strategic use of financial authorities. It administers portions of the federal Bank Secrecy Act and anti-money laundering regulations, which were significantly enhanced by the U.S. Patriot Act of 2001. The Codes and federal law require the OFR to monitor and assess state-chartered financial institutions' compliance with these laws, subject to significant federal confidentiality restrictions.

[10] *See, e.g.,* s. 655.057(9), F.S.; 12 C.F.R. pts. 261 and 309.

[11] Originally, the FHLBs were overseen by a FHLB Board, which was later abolished by the federal Financial Institutions Reform, Recovery, and Enforcement Act of 1989, and replaced by an independent agency, the Federal Housing Finance Board. In 2008, the Federal Housing Finance Agency became the successor regulatory agency with expanded legal and regulatory authority over government-sponsored enterprises Fannie Mae, Freddie Mac, and the FHLBs.

[12] In 1992, FHLBs were added to s. 655.057(5), F.S., as a permissible recipient of confidential information from the OFR, possibly as a result of the federal 1989 FIRREA amendments. Ch. 92-303, Laws of Fla.

Federal Home Loan Banks

In 1932, Congress created the FHLB System as a government-sponsored enterprise in order to provide liquidity to "building and loan institutions" and to support residential mortgage lending and community investment at a local level.[13] The FHLB System plays a critical role in the continuous flow of funds to the residential mortgage market. These funds originate with the sale of debt securities (i.e., consolidated obligations) in the capital markets. The proceeds of these sales are then loaned to member financial institutions, which in turn provide mortgage credit to homebuyers. While the Federal Home Loan Bank System mandate reflects a public purpose, each FHLB is privately capitalized and does not receive any taxpayer assistance.

Unlike the FDIC or the OCC, the FHLB System is not a federal regulatory agency, but is composed of eleven regional cooperative banks that are entirely owned by over 7,400 members, who are insured depositories like state or nationally chartered commercial banks, thrifts, and credit unions, in addition to insurance companies and community development financial institutions, that meet certain eligibility requirements. Each member is a shareholder in one of the regional FHLBs, which are privately capitalized, separate corporate entities operating in a cooperative structure.[14] Currently, 208 members of the FHLB of Atlanta are located in Florida, of which at least 124 are Florida banks and credit unions chartered and supervised by the OFR.[15]

Each regional FHLB is an individual corporate entity, which must meet strict management and capitalization criteria befitting its status as a government-sponsored enterprise. The federal regulator charged with overseeing the FHLBs is the Federal Housing Finance Agency (FHFA), and is thus considered a "federal agency responsible for the regulation of financial institutions" that the OFR is authorized by s. 655.057, F.S., to share certain confidential information. However, the OFR currently does not have a MOU with the FHFA.[16]

FHLB Membership Eligibility & Information

In order to be considered eligible for FHLB membership, federal law requires the institution to demonstrate compliance with certain financial condition requirements by providing documentation such as regulatory financial reports, financial statements, and regulatory examination reports.[17] Each potential member must agree to certain conditions, including that reports of examination by local, state, or federal agencies may be furnished by such authorities to the FHLB or the FHFA upon request.[18] According to the OFR, however, the laws pertaining to FHLBs do not address or protect the ownership or confidentiality of any information it may obtain from a state agency,[19] should a FHLB or the FHFA receive a Freedom of Information Act (FOIA) request.[20]

Effect of the Bill

The bill amends s. 655.057, F.S., to clarify that OFR is not prevented or restricted from providing otherwise confidential information to any FHLB *or* any state, federal, or foreign agency responsible for

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[13] FHLBanks, *History of Service*, at http://www.fhlb-of.com/ofweb_userWeb/pageBuilder/mission--history-29 (last visited Jan. 20, 2016).
[14] FHLBANKS, *Membership*, at http://www.fhlb-of.com/ofweb_userWeb/pageBuilder/membership-32;jsessionid=7E92B18976B5D8609412906D810258BB (last visited Jan. 20, 2016).
[15] FHLBANK ATLANTA, *Find a Member Near You*, http://corp.fhlbatl.com/find-member/ (search conducted Jan. 21, 2016).
[16] Office of Financial Regulation, Agency Analysis of 2016 House Bill 1233 ("OFR Analysis"), p. 5 (Jan. 21, 2016).
[17] 12 U.S.C. §1424(a)(2)(B) and § 1263.6(a)(4); 12 C.F.R. § 1263.11.
[18] 12 C.F.R. § 1263.31(b).
[19] OFR Analysis, p. 5.
[20] FOIA does not apply to "matters that are...contained in or related to examination, operating, or condition reports prepared by, or on behalf of, or for the use of an *agency* responsible for the regulation or supervision of financial institutions." 5 U.S.C. § 522(b)(8). For purposes of FOIA, "agency" means authorities of the government of the United States (excluding its territories and possessions), but not of the states themselves.

the regulation or supervision of financial institutions. This change correctly reflects the FHLBs' status as not being a federal financial institution regulator.

Secondly, the bill requires the OFR to make reports of examination (and other information relating to a FHLB member's condition) available to the FHLB.

B. SECTION DIRECTORY:

Section 1. Amends s. 655.057, F.S., relating to records; limited restrictions upon public access.
Section 2. Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

As noted above, the OFR's examination reports routinely contain other regulators' confidential information, which the OFR protects pursuant to federal laws and information-sharing agreements with those regulatory agencies. These agreements contain specific limitations on what information can be shared. The OFR notes that if it provided unredacted examination reports to the FHFB as a result of the bill, it would be in breach of their agreements with these other regulatory agencies.

According to the OFR, the bill will require indeterminate staff time for redaction and legal review as part of the production process to FHLB, in order to comply with existing federal confidentiality restrictions and the OFR's information-sharing agreements with other agencies.[21]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Indeterminate but positive. The bill's clarification of the OFR's ability to share information with the FHLBs may expedite or facilitate financial institutions' new membership in the FHLBs and continued supervision by the FHFA.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

[21] OFR Analysis, pp. 3-4.

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None provided by the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

According to the OFR, the bill could endanger the ability of the OFR to be accredited by the Conference of State Bank Supervisors ("CSBS") and the National Association of State Credit Union Supervisors ("NASCUS"). A key component of the accreditation process of a state financial institution's regulatory agency, such as the OFR, is the agency's ability to maintain complete control of the confidential supervisory information it possesses. As stated above, FHLBs are government-sponsored enterprises, not regulatory agencies. By providing confidential information to the FHLB, without any agreements in place to protect and maintain confidentiality, the OFR would be failing to maintain complete control of the confidential information and could fail to be accredited. Losing accreditation would create the inability for the OFR to coordinate and work with other regulators, including the sharing of information with those regulators.[22]

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[22] OFR Analysis, p. 5.

A bill to be entitled

An act relating to Federal Home Loan Banks; amending s. 655.057, F.S.; requiring the Office of Financial Regulation to provide certain reports and information relating to a Federal Home Loan Bank member to any Federal Home Loan Bank; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (b) of subsection (5) of section 655.057, Florida Statutes, is amended to read:

655.057 Records; limited restrictions upon public access.—

(5) This section does not prevent or restrict:

(b) Furnishing records or information to any Federal Home Loan Bank or any ~~other~~ state, federal, or foreign agency responsible for the regulation or supervision of financial institutions~~, including Federal Home Loan Banks~~.

Any confidential information or records obtained from the office pursuant to this subsection shall be maintained as confidential and exempt from s. 119.07(1). The office shall make available to any Federal Home Loan Bank reports of examinations and other information relating to the condition of any member of the Federal Home Loan Bank.

Section 2. This act shall take effect July 1, 2016.

INSURANCE & BANKING SUBCOMMITTEE

HB 1233 by Rep. Stevenson
Federal Home Loan Banks

AMENDMENT SUMMARY
January 25, 2016

Amendment by Rep. Stevenson (strike-all):

- Clarifies that the Office of Financial Regulation (OFR) is not prevented or restricted from furnishing certain confidential information to Federal Home Loan Banks (FHLBs) regarding its member institutions pursuant to an information sharing agreement between the OFR and the FHLBs.
- Requires the OFR and the FHLBs to complete the information sharing agreement by August 1, 2016.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 1233 (2016)

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Insurance & Banking Subcommittee

Representative Stevenson offered the following:

Amendment 1 (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Paragraph (b) of subsection (5) is amended, and paragraph (f) is added to subsection (5) of section 655.057, Florida Statutes, to read:

655.057 Records; limited restrictions upon public access.—

(5) This section does not prevent or restrict:

(b) Furnishing records or information to any other state, federal, or foreign agency responsible for the regulation or supervision of financial institutions~~, including Federal Home Loan Banks~~.

(f) Furnishing information to Federal Home Loan Banks regarding its member institutions, in accordance with an

information sharing agreement established between the Federal Home Loan Banks and the office. Such information sharing agreement shall be completed by August 1, 2016.

Any confidential information or records obtained from the office pursuant to this subsection shall be maintained as confidential and exempt from s. 119.07(1).

Section 2. The office shall execute the information sharing agreement with the Federal Home Loan Banks required by s. 655.057(5)(f), Florida Statutes, within 31 days of the effective date of this bill.

Section 3. This act shall take effect July 1, 2016.

T I T L E A M E N D M E N T

Remove lines 3-6 and insert:

s. 655.057, F.S.; revising exception to prohibited release of certain records or information; authorizing the office to furnish information to Federal Home Loan Banks regarding its member institutions; requiring an information sharing agreement to be completed by a certain date; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 671 Prohibited Insurance Practices
SPONSOR(S): Insurance & Banking Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:** SB 1248

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

SUMMARY ANALYSIS

The Department of Business and Professional Regulation (DBPR), together with the boards, programs, and commissions created within the DBPR, has responsibility for administering the licensing programs of most of the state's regulated non-medical, non-insurance businesses and professionals. Professionals within its jurisdiction include those typically involved in building and construction, as well as other forms of property development, repair, and maintenance. These professionals may engage in services involving property insurance claims.

The PCS prohibits activities by licensed professionals that may result in fraudulent or inflated property insurance claims. Specifically, the PCS creates new grounds for discipline against a licensee who:

- Gives or receives referral fees or other items of value as an inducement for business that is paid by property insurance proceeds;
- Interprets insurance coverages or duties of the policy, unless the licensee is separately licensed as an adjuster under part VI of ch. 626, F.S.; and
- Fails to give an insured a detailed estimate of the cost of services and materials provided in connection with a property insurance claim before executing the contract authorizing the work.

The PCS may have an indeterminate fiscal impact on the DBPR, but does not have a fiscal impact on local governments. It may have a positive but indeterminate fiscal impact on the private sector.

The PCS provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

The DBPR was established in 1993 with the merger of the Department of Business Regulation and the Department of Professional Regulation.[1] The DBPR, together with the boards, programs, and commissions created within the DBPR, has responsibility for administering the licensing programs of most of the state's regulated non-medical, non-insurance businesses and professionals. Professionals within its jurisdiction include, among others, those involved in building and construction, as well as other forms of property development, repair, and maintenance, such as: architects, asbestos contractors, building code administrators and investigators, construction industry contractors (air conditioning, building, general, mechanical, plumbing, roofing, drywall), electrical and alarm system contractors, geologists, home inspectors, and mold-related services.[2] These professionals may engage in services involving property insurance claims.

Chapter 455, F.S., sets forth general licensing provisions applicable to all professions regulated by the DBPR which supplement specific licensing requirements that may be included within a profession's practice act. For example, part I of ch. 489, F.S., regulates construction contracting and establishes the duties and powers of the Construction Industry Licensing Board (CILB). Section 455.227, F.S., sets forth grounds for discipline, penalties, and enforcement actions applicable to all professions. Section 489.129, F.S., further refines disciplinary proceedings with respect to professions licensed under part of ch. 489 and licensed and regulated by the CILB.

Chapter 455, F.S., does not currently prohibit the offering or receipt of referral fees by licensed professionals.[3] Referral fees are not direct costs of a repair covered by an insurance policy. When referral fees are offered and accepted, they may be inflating the cost of claims or creating incentives for filing fraudulent claims. Contractors are currently prohibited in part VI of ch. 626, F.S., from adjusting claims on behalf of an insured, unless they are licensed as a public adjuster.[4] The Department of Financial Services has authority to administer this prohibition, but does not have authority to take action against the license of a contractor who violates the prohibition. There have been reported incidences of professionals requiring an insured to sign an agreement authorizing work with limited or no detail regarding the scope or cost. This practice puts the consumer at risk of incurring unanticipated costs or authorizing unwanted work for which the consumer could be held liable by the professional.

Effect of the PCS

The PCS creates a new section within ch. 455, F.S., which prohibits activities by licensees[5] that may result in fraudulent or inflated property insurance claims. Specifically, a licensee commits a violation and may be disciplined if the licensee:

- Directly or indirectly offers, delivers, receives, or accepts any compensation, inducement, or reward for the referral of any business for which property insurance proceeds are payable.

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[1] Ch. 93-220, Laws of Fla.

[2] *See generally* FLORIDA DEPARTMENT OF BUSINESS & PROFESSIONAL REGULATION, *Our Businesses and Profession,* http://www.myfloridalicense.com/dbpr/divisions.html (last visited Jan. 22, 2016).

[3] However, fees may be prohibited by the practice acts of specific professionals. For example, s. 468.8419(1) , F.S., prohibits any person from accepting any compensation or other inducement from a mold remediator for the referral of business to the mold remediator.

[4] s. 626.854(16), F.S.

[5] Section 455.01(5), F.S., defines "licensee" as "any person issued a permit, registration, certificate, or license by the [DBPR]."

- Interprets or advises an insured regarding coverages or duties under the insured's property insurance policy or adjusts a property insurance claim on behalf of the insured, unless the licensee holds an unencumbered license as a public adjuster pursuant to part VI of ch. 626.
- Fails to provide an insured with a detailed, itemized estimate of the cost of services and materials to be provided for repairs undertaken pursuant to a property insurance claim before the agreement authorizing such repairs is executed.

B. SECTION DIRECTORY:

Section 1: Creates s. 455.2278, F.S., prohibited property insurance practices.
Section 2: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The DBPR may collect an indeterminate amount in fines associated with violations that are prosecuted under the new provisions.

2. Expenditures:

   The DBPR will incur an indeterminate amount in costs associated with investigating and prosecuting violations under the new provisions.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The PCS prohibits activities by licensed professionals that may result in fraudulent or inflated property insurance claims. To the extent that the new enforcement authority reduces these abuses, consumers will benefit from reduced costs for repairs. The cost of claims may be lower and, as a result, insurance premiums may be lower.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The PCS does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to prohibited property insurance practices; creating s. 455.2278, F.S.; providing grounds for the discipline of licensees of various professions and occupations regulated by the Department of Business and Professional Regulation; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 455.2278, Florida Statutes, is created to read:

455.2278 Prohibited property insurance practices.—A licensee commits a violation for which the disciplinary actions specified in s. 455.227(2) may be taken if the licensee:

(1) Directly or indirectly offers, delivers, receives, or accepts any compensation, inducement, or reward for the referral of any business for which property insurance proceeds are payable.

(2) Interprets or advises an insured regarding coverages or duties under the insured's property insurance policy or adjusts a property insurance claim on behalf of the insured, unless the licensee holds an unencumbered license as a public adjuster pursuant to part VI of ch. 626.

(3) Fails to provide an insured with a detailed, itemized estimate of the cost of services and materials to be provided

for repairs undertaken pursuant to a property insurance claim before the agreement authorizing such repairs is executed.

Section 2. This act shall take effect July 1, 2016.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 929 Peril of Flood
SPONSOR(S): Insurance & Banking Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 584

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

SUMMARY ANALYSIS

The National Flood Insurance Program (NFIP) is a federal program that offers federally-subsidized flood insurance to property owners and promotes land-use controls in floodplains. The Federal Emergency Management Agency (FEMA) administers the NFIP. The Biggert-Waters Flood Insurance Reform Act of 2012 (Biggert-Waters Act) made major changes to the NFIP, including an increase in rates charged by the NFIP for flood insurance, starting in 2013. However, starting October 1, 2013, some NFIP policies that were subsidized moved directly to full-risk rates, resulting in dramatic flood insurance rate increases for some homeowners. In March 2014, federal legislation was enacted to moderate some of the rate increases resulting from the Biggert-Waters Act.

Anticipating substantial rate increases in the NFIP, the 2014 Legislature enacted s. 627.715, F.S., to provide a framework for a private, personal lines flood insurance market in Florida. The section originally provided for four types of flood insurance: *standard flood insurance* (which is equivalent to a standard policy under the NFIP), *preferred flood insurance, customized flood insurance*, and *supplemental flood insurance*. In 2015, the Legislature amended the state-authorized flood insurance program to include a fifth category of insurance, "flexible flood insurance." Insurers who wish to provide Florida-authorized coverage may develop rates for flood coverage, by either filing the rate with the Office of Insurance Regulation (OIR) and obtaining approval, or, until October 1, 2019, using a rate without the OIR's approval, so long as the rate is not excessive, inadequate, or unfairly discriminatory. In addition, current law authorizes a surplus lines agent to export a policy without having to determine that coverage is unavailable from an admitted carrier. This exemption is scheduled for repeal July 1, 2017.

The bill extends to October 1, 2025 the period in which insurers may develop and use rates without first obtaining approval from the OIR. It also extends and broadens the exemption permitting the export of coverage to a surplus lines carrier without meeting statutory conditions. The exemption is extended to July 1, 2020. The exemption is broadened to eliminate the conditions related to comparability of premiums, policy contents, and deductibles, and the condition related to notifying a policyholder of the availability of coverage from Citizens Property Insurance Corporation (Citizens) (Citizens is prohibited by law from offering flood coverage).

The bill has no fiscal impact on state government revenues and an indeterminate fiscal impact on state and local expenditures. The bill may have a positive impact on the private sector.

The bill provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

National Flood Insurance Program

The National Flood Insurance Program (NFIP or program) was created by the passage of the National Flood Insurance Act of 1968 to offer federally-subsidized flood insurance to property owners and to promote land-use controls in floodplains. The NFIP is administered by the Federal Emergency Management Agency (FEMA). The federal government will make flood insurance available within a community, if that community adopts and enforces a floodplain management ordinance to reduce future flood risk to new construction in floodplains.[1]

Nationally, the NFIP insured almost $1.3 trillion in assets in 2014. Total earned premium for NFIP coverage for 2014 was $3.56 billion.[2]

The Biggert-Waters Flood Insurance Reform Act of 2012

Following flood losses from the 2005 hurricanes Katrina, Rita, and Wilma, the NFIP borrowed $21 billion from the U.S. Treasury in order to remain solvent. However, flood losses in 2012 from Super-storm Sandy increased the NFIP's deficit. In 2012, the United States Congress passed the Biggert-Waters Flood Insurance Reform Act (Biggert-Waters Act).[3] The Biggert-Waters Act reauthorized the National Flood Insurance Program for five years. Key provisions of the legislation require the NFIP to raise rates to reflect true flood risk, make the program more financially stable, and change how Flood Insurance Rate Map updates impact policyholders. These changes by Congress have resulted in premium rate increases for approximately 20 percent of NFIP policyholders nationwide.

The Biggert-Waters Act increases flood insurance premiums purchased through the program for second homes, business properties, severe repetitive loss properties, and substantially improved damaged properties by requiring premium increases of 25 percent per year until premiums meet the full actuarial cost of flood coverage. Most residences immediately lose their subsidized rates if the property is sold, the policy lapses, repeated and severe flood losses occur, or a new policy is purchased. Some flood maps used by FEMA have not been updated since the 1980s. Policyholders whose communities adopt a new, updated Flood Insurance Rate Map (FIRM) that results in higher rates will experience a five year phase in of rate increases to achieve rates that incorporate the full actuarial cost of coverage.

The Biggert-Waters Act also requires most NFIP policyholders to pay a 5 percent assessment on their policy to create a reserve fund for catastrophic losses.[4] Additional changes to premium rates, including those paid by the 80 percent of NFIP policyholders with non-subsidized rates, can occur upon remapping. Current law limits rate increases due to remapping to 10 percent per year; the Biggert-Waters Act allows a larger annual rate increase for remapped properties. However, federal action in the 2014 federal omnibus spending bill has delayed rate increases associated with remapping for 12-18 months, as described below.

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[1] FEMA, *National Flood Insurance Program, Program Description*, (Aug. 1, 2002), https://www.fema.gov/media-library/assets/documents/1150?id=1480 (last visited Jan. 14, 2016).

[2] FEMA, *Total Coverage by Calendar Year,* http://www.fema.gov/statistics-calendar-year (last visited Jan. 14, 2016).

[3] FEMA, *Flood Insurance Reform*, https://www.fema.gov/national-flood-insurance-program/flood-insurance-reform (last visited Jan. 14,, 2016).

[4] For those NFIP policies with a 25 percent rate increase, the 5 percent assessment is not on top of the 25 percent rate increase. In other words, 5 percent of the 25 percent increase will be allocated to the Reserve Fund.

2014 Federal Flood Reform Bills

The Consolidated Appropriations Act of 2014 and the Homeowner Flood Insurance Affordability Act of 2014[5] repealed or modified some provisions of the Biggert-Waters Act. The new law reduced the mandatory rate increases for subsidized properties from 25 percent annually to no less than 5 percent, generally not to increase more than 18 percent annually.[6] Properties that remain subject to the 25 percent annual increase include older business properties, older non-primary residences, severe repetitive loss properties, and pre-FIRM properties. The 20 percent annual phase-in of premium increases after adoption of a new or updated flood insurance rate map was reduced to a maximum of no more than an 18 percent annual premium increase. For property not currently at a full-risk rate, a minimum increase of 5 percent per year is required for flood policies on primary residences built on or before December 31, 1994, or before the effective date of the initial flood insurance rate map for the community was adopted.[7]

Private Market Flood Insurance in Florida

In response to the changes to the NFIP, the 2014 Legislature enacted s. 627.715, F.S., governing the sale of personal lines residential flood insurance.[8] Flood is defined in the standard NFIP policy as a general and temporary condition of partial or complete inundation of two or more acres of normally dry land area or of two or more properties from:

- Overflow of inland or tidal waters;
- Unusual and rapid accumulation or runoff of surface waters from any source;
- Mudflow; or
- Collapse or subsidence of land along the shore of a lake or similar body of water as a result of erosion or undermining caused by waves or currents of water exceeding anticipated cyclical levels that result in a flood as defined above.

Under the 2014 law, authorized insurers could sell four different types of flood insurance products:

- Standard coverage, which covers only losses from the peril of flood as defined in the bill, which is the definition used by the NFIP. The policy must be the same as coverage offered from the NFIP regarding the definition of flood, coverage, deductibles, and loss adjustment.
- Preferred coverage, which includes the same coverage as standard flood insurance and also must cover flood losses caused by water intrusion from outside the structure that are not otherwise covered under the definition of flood in the bill.
- Customized coverage, which is coverage that is broader than standard flood coverage.
- Supplemental coverage, which supplements an NFIP flood policy or a standard or preferred policy from a private market insurer. Supplemental coverage may provide coverage for jewelry, art, deductibles, and additional living expenses. It does not include excess flood coverage over other flood policies.

The 2015 Legislature amended the program to add a fifth category, "flexible flood coverage."[9] "Flexible flood coverage" is defined as the coverage for the peril of flood that may include water intrusion coverage, and includes or excludes specified provisions, including the authority to limit coverage to only the outstanding mortgage on the property and to allow dwelling loss to be adjusted only on the actual cash value of the property.

An insurer may establish flood rates through the standard process in s. 627.062, F.S. Alternatively, rates filed before October 1, 2019, may be established through a rate filing with the OIR that is not required to be

[5] Homeowner Flood Insurance Affordability Act of 2014, H.R. 3370, 113th Cong. (2014) (Pub. L. No. 113-89) .
[6] FEMA, *Changes to the National Flood Insurance Program – What to Expect, available at* https://www.fema.gov/media-library/assets/documents/96449, (last visited Jan. 14, 2016).
[7] Homeowner Flood Insurance Affordability Act of 2014, at s. 5, H.R. 3370, 113th Cong. (2014).
[8] Ch. 2014-80, Laws of Fla.
[9] Ch. 2015-69, Laws of Fla.

reviewed by the OIR before implementation of the rate ("file and use" review) or shortly after implementation of the rate ("use and file" review). Specifically, the flood rate is exempt from the "file and use" and "use and file" requirements of s. 627.062(2)(a), F.S. Such filings are also exempt from the requirement to provide information necessary to evaluate the company and the reasonableness of the rate. The OIR may, however, examine a rate filing at its discretion. To enable the office to conduct such examinations, insurers must maintain actuarial data related to flood coverage for two years after the effective date of the rate change. Upon examination, the OIR will use actuarial techniques and the standards of the rating law to determine if the rate is excessive, inadequate or unfairly discriminatory. The law allows projected flood losses for personal residential property insurance to be a rating factor. Flood losses may be estimated using a model or straight average of models found reliable by the Florida Commission on Hurricane Loss Projection Methodology.

A surplus lines agent can export a contract or endorsement for flood insurance without the obligation to conduct the due diligence required in s. 626.916(1)(a), F.S. That paragraph requires an agent to determine that the insurance is not available from a company currently writing in the state and limits any amount that may be exported to the amount in excess of the amount that can be procured in the state. The agent must document that he or she has made a diligent effort to procure the coverage from an admitted insurer.[10] This is one of five conditions currently applicable to agents who seek to export other lines of insurance. The four others relate to premium, the policy form, deductible amounts, and notice to an applicant of the availability of coverage from Citizens.[11] In general, the conditions prevent a surplus lines insurer, which is subject to substantially less regulation than an admitted carrier, from offering policies with terms and conditions that are more favorable than can be offered by an admitted insurer. This exemption is scheduled for repeal July 1, 2017.

Effect of the Bill

The bill extends to October 1, 2025 the period in which insurers may develop and use rates without first obtaining approval from the OIR. It also extends and broadens the exemption permitting the export of coverage to a surplus lines carrier without meeting statutory conditions. The exemption is extended to July 1, 2020. The exemption is broadened to eliminate the conditions related to comparability of premiums, policy contents, and deductibles, and the condition related to notifying a policyholder of the availability of coverage from Citizens. In addition, the bill makes a technical correction, adding the word "flexible," to the introductory language in s. 627.715, F.S.

B. SECTION DIRECTORY:

Section 1: Amends s. 627.715, F.S., relating to flood insurance.
Section 2: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

[10] Section 626.914, F.S., defines "diligent effort" as seeking and being denied coverage from at least three authorized insurers in the admitted market, unless the cost to replace the property insured is $1 million or more. In that case, diligent effort is seeking and being denied coverage from at least one authorized insurer in the admitted market.
[11] Current law prohibits Citizens from offering flood coverage. s. 626.916(6), F.S.

1. Revenues:

   None.

2. Expenditures:

   Indeterminate.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

To the extent that the bill encourages more private insurers to provide coverage for flood loss, consumers may ultimately benefit from increased competition. Relaxing the standards for placing flood insurance coverage in the surplus lines market may increase access to coverage for property owners, but could negatively affect the development of the Florida flood insurance market by creating an unlevel playing field for competition.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None provided by the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the peril of flood; amending s. 627.715, F.S.; authorizing an insurer to issue flood insurance policies on a flexible basis; extending the date by which an insurer may use certain statutory rate standards for establishing and using flood coverage rates; authorizing a surplus lines agent to export a contract or endorsement providing flood coverage to an eligible surplus lines insurer without complying with certain conditions in law and extending the date of the exemption; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 627.715, Florida Statutes, is amended to read:

627.715 Flood insurance.—An authorized insurer may issue an insurance policy, contract, or endorsement providing personal lines residential coverage for the peril of flood on any structure or the contents of personal property contained therein, subject to this section. This section does not apply to commercial lines residential or commercial lines nonresidential coverage for the peril of flood. This section also does not apply to coverage for the peril of flood that is excess coverage over any other insurance covering the peril of flood. An insurer

may issue flood insurance policies, contracts, or endorsements on a standard, preferred, customized, flexible, or supplemental basis.

(1)(a)1. Standard flood insurance must cover only losses from the peril of flood, as defined in paragraph (b), equivalent to that provided under a standard flood insurance policy under the National Flood Insurance Program. Standard flood insurance issued under this section must provide the same coverage, including deductibles and adjustment of losses, as that provided under a standard flood insurance policy under the National Flood Insurance Program.

2. Preferred flood insurance must include the same coverage as standard flood insurance but:

a. Include, within the definition of "flood," losses from water intrusion originating from outside the structure that are not otherwise covered under the definition of "flood" provided in paragraph (b).

b. Include coverage for additional living expenses.

c. Require that any loss under personal property or contents coverage that is repaired or replaced be adjusted only on the basis of replacement costs up to the policy limits.

3. Customized flood insurance must include coverage that is broader than the coverage provided under standard flood insurance.

4. Flexible flood insurance must cover losses from the peril of flood, as defined in paragraph (b), and may also

include coverage for losses from water intrusion originating from outside the structure which is not otherwise covered by the definition of flood. Flexible flood insurance must include one or more of the following provisions:

a. An agreement between the insurer and the insured that the flood coverage is in a specified amount, such as coverage that is limited to the total amount of each outstanding mortgage applicable to the covered property.

b. A requirement for a deductible in an amount authorized under s. 627.701, including a deductible in an amount authorized for hurricanes.

c. A requirement that flood loss to a dwelling be adjusted in accordance with s. 627.7011(3) or adjusted only on the basis of the actual cash value of the property.

d. A restriction limiting flood coverage to the principal building defined in the policy.

e. A provision including or excluding coverage for additional living expenses.

f. A provision excluding coverage for personal property or contents as to the peril of flood.

5. Supplemental flood insurance may provide coverage designed to supplement a flood policy obtained from the National Flood Insurance Program or from an insurer issuing standard or preferred flood insurance pursuant to this section. Supplemental flood insurance may provide, but need not be limited to, coverage for jewelry, art, deductibles, and additional living

expenses.

(b) "Flood" means a general and temporary condition of partial or complete inundation of two or more acres of normally dry land area or of two or more properties, at least one of which is the policyholder's property, from:

1. Overflow of inland or tidal waters;

2. Unusual and rapid accumulation or runoff of surface waters from any source;

3. Mudflow; or

4. Collapse or subsidence of land along the shore of a lake or similar body of water as a result of erosion or undermining caused by waves or currents of water exceeding anticipated cyclical levels that result in a flood as defined in this paragraph.

(2) Flood coverage deductibles and policy limits pursuant to this section must be prominently noted on the policy declarations page or face page.

(3)(a) An insurer may establish and use flood coverage rates in accordance with the rate standards provided in s. 627.062.

(b) For flood coverage rates filed with the office before October 1, 2025 ~~2019~~, the insurer may also establish and use such rates in accordance with the rates, rating schedules, or rating manuals filed by the insurer with the office which allow the insurer a reasonable rate of return on flood coverage written in this state. Flood coverage rates established pursuant

to this paragraph are not subject to s. 627.062(2)(a) and (f). An insurer shall notify the office of any change to such rates within 30 days after the effective date of the change. The notice must include the name of the insurer and the average statewide percentage change in rates. Actuarial data with regard to such rates for flood coverage must be maintained by the insurer for 2 years after the effective date of such rate change and is subject to examination by the office. The office may require the insurer to incur the costs associated with an examination. Upon examination, the office, in accordance with generally accepted and reasonable actuarial techniques, shall consider the rate factors in s. 627.062(2)(b), (c), and (d), and the standards in s. 627.062(2)(e), to determine if the rate is excessive, inadequate, or unfairly discriminatory. If the office determines that a rate is excessive or unfairly discriminatory, the office shall require the insurer to provide appropriate credit to affected insureds or an appropriate refund to affected insureds who no longer receive coverage from the insurer.

(4) A surplus lines agent may export a contract or endorsement providing flood coverage to an eligible surplus lines insurer without satisfying the conditions set forth in ~~making a diligent effort to seek such coverage from three or more authorized insurers under~~ s. 626.916(1) ~~626.916(1)(a)~~. This subsection expires July 1, 2020 ~~2017~~.

(5) In addition to any other applicable requirements, an insurer providing flood coverage in this state must:

(a) Notify the office at least 30 days before writing flood insurance in this state; and

(b) File a plan of operation and financial projections or revisions to such plan, as applicable, with the office.

(6) Citizens Property Insurance Corporation may not provide insurance for the peril of flood.

(7) The Florida Hurricane Catastrophe Fund may not provide reimbursement for losses proximately caused by the peril of flood, including losses that occur during a covered event as defined in s. 215.555(2)(b).

(8) An agent must, upon receiving an application for flood coverage from an authorized or surplus lines insurer for a property receiving flood insurance under the National Flood Insurance Program, obtain an acknowledgment signed by the applicant before placing the coverage with the authorized or surplus lines insurer. The acknowledgment must notify the applicant that, if the applicant discontinues coverage under the National Flood Insurance Program which is provided at a subsidized rate, the full risk rate for flood insurance may apply to the property if the applicant later seeks to reinstate coverage under the program.

(9) With respect to the regulation of flood coverage written in this state by authorized insurers, this section supersedes any other provision in the Florida Insurance Code in the event of a conflict.

(10) If federal law or rule requires a certification by a

state insurance regulatory official as a condition of qualifying for private flood insurance or disaster assistance, the Commissioner of Insurance Regulation may provide the certification, and such certification is not subject to review under chapter 120.

(11)(a) An authorized insurer offering flood insurance may request the office to certify that a policy, contract, or endorsement provides coverage for the peril of flood which equals or exceeds the flood coverage offered by the National Flood Insurance Program. To be eligible for certification, such policy, contract, or endorsement must contain a provision stating that it meets the private flood insurance requirements specified in 42 U.S.C. s. 4012a(b) and may not contain any provision that is not in compliance with 42 U.S.C. s. 4012a(b).

(b) The authorized insurer or its agent may reference or include a certification under paragraph (a) in advertising or communications with an agent, a lending institution, an insured, or a potential insured only for a policy, contract, or endorsement that is certified under this subsection. The authorized insurer may include a statement that notifies an insured of the certification on the declarations page or other policy documentation related to flood coverage certified under this subsection.

(c) An insurer or agent who knowingly misrepresents that a flood policy, contract, or endorsement is certified under this subsection commits an unfair or deceptive act under s. 626.9541.

Section 2. This act shall take effect July 1, 2016.

PCS for HB 1097

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 1097 Assignment of Post-loss Property Insurance Claims
SPONSOR(S): Insurance & Banking Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:** SB 596

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

SUMMARY ANALYSIS

Generally, an assignment of benefits allows a third party to collect insurance proceeds owed to the policyholder directly from the insurance company. Consequently, the proceeds are not paid to the policyholder.

Assignment of benefits are becoming more common in property insurance claims, particularly in water damage claims where a homeowner assigns his or her benefits from the property insurance policy to a contractor or water remediation company who repairs the damaged property. Insurers now report experiencing a higher percentage of litigated claims that involve an assignment agreement and these claims generally are resulting in higher payouts and higher litigation costs than claims not involving an assignment agreement. The PCS regulates the claims process to clarify the rights and responsibilities of the insured, the insurer, and the assignees.

Current law provides that an insurance policy may be assignable, or not assignable, as provided by its terms. The law allows for an insurance policy to prohibit a pre-loss assignment of benefits, but an insurance policy may not prohibit a post-loss assignment of claims.

- The PCS prohibits an assignment, except for emergency repairs, until the insured has notified the insurer of the loss; provides the insured with a right to cancel the agreement; requires notice to the insured of the right to cancel; requires the assignee to accept duties of the policy relevant to the claim; and prohibits an assignee from attempting to recover payment from an insured for work that is covered by the insurance policy. The insured retains the right to determine the scope of repairs and is also liable for relevant duties under the policy.

Current law prescribes various timeframes an insurer must comply with when processing property insurance claims.

- This PCS shortens the timeframes associated with property insurance claims, requiring insurers to fulfill certain duties related to property insurance claims more quickly.

In addition, the PCS gives insurers specific authority to require notice of loss to be reported as soon as practicable after the loss occurred and to limit the scope of repairs that may be undertaken before the insurer inspects the property.

The PCS does not have a fiscal impact on the state or on local governments. It may have a positive but indeterminate fiscal impact on the private sector.

The PCS provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background on Issue

Generally, an agreement assigning contract benefits allows a third party to collect insurance proceeds owed to the policyholder directly from the insurance company. Consequently, the proceeds are not paid to the policyholder. Assignment agreements are commonly used in health insurance and personal injury protection insurance. In health insurance, a policyholder typically assigns his or her benefits for a covered medical service to the health care provider. Thus, the treating physician gets paid directly from the insurer. Assignment agreements are becoming more common in property insurance claims, particularly in water damage claims where a homeowner assigns his or her benefits from the property insurance policy to a contractor or water remediation company who repairs the damaged property (hereinafter collectively referred to as a "vendor").

With losses caused by water damage, such as leaky pipes, the homeowner is often facing emergency circumstances where he or she must, as a condition of the insurance policy, mitigate the damage before further damage results. This often involves calling a vendor to the home to immediately mitigate and prevent further flooding. Some insurers assert that the increasingly popular practice of assigning benefits to a vendor in a water damage claim[1] can be problematic. In claims not involving an assignment agreement, typically, the homeowner notifies the insurance company of the loss and the company has the opportunity to inspect the property before permanent repairs begin. Insurers report that in claims involving an assignment agreement, often the work has begun and may be substantially completed before the insurer has the opportunity to inspect the property. This makes it difficult to verify the cause and the extent of the damage and, as a result, the scope of coverage and the appropriate amount of the claim. Insurance policies typically impose certain duties which policyholders must comply with in order to receive coverage under their policies; homeowners must file proofs of loss, produce records, and submit to examinations under oath. However, some Florida courts have held that vendors obtaining an assignment agreement for the claim do not have to comply with these obligations because they agreed only to an assignment of the insurance benefits and did not agree to assume any of the duties under the insurance policy.[2]

Assignment agreements used by some vendors attempt to transfer broad rights under the policy and combine the assignment with authorization to perform services described only in general terms.[3] "When a party assigns a contract, the party assigns all equitable and legal interest in the contract to the assignee. The assignee thereafter stands in the shoes of the assignor and may enforce the contract against the original obligor in the assignee's own name."[4] Thus, assignment of the right to receive payment under an insurance contract necessarily assigns the right to enforce payment. An unqualified assignment transfers to the assignee all of the interest the assignor has under the assigned contract and the assignor has no right to make any claim on the contract once the assignment is complete, unless authorized to do so by the assignee.[5] Thus, a homeowner who enters into an agreement may unknowingly be assigning away his or her right to determine whether or not to bring suit on the claim. Some industry representatives have reported that some homeowners have been unaware litigation was

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[1] Insurers report an increasing number of assignment agreements in connection with roof replacement and repair claims, as well.

[2] *See, e.g., Citizens Property Insurance Corporation v. Ifergane,* 114 So. 3d 190 (Fla. 3d DCA 2012); *Shaw v. State Farm Fire and Casualty, Co.,* 37 So. 3d 329, 332 (Fla. 5th DCA 2010).

[3] *See, e.g.*, ERICKSON'S, *Contract for Services, Assignment of Benefits*, http://ericksonsdrying.com/contact-us/contract-for-services-assignment-of-benefits/ (last visited Jan. 21, 2016) (assigning "any and all insurance rights, benefits, and proceeds under applicable insurance policies …; authorizing release of any and all information requested by Erickson's its representative, or its attorney to [sic] the direct purpose of obtaining actual benefits to be paid …; waiv[ing] privacy rights …; appointing Erickson's as attorney-in-fact, authorizing Erickson's to endorse [insured's] name, and to deposit insurance checks …."

[4] 3A Fla. Jur 2d *Assignments* § 34 (Nov. 2015).

[5] *See, e.g., State Farm Fire and Casualty Co. v. Ray,* 556 So. 2d 811, 813 (Fla. 5th DCA 1990) (citing 4 Fla.Jur.2d, *Assignments, § 23 (1978)).*

pending on their claim until they, themselves, were deposed or subpoenaed by one of the parties. In these cases, the suit may be proceeding against the homeowner's wishes.

Section 627.428(1), F.S., provides for an award of attorney's fees against an insurer in a court proceeding "in which the insured or beneficiary prevails ...." This "one-way" attorney fee provision, as it is commonly described, serves to level the playing field between an insurer and an insured, thereby creating a disincentive for an insurance company to improperly deny or delay coverage. The Florida Supreme Court has construed the statute as making an award of attorney's fees available to an insured, the insured's estate, specifically named policy beneficiaries, and "third parties who claim policy coverage by assignment from the insured."[6] The insured typically sues to be made whole for damages incurred and covered by the policy. Some vendors, however, may be motivated to use litigation and the threat of attorney's fees to maximize profit from an insurance claim. This combination of a broad assignment of rights, no assignment of duties, open-ended authorization to perform work, authority to enforce transferred rights to the exclusion of the assignee's authority to enforce, and the potential for attorney's fees has created an environment of escalating concern to insurers.

In testimony before the Insurance & Banking Subcommittee, Citizens Property Insurance Company ("Citizens") reported that 70 percent of the property insurance claims in 2014 were caused by water damage, 56 percent of which were caused by non-weather water damage.[7] Water damage claims appear to be highest in the counties of Miami-Dade, Broward, and Palm Beach (collectively referred to as the "Tri-County").[8] Citizens reported that of the volume of water damage claims from 2014, 72 percent were from the Tri-County.[9] Further, the results of a Citizens 2013 litigation study revealed that 75 percent of all 2013 litigation involved water claims.[10] In a more recent and exhaustive analysis of claims files, Citizens found:

- An increase in the percentage of water claims that have an assignment agreement;
- An increase in assigned claims as a percentage of total litigated claims; and
- Higher average litigated losses and loss adjust expenses per claim than litigated claims without assignment of benefits.[11]

Assignability of Insurance Policies

Background on Form Filing and Approval for Property and Casualty Insurance Forms

The Office of Insurance Regulation (OIR) has primary responsibility for regulation, compliance, and enforcement of statutes related to the business of insurance and the admission of new insurers to the market. The OIR oversees insurance company solvency, policy forms and rates, market conduct performance, and new companies entering the Florida market. With limited exceptions,[12] s. 627.410(1), F.S., requires every insurance policy form to be filed with the OIR and approved by the OIR before the form can be used by the insurance company. Thus, residential property insurance policies are not only contracts executed between an insured and insurer, but contracts whose terms are subject to oversight by the OIR.

[6] *Roberts v. Carter,* 350 So.2d 78, 79 (Fla. 1977)
[7] CITIZENS PROPERTY INSURANCE CORPORATION, *Citizens Presentation on Assignment of Benefits* (Feb. 9, 2015) (on file with Insurance & Banking Subcommittee).
[8] *Id.*
[9] *Id.*
[10] *Id.*
[11] CITIZENS PROPERTY INSURANCE CORPORATION, *Non-Catastrophic Homeowners Water Claims* (Jan. 2016) (on file with the House Insurance & Banking Subcommittee).
[12] Commercial property insurance forms are among the exceptions.

Background on Assignability of Insurance Policies

Currently, Florida law provides that "a policy may be assignable, or not assignable, as provided by its terms."[13] An assignment can occur in two circumstances: pre-loss assignments and post-loss assignments. A pre-loss assignment occurs before a policyholder experiences a loss, and a post-loss assignment occurs after a policyholder experiences a loss. Florida law allows an insurance company to include language in the policy prohibiting pre-loss assignments,[14] but bars an insurance company from including language in the policy prohibiting post-loss assignments.[15]

Florida case law provides that "a provision in a policy of insurance which prohibits assignment thereof except with the consent of the insurer does not apply to prevent assignment of the claim or interest in the insurance money then due, after loss."[16] In other words, an insurer can include a provision in a property insurance policy that prohibits a policyholder from assigning his or her policy to a third party. Such a prohibition does not prohibit the policyholder from assigning his or her rights under the policy once a claim arises. Nor may an insurer include language in a property insurance policy that prohibits a policyholder from assigning a post-loss claim.[17] The purpose of a provision that prohibits assignment of the policy is to protect an insurer against unbargained-for risks.[18] One reason a post-loss assignment is valid despite a provision prohibiting assignment without consent of the insurer is that once a loss occurs, the financial exposure of the insurance company does not change. If a post-loss assignment agreement is executed, the assignee cannot assert new rights of his or her own that did not belong to the assignor.

Effect of the PCS on Assignability of Insurance Policies

The PCS creates s. 627.4225, F.S., which establishes requirements applicable to the assignment of post-loss property insurance claims not involving issues of liability. An insured may not assign a claim, except for emergency repairs necessary to mitigate further damage, until the insured has notified the insurer of the loss. An assignee has three days after an assignment agreement is executed to provide a copy of the assignment agreement to the insurer. The insured may cancel the assignment for a period of three days after the assignment agreement is executed or received by the insurer, whichever is later. The agreement must contain a notice to the insured of the cancellation period. By executing the agreement, the assignee accepts relevant duties under the contract. An assignment may not divest an insured of the duty to comply with relevant duties under the policy or the right to determine the scope of repairs. Likewise, it may not itself authorize work or reimbursement greater than what is provided in the policy. The PCS prohibits an assignee from attempting to recover from the insured the difference between the payment received from the insurance company and the amount claimed by the assignee for work performed. The assignee is not prohibited from pursuing a claim against the insured for money owed for deductibles or work performed at the insured's request that is not covered by the policy.

Insurer's Duties and Timeframes with Respect to Property Insurance Claims

Background on Insurer's Duties and Timeframes with Respect to Property Insurance Claims

Current law prescribes various timeframes that insurers are required to comply with regarding property insurance claims. Current law provides that when an insurer receives initial communication with respect to a claim, the insurer must review and acknowledge receipt of the communication within 14 calendar

[13] s. 627.422, F.S.
[14] *Id.*
[15] *Security First Ins. Co. v. Fla. Office of Ins. Reg.*, 177 So. 3d 627 (Fla. 1st DCA 2015)
[16] *Gisela Invs., N.V. v. Liberty Mut. Ins. Co., 452* So. 2d 1056 (Fla. 3d DCA 1984); *see also West Florida Grocery Co. v. Teutonia Fire Ins. Co.*, 77 So. 209, 224 (Fla. 1917) ("[I]t is a well-settled rule that the provision in a policy relative to the consent of the insurer to the transfer of an interest does not apply to an assignment after loss."); *Better Construction, Inc. v. National Union Fire Ins. Co.*, 651 So. 2d 141, 142 ("[A] provision against assignment of an insurance policy does not bar an insured's assignment of an after-loss claim."); *Highlands Ins. Co. v. Kravecas*, 719 So. 2d 320, 321 (Fla. 3d DCA 1998); *One Call Prop. Serv, Inc. v. Sec. First Ins. Co.,* 165 So. 3d 749 (Fla. 4th DCA 2015).
[17] *Security First Ins.*, at 628.
[18] *Lexington Ins. Co. v. Simkins Industries, Inc.*, 704 So. 2d 1384, 1386 (Fla. 1998).

days, unless payment is made within that period of time or unless the failure to acknowledge is caused by factors beyond the control of the insurer which reasonably prevent such acknowledgment.[19] If the acknowledgment is not in writing, a notification indicating acknowledgment must be made in the insurer's claim file and dated.[20] The acknowledgement must be responsive to the communication.[21] If the communication is a notification of a claim, the acknowledgment must provide necessary claim forms and instructions, including an appropriate telephone number, unless the acknowledgment reasonably advises the claimant that the claim appears not to be covered by the insurer.[22]

Unless otherwise provided by the policy or law, the insurer must begin such investigation as is reasonably necessary within 10 working days after receiving proof of loss statements, unless the failure to begin the investigation is caused by factors beyond the control of the insurer which reasonably prevent the commencement of such investigation.[23] Upon written request, within 30 days after submitting a complete proof-of-loss statement to the insurer, the policyholder has the right to receive confirmation that his or her claim is covered in full, partially covered, or denied, or receive a written statement that his or her claim is being investigated.[24] Further, Florida law currently provides that a residential property insurer must pay or deny the property insurance claim or a portion of the claim within 90 days after receiving notice of the claim from the policyholder, unless the failure to pay is caused by factors beyond the control of the insurer which reasonably prevent such payment.[25]

Current law codifies a Homeowner Claims Bill of Rights, describing some of the rights held by insurance policyholders.[26] The insurer is required to provide the policyholder with a copy of the Homeowner Claims Bill of Rights within 14 days of a claim; however, the bill of rights does not create a new civil cause of action.[27]

Currently, there are protections in place for situations in which an insurer would be unable to meet such timeframes due to situations outside of their control, such as when there is a hurricane. As noted above, most of the provisions excuse an insurer from fulfilling its obligation within the prescribed timeframe when the failure to do so is "caused by factors beyond the control of the insurer which reasonably prevent" strict compliance.[28] Further, current law bestows certain powers to the Commissioner of Insurance (the "Commissioner") and the Governor in the case of a declared emergency:

- When the Governor declares a state of emergency, s. 252.63, F.S., provides the Commissioner with the authority to issue general orders applicable to all Florida insurance companies, entities, and persons;[29]
- When the Governor declares a state of emergency, s. 252.36(5)(a), F.S., provides the Governor with the authority to suspend the provisions of any regulatory statute prescribing procedures for conduct of state business or the orders or rules of any state agency, if strict compliance with the provisions of any such statute, order, or rule would in any way prevent, hinder, or delay necessary action in coping with the emergency.

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[19] s. 627.70131(1)(a), F.S.
[20] *Id.*
[21] s. 627.70131(2), F.S.
[22] *Id.*
[23] s. 627.70131(3), F.S.
[24] s. 626.9541(1)(i)3.e., F.S.
[25] s. 627.70131(5)(a), F.S.
[26] s. 627.7142, F.S.
[27] *Id.*
[28] s. 627.70131, F.S.
[29] Such orders remain in effect for 120 day unless terminated sooner by the Commissioner, and can be extended for an additional 120 days. By concurrent resolution, the Legislature may terminate any order issued by the Commissioner under this section. s. 252.63(2), F.S.

Effect of the PCS on Insurer's Duties and Timeframes with Respect to Property Insurance Claims

This PCS shortens the timeframes that insurers must comply with regarding property insurance claims. The changes apply to all claims, not just claims involving an assignment. This PCS may have the effect of requiring some insurers to alter some of their claims practices in order to meet the new statutory timeframes. Below is a table illustrating the various changes the PCS provides to the statutory timeframes:

	Current Timeframe	**PCS Timeframe**
Upon receiving communication with respect to a claim, insurer must review and acknowledge receipt of communication within:	14 calendar days	10 calendar days
Upon receiving communication with respect to a claim, insurer must provide policyholder with Homeowner Claims Bill of Rights within:	14 days	10 days
Upon receiving proof of loss statements, insurer must begin such investigation as is reasonably necessary within:	10 working days	7 working days
After insurer receives proof of loss, upon written request, insurer must provide policyholder with confirmation that claim is covered in full, partially covered, or denied, or provide written statement that the claim is being investigated, within:	30 days	20 days
Upon initial notice of claim, insurer must pay or deny such claim or part of such claim within:	90 days	60 days

The PCS does not change the statutory safeguards in place for exigent circumstances in which an insurer would be unable to meet the timeframe, such as a hurricane. The PCS does not change the language in the statutes excusing the insurer from strict compliance with the timeframe when the failure to do so "is caused by factors beyond the control of the insurer which reasonably prevent" the insurer from performing such duties. Further, the powers bestowed upon the Commissioner and the Governor during a state of emergency would remain in place.

In addition, the PCS expands the Homeowners Bill of Rights to add cautionary language regarding assignment agreements. The PCS also gives insurers specific authority to require notice of loss to be reported as soon as practicable after the loss occurred and to limit the scope of repairs that may be undertaken before the insurer inspects the property.

B. SECTION DIRECTORY:

Section 1: Creates s. 627.4225, F.S., relating to assignment of post-loss claims.

Section 2: Amends s. 626.9541, F.S., relating to unfair methods of competition and unfair or deceptive acts or practices.

Section 3: Amends s. 627.70131, F.S., relating to notice of loss; insurer's duty to acknowledge communications regarding claims; investigations.

Section 4: Amends s. 627.7142, F.S., relating to Homeowner Claims Bill of Rights.

Section 5 Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Indeterminate.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The PCS does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to assignment of post-loss property insurance claims; creating s. 627.4225, F.S.; providing requirements under a property insurance policy for the post-loss assignment of claims or policy provisions not related to liability coverage; providing requirements for an agreement to assign such claims; providing limitations on an assignee's rights to collect money from, sue, or lien the property of a policyholder; amending s. 626.9541, F.S.; revising the timeframe for paying undisputed benefits owed under first-party property insurance policies; amending s. 627.70131, F.S.; authorizing an insurer to require notice of loss within a time certain; revising the timeframes for an insurer to acknowledge communications and initiate an investigation regarding and pay claims; authorizing the insurer to limit the scope of permanent repairs; revising the Homeowner Claims Bill of Rights to conform timeframes; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 627.4225, Florida Statutes, is created to read:

627.4225 Assignment of post-loss claim.—

(1) This section sets forth the requirements to assign post-loss claims under a property insurance policy. This section does not apply to liability coverages in the policy or to the assignment of a claim to a subsequent purchaser of the property who acquires insurable interest following a loss.

(2) A policyholder who incurs a covered loss may not assign a post-loss claim, except for payment of the reasonable costs incurred for necessary repairs to protect the property from further damage as provided in the policy, until the policyholder has given notice of the loss to the insurer or the insurer's agent as required by the policy.

(3) A policyholder may cancel an assignment agreement without penalty or obligation, except for payment of the reasonable costs incurred for necessary repairs to protect the property from further damage, within 3 business days after the date on which the agreement is executed or received by the insurer, whichever is later; however, if the agreement is executed to perform work resulting from an event for which the Governor has declared a state of emergency and is within 1 year after such declaration, the insured has 5 business days after the date on which the agreement is executed or received by the insurer, whichever is later, to cancel the agreement.

(4) The assignment agreement must contain the following notice in capitalized 14 point type: YOU ARE AGREEING TO GIVE UP CERTAIN RIGHTS YOU HAVE UNDER YOUR INSURANCE POLICY TO A THIRD PARTY. PLEASE READ AND UNDERSTAND THIS DOCUMENT BEFORE SIGNING

IT. YOU HAVE THE RIGHT TO CANCEL THIS AGREEMENT WITHOUT PENALTY OR OBLIGATION, EXCEPT FOR PAYMENT OF THE REASONABLE COSTS INCURRED FOR NECESSARY REPAIRS TO PROTECT THE PROPERTY FROM FURTHER DAMAGE, WITHIN 3 BUSINESS DAYS AFTER THE DATE ON WHICH THIS AGREEMENT IS EXECUTED OR RECEIVED BY THE INSURER, WHICHEVER IS LATER. IF WORK IS BEING PERFORMED AS A RESULT OF DAMAGE CAUSED BY AN EVENT FOR WHICH THE GOVERNOR HAS DECLARED A STATE OF EMERGENCY AND IS WITHIN 1 YEAR AFTER SUCH DECLARATION, YOU HAVE 5 DAYS AFTER THE DATE OF EXECUTION OR RECEIPT BY THE INSURER, WHICHEVER IS LATER, TO CANCEL. THIS AGREEMENT DOES NOT CHANGE YOUR OBLIGATION TO PERFORM THE DUTIES UNDER YOUR PROPERTY INSURANCE POLICY.

(5) Within 3 business days after the agreement is executed, the assignee must deliver a copy of the executed assignment agreement to the insurer or the insurer's agent at the address required by the policy for delivery of such agreements. Delivery shall be by:

(a) Certified mail, return receipt requested;

(b) Personal, overnight, or electronic delivery, with evidence of delivery in the form of a receipt or other paper or electronic acknowledgment by the insurer or the insurer's agent; or

(c) As required by the policy.

(6) By executing an assignment agreement, the assignee agrees to comply with all duties after loss as provided in the policy that are applicable to the claim and the resulting

benefits of coverage.

(7) An assignment agreement may not:

(a) Divest the policyholder of his or her obligation under the policy to comply with all relevant duties after loss.

(b) Divest the policyholder of the right to determine the scope of repairs;

(c) Authorize the assignee to perform any services not specifically approved by the policyholder in a separate contract defining the scope and estimated cost of such repairs; or

(d) Authorize the assignee to receive payment that exceeds the cost for services and materials as provided under the policy.

(8) A policyholder who assigns the right to receive the benefit of payment under the policy is not liable to the assignee for services and materials for which the insurer is liable and the assignee may not collect or attempt to collect money from, maintain any action at law against, claim a lien on real property, or report a policyholder to a credit agency for payment for which the insurer is liable under the policy. However, nothing in this subsection prohibits the assignee from collecting or attempting to collect money from, maintaining an action at law against, claiming a lien on real property for, or reporting a policyholder to a credit agency for payment of the amount of the insurance deductible or any amount attributable to services and materials ordered by the policyholder which are not covered under the insurance policy. Section 2. Paragraph (i) of

subsection (1) of section 626.9541, Florida Statutes, is amended to read:

626.9541 Unfair methods of competition and unfair or deceptive acts or practices defined.—

(1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS.—The following are defined as unfair methods of competition and unfair or deceptive acts or practices:

(i) Unfair claim settlement practices.—

1. Attempting to settle claims on the basis of an application, when serving as a binder or intended to become a part of the policy, or any other material document which was altered without notice to, or knowledge or consent of, the insured;

2. A material misrepresentation made to an insured or any other person having an interest in the proceeds payable under such contract or policy, for the purpose and with the intent of effecting settlement of such claims, loss, or damage under such contract or policy on less favorable terms than those provided in, and contemplated by, such contract or policy; or

3. Committing or performing with such frequency as to indicate a general business practice any of the following:

a. Failing to adopt and implement standards for the proper investigation of claims;

b. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue; c. Failing to acknowledge and act promptly upon communications with respect to

claims;

d. Denying claims without conducting reasonable investigations based upon available information;

e. Failing to affirm or deny full or partial coverage of claims, and, as to partial coverage, the dollar amount or extent of coverage, or failing to provide a written statement that the claim is being investigated, upon the written request of the insured within 20 ~~30~~ days after proof-of-loss statements have been completed;

f. Failing to promptly provide a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a claim or for the offer of a compromise settlement;

g. Failing to promptly notify the insured of any additional information necessary for the processing of a claim; or

h. Failing to clearly explain the nature of the requested information and the reasons why such information is necessary.

i. Failing to pay personal injury protection insurance claims within the time periods required by s. 627.736(4)(b). The office may order the insurer to pay restitution to a policyholder, medical provider, or other claimant, including interest at a rate consistent with the amount set forth in s. 55.03(1), for the time period within which an insurer fails to pay claims as required by law. Restitution is in addition to anyother penalties allowed by law, including, but not limited

to, the suspension of the insurer's certificate of authority.

4. Failing to pay undisputed amounts of partial or full benefits owed under first-party property insurance policies within 60 ~~90~~ days after an insurer receives notice of a residential property insurance claim, determines the amounts of partial or full benefits, and agrees to coverage, unless payment of the undisputed benefits is prevented by an act of God, prevented by the impossibility of performance, or due to actions by the insured or claimant that constitute fraud, lack of cooperation, or intentional misrepresentation regarding the claim for which benefits are owed. Section 3. Section 627.70131, Florida Statutes, is amended to read:

627.70131 Notice of loss; insurer's duty to acknowledge communications regarding claims; investigation.—

(1) An insurer may require notice of loss to be reported as soon as practicable, but not less than 72 hours, after the insured knew or should have known that the loss occurred.

(2) (a) Upon an insurer's receiving a communication with respect to a claim, the insurer shall, within 10 ~~14~~ calendar days, review and acknowledge receipt of such communication unless payment is made within that period of time or unless the failure to acknowledge is caused by factors beyond the control of the insurer which reasonably prevent such acknowledgment. If the acknowledgment is not in writing, a notification indicatingacknowledgment shall be made in the insurer's claim file and dated. A communication made to or by an agent of an

insurer with respect to a claim shall constitute communication to or by the insurer.

(b) As used in this subsection, the term "agent" means any person to whom an insurer has granted authority or responsibility to receive or make such communications with respect to claims on behalf of the insurer.

(c) This subsection shall not apply to claimants represented by counsel beyond those communications necessary to provide forms and instructions.

(3) ~~(2)~~ Such acknowledgment shall be responsive to the communication. If the communication constitutes a notification of a claim, unless the acknowledgment reasonably advises the claimant that the claim appears not to be covered by the insurer, the acknowledgment shall provide necessary claim forms, and instructions, including an appropriate telephone number.

(4) ~~(3)~~ Unless otherwise provided by the policy of insurance or by law, within 7 ~~10~~ working days after an insurer receives proof of loss statements, the insurer shall begin such investigation as is reasonably necessary unless the failure to begin such investigation is caused by factors beyond the control of the insurer which reasonably prevent the commencement of such investigation. An insurer may limit the scope of repairs that may be undertaken without prior approval before the insurer conducts an onsite inspection, but must allow for necessaryrepairs to protect the property from further damage.

(5) ~~(4)~~ For purposes of this section, the term "insurer"

means any residential property insurer.

(6)~~(5)~~(a) Within 60 ~~90~~ days after an insurer receives notice of an initial, reopened, or supplemental property insurance claim from a policyholder, the insurer shall pay or deny such claim or a portion of the claim unless the failure to pay is caused by factors beyond the control of the insurer which reasonably prevent such payment. Any payment of an initial or supplemental claim or portion of such claim made 60 ~~90~~ days after the insurer receives notice of the claim, or made more than 15 days after there are no longer factors beyond the control of the insurer which reasonably prevented such payment, whichever is later, bears interest at the rate set forth in s. 55.03. Interest begins to accrue from the date the insurer receives notice of the claim. The provisions of this subsection may not be waived, voided, or nullified by the terms of the insurance policy. If there is a right to prejudgment interest, the insured shall select whether to receive prejudgment interest or interest under this subsection. Interest is payable when the claim or portion of the claim is paid. Failure to comply with this subsection constitutes a violation of this code. However, failure to comply with this subsection does not form the sole basis for a private cause of action.

Section 4. Section 627.7142, Florida Statutes, is amended to read: 627.7142 Homeowner Claims Bill of Rights.—An insurer issuing a personal lines residential property insurance policy in this state must provide a Homeowner Claims Bill of Rights to

a policyholder within 10 ~~14~~ days after receiving an initial communication with respect to a claim, unless the claim follows an event that is the subject of a declaration of a state of emergency by the Governor. The purpose of the bill of rights is to summarize, in simple, nontechnical terms, existing Florida law regarding the rights of a personal lines residential property insurance policyholder who files a claim of loss. The Homeowner Claims Bill of Rights is specific to the claims process and does not represent all of a policyholder's rights under Florida law regarding the insurance policy. The Homeowner Claims Bill of Rights does not create a civil cause of action by any individual policyholder or class of policyholders against an insurer or insurers. The failure of an insurer to properly deliver the Homeowner Claims Bill of Rights is subject to administrative enforcement by the office but is not admissible as evidence in a civil action against an insurer. The Homeowner Claims Bill of Rights does not enlarge, modify, or contravene statutory requirements, including, but not limited to, ss. 626.854, 626.9541 627.4225, 627.70131, 627.7015, and 627.7074, and does not prohibit an insurer from exercising its right to repair damaged property in compliance with the terms of an applicable policy or ss. 627.7011(5)(e) and 627.702(7). The Homeowner Claims Bill of Rights must state:

HOMEOWNER CLAIMS

BILL OF RIGHTS

This Bill of Rights is specific to the claims process and does

not represent all of your rights under Florida law regarding your policy. There are also exceptions to the stated timelines when conditions are beyond your insurance company's control. This document does not create a civil cause of action by an individual policyholder, or a class of policyholders, against an insurer or insurers and does not prohibit an insurer from exercising its right to repair damaged property in compliance with the terms of an applicable policy.

YOU HAVE THE RIGHT TO:

1. Receive from your insurance company an acknowledgment of your reported claim within 10 ~~14~~ days after the time you communicated the claim.

2. Upon written request, receive from your insurance company within 20 ~~30~~ days after you have submitted a complete proof-of-loss statement to your insurance company, confirmation that your claim is covered in full, partially covered, or denied, or receive a written statement that your claim is being investigated.

3. Within 60 ~~90~~ days, subject to any dual interest noted in the policy, receive full settlement payment for your claim or payment of the undisputed portion of your claim, or your insurance company's denial of your claim. 4. Free mediation of your disputed claim by the Florida Department of Financial Services, Division of Consumer Services, under most circumstances and subject to certain restrictions.

5. Neutral evaluation of your disputed claim, if your claim is for damage caused by a sinkhole and is covered by your policy.

6. Contact the Florida Department of Financial Services, Division of Consumer Services' toll-free helpline for assistance with any insurance claim or questions pertaining to the handling of your claim. You can reach the Helpline by phone at...(toll-free phone number)..., or you can seek assistance online at the Florida Department of Financial Services, Division of Consumer Services' website at...(website address)....

YOU ARE ADVISED TO:

1. Contact your insurance company before entering into any contract for repairs to confirm any managed repair policy provisions or optional preferred vendors.

2. Carefully read any agreement that assigns the benefit of payment or other rights under your policy to a third party. You retain the obligation to comply with all duties under your insurance policy related to the loss.

3. ~~2.~~ Make and document emergency repairs that are necessary to prevent further damage. Keep the damaged property, if feasible, keep all receipts, and take photographs of damage before and after any repairs.

4. ~~3.~~ Carefully read any contract that requires you to pay out-of-pocket expenses or a fee that is based on a percentage of the insurance proceeds that you will receive

for repairing or replacing your property.

5. ~~4.~~ Confirm that the contractor you choose is licensed to do business in Florida. You can verify a contractor's license and check to see if there are any complaints against him or her by calling the Florida Department of Business and Professional Regulation. You should also ask the contractor for references from previous work.

6. ~~5.~~ Require all contractors to provide proof of insurance before beginning repairs.

7. ~~6.~~ Take precautions if the damage requires you to leave your home, including securing your property and turning off your gas, water, and electricity, and contacting your insurance company and provide a phone number where you can be reached.

Section 5. This act shall take effect July 1, 2016.

INSURANCE & BANKING SUBCOMMITTEE

PCS/HB 1097 by Rep. Caldwell
Assignment of Post-loss Property Insurance Claims

AMENDMENT SUMMARY
January 25, 2016

Amendment 1 by Rep. Caldwell (Line 2): corrects a drafting error in the title by removing the phrase "assignment of post-loss," thereby more accurately reflecting the content of the PCS.

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Insurance & Banking Subcommittee

Representative Caldwell offered the following:

Amendment (with title amendment)

T I T L E A M E N D M E N T

Remove line 2 and insert:

An act relating to property