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"GET TO KNOW" INTERVIEWS THE INSURANCE COMMISSIONER - *Part II*

By: Karen Asher-Cohen

COMMISSIONER KEVIN MCCARTY is the Commissioner of the Florida Office of Insurance Regulation and the President-Elect of the National Association of Insurance Commissioners (NAIC). Last month, I presented Part I of my recent interview with the Commissioner. Below is Part II of that interview.

What do you see as some of the major issues facing the NAIC during your term as President?

These are exciting times in terms of insurance regulation. We fared very well in the 2008 meltdown of the banking industry and security sectors. That showed the strength of a state-based insurance regulation system. Our strength was demonstrated in how we handled that crisis. We are working with conglomerates and internationally active groups in agreeing to a regulatory framework going forward. It is important to balance the reduction of incidents of "too big to fail" while maximizing the efficiency of capital in the marketplace.

What do you think of the new products on the market nationally that are changing the old concepts of life insurance, e.g., accelerated benefit riders, lump sum payments not tied to traditional health care delivery systems (nursing homes, home health care), and long term care innovations?

As you've said, we are seeing a lot of new products in the life and health market. We are seeing the merger of life products with long term care components and long term

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Radey Thomas Yon & Clark Among Florida Trend Best Companies to Work For

Radey Thomas Yon & Clark, P.A. is pleased to announce that *Florida Trend* magazine ranked it among the Top 100 Best Companies to Work for in Florida. *Florida Trend* annually ranks the "Best Companies to Work for in Florida," and its August issue lists the 2011 winners. The firm is one of only four Tallahassee companies to appear on this year's list.

The annual "Best Companies to Work for in Florida" review considers Florida-based employers in all categories, including for-profit, not-for-profit and

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care coverage emphasizing home health care instead of institutional care. I think this is all positive and important for people to have choices. However, we need to be careful. Because of the sophistication of the products, consumers need to be sure to consult with certified financial planners before they buy any products. I cannot emphasize enough that this is a case of "buyer beware." Consumers need to seek professional advice about these products, because these policies can be very complicated. Basically, we would have suitability concerns and want to know that people are buying the right products for them. It is really a case of life benefits being combined with health indemnity benefits, to give consumers the maximum choice for whatever resources they have. The proliferation of products for consumers in the marketplace is always a good thing. We just need to be cautious because it is difficult sometimes to adequately shop and compare.

Speaking of Shop & Compare, is it coming back?

I am proud to say that the new and improved version of Shop & Compare will have a launch date in September, 2011.[1] We are even hoping to beat that date. We are making enhancements to the site, so that it will be an even better tool for policyholders, and will have additional links to other resources. This has been one of the most popular sites for consumers and receives about 20,000 hits per month. Of course, it is not a substitute for getting quotes from the company itself, but it is a good tool.

You recently conducted public hearings in Tallahassee of MetLife and Nationwide regarding unclaimed property and claims settlement practices in the life insurance industry. What is your goal for the OIR in this area? Do you plan to hold additional hearings? Do you think that new legislation is needed?

I think that the case can certainly be made that under Florida law, the actual knowledge of death of a policyholder that is constructively in the company's hands, creates a duty to investigate the claim. That doesn't necessarily mean that the claim should be paid, but the company must investigate. I do not see any need for new laws in this area. We have been conducting a series of market conduct investigations and public hearings. We have found that the practice of companies is to utilize the Social Security death master list to terminate annuity payments to the advantage of the companies, but to not use the same database to investigate death claims, and I think that is simply unconscionable. Perhaps it can be attributed to the structure of the companies themselves, given their silos of isolated systems; but perhaps it is the willful blindness to the practice to the detriment of the beneficiaries.

Keep in mind, that many policies have non-forfeiture provisions. These provide that in the event of illness or disability, the company will draw down the policy to pay the premiums for a temporary period of time. However, if the policyholder is dead, and the company keeps drawing down the policy to pay premiums, the policy will be extinguished. You either have to investigate the claim of death or remit the money to the state. We don't need new laws. Florida is chairing a 10-state NAIC Task Force. We are looking at the 40 largest companies that write 92% of the life and annuity premiums. We are conducting a sequential investigation of the largest components of the market share. We hope to achieve the return of money to policyholders and/or their beneficiaries and to establish practices and procedures to prevent this from ever happening again. We want to ensure that a promise made is a promise kept.

Commissioner Kevin McCarty

OIR and DFS recently signed the Non-admitted Insurance Multi-state Agreement (NIMA) to respond to the new changes to the surplus lines law, and how premium taxes are collected. How do you see this process working, going forward? Do you anticipate more states signing on?

We are very happy we met the first cut-off date of June 16th to solicit new signatories to the signing of the multi-state agreement.[2] The agreement fully complies with the spirit and intent of the law. It will enhance the collection and distribution of the states' premium tax. Also, it will allow us to preserve the integrity of state-based insurance regulation. Frankly, many states could not have delegated the authority to a third party. We had a great model in IFTA, which has been a simple formula for 30 years. It was a great model for us to use in a similar tax situation.

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Get to Know - *Continued*

Now that the Federal Insurance Office has a Director (Mike McRaith, ex-Illinois Commissioner), are you concerned that it will attempt to overreach and usurp states' authority over insurance regulation? How do you anticipate interacting with the FIO as NAIC President?

I have had the pleasure of working with the new Director of the FIO for the past seven years. Mike McRaith is a very accomplished Director of Insurance from the State of Illinois. Also, the NAIC was very active in the passage of the Dodd Frank Wall Street Reform and Consumer Protection Act. We were instrumental in the Treasury Department being limited in terms of insurance regulation. Treasury and the FIO are not regulators. The law explicitly exempts insurance from their purview. Their role is very limited to representing the United States in international agreements. The NAIC supported the creation of the FIO. We needed a voice to represent the United States at international meetings and in international treaties. They have no interest occupying the field of insurance.

Just last week I met with Director McRaith and Deputy Treasury Secretary Neal Wollen, to implement Dodd Frank and to work to implement an international regulatory framework. I very much look forward to working with the members of Treasury and in particular, Director McRaith.

Where do you see yourself in 5 years?

I would like to continue the pursuit of the work I've been involved with on the international front. I have been working on the development of a common framework for insurance regulation and the development of common core principles. I have participated in the International Association of Insurance Supervisors ("IAIS") and the supervisory forum. These are intriguing times, where entities and regulations cross borders, cross jurisdictions, and cross all sectors. I would like to still be involved with that.

Editor's Notes:

[1] *At the time of publication the OIR had reactivated the old "shop and compare" website now called the Consumer HomeOwners Insurance Comparison Electronic System (CHOICES).*

[2] *At the time of publication, the NIMA had eleven signatory members, other than Florida.*

On The Move - Robin Westcott Named as Florida's New Insurance Consumer Advocate

By: Karen Asher-Cohen

Chief Financial Officer Jeff Atwater has appointed Robin Westcott to serve as Florida's new Insurance Consumer Advocate. "Robin will be an ardent, outspoken and persistent advocate for Florida's insurance consumers," said CFO Atwater. "She is committed to holding insurance companies accountable and to ensuring consumers get exactly what they pay for and are protected from fraud and abuse. She has seen firsthand the tactics used to game the system and simply won't stand for it."

"I'm honored that CFO Atwater has given me the opportunity to continue to advocate for Florida's insurance consumers—a passion I have dedicated my career to," said Westcott. "I am excited and committed to ensuring Florida's consumers have the best products at the most competitive prices." Westcott stated that her first goal as Insurance Consumer Advocate will be to address cost drivers in auto and property insurance rates.

Westcott started at the (then) Florida Department of Insurance, Division of Rehabilitation and Liquidation, in 1993, where she stayed until 2001, when she entered private practice. Westcott served as Assistant General Counsel and Counsel to the Florida Partnership for School Readiness in 2002 at the Florida Agency for Workforce Innovation. In 2004, she returned to the Office of Insurance Regulation, most recently serving as the Acting Deputy Commissioner of Property and Casualty. Westcott will also continue to serve as the Executive Director of the Medicaid and Public Assistance Fraud Strike Force.

Commissioner McCarty commented on Robin's appointment: "I would like to commend CFO Atwater for his selection of Robin Westcott as the new Florida Insurance Consumer Advocate. I have had the pleasure of working with Robin in several capacities, and believe that her abilities and experience make her well-suited for this position. Robin is a respected professional in the insurance industry nationally, with a solid understanding of the Florida insurance marketplace. I am confident that Robin will be a powerful voice for consumer interests, and bring new prestige to this position; I congratulate her for accepting this new role."

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governmental entities. Participating companies are evaluated based on their responses to a comprehensive questionnaire regarding company benefits and policies in categories such as benefits, career development, training and retention. Companies' employees then are contacted individually and surveyed with more than 70 questions relating to their satisfaction and their companies' policies. As a testament to the dedication of its employees, the response rate of Radey Thomas Yon & Clark's employees was double the required number for organizations of its size.

"We are proud of this recognition because it is based on the participation and responses of all of our employees," said firm president Travis Miller. "We have received many accolades individually and as a firm for our legal work, but being named one of the Best Companies to Work for in Florida is a special honor because it reflects our firm's work environment and culture."

Radey Thomas Yon & Clark employees cited the firm's collegial working environment, family-friendly atmosphere and strong commitment to employee benefits as key factors in their job satisfaction. In addition, Radey Thomas Yon & Clark supports employee wellness through walking teams and sponsoring wellness fairs. The firm also participates in many charitable initiatives through the active involvement of its employees and through its financial support.

"As a firm, our employees are dedicated to helping others. This extends not only to the work environment we create for ourselves, but also to our surrounding community," Miller said.

Senate Committees to Study Insurance Issues

By: Travis Miller

Each year, the legislature asks its committees to review significant issues and prepare reports in anticipation of the next legislative session. This year is no different, and the Senate recently released its list of interim projects.

Property & Casualty Insurance

Project 2012-11 will be a review of Florida's medical malpractice insurance market. The project will analyze the effectiveness of the 2003 medical malpractice reforms that were designed at that time to respond to problems with the affordability and availability of coverage in some practice areas. The 2003 reforms led to a "presumed factor" rate reduction based on anticipated loss savings. The report will evaluate whether the reforms have reduced medical malpractice losses and associated costs and determine whether the full value of the reforms has been passed on to physicians in the form of lower premiums. The report will also investigate whether medical malpractice premiums and the litigation environment in Florida are continuing to create barriers to access to care and placing the state at a disadvantage when attempting to attract highly competent medical providers.

Another project, 2012-226, will address Citizens Property Insurance Corporation. The objective is to examine Citizens' assets available to meet potential obligations. This will include analysis of Citizens' ability to absorb claims without issuing bonds and the effects of a 50-year and 100-year event.

Project 2012-203 will study Personal Injury Protection (PIP) coverage in Florida. The summary observes that Florida has experienced an increase in motor vehicle related insurance fraud cases and costs associated with PIP coverage. The objective of the issue brief is to outline issues related to motor vehicle insurance fraud and rising costs in the PIP system. The project will analyze the motor vehicle insurance market according to specified criteria including, but not limited to, affordability, availability, and the provision of benefits.

The committee also will review certain exemptions from the public records laws that are contained in various insurance provisions. One review will pertain to Personal Injury Protection (PIP) and Property Damage Liability insurance policies. The exemption for personal identifying

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information held by the Department of Highway Safety and Motor Vehicles will be reviewed using the standards provided in s. 119.15, F.S., the Open Government Sunset Review Act, to determine if they meet those standards and to determine if a recommendation should be made to save the exemption from repeal. The review will focus on the exemption and application of the exemption by the department.

Likewise, the committee will conduct an open government sunset review of section 624.23, F.S., Consumer Complaints and Inquiries Received by the Department of Financial Services. The purpose is to review s. 624.23, F.S., to determine if it meets the standards established in the Open Government Sunset Review Act and to recommend whether the exemption should be saved from repeal, revised, or allowed to sunset.

A similar review will pertain to section 717.117(8), F.S., Unclaimed or Abandoned Property. The exemption of property identifiers with relation to unclaimed or abandoned property held by the Department of Financial Services will be reviewed using the standards provided in s. 119.15, F.S., the Open Government Sunset Review Act, to determine if they meet those standards and to determine if a recommendation should be made to save the exemption from repeal. The review will focus on the exemption and application of the exemption by the department.

In addition, the legislative committees monitor recently enacted legislation each year to assess whether it is meeting its objectives. The Banking & Insurance Committee will monitor the property insurance reforms passed in SB 408 during 2011. Committee staff will evaluate the provisions imposed by the Legislature through the passage of CS/CS/CS/SB 408 to determine the effects on the property insurance marketplace and the regulation of property insurance. Finally, committee staff will evaluate the regulatory and marketplace impact of the expansion of the types of commercial lines insurance that are subject to the filing and review exemptions specified in CS/CS/CS/HB 99.

The insurance industry also will be interested in an interim project to be conducted by the Judiciary Committee relating to the bad faith law. After proposed bad faith reforms were heavily debated in 2011 but did not pass, the committee again will evaluate the status of bad faith laws and bad faith litigation in Florida.

Life & Health Insurance

The Florida Senate will conduct several interim projects in anticipation of the 2012 session that may be of interest to health insurers. In particular, the following projects relating to Health Regulation may have direct or indirect impacts on the health insurance market:

Review 24-hour Admissions Limitations in Ambulatory Surgical Centers

Review Consolidating, Eliminating, or Reorganizing Health Related State Agencies

Review Eligibility of Dentist Licensure in Florida and Other Jurisdictions

Review Regulatory Oversight of Assisted Living Facilities in Florida

Referrals Between Health Care Providers in Delivery of Radiation Therapy Services

The Senate also will monitor the effectiveness of legislation passed during the 2011 session. Among the bills slated to be monitored this fall are the new Medicaid Managed Care Legislation and Regulating Controlled Substances in Pain Management.

The reports on most projects are due either September 1 or October 1. However, the committees sometimes find that additional time is necessary to properly evaluate the complex issues.

2012 Changes to Florida Legislative Session

The 2012 Florida Legislative Session is scheduled from January to March, 2012. The first day of the 2012 session is January 6th and ends 60 days later on March 6, 2012. Interim committee meetings in anticipation of the 2012 session are scheduled to begin in September. This is a departure from the customary Spring sessions of years past.

NRRA Implemented

By: David Yon

The Florida Surplus Lines Office and the Department of Financial Services (collectively "Florida") moved forward on July 1, to implement the Nonadmitted and Reinsurance Reform Act of 2010 (NRRA) enacted by Congress and chapter 2011-46, Laws of Florida, enacted by the Florida Legislature. Florida selected July 1 as the date the surplus lines risks for which Florida is the "home state" must begin paying all surplus lines taxes for such risks (and a .03 per cent fee) to the state of Florida. Since this date does not match the primary effective date of the NRRA (July 21, 2011), it has the potential to create confusion among surplus lines agents and other states.

NRRA provides that effective July 21, 2011, all surplus lines taxes must be paid to the home state of the policyholder. Home state is defined generally as "the state in which an insured maintains its principal place of business." However, the law also has a provision, section 521, that authorizes states to "enter into a compact or otherwise establish procedures to allocate among the States the premium taxes paid to an insured's home State." The law further provides that if the compact or procedures are enacted within 330 days of July 21, 2010 they "apply to any premium taxes that, on or after such date of enactment, are required to be paid to any State that is subject to such compact or procedures." Chapter 2011-46 became law within the 330-day time period and Florida takes the position that as of July 1, 2011, it is entitled to collect and retain all surplus lines premium taxes for businesses whose home state is Florida. It is not clear whether another state which has not enacted procedures or compacts within the first 330 days would agree with this reading. It is possible other such states would assert they remain entitled to receive surplus lines taxes for the portion of the risk in their state until the July 21, 2011 date. There is a pre-emption provision for the federal law in section 522 of the Act. Florida takes the position that this provision protects companies that comply with its procedures.

While July 1 may be the effective date for collecting the taxes, under the new law the taxes do not have to be remitted until the 45th day following each calendar quarter, making the first due date October 15.

As of July 25, 2011 the state of Florida had reached agreement with 11 states (Alaska, Connecticut, Hawaii, Louisiana, Mississippi, Nebraska, Nevada, Puerto Rico, South Dakota, Utah, and Wyoming) to be part of the Non-Admitted Insurance Multi-State Agreement coalition. Early on there were discussions that Florida might apply a percentage to the out of state premium to collect an amount equal to the special assessments levied for the Florida Hurricane Cat Fund and Citizens Property Insurance Corporation. This idea has been abandoned.

The Federal law also makes the home state the sole entity responsible for the statutory and regulatory requirements for the nonadmitted market. Section 524 of the NRRA establishes uniform standards for surplus lines eligibility, limiting a state's ability to impose eligibility requirements. A broker cannot be prohibited from placing nonadmitted insurance with a nonadmitted reinsurer not domiciled in the United States as long as the company is listed on the quarterly listing of alien insurers maintained by the NAIC.

OIR Announces "Re-Launch" of Homeowners' Rate Comparison Site

By: David Yon

On July 26, 2011, the Office of Insurance Regulation re-launched the former "Shop and Compare" interactive tool that allowed Floridians to shop and compare homeowners rates in their county. The new system called the Consumer HomeOwners Insurance Comparison Electronic System (CHOICES) is available on the OIR website.

Commissioner McCarty praised the revamped program, stating, "The system ranks companies' rates in a given county, along with company contact information, to encourage Floridians to shop for a better rate; the system also illustrates the competitiveness of the homeowners' insurance market in Florida and the benefits of shopping for insurance."

Appellate Update

By: Tom Crabb

A PIP Insurer May Not Use Medicare Part B Fee Schedules Contrary To A "Reasonable Expenses" Payment Methodology Set Forth In The Policy

Kingsway Amigo Insurance Company v. Ocean Health, Inc., --- So. 3d ---, Case No. 4D10-4887 (Fla. 4th DCA 2011).

The PIP law has long required policies to pay 80% of "all reasonable expenses" for medically necessary medical services. In 2007, the PIP law was amended in part to provide that an insurer "may limit reimbursement to 80 percent" of certain schedules of maximum charges, including 200% of the allowable amount under the participating physicians schedule of Medicare Part B, ostensibly indicating that payment of the schedule rate is necessarily "reasonable." Over the last few years, however, there has been extensive litigation on the issue of whether the statute alone gives the insurer the right to limit payment to the Medicare schedule or whether the insurer must amend its policy language to specifically inform the insured that payment for medical services will be so limited. More than a dozen county and circuit courts had weighed in on the issue and reached contrary conclusions, some holding that no amendment to the policy was required as the PIP law is specifically incorporated into every PIP policy and some holding that in order to use the Medicare reimbursement schedule, the policy specifically had to reference the schedules. An appellate court, the Fourth District Court of Appeal, has now weighed in on the issue, holding that the payment methodology must be set forth in the policy.

In this case, an insurer's policy provided that it would pay 80% of "all reasonable expenses" for medical services, without specifically mentioning the Medicare schedule or the alternative payment methodology from the 2007 PIP amendments. Nonetheless, the insurer paid a claim based on the Medicare schedule amount. The insured sued, arguing to the trial court that the Medicare schedule resulted in a payment that was not "reasonable" and the 2007 amendments did not prohibit an insurer from providing more coverage than the schedule amount and that by not specifically noting the new methodology, the insurer had simply chosen to provide a higher reimbursement rate. In other words, because the statute says an insurer "may" limit reimbursement to the Medicare schedule, it is only permissive and not mandatory. If an insurer wishes to use the alternative payment methodology it must have language to that effect in the policy. Because this insurer did not have such operative language in its policy, it could not limit payment to the Medicare schedule amount. The trial court agreed, concluding that because the new 2007 PIP law provides both mandatory ("...reasonable expenses") and permissive ("may limit reimbursement to...") methods of reimbursement, "it is important for the PIP insurer to clearly and unambiguously choose and identify its selected payment methodology." On May 18, 2011, the Fourth District Court of Appeal agreed, holding that the plain language of the statutes "allow an insurer to choose between two different payment calculation methodology options," but it has to express its choice in its policy language. This important issue will most certainly be addressed by the other district courts of appeal in the future.

A Dispute Over The Amount Of Damages Is Not An Affirmative Denial Of Coverage Subjecting FIGA To Attorney's Fees

Fla. Ins. Guar. Ass'n v. Smothers, Case No. 4D09-4597 (Fla. 4th DCA 2011).

An insured whose home was damaged by Hurricane Wilma had a policy with Atlantic Preferred Insurance Company, whose claims became the responsibility of the Florida Insurance Guaranty Association after Atlantic Preferred became insolvent. FIGA reviewed the insured's claim and sent an independent third party adjuster to inspect the home, who found $3,800 in damage solely to the exterior, specifically finding no damage to the interior. By letter to the insured, FIGA agreed to pay that amount less the insured's deductible. FIGA did not indicate in the letter that it was denying coverage and the insured did not object to the amount at that time. Subsequently, however, the insured sued FIGA to recover additional money under the policy. FIGA moved for an appraisal and the suit was stayed. The appraisal determined there was some $22,000 in damage – to both the interior and exterior – for which FIGA was responsible and FIGA paid that amount. The insured then claimed that he was also entitled to attorney's fees. Under the FIGA Act, FIGA is responsible for attorney's fees only if it denies a covered claim by "affirmative action, other than delay" (s. 631.70). The insured argued to the trial court that by refusing to pay the additional amount prior to his filing a lawsuit, FIGA had denied his claim by affirmative action. The trial court agreed, concluding that when the adjuster found no damage to the interior (contrary to the appraiser's later decision), that finding was an affirmative denial of coverage making FIGA liable for attorney's fees. On June 8, 2011, the Fourth District Court of Appeal reversed, holding that a dispute about the amount of damages does not constitute a denial of coverage by affirmative action. A dispute as to the amount to be paid is not a denial of coverage. Accordingly, the insured was not entitled to attorney's fees.

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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.

Division of Agent & Agency Services Discusses Key Issues

By: David Yon

The Division of Agency and Agency Services at the Department of Financial Services is moving forward with rule making on the following topics.

Annuity Contract Cover Pages

Rule 69B-162.011, F.A.C., relates to the design and content of annuity contract cover pages. The Division states the purpose of the proposed amendment is to revise the existing rule to reflect provisions of Senate Bill 2176, passed during the 2010 Legislative Session. The bill amended section 626.99(4)(c), F.S., to require cover pages for fixed and variable annuity contracts. The goal for the proposed rule amendment is to provide "clear and concise" information to consumers regarding the circumstances under which an annuity contract may be cancelled for an unconditional refund. In addition to mandatory formatting requirements, the proposed rule amendment requires that annuity cover pages contain specific cautionary language to inform consumers of the risks, policy features and contact sources for those seeking additional information or to report complaints. A public hearing will be held on August 16th if requested within the 21-day time period.

Use of Designations and Certifications

Rule 69B-215.235, F.A.C., relates to the use of designations and certifications in the marketing and sale of insurance products.

The Division states the purpose of the proposed rule is to extend guidance and establish standards for the use of professional designations or certifications by licensees engaged in the marketing and sale of insurance products. The proposed rule, according to the notice, clarifies that lawful designations must be granted by recognized organizations that maintain published standards and procedures that assure the ongoing competency and ethical conduct of members or conferees. The proposed rule prohibits any use of self-conferred or baseless designations by licensees engaged in the marketing of insurance products. The proposed rule is designed, according to the notice, to protect consumers from deceptive trade practices by licensees who claim, or falsely imply, certain levels of expertise or credentials that could reasonably lead consumers to place unwarranted confidence in the quality, accuracy, or veracity of their statements.