Florida Insurance Report

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RADEY | THOMAS | YON | CLARK

Attorneys & Counselors at Law

Florida Legislative Session – 2011 – A Break Before the Home Stretch

By: David Yon

The 2011 Florida Legislative Session has passed its half-way mark and will soon be in the home stretch. There is a constant stream of activity in both chambers as bills work through committees. The following is a quick look at where some important bills were at the end of week number 6. We will provide a complete overview of what happens after the session is over.

Property Insurance
(Omnibus Bills – CS/CS/CS/SB 408 and HB 803)

In the Senate, the omnibus property bill has passed out of its last committee and is on second reading before the full Senate. By the time this report is issued the bill could possibly clear the Senate and move over to the House. The Senate Rules Committee was the last to hear the bill and on April 5th the committee included the following changes, described in the staff summary highlights:

- Requires the Florida Hurricane Catastrophe Fund to provide reimbursement for all incurred losses including amounts paid as fees on behalf of the policyholder, with exclusions;
- Increases over time the minimum surplus requirement for residential property insurers to $15 million;
- Allows insurers offering personal lines property insurance to provide written notice of policy changes to their policyholders without having to non-renew an entire insurance policy due to a change in policy terms;
- Reduces the insurer's written notice of nonrenewal, cancellation, or termination of a personal lines or commercial residential property insurance policy to 90 days;
- Modifies current replacement cost coverage and actual cash value provisions relating to dwellings and personal property;
- Requires windstorm and hurricane property insurance claims to be brought within three years and sinkhole loss claims to be brought within two years;
- Modifies provisions related to windstorm damage mitigation discounts for residential property insurance and repeals the provision requiring the Office of Insurance Regulation to develop a method correlating mitigation discounts to the uniform home grading scale;

- Repeals the requirement that the Consumer Advocate prepare an annual report card for personal residential property insurers;
- Changes the name Citizens Property Insurance Corporation to Taxpayer-Funded Property Insurance Corporation;
- Renames the Citizens High Risk Account the Coastal Account and repeals the requirement to reduce the boundaries of the Citizens' High Risk Account (wind-only coverages);
- Allows an insurer seeking to take policies out of Citizens to do so in 45 days;
- Clarifies the ethics requirements for specified board members of Citizens and requires that Board members abstain from voting under certain circumstances;
- Allows an insurer to cancel or non-renew a property insurance policy upon a minimum of 45 days notice based on a finding that the insurer lacks adequate reinsurance coverage for hurricane risk and other financial factors;
- Revises the regulation of public adjusters by placing limits on public adjuster compensation, prohibiting certain statements in public adjuster advertising, and revising the contents of the public adjuster contract;
- Removes the requirement that a privately owned property insurer must offer sinkhole coverage, but requires Citizens to continue to offer sinkhole coverage, with substantial changes in coverage requirements;
- Revises the definition of a sinkhole loss;
- Limits the authority of the Office of Insurance Regulation (OIR) to disapprove rates for sinkhole insurance;

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- Revises procedures for insurers and policyholders relating to standards for sinkhole insurance claim investigations and revises the neutral evaluation process for sinkhole disputes; and
- Provides changes to the procedures pertaining to sinkhole reports by professional engineers or professional geologists and repeals the sinkhole database.

The House version, CS/HB 803 was passed by a vote of 11-7 by the Economic Affairs Committee on April 14, 2011. There are major favorable portions of the Senate bill that are not addressed in the House version of this legislation.

Citizens Property Insurance Corporation CS/SB 1714 and CS/CS/HB 1243

CS/SB 1714 passed the Banking and Insurance Committee on a vote of 6-4. The bill was scheduled to be heard on April 15th in the Budget Committee, but was postponed. The bill toughens the eligibility requirements for obtaining a policy from Citizens (among other things making structures above $1,000,000 in value and applicants with a private market quote within 25% of the Citizens rate ineligible), requires Citizens to increase rates by up to 20% in each territory where indicated, requires a number of surcharges, limits the type of coverage that Citizens can offer, prohibits policyholders from contracting with a public adjuster before Citizens makes an offer to pay a claim, limits fees that public adjusters can receive and makes a number of other changes.

The House bill (CS/CS/HB 1243) passed the House Economic Affairs Committee by a 10-6 vote and has been placed on the calendar to be heard by the full House. This version contains measures similar to those in the Senate bill including the increased cap on rate increases. It does not contain the same limits on public adjusters found in the Senate version.

Commercial Deregulation (CS/CS/SB 178 and CS/CS/HB 99)

The commercial insurance rating bills which substantially eliminate rate regulation for a number of commercial lines are in good position to become law. CS/CS/HB 99 passed the House unanimously and is currently in Messages in the Senate. The Senate version CS/CS/SB 178 remains in the Budget Committee, but the Senate is now free to take up the House bill and vote on it or continue to move its own bill.

These bills expand last year's "commercial deregulation" categories or lines of insurance to include fiduciary liability (for directors and officers, employment practices and management liability), general liability, nonresidential property except for collateral protection insurance, nonresidential multi-peril, excess property and burglary and theft. An insurer may implement such rates without OIR review and must make only a limited filing with OIR. In addition, the type of information OIR may request should it choose to review the rates, and the information an insurer must retain in its file, are reduced.

Residential Property Insurance—Rate Filings CS/HB 885

The bill broadens the types of costs that may be included in an expedited rate filing under section 627.062, Florida Statutes. All reinsurance costs, the cost of financing products used to replace reinsurance, the financing costs incurred in the purchase of reinsurance and the costs of the price increase of the FHCF mandatory option coverage are allowed.

The bill also allows an insurer to request a rate increase of a maximum of 15 percent per policy, rather than 10 percent. Current provisions prohibiting insurers from including expenses or profits paid by the insurer in an expedited rate filing are deleted. As under current law, an insurer can only file an expedited rate filing once every 12 months.

However, this bill removes current provisions that restrict insurers from using an expedited rate filing if the insurer has implemented a rate increase in the prior six months and restricts insurers from making any other rate filing for six months after the expedited rate filing.

The bill has passed out of all of its committees and is ready to be voted on by the House, but does not have a companion in the Senate. Many of the same changes, however, are included in CS/CS/CS/SB 408.

Civil Remedies Against Insurers "Bad Faith" CS/SB 1592 and HB 1187

These bills seek to better define and limit the circumstances under which an insurer can be held liable for bad faith judgments.

HB 1187 was scheduled to be heard this week by the Civil Justice Subcommittee, but was temporarily postponed. A recent staff analysis shows that the bill provides:

- Specific statutory standards for a bad faith claim against an insurer and replaces any related common law causes of action currently available in Florida;

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- That a bad faith claim arises where the insurer acts in gross disregard of the insured's interest by failing to accept a good faith written demand to settle within policy limits;
- That only an insured person or that person's assignee has a cause of action under the bill, thus eliminating a direct cause of action brought by a third-party claimant against an insurer without an assignment from the insured;
- That in a bad faith action arising out of failure to settle with a third-party claimant, the insurer's duty to offer policy limits does not arise unless a plaintiff shows that during settlement negotiations the third party submitted a detailed written demand to settle with the insurer within policy limits that meets criteria specified in the bill;
- A process for insurers to facilitate settlement within policy limits in the event of multiple third-party claims;
- Evidentiary standards for bad faith cases, stating that an insurer does not have a fiduciary relationship with a first-party claimant and retains the right to protect privileged work product. With respect to third-party claims, the insurer's work product is immune from discovery until the underlying claim for payment on the insurance policy is final; and
- Prohibits the inclusion of a multiplier or enhancement with an award for attorneys' fees and costs and limits damages recoverable in bad faith actions involving uninsured motorist coverage to two times the policy limits.

The Senate bill (CS/SB 1592) remains in the Budget Committee and has been referred to the Rules Committee, its last stop before being heard on the floor of the Senate.

The Senate version creates specific statutory standards for a bad faith claim against an insurer which "apply equally and without limitation or exception to all common law remedies and causes of action for bad faith failure to settle." The bill specifies that a bad faith claim arises where the insurer acts "arbitrarily and contrary to the insured's interests in failing to settle claims within the policy limits if, under all the circumstances existing at the relevant time, it could and should have done so, had it acted fairly and honestly toward its insured." Only an insured person or that person's assignee has a cause of action under the bill, thus eliminating a direct cause of action brought by a third-party claimant against an insurer without an assignment from the insured. In a bad faith action arising out of failure to settle with a third-party claimant, the insurer's duty to offer policy limits does not arise unless a plaintiff shows that during settlement negotiations the third party submitted a detailed written demand to settle with the insurer within policy limits which meets criteria specified in the bill. The bill also provides a process for insurers to facilitate settlement within policy limits in the event of multiple third-party claims.

Surplus Lines Insurance
CS/CS/SB 1816 AND CS/HB 1227

These bills, while not identical, make similar changes to the surplus lines statutes. Among other things, they modify the reporting periods for surplus lines agents and change the basis for computing surplus lines taxes. The surplus lines tax would be computed on the gross premium when the surplus lines policy covers risks that are only partially in Florida and Florida is the home state as defined by the Nonadmitted and Reinsurance Reform Act of 2010 (NRRA). The bills authorize the Department of Financial Services and the OIR to enter into cooperative reciprocal agreements with other states to collect and allocate non-admitted insurance taxes for multistate risks pursuant to the NRRA.

The Senate bill (CS/CS/SB 1816) has one more stop in the Budget Committee. The House bill (CS/HB 1127) was approved by the Insurance and Banking Subcommittee and is now in Finance and Tax with a stop after that in Economic Affairs.

Medical Malpractice
CS/CS/CS/HB 479 and CS/SB 1590

The House bill was approved by the Judiciary Committee on April 14th by a vote of 15-3. The bill now goes to the floor of the House.

The Senate bill unanimously passed the Banking and Insurance Committee on April 12th as a committee substitute and is now nearly identical to the new House version. The bill heads to the Budget Committee, its last stop before being heard by the Senate.

The bills seek to make a number of reforms that are intended to reduce medical malpractice litigation in Florida, including requiring expert witness certificates, for experts from out of state.

No Fault/PIP
CS/SB 1694, CS/SB 1930, CS/CS/HB 967 and CS/HB 1411

Four bills on the subject of no fault/PIP have been filed. Two focus on preventing fraud and two on PIP reform.

CS/CS/HB 967 - The Florida Motor Vehicle No-Fault Law (No-Fault Law) requires motorists to carry at least $10,000 of no-fault insurance, known as personal injury protection (PIP) coverage. PIP provides payment of medical, surgical, funeral and disability benefits to the named insured and persons injured while in, or

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struck by, the insured motor vehicle without regard to fault. In return for assurance of payment of these benefits, the No-Fault Law places limitations on lawsuits for non-economic damages (pain and suffering).

The current version of CS/CS/HB 967 includes the following changes to Florida's no-fault motor vehicle law:

- Authorizes PIP insurance policies that require or allow the use of arbitration to resolve disputes;
- Charges the Department of Financial Services with adopting by rule, procedures to implement arbitration of PIP disputes;
- Grants exclusive original jurisdiction to circuit courts to hear challenges to PIP arbitration decisions; provides for a trial *de novo* (new trial) in circuit court;
- Requires insurers to pay the costs of arbitration as well as attorney fees in certain situations;
- Caps attorney fee awards in disputes under the No-Fault Law based on a tiered system based on the amount of the disputed claim;
- Bars use of a contingency risk multiplier in determining fee awards in No-Fault cases;
- Permits insurers to use the schedule of maximum charges that is based on Medicare Part B when providing reimbursement for durable medical equipment and care and services rendered by clinical laboratories care and services rendered in ambulatory surgical centers;
- Establishes that the applicable Medicare fee schedule in effect on January 1st is to be used throughout the year in calculating reimbursements made that rely on Medicare-based charges;
- Requires insureds who seek PIP benefits to comply with all terms of the insurance policy, including submitting to an examination under oath (EUO). Makes compliance with policy terms a condition precedent to eligibility for policy benefits. Permits EUOs to be recorded. Requires assignees of PIP payment rights to comply with policy terms and cooperate with the insurer, including submitting to an EUO;
- Requires the insurer to make a written request for information sought before requesting an EUO from an assignee. Entitles assignees to reasonable compensation for time spent participating in an EUO; and
- Provides that it is an unfair and deceptive trade practice for an insurer, as a general business practice, to request EUOs without a reasonable basis.

The bill is currently in the Health and Human Services Committee and has one more stop—Economic Affairs.

CS/HB 1411 - The "Comprehensive Insurance Fraud Investigation and Prevention Act" revises provisions relating to crash reports to require more comprehensive reports; authorizes an officer to testify at trial or provide an affidavit; defines terms; revises requirements relating to the form submitted by providers; revises provisions relating to payment; provides that time for paying or denying a claim is tolled during investigation of fraudulent act; specifies when benefits are not payable; provides that claimant violating certain provisions is not entitled to payment, provides that sitting for an EUO is a condition precedent and the failure of a claimant to appear creates a presumption of unreasonable refusal to submit to an examination.

The bill is currently in the Health and Human Services Committee. It then has one more committee stop - Economic Affairs before being heard on the floor of the House.

CS/SB 1694 - Senate Bill 1694 enacts limits on attorneys' fee awards. The bill limits attorney's fees recovered pursuant to a No-Fault dispute to a maximum hourly rate of $200. Alternatively fees may be paid subject to:

- For a disputed amount less than $500, 15 times the disputed amount recovered, up to a total of $5,000;
- For a disputed amount of $500 or more, but less than $5,000, 10 times the disputed amount recovered, up to a total of $10,000;
- For a disputed amount of $5,000 up to $10,000, 5 times the disputed amount recovered, up to a total of $15,000; and
- For class actions, 3 times the disputed amount recovered, up to a total of $15,000.

The bill also prohibits using a contingency risk multiplier to calculate attorneys' fees recovered under the No-Fault law.

CS/SB 1694 narrowly passed the Senate Banking and Insurance Committee (6-5) on April 12th and has assignments to Judiciary and Budget remaining.

CS/SB 1930 - Senate Bill 1930 revises the Florida Motor Vehicle No-Fault Law and related statutory provisions. The bill makes changes in the following areas:

- Motor Vehicle Fraud – includes revisions to crash report forms to include information about passengers, written notice to applicants for clinic licensure receive written notice that a fraudulent application is a fraudulent insurance act, creates an auto insurance fraud direct support organization controlled primarily by

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appointees of the CFO, requires the suspension of an occupational license and health care practitioner license for any person convicted of insurance fraud and prohibits such persons from receiving PIP reimbursement for 10 years and creates civil penalties for motor vehicle insurance fraud;

- Investigation of Claims for No-Fault Benefits - defines "claimant" to include any person seeking PIP benefits, including a person who accepts an assignment of benefits from the insured, allows insurers 90 days to investigate possible fraudulent insurance acts, specifies that the insurer may require copies of medical treatment records to be reviewed by a medical provider within the same license chapter, authorizes insurers to conduct onsite physical examinations of a medical provider's office and equipment used for treatment and requires a medical provider that accepts an assignment of benefits to submit to an EUO and otherwise cooperate with the insurance investigation, creates a rebuttable presumption that failure to appear for two examinations is unreasonable, and provides that submitting to an examination is a condition precedent to receiving benefits;
- Denial of Fraudulent No-Fault Claims - authorizes the insurer to deny benefits to a claimant who knowingly submits a false or misleading statement, document, bill, record, or information; or commits or attempts to commit a fraudulent insurance act and authorizes the insurer to recover previous payments made to such providers who commit fraud or knowingly submit false or misleading bills, records, information, documents, or statements;
- Submission of Bills to Insurer - specifies that the insured must verify treatment was rendered by countersignature, or insurer is not provided with notice;
- Reimbursement of No-Fault Benefits - defines what constitutes an "entity wholly owned" by medical providers that is eligible to receive reimbursement for PIP treatment, clarifies the PIP benefit fee schedule by specifying that the Medicare fee schedule effective on January 1 will apply for the rest of the calendar year, limits reimbursement for durable medical equipment and services rendered by ambulatory surgical centers and clinical laboratories to 200% of Medicare Part B, requires effective January 1, 2012, that insurers include the PIP fee schedule in their policies and preempts local lien laws favoring hospitals in accordance with the statutory requirement that the insurer reserve $5,000 to pay physicians rendering emergency treatment or inpatient hospital care;
- Demand Letters - provides that premature demand letters cannot be cured unless the court abates the action or the claimant files a voluntary dismissal, provides that demand letters sent during a lawsuit are defective, prohibits using a demand letter to request documents and provides 10 additional days for insurer to correct an incorrect payment in response to a demand letter; and
- Preferred Provider PIP Networks - authorizes insurers to provide a premium discount to policyholders who select a policy that provides benefits using the preferred provider network (PPO), but specifies that insured loses discount once it uses a non-network physician. Also specifies that all providers eligible for PIP reimbursement may be a part of a PPO network.

The bill narrowly passed the Senate Banking and Insurance Committee on a vote of 7-4 on April 12th and still has to be heard in the Judiciary and Rules committees.

Florida Legislature Again Looks to Alter Rulemaking Requirements

By: Travis Miller

In late 2010, the Florida Legislature overrode a veto and thereby adopted legislation requiring certain agency rules to be approved by the legislature before they become final. This inserts the legislature into a process that historically has rested with Florida's agencies. In the current session, the legislature again seeks to fundamentally alter the Florida rulemaking process. Proposed legislation would provide a summary repeal process allowing newly elected officials to summarily repeal existing rules of agencies subject to their oversight for reasons such as the rules' inconsistency with the elected officials' desired philosophies. Although affected parties would be able to challenge the repeal of these rules, the proposed legislation would place upon these parties the burden to monitor agencies' activities for efforts to repeal these rules.

In the Spring 2011 edition of the Federation of Regulatory Counsel's quarterly journal (www.forc.org), I wrote about the public policy implications of the legislature's veto override and an Executive Order entered by Governor Rick Scott earlier this year. The legislature's proposal in the current session would result in a further erosion of the status of administrative rules in guiding regulated parties in Florida. Although this may be viewed favorably when rules are perceived to create barriers to efficiently conducting business, a decline in agency rulemaking can have adverse consequences when rules are intended to create level playing fields and put affected parties on notice of regulatory policies.

OIR Issues Report on PIP Data Call

By: David Yon and Bert Combs

The OIR issued a report compiling the results from its recent voluntary data call from insurers writing personal automobile insurance in Florida. Thirty-one companies responded, representing more than 80% of the market. In addition to reviewing the data from the call, the report also compiled data from insurance company annual reports, the Fast Track Monitoring System and the Department of Highway Safety. Not surprisingly the data showed the cost of PIP claims rising dramatically over the period beginning in 2006 and ending in 2010, with the last two years being especially bad. Combined loss ratios have gone from mid 90% to more than 115%. The frequency of PIP claims has climbed dramatically even though overall crashes reported by Highway Safety are down. Most who write in this line will not be surprised to hear that Tampa has become the new "staged crash" capital of the state.

Other notable statistics included in the report show:

- The total number of PIP claims opened or recorded in 2010 (386,464) increased 28% since 2006 (302,141).
- The number of pending and settled PIP-related lawsuits in which the insurer was the defendant has increased significantly from 2006 to 2010. The number of lawsuits pending at year-end increased by 387%, while the number settled during the year increased 315%.
- The median duration of treatment has remained relatively stable, but the median number of procedures per claim has increased 59% from 2006 to 2010.
- From 2008 to 2010, the total billed amount for medical services increased by 173%.
- In 2010, almost a quarter of the allowed amounts paid by the insurer under physical medicine and rehabilitation were for massages. The number of units of massages increased 251% from 2007 to 2010, while the total allowed reimbursement amount increased 202%.
- The total Florida direct earned premiums for PIP coverage has remained relatively stable from 2006 to 2010, decreasing 8% from 2006 to 2010, while only decreasing 2% from 2008 to 2010.
- Data from the Florida Department of Highway Safety and Motor Vehicles shows the number of licensed drivers decreased by 0.5% from January 1, 2008 to January 1, 2011.

OIR Issues Three New Informational Memoranda

By: Karen Asher-Cohen

The OIR recently issued three Informational Memoranda.

Informational Memorandum #OIR-11-02M is directed to all property and casualty insurers and discusses "Partners in Recovery" – a not-for-profit organization that assists with disaster preparedness and property insurance claims following a disaster. It includes three components: The Insurance Liaison Team, the Insurance Disaster Assessment Team, and the State Emergency Response Team.

Informational Memorandum #OIR-11-03M is intended to notify all assessable and surplus lines insurers that the OIR approved a reduction in Citizens' emergency assessment for the 2005 plan year within the High Risk Account from 1.4% to 1%, effective July 1, 2011. All other provisions of the original January 11, 2006, OIR Order remain in effect.

Most recently, on April 11, 2011, OIR issued Informational Memorandum #OIR-11-04M, as guidance to motor vehicle service associations and property and casualty companies with an auto warranty line of business. Pursuant to sections 634.121 and 634.282, Florida Statutes, companies must document that refunds of unearned premium due to cancellations, as well as other payments due to consumers, are being made in accordance with these statutory provisions. The Memorandum gives examples of types of satisfactory documentation that will demonstrate compliance with the Insurance Code, such as a copy of the front and back of a canceled check showing the full refund amount to the consumer or financial institution.

For copies of the Informational Memoranda, please see our website at www.radeylaw.com.

$5.2 Million Judgment Illustrates The Use Of A Bad Faith Claim As A Strategy

By: Tom Crabb

United Automobile Insurance Company v. The Estate of Stephen D. Levine et al., Case No. 3D09-3234 (Fla. 3d DCA March 30, 2011).

On March 30, the Third District affirmed a $5.2 million judgment against an auto insurer that illustrates how a savvy plaintiff can use a bad faith claim as a strategy by tailoring its conduct in claims settlement in a way that makes a bad faith claim against an insurer more likely to succeed. In 2001, a vehicle driven by an insured under a personal injury protection policy was in a collision with another vehicle, killing the driver and passenger of the other vehicle and injuring the insured and his passenger. The same day it was notified of the claim, the insurer sent a $10,000 check to the attorney for the estate of the other driver, representing the bodily injury limit under the policy, along with a subrogation waiver, disclosure of liens form, hold harmless agreement and forms requesting additional information from the estate. It was unclear whether the estate had to execute the documents in exchange for the $10,000 check. Two weeks later, the estate requested a copy of the policy and it was immediately provided. Two months later, the $10,000 check was returned to the insurer without explanation, despite an adjuster from the company calling the estate monthly. The insurer received no claim for property damage to the other vehicle and made no tender of the property damage policy limits of $10,000.

In 2002, the estate sued the insured and obtained a $5.2 million judgment against him. The insured then assigned to the estate all his rights to sue the insurer. The estate then, asserting the insured's rights, sued the insurer for bad faith for failing to timely settle the estate's claim against the insured. The estate claimed that had the insurer "timely tendered the policy limits" it would have accepted that amount and released the insured. That is, the estate claimed that had the insurer paid it the policy limits without condition, it would never have sued the insured and hence never would have recovered the $5.2 judgment million against him. Accordingly, the insurer's alleged "failure" to settle the claims of the estate resulted in a $5.2 million judgment against the insured. The trial court returned a verdict for the estate on the bad faith claim and entered a $5.2 million judgment against the insurer.

On appeal to the Third District, the insurer made a number of arguments, all of which were rejected: 1) that the jury should have been presented evidence of how the insurer promptly settled claims of others involved in the collision; 2) that the assignment by the insured to the estate was improper; 3) that the jury instructions given were improper; and 4) that the case should not have even been submitted to a jury because the conduct of the insurer could not have been bad faith. The court recognized, however, that the essence of the insurer's position "though not directly articulated," was that it had been set up for a bad faith claim as a strategy by the estate's failure to communicate with the insurer about why the insurer's tender, release, and other requirements were unacceptable. The Third District noted that until there is a "substantial change" in the bad faith statutory scheme, "juries will continue to render verdicts regarding an insured's alleged bad faith when the pertinent facts are in dispute." A dissenting judge on the court succinctly described the issue: "While juries are responsible for determining bad faith claims, it is the responsibility of the courts to treat all litigants which or who come before them on a fair and equal basis. This, of course, applies to insurance companies. It is therefore incumbent on courts to view the facts objectively and, where appropriate, to preclude obviously collusive or contrived claims from moving forward. This action presents just such a case where counsel for an injured party refuses to communicate or negotiate following a good faith offer by an insurer and after dodging information requests via vague responses by office staff, brings an action for bad faith."

DOR Updates Database for Reporting Premium Taxes

By: Bert Combs

The Florida Department of Revenue (DOR) issued a Taxpayer Information Publication (TIP #11B8-01) describing changes to its electronic address/jurisdiction database. Insurance companies use these database files for allocating premium tax to the various firefighters' and police officers' pension trust funds and local taxing districts.

Insurers can register at http://geotax.state.fl.us to download the address/jurisdiction database files. The database contains changes submitted by the local jurisdictions that reflect annexations, new addresses, and other relevant changes. Only one change to participating jurisdictions occurred: Village of Palm Springs, Palm Beach County, (Police/Code 947).

The TIP reminds insurers that DOR's address/jurisdiction database is updated every April and October. Insurers should continue to report their local insurance premium taxes yearly on Schedules XII and XIII of their *Insurance Premium Taxes and Fees Return* (Form DR-908). Insurers **must** use the updated address/jurisdiction database available in October 2011 to report premiums for the 2012 calendar year (Form DR-908 is due by March 1, 2013).

We're on the Web at
www.radeylaw.com

301 South Bronough Street
Suite 200
Tallahassee, FL 32301
850-425-6654 - Phone
850-425-6694 - Fax

Editors & Contributors


Travis Miller
tmiller@radeylaw.com
850-425-6654


David Yon
david@radeylaw.com
850-425-6671


Karen Asher-Cohen
karen@radeylaw.com
850-425-6654


Bert Combs
bcombs@radeylaw.com
850-425-6654


Tom Crabb
tcrabb@radeylaw.com
850-425-6654

Kendria Ellis*
kellis@radeylaw.com
850-425-6686
*not an attorney

REMINDER!

May 1st is the deadline for companies to submit their 2011 Annual Report to the Florida Division of Corporations. The Division will assess a $400 late penalty if the deadline is not met.

RADEY | THOMAS | YON | CLARK
Attorneys & Counselors at Law

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Radey Thomas Yon & Clark, P.A. believes that service to clients must be efficient and dedicated. Our location in Tallahassee, Florida, provides us the opportunity to be at the heart of the regulatory, legislative, and judicial arenas. The Florida Insurance Report is provided to our clients and friends in a condensed summary format and should not be relied upon as a complete report nor be considered legal advice or opinion.

OIR Seeks Penalties Against Insurer For Not Offering Major Medical Conversion Policies

By: Bert Combs

OIR seeks to impose penalties against an insurer for not offering a major medical conversion policy to its policyholders. These policyholders had purchased major medical expense policies under a program that the insurer filed as an out-of-state group policy. The insurer provided its policyholders with a notice of termination, but did not offer them a conversion policy. OIR issued a show cause order that required the insurer to demonstrate why the insurer's certificate of authority should not be suspended or revoked or why it should not be subject to other penalties. The case is pending at the Division of Administrative Hearings and set for hearing. *Guarantee Trust Life Insurance Company v. Office of Insurance Regulation*, Case No. 111755-10.

OIR contends that the insurer is offering a group policy, and therefore required to offer a converted policy on termination of eligibility pursuant to section 627.6675, Florida Statutes. The insurer contends that it is not offering a group policy, but instead that it offers individual coverage. Accordingly, the insurer maintains that it is subject to another statute (section 627.6425), that the applicable statutory requirements for terminating policies have been met, and that it is not subject to 627.6675. Another important issue in the case involves the fact that the insurer designated the coverage as "out-of-state group" when it filed with OIR. OIR contends that the insurer is now estopped to deny that its coverage is out-of-state group. However, the insurer argues that OIR's filings system (i-File) is a rule that is changed on a regular basis without the required rulemaking proceedings, making the requirement that applicants designate a type of group an invalid and unadopted rule.

First Tier Rankings

Administrative/Regulatory Law

Insurance Law