FAIA's 2016 Legislative Summary

Each year, FAIA provides a line-by-line analysis of legislation and how it affects the insurance industry. Where shown, page numbers refer to pages in the enrolled bill. Section (§) numbers refer to Florida Statutes. Content shown in italics represents comments on final provisions.

Insurance Agents
CS/CS/SB 1386

Agent Compensation on Health Insurance Policies

p.1, §626.593

Amends §626.593, F.S., to allow health insurance agents providing services on an individual health plan to contract with the insured for an additional service fee above the commission paid by the insurer. If a contract for an additional fee is agreed to, then the agent must rebate to the insured any commissions paid by the insurer to the agent.

Current law applies the identical provision above to the sale and servicing of group health insurance policies, but not to individual health insurance policies.

Life Insurance Policies Covering Burial-Related Expenses

pp. 2–3, §626.785

Amends §626.785, F.S., to increase the allowable amount of coverage an insurance agent is able to sell for insurance policies covering burial-related expenses (i.e., to secure preneed contracts). The bill increases the policy coverage maximum to $21,000, plus an annual increase based on the CPI, beginning with the 2016 CPI. The bill will allow individuals securing preneed contracts by means of insurance policies to obtain a greater amount of coverage for burial services and merchandise.

Current law authorizes licensed insurance agents to sell insurance policies for the coverage of burial-related expenses, as long as the policies do not exceed $12,500 per person, plus an annual percentage increase based on the Annual Consumer Price Index (CPI) compiled by the United States Department of Labor for the year 2003. When taking into account the consumer price index from 2003 through 2015, the current cap for an insurance policy covering a preneed contract would be approximately $16,000.

Effective date: April 8, 2016
Chap. No. 2016-202, LOF

Citizens Property Insurance Corporation
CS/CS/HB 931

Depopulation
pp. 29–30, §627.351(6)

Changes the current depopulation procedures by requiring that take-out offers be communicated by Citizens and not the take-out company. Notice of a take-out offer must include standardized information that compares the coverage and estimated premium of each take-out offer to the coverage and premium provided by Citizens and must advise policyholders that they may accept or reject any offer. The reforms must be in place by January 1, 2017.

Citizens is required to adopt programs to reduce the number of insured properties and to decrease its financial exposure. The depopulation program, as it is known, encourages insurance companies licensed in Florida to assume policies currently covered by Citizens, thus reducing Citizens' policy count and exposure.

Confidential Underwriting Files
pp. 27–28, §627.351(6)

Expands the list of who may receive information from the confidential underwriting and claims files to include an entity that has obtained a permit to become an authorized insurer, a reinsurer, a licensed reinsurance broker, a licensed rating organization, or a modeling company. The information may be used by these entities only for the purpose of developing a take-out plan or rating plan, or analyzing risks for underwriting in the private insurance market. In addition, the bill expressly prohibits an insurance agent from using the data to solicit policyholders.

This provision was drafted by FAIA in consultation with Citizens to protect agents' ownership of their customer information.

Current law allows Citizens to share confidential underwriting and claims files with an insurer that is contemplating underwriting a risk insured by the corporation, provided the insurer executes a notarized agreement to retain their confidentiality. Citizens may also make specified information from the underwriting and claims files available to general lines insurance agents. The law requires the agent to keep the information confidential.

Citizens' Board
p. 8, §627.351(6)

Provides the consumer representative on the Citizens' board with the same exemption from the conflict of interest statute as is provided in current law to the board members with insurance expertise.

Agent Appointments
p.19, §627.351(6)

Requires an insurance agent to have at least one appointment with an insurer in order to retain eligibility to write insurance with Citizens.

Public Hurricane Loss Projection Model
p. 23, §627.351(6)

Allows Citizens to use the public hurricane loss projection model results in combination with the results of private models to calculate windstorm rates.

Effective date: July 1, 2016
Chap. No. 2016-229, LOF

Limited Sinkhole Coverage Insurance
CS/CS/SB 1274

pp.3–7, §627.7151

Creates §627.7151, F.S., which allows insurers to offer a new type of personal lines residential "limited" sinkhole insurance coverage.

Limited sinkhole coverage authorized under this new section of law is for personal lines residential coverage only, and does not include commercial lines residential, commercial lines nonresidential, or excess coverage over any other policy covering the peril of sinkhole loss.

Limited sinkhole coverage must cover only losses from the peril of "sinkhole loss," as defined in §627.706(2)(j), F.S., which is structural damage to the covered building, including the foundation, caused by sinkhole activity.

Limited sinkhole coverage is also subject to the statutory requirements for sinkhole insurance in §§627.706–627.7074, F.S., with the following exceptions:
- Coverage may be limited to repairs to stabilize the building and repair the foundation;
- Coverage does not have to include contents replacement or coverage for additional living expenses;
- Deductibles may be in an amount agreed to by the insured and insurer;
- Policy limits may be in an amount agreed to by the insured and insurer, provided policy limits below $50,000 are not allowed unless that amount exceeds full replacement cost of the property;

Before issuing a policy under this section, the insurance agent must obtain a signed acknowledgement from the applicant stating that the applicant has read and understands the coverages of limited sinkhole coverage, including when insuring for less than replacement cost or agreeing to a deductible greater than allowed in §627.706(1)(b), F.S.

> *Specifically, the acknowledgement must include the following statement in at least 12-point bold, uppercase type:* "BY ACCEPTING THIS LIMITED SINKHOLE COVERAGE INSURANCE POLICY, I HAVE READ AND UNDERSTAND THE LIMITATIONS THAT MAY APPLY TO MY POLICY AND I UNDERSTAND THAT MY POLICY IS A "REPAIR-ONLY" POLICY WHICH MEANS ONLY REPAIR AND/OR STABILIZATION OF THE SPECIFIED BUILDING AND ITS FOUNDATION IS COVERED, NOT TO EXCEED THE POLICY LIMITS AFTER APPLICATION OF MY DEDUCTIBLE. I ALSO UNDERSTAND THAT IT IS RECOMMENDED THAT I CONSULT WITH A QUALIFIED PROFESSIONAL TO IDENTIFY THE APPROXIMATE COST OF REPAIRING OR STABILIZING THE SPECIFIED BUILDING AND ITS FOUNDATION SO THAT I CAN MAKE AN INFORMED DECISION WHEN SELECTING MY POLICY LIMITS AND DEDUCTIBLE."

For a policy that provides limited sinkhole coverage insurance in an amount less than the full replacement cost of the property, the acknowledgment must also contain this statement: "THIS POLICY LIMITS SINKHOLE COVERAGE TO LESS THAN THE FULL COST OF REPLACEMENT FOR THE PROPERTY, WHICH MAY RESULT IN HIGH OUT-OF-POCKET EXPENSES TO YOU AND MAY PUT YOUR EQUITY IN THIS PROPERTY AT RISK."

For a policy that provides for a deductible that exceeds the deductibles authorized under §627.706(1)(b), the acknowledgement must also contain this statement: "THIS POLICY EXCEEDS THE DEDUCTIBLE AMOUNT PERMITTED FOR OTHER AUTHORIZED SINKHOLE LOSS INSURANCE POLICIES, WHICH MAY RESULT IN HIGH OUT-OF-POCKET EXPENSES TO YOU."

Provides that if a loss exceeds the policy limits, the insurer must agree to pay above policy limits to complete the repair or pay a contractor policy limits after the policyholder has signed a contract to repair. If the insured obtains a lower-cost alternative repair recommendation, the insurer must pay up to policy limits to complete the lower-cost alternative repair.

Notwithstanding §627.410, F.S., insurers may establish limited sinkhole policy forms not subject to filing with and approval by the Office of Insurance Regulation (OIR).

Until October 1, 2019, insurers may file rates for limited sinkhole coverage that are not subject to the filing and review requirements of §627.062(2)(a) and (f), however, insurers: must notify the OIR within 30 days after the effective date of such rates; must maintain for two years actuarial data to support rates, with such data subject to OIR review; and cannot implement rates that are excessive, inadequate or unfairly discriminatory.

Prohibits Citizens Property Insurance Corporation from offering limited sinkhole coverage.

Insurers providing limited sinkhole coverage must notify the OIR at least 30 days prior to offering the coverage in the state. Such insurers must file a plan of operation and financial projections or revisions to such plan, as applicable, with the OIR.

pp.1-3, §624.407, §624.408

Establishes surplus requirements of $7.5 million for new and existing insurers that solely transact limited sinkhole coverage insurance.

Effective date: July 1, 2016
Chap. No. 2016-197, LOF

Automobile Insurance
CS/CS/HB 659

Motor Vehicle Insurance Rating
pp. 2–3, §627.0651

Allows single zip code rating territories for motor vehicle insurance if the rates are actuarially sound and are not excessive, inadequate or unfairly discriminatory.

The Florida Automobile Joint Underwriting Association (FAJUA)
pp. 3–4, §627.311

Authorizes the FAJUA to cancel policies it has issued within the first 60 days for non-payment, and prohibits insureds from cancelling coverage issued by the FAJUA in the first 90 days, except upon total destruction of the insured motor vehicle, upon transfer of ownership of the insured motor vehicle, or after purchase of another policy covering the motor vehicle that was covered under the policy being canceled.

Return of Unearned Premium
pp. 4–5, §627.7283

Allows the insured to apply the unearned premium to any other policies issued to the insured by the insurer or the insurer group upon cancellation of a motor vehicle insurance policy by the insured or by the insurer.

Prepayment of Premium
pp. 5–6, §627.7295

Adds another exception (namely, a recurring credit or debit card payment agreement) to the requirement that insurers must collect two months of premium prior to issuing a private passenger motor vehicle policy or binder for Personal Injury Protection (PIP) and property damage liability coverage.

The current exceptions to this requirement include policy payments pursuant to a payroll deduction plan or an automatic electronic funds transfer payment plan.

Methods of Payment
p. 7, §627.7295

Adds payments by a “draft” to the list of acceptable payment methods for motor vehicle insurance contracts.

Insufficient Funds Fee
p. 7, §627.7295

Authorizes motor vehicle insurers to charge $15, pursuant to policy terms, if an electronic premium payment fails due to insufficient funds.

This charge is in addition to any fees charged by an insured’s financial provider.

Pre-insurance Inspection Data Report
pp. 7–8, §627.744

Requires the Division of Insurance Fraud of the Department of Financial Services (DFS) to report pre-insurance inspection data, including certain specified data elements, to the governor and the presiding officers of the Legislature by December 1, 2016. The Legislature may use the report data in determining the future public necessity for the pre-insurance inspection statutory requirement in §627.744, F.S.

The reported data must include:
1. *A written estimate of the total cost incurred by insurers and policyholders in order to comply with the inspections.*
2. *A written estimate of the total cost incurred by insurers to have their motor vehicles inspected.*
3. *Documentation regarding the total premium savings for policyholders as a result of the inspections.*
4. *Documentation of the total number of inspected motor vehicles that had a preexisting condition.*
5. *Documentation regarding the potential fraud in motor vehicle claims incurred within the first 125 days after issuance of a new policy.*
6. *Documentation of the total number of referrals of fraudulent acts to the National Insurance Crime Bureau by pre-insurance inspectors during the past five years.*

Medical Diagnosis Coding Manuals
pp. 8–9, §627.736

Replaces the International Classification of Diseases, 9th Revision, for coding of PIP medical services with the International Classification of Diseases, 10th Revision.

PIP Eligible Health Care Clinics
p. 11, §627.736

Allows medical clinics that are managed by a licensed health care practitioner (who has certain specified responsibilities) and owned, directly or indirectly, by a publicly traded corporation that has $250 million or more in total annual sales of health care services to receive reimbursement from insurers for PIP medical services without having to be separately licensed under the Health Care Clinic Act.

Effective date: July 1, 2016
Chapter No. 2016-133, LOF

Out-of-Network Health Insurance Coverage
CS/CS/CS/HB 221

pp. 10–15, §627.662, §627.6471, §627.64194, §626.9541

Prohibits out-of-network providers from balance billing members of a PPO or EPO for emergency services or for nonemergency services when the nonemergency services are provided in a network hospital and the patient had no ability and opportunity to choose a network provider. The bill establishes standards for determining reimbursement to the providers and authorizes providers and insurers to settle disputed claims under the statewide provider and health plan claim dispute resolution program.

Current law requires an HMO to provide coverage for emergency services and care without prior authorization and without regard for whether the provider has a contract with the HMO. The HMO must reimburse a nonparticipating provider according to the formula in statute. The nonparticipating provider may not collect additional reimbursement from the subscriber. In other words, the provider cannot balance bill the patient. Current law does not prohibit providers who are not part of a PPO or EPO network from balance billing patients.

Effective date: July 1, 2016
Chap. No. 2016-222, LOF

Unclaimed Property
CS/SB 966

pp. 2–9, §717.107

Amends the Florida Disposition of Unclaimed Property Act to subject life insurers to the requirements in regulatory settlement agreements (RSAs) that many of the largest life insurers have entered into with the state regarding life insurance claims handling practices.

Requires life insurers, except those who have already settled with the state, to determine whether their life or endowment insurance policyholders, annuitants, and retained asset account holders have died by performing annual comparisons against the U.S. Social Security Administration's Death Master File (DMF).

The requirement applies to all life or endowment insurance policies, annuity contracts, and retained asset accounts that were in force on or after January 1, 1992. However, for life insurers who have either entered into RSAs or have received a targeted market conduct examination report with no violations as of June 30, 2016, the requirement applies to all in-force policies.

Provides that within four months of learning of an insured's death through the DMF, the insurer is required to verify the death, verify if the insured had other products with the company, determine if benefits are due, and attempt to locate and contact beneficiaries.

Provides that policy or contract proceeds that remain unclaimed five years after the date of death of the insured, annuitant, or account holder must be reported and remitted to the Department of Financial Services (DFS) Bureau of Unclaimed Property.

Provides that fines, penalties, or additional interest may not be imposed on the insurer for failure to report and remit property under the bill, if such proceeds are reported and remitted to DFS Bureau of Unclaimed Property no later than May 1, 2021.

Prohibits insurers and certain third parties from charging fees associated with the search, verification, claim, or delivery of funds to beneficiaries.

This bill was the number one priority of CFO Jeff Atwater and supported by FAIA.

Effective date: April 12, 2016
Chap. No. 2016-216, LOF

Workers' Compensation System Administration
CS/HB 613

p. 2, §440.021

Makes technical cross-references to the application of the Florida Administrative Code (FAC) to Judges of Compensation Claims (JCC).

By law, workers' compensation adjudications by JCCs are exempt from Chapter 120, and no JCC shall be considered an agency or part of the FAC.

p. 3, §440.05(1)

Provides that corporate officers who elect to not accept the provisions of workers' compensation or who, after such election, revoke that exemption, shall *submit* (rather than mail) the notice to the Department of Financial Services (DFS) on an approved form.

Since the DFS now allows electronic submission, mailing of the form, while still permitted, will not be required.

p. 3, §440.05(2)

Makes the same requirement for submitting, rather than mailing, for sole proprietors or partners who elect to be included in the definition of "employee" or who, after such election, revoke the election.

p. 4, §440.05(3)

Deletes the requirement that an officer of a corporation engaged in the construction industry who elects an exemption from Ch. 440 or who, after such election, revokes it, must send a form to the DFS indicating such intent. It also removes the requirement that notice of election by an officer of a corporation to be exempt must include a federal tax identification number.

Since the exemption information is maintained online by the DFS, there is no longer need of a separate form. The IRS does not issue Federal Tax Identification Numbers to individual officers; they are issued to corporations. The Federal Tax ID Number will still be collected on the applicant's employer.

p. 5, §440.05(5)

Makes a technical change consistent with required forms being "submitted" rather than being "mailed."

Page 6, §440.05(10)

Modifies the requirement that officers of a corporation in the construction industry who exempt themselves maintain written statements by the exempt persons affirmatively acknowledging each individual's exempt status. In its place will be a requirement that the records shall be maintained as specified by the DFS.

p. 6, §440.05(11)

Removes the three-day response requirement applicable to exemption information held by the employer since the DFS maintains these records online.

Current law requires the issuance of a Stop Work Order (SWO) if a corporation, whose employee claims to be an exempt officer, fails or refuses to produce proper documentation within three business days after a request for the information is received.

p. 7, §440.107(7)

Makes several changes aimed at making enforcement of workers' compensation coverage mandates more effective. They include:

- Reducing the imputed payroll multiplier from twice the statewide average weekly wage (SAWW) and returning it to the pre-2014 level of one and one-half times the SAWW.
- Allowing employers who have not been issued an Order of Penalty Assessment (OPA) to be eligible for a credit for initial payment of premium under §440.107(7)(d)1a if the employer then secures the required workers' compensation coverage. Currently, this provision only applies to SWO situations. To receive the credit in the case of leased employees, §440.107(7)(d)1b requires the employer to show the DFS, within 28 days, that payment has been made to the PEO. If the employer meets the above criteria and provides the DFS business records proving it within 10 business days, then the DFS must reduce the final assessed penalty by 25 percent.

Under current law, if an employer fails to comply with workers' compensation coverage requirements, the DFS must issue a Stop-Work Order (SWO) within 72 hours of the DFS determining employer non-compliance. SWOs require the employer to cease business operations until the DFS issues an order releasing the SWO. Additionally, employers are assessed penalties equal to two times what the employer would have paid in workers' compensation premiums for all periods of non-compliance during the preceding two-year period or $1,000, whichever is greater. Further, if an employer comes into compliance after an investigation is initiated, but before a SWO is issued, the DFS may assess penalties via an Order of Penalty Assessment (OPA). The OPA allows the employer to avoid a SWO and may receive a credit against the penalty equal to the initial payment bringing them into compliance. Finally, if the employer lacks sufficient payroll records to calculate the penalties under a SWO, the DFS may impute payroll to be twice the SAWW for each uncovered employee.

p. 9, §440.13(7)

Removes insurers and employers from the provisions allowing the filing of a medical reimbursement dispute over the disallowance or adjustment of a medical payment.

Only health care providers will be permitted to file petitions for resolution of medical billing disputes. Insurers and employers will continue to meet their statutory reporting obligations through required data filing and elective violation reports if the insurer or employer suspects provider violations or overutilization.

p. 9, §440.13(9)

Allows the injured worker and a self-insured employer or insurer to jointly select a health care provider to participate in their case as an Expert Medical Advisor (EMA). Since there are no particular qualification requirements specified for a jointly selected EMA, the parties have maximum freedom in choosing a mutually agreed upon provider. If there is no agreement between the parties, the JCC can appoint an EMA. In both cases, the selected EMA is not required to be certified by the DFS.

Currently, if there is a conflict in medical evidence or medical opinion, the JCC must appoint an EMA to address the conflict. The EMAs are certified by the DFS and are required to meet specialized workers' compensation training or experience and medical certification or eligibility, as well as meeting other criteria. Currently, there are only 153 EMAs certified by the DFS for the entire state, and this often leads to difficulty in the parties finding a certified EMA.

p. 12, §440.185(3)

Eliminates the current requirement that the employer notify the DFS within 24 hours by telephone or telegraph of any injury resulting in death. Other reporting requirements provide the same information.

p. 15, §440.49(7)(c) & (d)

Eliminates the notice of claim fee and the proof of claim fee currently required when making a claim against the Special Disability Trust Fund (SDTF).

p. 15, §440.49(8)

Eliminates the Preferred Worker Program (PWP).

This program was created in 1994 to reward employers who hired injured workers who could not return to their prior job due to the injury. The "reward" was three years' worth of the workers' compensation premium associated with that worker. The program last issued a reimbursement in 2002.

p. 17, §440.52(1)

Removes the $100 fees currently collected by the DFS for the registration of new insurers to write workers' compensation in Florida.

It also makes numerous cross reference changes that are technical in nature. See the bill for details.

Effective date: October 1, 2016
Chapter No. 2016-56, LOF

Workers' Compensation Health Care Provider Reimbursement Manual
SB 1402

p. 1

Ratifies Rule 69L-7.020, Florida Administrative Code, titled "Florida Workers' Compensation Health Care Provider Reimbursement Manual," as filed by the Division of Workers' Compensation for adoption with the Department of State pursuant to the certification package dated July 16, 2015.

Florida's Workers' Compensation Law requires that the provider reimbursement manual setting the maximum reimbursement rates for workers' compensation medical services be updated every three years and be adopted by rule. As part of their rule-making process, the rule must undergo a Statement of Estimated Regulatory Costs (SERC). If the SERC shows that the rule would have an adverse impact on

small business, or that it would increase regulatory costs more than $200,000 within one (1) year after the implementation of the rule, then the rule must be ratified by the Legislature. This rule exceeds that threshold, and therefore must be ratified.

Effective: July 1, 2016
Chap. No. 2016-203, LOF

Florida Workers' Compensation Insurance Guaranty Association
CS/CS/SB 828

p. 1, §631.914(1)(a)

Assessments may be levied against all workers' compensation insurers and self-insurance funds to secure payment of covered claims resulting from an insurer insolvency, under the provisions of the Florida Workers' Compensation Insurance Guaranty Association (FWCIGA). The ability to levy those assessments and to require reporting relating to financial condition is transferred from the Department of Financial Services (DFS) to the Office of Insurance Regulation (OIR). Additionally, the amount of the assessment must be computed and levied on the basis of the full policy premium value on the net direct written premium amount without consideration of any applicable discount or credit for deductibles. Finally, it provides that the initial assessment cap for self-insurance funds is increased from the current 1.5 percent to 2 percent, the same as it is for insurers.

This method of calculating the assessment base removes any distortion that could be caused by "jumbo" deductibles.

p. 2, §631.914(1)(b)

Revises the insurer's premium subject to an assessment from being based on the prior year's net direct written premium to the net direct written premium for the calendar year of the assessment. It also allows for recoupment of the assessment as a separate surcharge against policyholders

Currently, the assessment amounts are included in the overall rate making process.

p.3, §631.914(1)(d)

Provides criteria for the FWCIGA to require the insurer either to use an installment method to remit the assessment as premium written or to remit the assessment to the FWCIGA before actually collecting the policyholder surcharge. See the bill for details.

p.5, §631.914(2)

Provides that assessments levied are not premium and are not subject to any premium tax, fees, or commissions. Failure of an insured to pay the surcharge or recoupment of the assessment is considered nonpayment of premium, which could result in the cancellation of a policy. Finally, an insurer is not liable for any uncollectable assessment-related surcharges.

p.5, §631.914(3)

Provides that only insurers are subject to assessments by the FWCIGA and the provisions to not give a policyholder a cause of action regarding the FWCIGA assessments.

Effective date: July 1, 2016
Chapter No. 2016-170, LOF

Department of Financial Services
CS/CS/CS/HB 651

Service of Process
pp. 5–6, 20–24, §48.151, §624.307, §624.423, §624.502, §626.907

Allows the Department of Financial Services (DFS) to create a system for electronic service of process when accepting service on behalf of insurers doing business in Florida, and creates an internet-based system for distributing such legal documents to insurance companies.

Current law requires plaintiffs to serve lawsuits on insurance companies by serving documents initiating the lawsuit at the DFS by mail or by process server.

Cat Fund Assessments
pp. 8–13, §215.555

Extends the current exemption for medical malpractice insurance premiums from emergency assessments of the Florida Hurricane Catastrophe Fund (Cat Fund) from May 31, 2016, until May 31, 2019.

DFS Investigations
pp. 16–17, §322.142

Authorizes the DFS to have access of digital photographs from the Department of Highway Safety and Motor Vehicles to investigate allegations of violations of the Insurance Code.

Public Adjusters
p 22, §626.854

Provides that a licensed health insurance agent who assists an insured with coverage questions, medical procedure coding issues, balance billing issues, understanding the claim filing process, or filing a claim is not acting as a public adjuster.

Florida Surplus Lines Service Office
p. 24, §626.921

Authorizes the DFS to select five persons nominated by the Florida Surplus Lines Association to serve on the Florida Surplus Lines Service Office (FSLSO) Board of Governors.

Current law requires the DFS to select members from the Florida Surplus Lines Association's regular membership but does not provide for nominations.

Surplus Lines Agent Affidavit
pp. 24–25, §626.931

Provides that a surplus lines agent who has not transacted business during a quarter need not file an affidavit with the FSLSO stating that all business conducted by the agent has been submitted to the FSLSO.

Sinkhole Neutral Evaluation Program
pp. 25–26, §627.7074

Amends the qualifications of the neutral evaluator under the DFS Sinkhole Neutral Evaluation Program to provide that an individual cannot serve as a neutral evaluator on a claim if that individual was employed, within the previous five years, by the firm that did the initial sinkhole testing.

Travel Insurance
pp. 37–41, §627.062, §627.0645

Exempts travel insurance from the full rate review requirements of §627.062(2)(a) and (f), F.S., and the requirement to annually make a rate filing under §627.0645, F.S., if the insurance is issued as a master group policy, with a situs in another state, where each certificate-holder pays less than $30 for each covered trip, and if the insurer has written less than $1 million in annual travel insurance premiums in this state during the most recent calendar year.

Effective date: July 1, 2016
Chap. No. 2016-132, LOF