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June 1 Deadline Brings Mixed Results for Insurers

By: Travis Miller

The start of the Atlantic hurricane season on June 1 also marked the end of speculation on the fate of two prominent insurance bills passed by the legislature during the 2010 session. The Governor approved SB 2176, which included changes to the commercial rate filing process, annuity sales practices, and service contract regulation. These new laws are discussed in more detail elsewhere in this Report. However, the Governor at the same time vetoed SB 2044, which was the 2010 session's major property insurance package.

Many observers have called the Governor's veto of SB 2044 disappointing, but not surprising. The bill reflected the input of numerous parties, including the insurance industry and the Florida Office of Insurance Regulation. Commissioner Kevin McCarty wrote in favor of the bill, and several consumer groups also urged its adoption. However, the Governor ultimately vetoed the bill because he believes the expansion of Florida's expedited rate filing process will result in insurers too easily seeking rate increases and because he fears provisions on mitigation will diminish the value of Floridians' investments in hardening their homes.

These grounds for veto are curious in that even under the expedited rate filing process, the Office of Insurance Regulation retains full authority to review the proposed rates on a prior approval basis. In addition, an insurer could not adjust its mitigation discounts without submitting a filing to the OIR, again meaning that any changes would be subject to regulatory approval.

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OIR Approves NCCI's Proposed Reduction for Workers' Compensation Rates in Florida

By: David Yon

On May 7, 2010, the National Council on Compensation Insurance (NCCI) requested a rate level decrease of 4.2% for industrial classifications and for F-Classifications effective July 1, 2010 for new and renewal policies.

The Florida Department of Financial Services revised the Special Disability Trust Fund (SDTF) assessment effective July 1, 2010, reducing it from the statutory max of 4.52% to 1.46%. NCCI advised this had a rate impact of -4.2%. The SDTF reimburses insurance carriers and self-insured employers for benefits they must pay because a pre-existing permanent impairment has merged with a subsequent permanent impairment as a result of a work-related accident.

NCCI is also likely to submit another workers' compensation rate filing this year, probably in August 2010 with a proposed effective date of January 1, 2011.

GET TO KNOW…

By Karen Asher-Cohen

WAYNE JOHNSON – Wayne received his B.S. in Accounting from Florida State University. He joined the (then) Department of Insurance in 1990 as an Examiner in the Property & Casualty Solvency Bureau. Wayne was promoted to Financial Administrator, and ultimately to the Bureau Chief in 1994. During his tenure there, Florida experienced Hurricane Andrew. In 2001, Wayne left the Office of Insurance Regulation, and became Assistant Director of the Division of Rehabilitation and Liquidation at the Department of Financial Services. In December, 2008, Wayne was promoted to Division Director.

Recently, I asked Wayne the following questions.

What is the best part of your job?

I think the best part is being able to help the consumers when an insurance company has troubles and avoid or minimize the financial impact to those consumers. We have been able to create some success stories by finding coverage for some policyholders and jobs for some employees. In a number of receiverships we have been very successful in recovering assets to the point of being able to pay all the claims in full. Each success story serves as a challenge to match that result in the event of a future company failure.

What is the worst part of your job?

Seeing the people in emotional and financial distress as a result of a company failure is always difficult. A company failure adversely impacts policyholders, claimants, agents, employees and creditors. The most challenging part of my job is trying to create a winning situation for some of these groups in the face of the failure of the company.

How has insurance regulation changed since you started as a regulator?

I think it has changed tremendously for the better in terms of solvency regulation. There has been a huge leap forward in protecting the consumer and monitoring the solvency of companies. That's been accomplished through adoption of additional laws and regulations, increased and more uniform financial reporting as well as more and better tools available to the regulator.

You've had different roles here – solvency, receivership – which job do you like best?

Both roles are extremely challenging. I think I'm able to help people more in my job as a receiver.

Do you think your different jobs have complemented each other?

Definitely. Understanding the licensing and regulatory process provides tremendous insight into the causes of any receivership. That insight provides a jump-start towards dealing with the problems in a receivership and potential solutions to those problems. Conversely, it is essential for the regulator to have a clear understanding of the grounds for a receivership and the consequences to the insurer if their problems go unresolved. Unfortunately there are very few people who have worked both as a regulator and receiver.

How do think it helped to go from one to the other?

The experience in the licensing, financial analysis, financial examinations and receivership processes has given me better insights into possible solutions for troubled companies. There is a broad spectrum of stakeholders that all need to be considered when dealing with troubled companies.

What are the biggest challenges facing the insurance market these days?

Clearly in the property insurance market there is a need to create a more stable marketplace for the benefit of the consumers, agents and insurers. Each of these groups needs to help find a long-term formula that works not just for their interest, but for all of the stakeholders.

Insurance fraud at various levels continues to adversely impact the entire market and the citizens of this state and has played a factor in a number of insolvencies.

How do you get away from it all?

With the hectic pace of work and life that we all face this becomes a bigger challenge all the time. I like to plan something in a place that is several time zones away from Tallahassee and has limited or no cell phone service.

New Condo Laws Take Effect July 1

By: Travis Miller

The Governor has approved a new law, now known as Chapter Law 2010-174, revising Florida's condominium insurance statutes. Among the changes, the new law affects several insurance requirements applicable to condominium associations and unit owners. The following are among the revisions that take effect July 1:

Loss Assessment Coverage

A new section 627.714 governs loss assessment coverage under unit owners' policies. The statute continues existing law by requiring unit owners' policies to provide at least $2000 in property loss assessment coverage. However, the specific characteristics of the coverage have changed slightly. The loss assessment limit applies to all assessments made as a result of the same direct loss to the condominium property, regardless of the number of assessments levied by the association. In addition, losses for which assessments are levied must be of a type covered by the unit owners' policies.

A deductible of up to $250 may be applied to the loss assessment coverage, unless a deductible applies to other property losses sustained by the unit owner resulting from the same direct cause of loss. In the latter case, no deductible may be applied to the loss assessment coverage. The statute also specifies that the maximum amount of loss assessment coverage available to a unit owner is the amount in effect on the day before the loss occurrence, meaning that the insured cannot increase his or her loss assessment protection for an event that has already occurred.

The new law also specifies that individual unit owners' policies must contain provisions stating that the coverage under those policies is excess over amounts recoverable under any other policy covering the same property.

Adequate "Property" Insurance

Current law requires condominium associations to obtain adequate "hazard" insurance, which has raised questions of interpretation. This reference has been clarified to require associations to obtain adequate "property" insurance. A reference to determining the "full insurable value" of condominium property every three years also is updated to require the "replacement cost" to be determined every three years.

Unit Owners' Coverage

In recent years, the legislature has attempted to better define the relative insurance responsibilities of associations and unit owners. Under current law, the association policy excludes personal property within the unit or limited common areas, and floor, wall, and ceiling coverings, electrical fixtures, appliances, water heaters, water filters, built-in cabinets and countertops, and window treatments including curtains, drapes, blinds, hardware and similar window treatment components. A new provision clarifies these items are the insurance responsibility of the unit owner to the extent they are within the boundaries of the unit and serve only the unit.

The new law deletes a current law requirement specifying improvements or additions to condominium property that benefit fewer than all of the unit owners are the insurance responsibility of the unit owners having use of the property or may be insured by the association at the expense of the unit owners having use of the property.

The legislature also has deleted a provision of current law requiring unit owners to provide evidence of insurance upon the request of the association and allowing the association to purchase insurance on behalf of unit owners without insurance at the unit owners' expense.

The new law also eliminates a current provision specifying that associations must be listed as additional named insureds and loss payees under unit owners' policies.

Workers' Compensation Excess Profit Orders

By: Karen Asher-Cohen

The Office of Insurance Regulation ordered 16 workers' compensation insurance carriers to refund over $9.4 million in excess profits to their policyholders. Pursuant to the orders, the companies have 60 days from the date of the order to return the stated premiums to their policyholders in the form of a cash refund or premium renewal credits. The orders are the result of the Office's analysis of data submitted by the workers' compensation insurance carriers by July 1 of each year, regarding earned premium and incurred losses. Section 627.215, Florida Statutes, requires workers' compensation insurers to return excess profits to their policyholders.

Florida Reduces Service Contract Regulations

By: Travis Miller

The Governor's approval of SB 2176 on June 1 will bring changes to Florida law in three widely different areas. The impact of new laws on commercial insurance rate filings and on annuity sales practices are discussed elsewhere in this edition of the *Florida Insurance Report*. In addition, Florida will see significant changes to the regulation of service agreement companies governed by Chapter 634, Florida Statutes, such as the following:

Motor Vehicle Service Agreements

The new law specifies that motor vehicle service agreement regulations do not apply to agreements covering commercial vehicles.

To offset the reduction in certain areas of regulatory oversight contained in the new law, the law adds criminal penalties for persons engaged in unlicensed service agreement activity.

The law adds to the list of actions considered to be deceptive, including advertising that (i) improperly suggests an affiliation with a manufacturer, (ii) improperly indicates that the provider has information about a consumer's original factory warranty or the expiration of that warranty, or (iii) indicates that the consumer must purchase a new warranty to maintain coverage under an existing warranty. The new law also prohibits the remitting of premiums received under service agreements to any person other than the provider if the agreement between the provider and the salesperson requires that premiums be submitted directly to the provider.

The requirement for service agreement companies to submit their forms to the Office of Insurance Regulation for approval has been eliminated. However, the law continues to specify that companies are responsible for ensuring their forms meet legal requirements.

The new law clarifies that when returning unearned premiums upon cancellation, service agreement companies may deduct the amounts of any claims paid.

By July 1, 2011, service agreement companies must incorporate into their agreements or provide separately a disclosure informing consumers that the rates are not subject to regulation by the Office of Insurance Regulation.

Service agreement companies will be required to submit financial statements annually by March 1 and will no longer be required to submit quarterly financial statements.

Examinations by the Office of Insurance Regulation will no longer be mandatory, but instead will be conducted as the OIR deems appropriate taking into account providers' history of compliance, financial condition and other factors.

Salespeople will be required to obtain approval of the service agreement companies they represent before offering rebates of their commissions to consumers.

Current law prevents a service agreement company from charging more or less than its filed rate for any service contract. The new law allows a company to rectify any errors in the rate charged by returning an excess charge within 45 days of receipt of the contract or by deducting any undercharge from the commissions otherwise payable to the salesperson.

The unfair trade practices statute is updated to require a service agreement company, upon the request of a consumer, to provide a sample copy of its contract prior to sale. This can be done by furnishing a copy of the contract or directing the consumer to a website.

The new law also eliminates an existing recordkeeping requirement relating to maintaining registers of contracts distributed to salespersons and dealers.

Home Warranty Companies

Historically, home warranties in Florida have included only contracts issued in connection with the sale of residential property, home inspections, loans on property, or significant home improvements. This restriction is being eliminated, allowing providers to offer home warranty contracts in broader contexts.

The new law adds criminal penalties for violations of the licensing requirement.

Under newly adopted statutory revisions, the cost of a renewal contract may exceed the price in effect for a new contract if the increase is supported by claims history or claims cost data.

The new law also eliminates the form filing requirement.

The law clarifies that a provider may deduct the amount of any claims paid from the pro rata refund to be made upon cancellation.

By July 1, 2011, providers will be required to add a disclosure to their agreements, or provide a separate disclosure, indicating that the rates are not subject to regulation by OIR.

The Office of Insurance Regulation will not be required to examine service agreement companies, but instead will have the discretion to do so based on assessment of their compliance history, financial condition and other factors.

Salespeople will be required to obtain approval of their service agreement

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Appellate Updates

By: Tom Crabb

Eleventh Circuit Affirms The OIR Can Require Viatical Settlement Providers To Produce Records Of Non-Florida Transactions

In 2008, the OIR requested that Coventry First, LLC, a Florida-licensed viatical settlement provider, produce extensive records of its business, including records of viatical settlement transactions with viators residing outside Florida. Coventry petitioned the federal district court in Tallahassee to declare that the request for the out-of-state records exceeded OIR Commissioner Kevin McCarty's authority under the Florida Viatical Settlement Act and that the Act violated the constitution by impermissibly regulating interstate commerce. The district court concluded that the Commissioner had the statutory authority under the Act to demand Coventry's out-of-state records because the Act does not limit the scope of the records that the OIR can demand to in-state transactions. The district court also concluded that the federal McCarran-Ferguson Act (giving states the authority to regulate the insurance business) shielded the Florida Viatical Settlement Act from potential violation of the constitution. On May 5, 2010, the U.S. Court of Appeals for the Eleventh Circuit affirmed the district court's order, affirming both the right of the Commissioner of the OIR to demand records of viatical settlement providers related to viators residing outside Florida and that the Florida law giving the Commissioner that right does not violate the constitution. The Court similarly concluded that Coventry's right to do business in Florida arises from the Florida Viatical Settlement Act and not the constitution and therefore Coventry does not have a "fundamental" right to transact viatical settlement business in Florida such that the demand to produce its out-of-state records violates Coventry's due process rights. *Coventry First, LLC, v. Kevin McCarty, Commissioner of the Florida Office of Insurance Regulation*, Case No. 09-11682 (11th Cir. 2010).

48 Hour Ban On Face-To-Face And Telephonic Solicitation By Public Adjusters Upheld

Although the title of this column is Appellate Update, one of the most interesting cases to be decided in the last month was by the Circuit Court here in Tallahassee. The Florida Insurance Code prohibits public adjusters from, among other things, engaging in "face-to-face or telephonic solicitation" of an insured or claimant for at least 48 hours after an event such as a storm that may be the subject of a claim. s. 626.854(6), Fla. Stat. A public adjuster sought a declaration from the court that the statute was unconstitutional as it violated his rights to free speech and equal protection of the law. The Court first determined that the statute did not prohibit all contact from a public adjuster during that 48 hour period, only face-to-face or telephonic solicitation. Other forms of contact, such as e-mails, letters, flyers, or door hangers are not prohibited. Rather than ban speech by the adjuster, the court concluded that the statute simply bans certain types of conduct by the adjuster during that period, which serves the legitimate state purpose of giving insureds who have been "traumatized by a casualty loss . . . some breathing room." Furthermore, the statute is narrowly drawn, lasting only 48 hours, and does not ban any specific kind of speech. Accordingly, the Court concluded the 48 hour ban did not violate the public adjuster's free speech rights. The adjuster also argued that the statute violated his right to equal protection of the law because it allows company adjusters to contact insureds immediately. The Court again disagreed, finding that the purpose of the ban is to prohibit contact designed to lead to a contract between the insured and the public adjuster. A company adjuster is already in a contractual relationship with the insured and therefore is not contacting the insured for the purpose of gaining employment. Because of this "fundamental difference," there is no equal protection violation. *Kortum v. Alex Sink*, Case No. 2009 CA3926 (Fla. 2d Jud. Cir. May 7, 2010). The public adjuster has appealed the Circuit Court's judgment to the First District Court of Appeal, which I will monitor.

Coverage Liability Has To Be Determined Before Entering Judgment For Amount Of Loss Determined By Appraisal

After a condo building was damaged by Hurricane Wilma in 2005, the condo association's public adjuster demanded an appraisal of the damage pursuant to the appraisal clause in the association's policy. The appraisal award was $7.1 million, of which $3.8 million was allotted for waterproofing and painting. In the subsequent coverage lawsuit, the insurer argued that the policy's "Windstorm Exterior Paint and Waterproofing Exclusion" endorsement mandated that the award be reduced by the amount allocated for waterproofing and painting. The trial court confirmed the full amount of the appraisal award and did not consider the insurer's contested paint claim. The Fourth District reversed the trial court, holding that the lower court should have first considered the insurer's coverage liability before awarding the amount of the appraisal. "[I]t is not reasonable to order an insurer to pay for all elements set forth by an appraiser if the insurer raises an issue of coverage as to only one element and not the whole claim." "It is the appraiser's duty to determine the amount of coverage, while questions of coverage liability are left for the judiciary." *FIGA v. Olympus Association, Inc.*, Case No. 4D09-11 (Fla. 4th DCA 2010).

Safeguard Our Seniors Included in New Commercial Rating Law

By: Travis Miller

Along with the streamlining of commercial insurance rates, the Governor's approval of SB 2176 ushered in new annuity sales regulations. The set of new requirements, often called the "Safeguard Our Seniors" proposal, has been championed by CFO Alex Sink for three years. CFO Sink has made the pursuit of senior investor fraud a priority of her administration.

"Finally, the Legislature and the Governor did the right thing by enacting better protections and harsher penalties against senior scammers," said CFO Sink. "I fought for three years for the Safeguard Our Seniors legislation after meeting with hundreds of senior victims throughout Florida and hearing their heartbreaking stories. This legislation will have a real impact."

The Safeguard Our Seniors Act, originally sponsored by Senator Mike Bennett and Representative Maria Sachs includes the following among its provisions:

* Increases the financial penalty for the willful act of "twisting" or "churning" of an annuity to a maximum of $75,000.

* Limits the period of a surrender charge for an annuity sold to a senior consumer (age 65 or older) to 10 years and limits the surrender charge to 10 percent.

* Extends the "free look" period for the purchase of an annuity by a senior consumer from 14 to 21 days.

* Authorizes the Department of Financial Services to require an agent to make monetary restitution to a senior consumer harmed by a violation of the insurance code under certain circumstances.

* Includes a third party marketer that aids and abets an insurance agent in the violation of the insurance code involving an annuity sale to a senior consumer as an affiliated party of the insurance agent, bringing that marketer under the regulatory authority of the department.

* Gives the department authority to take license disciplinary action against an agent who has been disciplined under his or her securities broker-dealer license or a related license.

* Prohibits the department from issuing a license to a former licensee who has had his or her license revoked resulting from the solicitation or sale of an insurance product to a senior consumer.

* Extends the prohibition on a life insurance agent being the beneficiary of a life insurance policy by including the agent's family members within the prohibition and by prohibiting the agent from serving as a guardian, trustee, or having power of attorney over the insured.

* Requires an insurer to provide a cover sheet attached to the policy when an annuity is issued informing the purchaser about the free look period and about how to contact the insurer and the department if they have questions about the annuity.

* Allows the use of video depositions in administrative hearings involving a senior consumer and requires compliance with the Rules of Civil Procedure.

Service Agreements - *Cont. from Page 4*

companies before offering rebates on their commissions.

Upon a consumer's request, a service agreement company prior to sale will be required to provide a sample copy of the contract or direct the consumer to a website where a sample may be found.

The concept of "indemnity" is expanded to include not only repairs or replacement, but also payments by cash, check, store credit or similar means.

Consumer Product Warranties

As with the other types of service agreements, the consumer product warranty statutes have been updated with criminal penalties for unlicensed activity. The statutes also are being revised to eliminate the form filing requirement and to specify that paid claims may be deducted from pro rata premium returns.

By July 1, 2011, service agreement companies will be required to notify consumers that their rates are not regulated by the Florida Office of Insurance Regulation.

Providers also will be required to file only an annual financial statement, with quarterly reports no longer necessary. The Office of Insurance Regulation will not be required to examine companies, but instead will be able to exercise discretion in determining whether to do so taking into account factors such as prior compliance history.

Salespersons will be prohibited from rebating commissions without the approval of the service agreement companies they represent.

Upon request, a service agreement company will be required to provide a copy of its contract, or direct a consumer to a website containing its contract, prior to sale.

Office of Insurance Regulation Notifies Health Insurers of Federal Requirements

By: Travis Miller

The Office of Insurance Regulation has issued informational memorandum OIR-10-03M informing health insurers and health maintenance organizations of certain requirements under the federal health insurance law. According to the memorandum, the following changes are effective September 23, 2010, and are applicable to a group health plan and a health insurance issuer offering group or individual health insurance coverage. Policies issued on or after September 23, 2010, will have to comply with the reforms outlined below:

✓ Rescissions will be prohibited except for instances of fraud or intentional misrepresentations (also applicable to grandfathered plans and self-insured plans) (Section 2712);

✓ Plans will be required to provide first-dollar coverage for a defined set of preventive medical services without cost to the policyholder or certificateholder (not applicable to grandfathered plans, applicable to self-insured plans) (Section 2713);

✓ Plans may not establish lifetime limits on the dollar value of benefits; plans may only establish restricted annual limits prior to January 1, 2014, on the dollar value of Essential Health Benefits (also applicable to grandfathered plans and self-insured plans) (Section 2711);

✓ Plans will be required to implement an internal and external appeals process pertaining to coverage determinations and claims (not applicable to grandfathered plans, applicable to self-insured plans) (Section 2719);

✓ Plans will be prohibited from including preexisting condition exclusions for dependents under age 19 (also applicable to grandfathered plans and self-insured plans)(Section 2704);

✓ Plans that offer and provide dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age (also applicable to grandfathered plans and self-insured plans) (Section 2714);

✓ Plans will be prohibited from requiring "preauthorization" for emergency health services. A patient cannot be penalized for visiting a hospital outside of the plan's network for emergency services. The health plan cannot charge the patient a higher co-payment than if the emergency services were provided by an in-network hospital (not applicable to grandfathered plans, but applicable to self-insured plans) (Section 2719A);

✓ Plans may not require authorization or referral for female patients to receive obstetric or gynecological care from participating providers and must treat their authorizations as the authorization of a primary care provider (not applicable to grandfathered plans, but applicable to self-insured plans) (Section 2719A); and

✓ Plans must submit to the U.S. Secretary of Health and Human Services and State insurance commissioner and make available to the public the following information in plain language:

⇒ Claims payment policies and practices

⇒ Periodic financial disclosures

⇒ Data on enrollment

⇒ Data on disenrollment

⇒ Data on the number of claims that are denied

⇒ Data on rating practices

⇒ Information on cost-sharing and payments with respect to out-of-network coverage

⇒ Other information as determined appropriate by the Secretary.

The following change is effective for plan years beginning September 23, 2010 and is applicable to a group health plan and a health insurance issuer offering group or individual health insurance coverage and will have to comply with the reform outlined below (Section 2718):

✓ Medical loss ratio requirements

⇒ Large group market: 85%

⇒ Small group and individual markets: 80%

Mixed Results - *Cont. from Page 1*

Although SB 2044 could not single-handedly solve problems in the residential property insurance market that have led to lackluster underwriting performance even in the recent non-catastrophe years, many believed the bill was a step in the right direction. The Florida Hurricane Catastrophe Fund recently determined it needed an additional $700 million to pay for hurricane claims that continue to roll in five years after the last hurricanes struck Florida. Meanwhile, sinkhole losses mount and three groups have presented a clear picture of problems with Florida's mitigation discount process. The state had an opportunity to begin addressing these and other issues in 2010 but has failed to do so, at least legislatively.

The veto of SB 2044 was based on the possibility of rate increases to consumers. However, by failing to even begin taking steps to address the "cost drivers" so significantly impacting the residential property insurance market right now, the veto assures that future increases will be needed.

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FLORIDA POLITICAL SCENE

By: David Yon

The race to replace Charlie Crist as Florida Governor took yet another twist recently when Lawton "Bud" Chiles, son of former Democratic Governor Lawton Chiles, entered the race as an independent candidate. He became the second candidate to "crash" the party. Originally, it appeared this race was a straight ahead battle between Chief Financial Officer and Democrat, Alex Sink and Attorney General and Republican, Bill McCollum. McCollum got the first surprise as former Columbia/HCA executive Rick Scott jumped into the Republican primary. Scott, a multi-millionaire, has aggressively hit the airwaves and turned himself from an unknown to a serious contender running even or ahead in several polls to McCollum.

Chiles apparently believes running as an independent gives him his best chance of success by avoiding a primary battle with Sink.

Alex Sink's entry into the Governor's race of course leaves the CFO position open. Senate President Jeff Atwater, a Republican, continues to lead the race for this position. Loranne Ausley, a former state legislator who represented the Tallahassee area, is the Democrat in the race. She is off to a good start, but has ground to make up. In a recent poll by Mason Dixon, undecideds led the race with 41%. Atwater claimed 33% of the respondents, while Ausley claimed 26%.

Other significant numbers give Democrat and former Tallahassee Mayor Scott Maddox a slim lead over Republican candidate Adam Putnam in the race for Agriculture Commissioner. Dan Gelber and Dave Aronberg remain locked in a tight race for the Democratic nomination for Attorney General, again with a huge majority of voters undecided. The same holds true for the Republican side where Lt. Governor Jeff Kottkamp faces prosecutor Pam Bondi and former legislator Holly Benson.