FAIA’s 2017 Legislative Summary

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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.

This summary is not intended to constitute legal advice. If you have questions of a legal nature, please consult your attorney. Any redistribution or republication without the express written approval of FAIA is prohibited.
Insurance Adjusters
CS/CS/HB 911

p. 3, §626.015

Eliminates a reference to public adjuster apprentices. It is recreated in a new section 626.8561.

Current law provides for five adjuster licenses: public adjuster, all-lines adjuster, temporary license (all-lines adjuster), public adjuster apprentice, and catastrophe or emergency adjuster.

p. 3, §626.854(1)

Provides that a public adjuster is a person who accepts anything of value, either directly or indirectly, who adjusts a claim. It provides that it also includes any person who solicits or adjusts a claim on behalf of an insured or third-party claimant. It further exempts from the definition “…a person who photographs or inventories damaged personal property or business personal property or a person performing duties under another professional license, if such person does not otherwise solicit, adjust, investigate, or negotiate for or attempt to effect the settlement of a claim.”

The legislature heard evidence that there were unlicensed persons operating as “loss consultants” in claims involving an assignment of benefits (AOB).

p. 4, §626.854

Eliminates §626.854 (6), F.S., that prohibited a public adjuster from contacting a policyholder within 48 hours of an occurrence that might be the basis of an insurance claim, and re-numbers subsequence subsections.

This provision was declared unconstitutional by the Florida Supreme Court in the case of Atwater v. Kortum, 95 So. 3d 85 (Fla. 2012), as unduly restricting the commercial free speech of public adjusters.

p. 5, §626.854(6)

Eliminates the requirement that the notice of cancellation of a public adjuster’s contract to adjust a claim without penalty or obligation within three days must be by phone or in writing.

This allows cancellation by any means.

p. 6, §626.854(10)(b)2(c)

Prohibits a public adjuster from charging a fee that is based on the policy deductible portion of a claim.

p. 7, §626.584(17)

Prohibits a public adjuster, a public adjuster apprentice, or a person working on behalf of a public adjuster from contracting for goods or services that will require the insured or third-party claimant to expend funds in excess of those payable to the public adjuster under the terms of the contract for adjusting services.

This expands the current law’s prohibition, which is limited to contracts for repair, and further limits the opportunity for self-dealing.

p. 7, §626.584(19)
Provides that no person, not licensed as a public adjuster or an attorney, for money, commission, or any other thing of value, directly or indirectly:

- Prepares, completes, or files an insurance claim for an insured or third-party claimant;
- Acts on behalf of or aids an insured or third-party claimant in negotiating for or effecting the settlement of a claim for loss or damage covered by an insurance contract;
- Advertises for employment as a public adjuster; or
- Solicits, investigates, or adjusts a claim on behalf of a public adjuster, an insured, or a third-party claimant.

p. 8, §626.8541

Repeals §626.8541, relating public adjuster apprentices.

This category is recreated and strengthened in §626.8561 (see below).

p. 8, §626.8548

Defines “all-lines adjuster” to include any person who, for compensation, directly or indirectly, undertakes on behalf of an insurer or public adjuster to ascertain and determine the amount of any claim, loss, or damage payable under an insurance contract or undertakes to effect settlement of such claim, loss, or damage. It also includes a person who, for compensation, directly or indirectly, solicits claims on behalf of a public adjuster.

This definition does not include a paid “spokesperson” used as part of a written or electronic advertisement, or a person who photographs or inventories damaged personal property or business personal property if such person does not otherwise adjust, investigate, or negotiate for or attempt to effect the settlement of a claim.

p. 9, §626.8561

Creates a new section defining a public adjuster apprentice as a person licensed as an all-lines adjuster who:

- Is appointed and employed or contracted by a public adjuster or public adjusting firm;
- Assists the public adjuster in ascertaining and determining the amount of any claim, loss, or damage payable under an insurance contract, or who undertakes to effect settlement of such claim, loss, or damage; and
- Satisfies the requirements of §626.8651, relating to licensure as an all-lines adjuster, maintain certain bond requirements. See below.

p. 9, §626.8584(3)

Amends the definition of “non-resident all-lines adjuster” to include a person contracted by an independent adjusting firm or other independent adjuster, by an insurer admitted to do business in Florida or a wholly owned subsidiary of such insurer, or a public adjusting firm.

Current law only allows for persons appointed by or employed by those firms, rather than also contracted by them.

p. 10, §626.861

Allows employees of insurers to handle residential property insurance claims that are subject to a coverage limit in the policy of $500 or less.

p. 10, §626.864(3)
Provides that an all-lines adjuster may be appointed as an independent adjuster, a public adjuster apprentice, or a company adjuster, but not more than one of these concurrently.

p. 10, §626.865

Reduces from one year to six months the time an all-lines adjuster must be licensed and appointed as an independent adjuster, company adjuster, or public adjuster apprentice before becoming eligible for licensure as a public adjuster.

pp. 11–12, §626.8651(1)(a)

Sets forth the new qualifications for becoming an appointed—rather than licensed—public adjuster apprentice to include a person who:

- Is licensed as an all-lines adjuster under §626.866;
- Has filed with the Department of Financial Services (DFS) a bond executed and issued by a surety insurer that is authorized to transact such business in Florida in the amount of $50,000, which is conditioned upon the faithful performance of his or her duties as a public adjuster apprentice; and
- Maintains such bond unimpaired throughout the existence of the appointment and for at least 1 year after termination of the appointment.

It deletes the current criteria.

p. 14, §626.8651(2)

Provides that an appointing public adjusting firm may not have more than four public adjuster apprentices simultaneously, and a supervising public adjuster may not be responsible for more than one public adjuster apprentice.

Current law allows for the maintaining of 12 apprentices simultaneously and allows a supervising public adjuster to be responsible for three adjusters.

pp. 15–16, §626.8651(3)

Removes the current prohibition that a public adjuster apprentice may not solicit contracts for the public adjuster except under the direct supervision and guidance of the supervisory public adjuster.

pp. 16–18, §626.8695(5)–(7)

Clarifies the requirements for designating a primary adjuster and allows for the primary adjuster to be designated for more than one location, as long as no person engages in activities requiring licensure as an adjuster at any location when an adjuster is not physically present. The primary adjuster is accountable for misconduct or violations of the Insurance Code committed by any other person under his or her direct supervision while acting on behalf of the adjusting firm. Different criteria apply for criminal liability. It also sets forth other criteria. See the bill for details.

pp. 18–19, §626.8695(8)

Provides that an adjusting firm may not conduct the business of insurance unless a primary adjuster is designated and provides services to the firm at all times. It provides that, if the designated primary adjuster ends affiliation with the firm and the firm fails to designate another primary adjuster within 90 days, the firm’s license automatically expires on the 91st day.

p. 19, §626.872

Repeals the current requirements of a “temporary license” for adjusters. See §626.874(1), below.
pp. 19–20, §626.874(1)

Clarifies that only authorized insurers or adjusting firms contracted with authorized insurers may designate emergency adjusters for temporary licensure by the DFS during an emergency.

p. 20, §626.875(2)

Changes the required retention for adjuster claim records from three years to five years.

This aligns with other provisions of the Insurance Code.

p. 21, §626.876

Addresses potential conflict of interest by prohibiting concurrent licensure as an all-lines adjuster and a public adjuster and prohibiting concurrent employment by an independent, company employee, or public adjuster apprentice.

p. 21, §626.879

Repeals the current provisions relating to “pools of insurance adjusters.”

It is no longer necessary due to the structural changes to the process contained in the bill.

Effective date: July 1, 2018

Chapter No. 2017-147, LOF

Department of Financial Services
CS/CS/HB 925

Regulation of Insurance Agents and Adjusters

pp. 34–35 and 44–45, §626.015 and §626.2815(3)

Amends statutes relating to continuing education requirements for Department of Financial Services (DFS) licensees and provides that “active participants” in “associations” may receive two hours of continuing education credit each calendar year. The bill defines “active participant” as a member who attends four or more hours of association activities each year. Additionally, the bill defines “association” to include:

• Florida Association of Insurance Agents (FAIA);
• National Association of Insurance and Financial Advisors (NAIFA);
• Florida Association of Health Underwriters (FAHU);
• Latin American Association of Insurance Agencies (LAAIA);
• Florida Association of Public Insurance Adjusters (FAPIA);
• Florida Bail Agents Association (FBAA); or
• Professional Bail Agents of the United States (PBUS).

pp. 39–41, §626.221(2)(j), §626.2815(7)(i), and §626.8734

Exempts persons who have the Universal Claims Certification from the Claims and Litigation Management Alliance from the licensure examination for all-lines adjuster and adds that certification training to the approved continuing education requirements for certain adjusters and agents.

pp. 35–38 and 41–44, §626.207 and §626.9954
Provides that upon a grant of a pardon or the restoration of civil rights, criminal offenses that would otherwise temporarily or permanently bar certain individuals or entities seeking licensure as an insurance agent, agency, or public adjuster do not automatically bar or disqualify the applicant. The bill also applies this same principle to a health insurance navigator’s application for registration.

Current law provides that persons with specified felony convictions are permanently barred from applying for licensure under Chapter 626, F.S. It also provides that persons with convictions for other than permanent bar felonies are barred from licensure for specified periods of time. In Kauk v. Department of Financial Services, the court considered whether the per se bar in current statute applied to someone who had had his civil rights restored through executive clemency. The court held that the DFS could not impose a bar against Kauk because Kauk had his civil rights restored and a hearing officer had found Kauk to be a “citizen fully rehabilitated.” The bill codifies the holding of Kauk by providing that the current time restrictions do not apply to someone who has had his or her civil rights restored or has been issued a pardon. The bill does not require the DFS to issue a license if a person has been granted a pardon or had his or her civil rights restored. Rather, it provides that the DFS cannot consider the finding of guilt or entry of the plea for which clemency was granted as grounds to deny the application.

pp. 37 and 43, §626.207(5) and §626.9954(5)

Amends current law to provide that a disqualifying period for applying for licensure begins to run upon completion of an applicant’s criminal sentence (including the end of any period of probation or community control) and provides that a license cannot be issued until all fines, restitution, and court costs are paid.

Currently, the disqualifying period for applying for licensure begins to run upon completion of the criminal sentence including the payment of all fines, restitution, and court costs. This change will allow applicants who pay their restitution during, for example, a period of probation, to be licensed sooner.

pp. 45–46, §626.611

Deletes the reference to felonies involving “moral turpitude,” which will result in a requirement for the DFS to deny, suspend, revoke, refuse to renew or continue the license or appointment for all felonies punishable by imprisonment of one year or more.

Currently, the DFS is required to deny an application, suspend, revoke, or refuse to renew or continue the license or appointment of any applicant for convictions of felonies involving moral turpitude.

pp. 46–47, §626.621

Deletes the DFS’s “discretionary” authority to deny an application for, suspend, revoke, or refuse to renew or continue a license or appointment due to a felony conviction and now makes it mandatory.

Current law provides the DFS with the discretion to deny an application for, suspend, revoke, or refuse to renew or continue the license or appointment who has been convicted of any felony, unless it is a mandatory requirement under another statute.

pp. 47–49, §626.7845 and §626.8305

Clarifies certain exceptions to the unlicensed transaction of life or health insurance and allows trustees to advise persons, settlors, or beneficiaries regarding their interests in a trust regarding life or health insurance plans. The bill clarifies that individuals who provide health insurance counsel and advice when acting as a trustee advising a settlor, a beneficiary, or a person regarding his or her interests in a trust or are an employee who counsels and advises employees of the same business, union, or association are not practicing the unlicensed transaction of health insurance.

pp. 49–50, §626.861
Allows a regular employee of an insurer handling claims to adjust claims with respect to residential property insurance when the sublimit coverage does not exceed $500.

Miscellaneous DFS Provisions

Amends various other statutes related to DFS, including:

pp. 8–9, §17.575

Replaces the Treasury Investment Committee with the Treasury Investment Council within the Division of Treasury and provides for the duties of the council.

p. 9, §215.422

Applies timely payment and other requirements related to state payments, warrants, and invoices for payments made in relation to certain agreements funded with federal or state assistance.

pp. 9–33, §554.1021–§554.1151

Updates the 1991 Boiler Safety Act (Act) as to installation requirements, who can conduct inspections of boilers in public assembly locations, continuing education of inspectors, and changes criminal penalties to administrative fines for violations of the Act.

p. 34, §624.307

Authorizes the DFS, within existing resources, to expend funds for the purpose of staff professional development for certain divisions.

pp. 50–51, §626.9543

Removes the July 1, 2018, deadline for Holocaust victims to file insurance claims or civil actions to obtain proceeds from an insurance policy.

p. 51, §633.516

Allows for the use of firefighter’s confidential information for the purposes of certain studies.

pp. 51–53, §768.28

Removes a requirement for an individual to send a written notice of claim or serve a summons on the DFS for an action against a county.

Effective date: July 1, 2017
Chapter No. 2017-175, LOF
Public Housing Authority Insurance  
**CS/CS/HB 421**  
pp. 4–5, §624.46226  

**Expands** the public housing authority self-insurance fund to allow for-profit corporations, not-for-profit corporations, limited liability companies, or other similar business entities that a public housing authority owns, in whole or in part, or participates in the governance thereof, to join the same self-insurance fund as the authority that owns or governs them, but requires that these entities may only self-insure their public housing risks.

**Authorizes** these additional entities, when self-insured, to purchase reinsurance as if they were an insurer, in the same manner as self-insured public housing authorities.

*Public housing authorities, and the entities that are permitted to join them in self-insurance funds, may only purchase reinsurance if they are participating in a self-insurance fund.*

**Effective date:** July 1, 2017.  
Chapter No. 2017-104, LOF.

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Insurance Policy Transfers  
**CS/CS/HB 805**

p. 1, §627.4133(8)  

**Allows** an insurer, at renewal, to transfer a personal lines residential policy or a commercial residential policy to another insurer that is a member of the same insurer group, and such transfer is considered a renewal instead of a cancellation or nonrenewal.

*Under current law, this is allowed for commercial policies, but not for residential or commercial residential policies. Currently, an insurer wishing to transfer a residential or commercial residential policy to another insurer within the same insurer group must first cancel or non-renew the policy and provide the appropriate 120-day notice to the insured.*

p. 2, §627.4133(8)  

**Requires** the following conditions to be met prior to the transfer of a personal lines residential or commercial residential policy to another insurer within the same insurer group:

- The insurer to which the policy is being transferred must be admitted in Florida and other states, and presently writing residential property insurance in multiple states.
- The insurer to which the policy is being transferred cannot convert the policy to a surplus lines policy, and such insurer must be determined by the Office of Insurance Regulation (OIR) to have the same or better financial strength than the transferring insurer.
- The transfer must result in substantially similar coverage.
- The insurer to which the policy is being transferred must provide a notice of change in policy terms to the policyholder in compliance with §627.43141, F.S., which must also include notice of the policy transfer and the new insurer’s financial rating, and these notices must be provided along with the notice of renewal premium at least 60 days prior to the effective date of the transfer.
• The policyholder of the policy being transferred must be selected on a nondiscriminatory basis.

• The OIR must approve the transfer.

_Under current law, the notice of change of policy terms must be provided to the agent as well as the policyholder._

**Effective date:** July 1, 2017

**Chapter No.** 2017-19, LOF

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**Flood Insurance**

**CS/CS/HB 813**

_Makes_ numerous changes regarding flood insurance.

_The National Flood Insurance Program (NFIP) is a federal program that offers subsidized flood insurance to property owners and promotes land-use controls in floodplains. Anticipating substantial rate increases in the NFIP, the Legislature created §627.715, F.S., in 2014 to provide a framework for a private, personal lines flood insurance market in Florida. This law does not apply to excess flood insurance or commercial lines flood insurance._

_p. 2, §627.0628_

**Changes** the frequency of Florida Commission on Hurricane Loss Projection Methodology adoptions of flood loss projection guidelines from every odd-numbered year to at least once every four years.

_The Florida Commission on Hurricane Loss Projection Methodology is required to adopt actuarial methods, principles, standards, models, or output ranges for personal lines residential flood loss and is required to revise these adoptions each odd-numbered year._

/pp. 2–9, §627.715_

**Moves** the expiration of an exception to ratemaking requirements that allows flood insurers to make informational rate filings, rather than “use and file” or “file and use” ratemaking, from October 1, 2019, to October 1, 2025.

**Extends** the exemption from the statutory due diligence requirement (i.e., obtaining coverage declinations from three admitted flood insurers) when exporting flood insurance to surplus lines insurers from July 1, 2017, to July 1, 2019, and provides the exemption ends earlier in certain circumstances.

**Provides,** upon expiration of the exemption, for an exception related to the statutory due diligence requirement if there are fewer than three admitted flood insurers so that policies can be exported to surplus lines insurers when all admitted insurers decline coverage.

**Changes** the time when insurance agents are required to obtain a signed acknowledgement of the possible impact before placing the policy from the time of application to prior to placing the coverage.

**Eliminates** an exclusion that held that regulation under Florida’s flood insurance statute did not apply to excess flood insurance and allows excess flood insurers to make information rate filings and gives them relief from due diligence requirements.
Corrects a technical error regarding issuance of flexible flood insurance coverage. The bill has no fiscal impact on state government and an indeterminate, but likely positive, fiscal impact on local government expenditures. The bill may have a positive impact on the private sector.

Effective date: July 1, 2017
Chapter No. 2017-142, LOF
Transportation Network Companies
CS/HB 221

Abstract

Defines terms.

Provides that a Transportation Network Company (TNC) is not a common carrier, contract carrier, or motor carrier and does not provide taxicab or for-hire vehicle service.

Requires a TNC to maintain an agent for service of process in the state.

Requires a TNC to disclose certain information related to the collection of fares.

Requires a TNC’s digital network to display a photograph of the TNC driver and the license plate number of the TNC vehicle.

Provides minimum insurance requirements for TNCs and TNC drivers and provides for certain TNC and insurer disclosures and exclusions.

Provides that TNC drivers are independent contractors if certain conditions are met.

Requires TNCs to implement a zero tolerance policy regarding drug and alcohol use.

Establishes certain TNC driver requirements and prohibits persons from being a TNC driver if they have been convicted of certain crimes or a certain number of moving violations.

Requires TNCs to submit to the Department of Financial Services (DFS) an independent examination report and establishes penalties for noncompliance.

Prohibits TNC drivers from accepting rides for compensation outside of the TNC’s digital network and from soliciting or accepting street hails.

Requires TNCs to adopt and TNC drivers to comply with policies related to nondiscrimination and disability access.

Requires TNCs to maintain certain records relating to riders and TNC drivers.

Authorizes airports and seaports to charge TNCs reasonable pickup fees consistent with what is charged for taxicabs.

Insurance Requirements

p. 7–14, §627.748

Requires, a TNC driver, or a TNC on behalf of the TNC driver to maintain primary automobile insurance that recognizes that the TNC driver is a TNC driver or otherwise uses a vehicle to transport riders for compensation; and covers the TNC driver while the TNC driver is logged on to the TNC’s digital network or while the TNC driver is engaged in a prearranged ride, beginning July 1, 2017.

Requires the TNC or TNC driver, when logged on to the digital network but not engaged in a prearranged ride, to have automobile insurance that provides:

- Primary automobile liability coverage of at least $50,000 for death and bodily injury per person, $100,000 for death and bodily injury per incident, and $25,000 for property damage.
• Personal injury protection benefits that meet the minimum coverage amounts required under the Florida Motor Vehicle No-Fault Law. The amount of insurance required is $10,000 for emergency medical disability, $2,500 non-emergency medical, and $5,000 for death. It is notable that no-fault coverage is for the named insured (TNC driver), relatives residing in the same household, persons operating the insured motor vehicle, riders in the motor vehicle, and other persons struck by the motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle.

• Uninsured and underinsured vehicle coverage.

Requires that when a TNC driver is engaged in a prearranged ride, automobile insurance must provide:

• Primary automobile liability coverage of at least $1 million for death, bodily injury, and property damage.

• Personal injury protection benefits that meet the minimum coverage amounts required of a limousine under the Florida Motor Vehicle No-Fault Law. Pursuant to s. 627.733(1)(a), F.S., limousines are exempt from the Florida Motor Vehicle No-Fault Law. However, if the Legislature removes this exemption or makes certain parts of the Florida Motor Vehicle No-Fault Law applicable to limousines, the changes in that law would also apply to TNCs and their drivers.

• Uninsured and underinsured vehicle coverage.

The coverage requirements may be satisfied by automobile insurance maintained by the TNC driver, an automobile insurance policy maintained by the TNC, or a combination of automobile insurance policies maintained by the TNC driver and the TNC.

For purposes of comparison, §324.032, F.S., requires for-hire passenger transportation vehicles to carry limits of $125,000/$250,000 for bodily injury and $50,000 for property damage. The bill requires less coverage than required for for-hire passenger transportation vehicles when a driver is logged onto the TNCs digital network, but is not engaged in TNC service. However, the bill requires more coverage than required for for-hire passenger transportation vehicles when a driver is engaged in providing TNC service.

Provides that if the TNC driver’s insurance policy has lapsed or does not provide the required coverage, the insurance maintained by the TNC must provide the required coverage, beginning with the first dollar of a claim, and have the duty to defend such claim. Coverage under an automobile insurance policy maintained by the TNC must not be dependent on a personal automobile insurer first denying a claim, and a personal automobile insurance policy is not required to first deny a claim. The required insurance must be provided by an insurer authorized to do business in this state which is a member of the Florida Insurance Guaranty Association or an eligible surplus lines insurer that has a superior, excellent, exceptional, or equivalent financial strength rating by a rating agency acceptable to the Office of Insurance Regulation (OIR).

Insurance satisfying the above requirements is deemed to satisfy the financial responsibility requirement for a motor vehicle under the Financial Responsibility Law of 1955 and the security required under §627.733, F.S., for any period when the TNC driver is logged onto the digital network or engaged in a prearranged ride.

Requires a TNC driver to carry proof of insurance coverage with him or her at all times while using a TNC vehicle in connection with a digital network. In the event of an accident, a TNC driver must provide this insurance coverage information to any party directly involved in the accident or the party’s designated representative, automobile insurers, and investigating police officers. Proof of financial responsibility may be presented through an electronic device, such as a digital phone application. Upon request, a TNC driver must also disclose to any party directly involved in the accident or the party’s designated representative, automobile insurers, and investigating police officers whether the driver was logged on to a digital network or was engaged in a prearranged ride at the time of the accident.

Provides that if a TNC’s insurer makes a payment for a claim covered under comprehensive coverage or collision coverage, the TNC must cause its insurer to issue the payment directly to the business repairing the vehicle or jointly to the owner of the vehicle and the primary lienholder on the covered vehicle.
Requires the TNC to disclose to the TNC driver, before a TNC driver can accept a request for a prearranged ride on the digital network, in writing:

- The insurance coverage, including the types of coverage and the limits for each coverage, which the TNC provides while the TNC driver uses a TNC vehicle in connection with the TNC's digital network;
- That the TNC driver's own automobile insurance policy might not provide any coverage while the TNC driver is logged on to the digital network or is engaged in a prearranged ride depending on the terms of the TNC driver's own automobile insurance policy; and
- That the provision of rides for compensation that are not prearranged rides subjects the TNC driver to the coverage requirements imposed under §324.032(1), F.S., and that failure to meet such coverage requirements subjects the TNC driver to penalties provided in §324.221, F.S., up to and including a misdemeanor of the second degree.

Allows an insurer that provides an automobile liability insurance policy under part XI of Chapter 627, F.S., may exclude any and all coverage afforded under the policy issued to an owner or operator of a TNC vehicle while driving that vehicle for any loss or injury that occurs while a TNC driver is logged on to a digital network or while a TNC driver provides a prearranged ride. This right to exclude all coverage may apply to any coverage included in an automobile insurance policy, including, but not limited to:

- Liability coverage for bodily injury and property damage;
- Uninsured and underinsured motorist coverage;
- Medical payments coverage;
- Comprehensive physical damage coverage;
- Collision physical damage coverage; and
- Personal injury protection.


Does not require a personal automobile insurance policy to provide coverage while the TNC driver is logged on to a digital network, while the TNC driver is engaged in a prearranged ride, or while the TNC driver otherwise uses a vehicle to transport riders for compensation.

The bill's insurance provisions must not be construed to require an insurer to use any particular policy language or reference the above statutes in order to exclude any and all coverage for any loss or injury that occurs while a TNC driver is logged on to a digital network or while a TNC driver provides a prearranged ride. The bill does not preclude an insurer from providing primary or excess coverage for the TNC driver's vehicle by contract or endorsement.

Provides that an automobile insurer that excludes the coverage described above does not have a duty to defend or indemnify any claim expressly excluded thereunder. The bill does not invalidate or limit an exclusion contained in a policy for vehicles used to carry persons or property for a charge or available for hire by the public, including a policy in use or approved for use in this state before July 1, 2017. An automobile insurer that defends or indemnifies a claim against a TNC driver, which is excluded under the terms of the policy, has a right of contribution against other insurers that provide automobile insurance to the same TNC driver in satisfaction of the coverage requirements of §316.68(7), F.S., at the time of loss.

Provides that in a claims coverage investigation and upon request by a directly involved party or any insurer of the TNC driver, a TNC must immediately provide the precise times that the TNC driver logged on and off the digital network in the 12-hour period immediately preceding and in the 12-hour period immediately following the accident. Upon request by any other insurer involved in the particular claim, an insurer providing coverage pursuant to §316.68, F.S., must disclose, the applicable coverages, exclusions, and limits provided under any automobile insurance maintained in order to satisfy the bill's insurance requirements.
HB 221 provides the necessary regulatory framework for transportation network companies to operate throughout Florida without regard for local/municipal ordinances. The bill also clearly defines when “commercial use” begins, which will allow insurers to appropriately price TNC endorsements to the personal auto policy.

Effective date: July 1, 2017
Chapter No. 2017-12, LOF
Public Records/Workers’ Compensation
CS/CS/HB 1107

pp. 1–3, §440.1851

Provides that personal identifying information of an injured or deceased worker filed with the Department of Financial Services (DFS), the Agency for Health Care Administration (AHCA), and the Division of Administrative Hearings (DOAH) is confidential and exempt from the requirements of §119.07 (1), F.S. (public records laws), and §24(a), Article I of the Florida Constitution.

Creates a new §440.1851, defining “personal identifying information” to include the following: the injured or deceased employee’s name, date of birth, home address or mailing address, e-mail address, or telephone number.

§440.1851(1)

Provides for the disclosure of the information only:
- To the injured employee, the spouse or dependent of the deceased employee, the spouse or dependent of the injured employee if authorized by the injured employee, or to the legal representative of the deceased employee’s estate;
- To a party litigant, or his or her authorized representative, in matters pending before the Office of the Judges of Compensation Claims;
- To a carrier or an employer for the purpose of investigating the compensability of a claim or for the purpose of administering its anti-fraud investigative unit established pursuant to §626.9891, F.S.;
- In an aggregate reporting format that does not reveal the personal identification information of any employee;
- Pursuant to a court order or subpoena;
- To an agency for administering its anti-fraud function or in furtherance of the agency’s official duties and responsibilities; or
- To a federal governmental entity in the furtherance of the entity’s official duties and responsibilities.

Provides that a carrier, employer, agency, or governmental entity receiving personal identifying information from the DFS shall maintain the confidential and exempt status of the information. This exemption applies to personal identifying information held by the DFS before, on, or after the effective date of July 1, 2017.

§440.1851(2)

Makes it a first degree misdemeanor for a person to willfully and knowingly disclose personal identifying information made confidential and exempt under this new statute.

Provides that the provisions of this act shall “sunset” on October 2, 2022, unless renewed by the Legislature.

p. 3, section (3)

Provides legislative rational and intent for enacting the exemption. The Legislature makes a specific finding that public records requests of this information have resulted in unwanted solicitation of the injured workers and their families, and, additionally, release of such information could lead to discrimination against the employee by coworkers, potential employers, and others because of perceived social stigma related to injuries or disabilities.

The DFS reports that requests for this information are primarily from law firms.

Effective date: July 1, 2017
Chapter No. 2017-185, LOF
Florida Life and Health Insurance Guaranty Association
CS/HB 307

pp. 1–2, §631.713

Expands the scope of coverage of the Florida Life and Health Insurance Guaranty Association (FLAHIGA) to include annuities that are part of an individual retirement account and individual retirement annuities.

Current law excludes these type of annuity contracts from coverage by FLAHIGA.

pp. 2–3, §631.717

Provides that effective January 1, 2020, the cap on benefits paid by the FLAHIGA for any one person for specified hospital and medical insurance increases from $300,000 to $500,000.

Effective date: July 1, 2017, except as otherwise provided
Chapter No. 2017-131, LOF

Regulation of Insurance Companies
CS/HB 359

The bill makes several changes relating to the regulation of insurance companies.

p. 5–10, §215.555

Deletes the future repeal of the exemption of medical malpractice insurance premiums from the Florida Hurricane Catastrophe Fund assessments.

Under current law, the exemption is repealed May 31, 2019.

pp. 10–13, §624.407 and §624.408

Allows an insurer issuing only renter’s insurance, tenant’s coverage, or cooperative unit owners insurance to maintain a surplus of $10 million to do business in the state.

pp. 13–14, §624.424

Removes the requirement that all members of an audit committee for an insurer must be free of any relationships that could interfere with the member’s independent judgement.

pp. 14–15, §FS 625.012

Allows Florida Workers’ Compensation Insurance Guaranty Association surcharges to be counted as insurer assets if those surcharges are paid to the association before the surcharges are collected from the insureds.

pp. 15–16, §627.062

Removes the requirement on insurers writing certain lines of medical malpractice insurance to make a full rate filing annually; these insurers will have the option to certify their rates with the Office of Insurance Regulation (OIR).
pp. 3–5, 19–21, §177.041, §177.091, and §627.7843

Renames “owners and encumbrance” reports to “property information” report and clarifies such reports are not title insurance.

pp. 16–19, §627.435

Allows electronic checks and drafts as acceptable methods of payment for specified lines of insurance and allows insurers to charge a $15 insufficient funds fee.

pp. 18–19, §627.421

Specifies display requirements for the electronic delivery of documents.

Effective date: June 26, 2017
Chapter No. 2017-132, LOF

Limitations on Actions other than for the Recovery of Real Property
CS/CS/HB 377

pp. 1–2, §95.11(3)(c)

Provides that, for the purposes of both the statute of limitations (SOL) and the statute of repose (SOR), a construction contract is considered complete on the later of the date of final performance of all the contracted services or the date that final payment for such services becomes due without regard to the date final payment is made. It applies to contracts with professional engineers, registered architects, or licensed contractors.

Under current law, a cause of action founded on the design or construction of a building is subject to a four-year SOL and a 10-year SOR. This limit starts at the latest date of the following: the date of actual possession; the date a certificate of occupancy is issued; the date construction, if not completed, is abandoned; or the date the contract is completed or terminated. There are exceptions for the SOL relating to latent defects, but that time cannot extend beyond the SOR. A recent court case, Cypress Fairway Condominium v. Bergeron Construction Company, Inc., 164 So. 3d 706, 707 (Fla. 5th DCA 2015), found that a construction contract is complete when the final payment is actually made, rather than when the final payment becomes due.

Effective date: July 1, 2017, and applies to causes of actions that accrue on or after that date
Chapter No. 2017-101, LOF

Insurer Insolvency
CS/CS/HB 837

pp. 5–29, Part I of Chapter 631, F.S.

Amends various provisions of part I of Ch. 631, F.S., governing insurer rehabilitation and liquidation in Florida.

Many of the revisions are based upon portions of the National Association of Insurance Commissioners (NAIC) Insurer Receivership Model Act (IRMA).
Extends reciprocity in the administration of receiverships to states that have adopted the IRMA.

Revises the requirements related to delinquency proceedings to update the list of guaranty associations that must receive notice of hearings, clarifies the court’s jurisdiction over assets of the insurer, and provides a conflict of laws provision.

Establishes timeframes for initiating and commencing delinquency proceedings. Provides that an insurer subject to an order to show cause must file a written response no later than 20 days after service of order to show cause, but no fewer than 15 days prior to date of hearing set by order to show cause, and that hearing must be commenced within 60 days after issuance of the order to show cause.

Clarifies that the automatic stay during the pendency of the proceeding does not apply to the Office of Insurance Regulation (OIR).

Specifies that the receiver appointed by the Department of Financial Services (DFS) may assume or reject any executory contract or unexpired lease of the insurer and clarifies the receiver’s authority for paying expenses. Also clarifies that the insurer’s management has no authority subsequent to a liquidation.

Specifies what defenses may be raised against the receiver and the form of required evidence to assert a defense.

Revises claim filing procedures to allow the court to approve alternatives and establish a filing deadline.

Establishes the process for administering workers’ compensation large deductible policies during an insolvency proceeding.

Disallows claims for post judgment interest.

Revises the priority of claims to add claims for expenses incurred during administrative supervision and for medical providers, and revises the methodology for calculating interest allowed on claims.
pp. 28–29, §631.397

Revises the procedures applicable to early access distributions to guaranty funds.

Effective date: July 1, 2017
Chapter No. 2017-143, LOF

Prohibited Insurance Acts
CS/CS/CS/HB 1007

p. 4, §626.9891(1)(a), §626.9891(1)(b)

Defines “anti-fraud investigative unit” and “Designated anti-fraud unit or division.”

Insurance fraud is a large and growing problem. The FBI estimates that the total cost of insurance fraud nationwide, excluding health insurance fraud, exceeds more than $40 billion per year. These definitions and the changes to follow are part of an effort to establish uniform fraud prevention standards applicable to all insurers.

p. 5, §626.9891(2)

Provides that all insurers admitted to do business in Florida shall, by December 31, 2017:

• Establish and maintain a designated anti-fraud unit or division within the company to investigate and report possible fraudulent insurance acts, or contract with others to do so.
• Adopt an anti-fraud plan.
• Designate at least one employee with primary responsibility for implementing the requirements of the section.
• File electronically with the Division of Investigative and Forensic Services (DIFS), and annually thereafter, a detailed description of the designated anti-fraud unit or division, a copy of the anti-fraud plan, and the name of the designated employee in charge. The insurer must include, as an additional expense for ratemaking purposes, the additional costs incurred in creating a distinct unit or division, hiring of additional employees, or contracting with another entity to fulfill these requirements.

Current law only requires an insurer to establish anti-fraud units if they had a direct written premium of $10 million or more in the previous year.

p. 6, §626.9891(3)

Requires each insurer to provide:

• An acknowledgement that they have established procedures for detecting and investigating possible fraudulent insurance acts by all types of insurance that the insurer writes.
• An acknowledgement that the insurer has established procedures for mandatory reporting of possible fraudulent insurance acts to DIFS.
• An acknowledgement that the insurer provides for anti-fraud training and education required by this section.
• A description of the required anti-fraud education and training.
• A written description or chart of the insurer’s anti-fraud investigative unit, including the position titles and descriptions of staffing.
• The rationale for the level of staffing and resources being provided for the unit, which may include objective criteria.

The bill gives numerous examples of items that may be included in the rationale for the level of staffing and resources provided for the unit. See the bill for details.
p. 8, §626.9891(4)

Requires that each insurer, by December 31, 2018, provide staff of the anti-fraud investigative unit at least two hours of initial anti-fraud training. Annually thereafter, an insurer shall provide such employees a one-hour course.

The bill details required elements of the training.

p. 8, §626.9891(5)

Requires each insurer to report data relating to the fraud for each identified line of business written by the insurer during the prior calendar year. The data shall be reported to the Department of Financial Services (DFS) by March 1, 2019, and annually thereafter, and must include, at a minimum:

- The number of policies in effect;
- The amount of premiums written for policies;
- The number of claims received;
- The number of claims referred to the anti-fraud investigative unit;
- The number of other insurance fraud matters referred to the anti-fraud investigative unit that were not claims-related;
- The number of claims investigated or accepted by the anti-fraud investigative unit;
- The number of other insurance fraud matters investigated or accepted by the anti-fraud investigative unit that were not claims related;
- The number of cases referred to the DIFS;
- The number of cases referred to other law enforcement agencies;
- The number of cases referred to other entities; and
- The estimated dollar amount or range of damages on cases referred to the DIFS or other agencies.

The DFS is required to adopt specific rules to administer this subsection.

p. 9, §626.9891(6)

Requires that, in addition to providing information required under subsections (2), (4), and (5), each insurer writing workers’ compensation insurance, shall also report the following information to the DFS, on or before March 1, 2019, and annually thereafter:

- The estimated dollar amount of losses attributable to WC fraud delineated by the type of fraud, including claimant, employer, provider, agent, or other type.
- The estimated dollar amount of recoveries attributable to WC fraud delineated by the type of fraud, including claimant, employer, provider, agent, or other type.
- The number of cases referred to the DIFS, delineated by type of fraud, including claimant, employer, provider, agent, or other type.

p. 11, §626.9891(8)

Provides penalties for insurers that fail to meet the requirements of this act.

p. 11, §626.9891(9)

Requires DIFS, on or before December 31, 2018, to create a report detailing the best practices for the detection, investigation, prevention, and reporting of insurance fraud and other fraudulent insurance acts. The report must be updated as necessary, but at least every two years. The report must provide:

- Information on the best practices for the establishment of anti-fraud investigative units within insurers;
- Information on the best practices and methods for detecting and investigating insurance fraud and other fraudulent insurance acts;
• Information on appropriate anti-fraud education and training of insurer personnel;
• Information on the best practices for reporting insurance fraud and other fraudulent insurance acts to the DIFS and other law enforcement agencies;
• Information regarding the appropriate level of staffing and resources for anti-fraud investigative units within insurers;
• Information detailing statistics and data relating to insurance fraud which insurers should maintain; and
• Other information as determined by the DIFS.

p. 12, §626.9896
Creates a new §626.9896, F.S., requiring the DFS to collect data from each state attorney office that receives an appropriation to fund attorneys and paralegals dedicated solely to the prosecution of insurance fraud cases and report on the use of such funds. It sets forth criteria for the data to be collected and sets forth the process for making the report. See the bill for details.

p. 13, §641.221(2)
Provides that in order to maintain a certificate of authority, an HMO authorized to exclusively market, sell, or offer to sell Medicare Advantage plans shall be actively engaged in managed care within 24 months after licensure, shall designate and maintain at least one primary anti-fraud employee, and shall adopt an anti-fraud plan. The OIR may extend the period of eligibility upon written request.

p. 15, §626.9911(2)
Defines “Fraudulent viatical act” to mean an act or omission committed by a person who knowingly, or with intent to defraud for purposes of depriving another of property or for pecuniary gain, commits or allows an employee to commit any of the following acts:
(a) Presenting, causing to be presented, or preparing with the knowledge or belief that it will be presented to or by another person, false or concealed material information as part of, in support of, or concerning a fact material to:
• An application for the issuance of, or the underwriting of, a viatical settlement contract or a life insurance policy;
• A claim for payment or benefit pursuant to such policy;
• Premiums paid on a life insurance policy;
• Payments and changes in ownership or beneficiary made in accordance with the terms of a viatical settlement contract or life insurance policy;
• The reinstatement or conversion of a life insurance policy;
• The solicitation, offer, effectuation, or sale of a viatical settlement contract or a life insurance policy; or
• A financing transaction for a viatical settlement contract or life insurance policy.
(b) Employing a plan, financial structure, device, scheme, or artifice relating to viaticated policies for the purpose of perpetrating fraud.
(c) Engaging in a stranger-originated life insurance practice.
(d) Failing to disclose, upon request by an insurer, that the prospective insured has undergone a life expectancy evaluation by a person other than the insurer or its authorized representatives in connection with the issuance of a life insurance policy.
(e) Perpetuating a fraud or preventing the detection of a fraud by:
• Removing, concealing, altering, destroying, or sequestering from the office the assets or records of a licensee or other person engaged in the business of viatical settlements;
• Misrepresenting or concealing the financial condition of a licensee, financing entity, insurer, or other person;
• Transacting in the business of viatical settlements in violation of laws requiring a license, certificate of authority, or other legal authority to transact such business; or,
• Filing with the Office of Insurance Regulation (OIR) or equivalent chief insurance regulatory official of another jurisdiction a document that contains false information or conceals information about a material fact from such official.
(f) Embezzlement, theft, misappropriation, or conversion of moneys, funds, premiums, credits, or other property of a viatical settlement provider, insurer, insured, viator, insurance policyholder, or other person engaged in the business of viatical settlements or life insurance.

(g) Entering into, negotiating, brokering, or otherwise dealing in a viatical settlement contract, the subject of which is a life insurance policy that was obtained based on information that was falsified or concealed for the purpose of defrauding the policy’s insurer, viatical settlement provider, or viator.

(h) Facilitating the viator’s change of residency state to avoid the provisions of this act.

(i) Facilitating or causing the creation of a trust with a non-Florida or other nonresident entity for the purpose of owning a life insurance policy covering a Florida resident to avoid the provisions of this act.

(j) Facilitating or causing the transfer of the ownership of an insurance policy covering a Florida resident to a trust with a situs outside this state or to another nonresident entity to avoid the provisions of this act.

(k) Applying for or obtaining a loan that is secured directly or indirectly by an interest in a life insurance policy with the intent to defraud, for the purpose of depriving another of property, or for pecuniary gain.

(l) Attempting to commit, assisting, aiding, or abetting in the commission of, or conspiring to commit, an act or omission specified in this subsection.

p. 18, §626.9911(9)

Defines “Stranger-originated life insurance practice” to mean an act, practice, arrangement, or agreement to initiate a life insurance policy for the benefit of a third-party investor who, at the time of policy origination, has no insurable interest in the insured. They include, but are not limited to:

- The purchase of a life insurance policy with resources or guarantees from or through a person who, at the time of such policy’s inception, could not lawfully initiate the policy and the execution of a verbal or written arrangement or agreement to directly or indirectly transfer the ownership of such policy or policy benefits to a third party.

- The creation of a trust or other entity that has the appearance of an insurable interest in order to initiate policies for investors, in violation of insurable interest laws and the prohibition against wagering on life.

p. 20, §626.99275(1)

Provides that it is unlawful for a person to:

- Knowingly enter into a viatical settlement contract before the application for or issuance of a life insurance policy unless the viator provides a sworn affidavit and accompanying independent evidentiary documentation in accordance with §626.99287, F.S.

- Engage in a fraudulent viatical settlement act, as defined in §626.9911, F.S.

- Knowingly issue, solicit, market, or otherwise promote the purchase of a life insurance policy for the purpose of or with the emphasis on selling the policy to a third party.

- Engage in a stranger-originated life insurance practice, as defined in §626.9911, F.S.

p. 21, §626.99287(2)

Provides that if a viatical settlement policy is subject to a loan secured directly or indirectly by an interest in the policy within a five-year period commencing on the date of issuance of the policy or certificate, the viatical settlement contract is void and unenforceable by either party.

p. 22, §626.99287(3)

Provides that notwithstanding the limitations above, the contract is not void and unenforceable if the viator provides a sworn affidavit and accompanying evidentiary documentation certifying to the viatical settlement provider that one or more of the following conditions were met during the periods applicable to the viaticated policy:

- The policy was issued upon the owner’s exercise of conversion rights arising out of a group or term policy if the total time covered under the prior policy is at least 60 months. The time covered must be calculated without regard to change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship.

- The owner of the policy is a charitable organization exempt from taxation under 26 U.S.C. §501(c)(3).
• The viator certifies to the viatical settlement provider that one or more of the following conditions were met:
  o The viator or insured is terminally or chronically ill, and the condition was not known to the insured at the time that the life insurance contract was entered into;
  o The viator’s spouse dies;
  o The viator divorces his or her spouse;
  o The viator retires from full-time employment;
  o The viator becomes physically or mentally disabled and a physician determines that the disability prevents the viator from maintaining full-time employment;
  o The owner of the policy was the insured’s employer at the time the policy or certificate was issued and the employment relationship terminates;
  o There is an order declaring the viator bankrupt, or a petition seeking reorganization of assets; or,
  o The viator entered into a viatical settlement contract more than two years after the policy’s issuance.

Other conditions also apply, such as: the viator experiences a significant decrease in income which is unexpected by the viator and impairs his or her reasonable ability to pay the policy premium, the policy was funded exclusively from unencumbered assets, as well as other criteria. See the bill for details.

p. 25, §626.99289
Provides that notwithstanding §627.455, F.S., a contract, agreement, arrangement, or transaction, including, but not limited to a financing agreement or any other agreement or understanding entered into, whether written or verbal, for furtherance or aid of a stranger-originated life insurance practice is void and unenforceable.

p. 25, §626.99291
Provides that notwithstanding §627.455, F.S., a life insurer may contest a life insurance policy if the policy was obtained by a stranger-originated life insurance practice, as defined in §626.9911, F.S.

p. 25, §626.99292(1)
Requires a life insurer to provide an individual life insurance policyholder with a statement informing him or her that if he or she is considering making changes in the status of the policy, he or she should consult with a licensed insurance or financial advisor. The statement may be accompanied or be included in notices or mailings otherwise provided to the policyholder.

p. 26, §626.99292(2)
Provides that the above statement must also advise the policyholder that he or she may contact the DFS for more information and include a website address or other location or manner by which the policyholder may contact the department.

pp. 28–30, §627.744
Removes the language in (3) regarding motor vehicle preinsurance inspection, and creates a new (7), allowing an insurer to opt out of the inspection requirements of the section, but does allow an insurer to develop its own inspection process. It provides for filing of manual rules with the OIR and sets forth criteria. It specifies that the insurer opting out of the statutory inspection requirements and developing its own program, may not require an applicant to pay for the cost of an inspection.

Effective date: June 27, 2017, except as otherwise provided
Chapter No. 2017-178, LOF
Pub. Rec./Insurance Fraud Information/DFS
CS/HB 1009

p. 1, §626.9891(9)

Creates a public records exemption that makes the following information, when submitted to the Division of Forensic Services (DIFS) within the Department of Financial Services (DFS), exempt from §119.07(1), F.S., and §24(a), Article I of the Florida Constitution:

- The description of an insurer’s anti-fraud education and training;
- The description of an insurer’s anti-fraud investigative unit (Unit);
- The insurer’s rationale for the level of staffing and resources for the Unit;
- The number of claims referred to the Unit;
- The number of other insurance fraud matters referred to the Unit that were not claim related;
- The number of claims accepted or investigated by the Unit;
- The number of other insurance fraud matters investigated by or accepted by the Unit that were not claim related; and
- The estimated dollar amount or range of damages on cases referred to the DIFS or other agencies.

The exemption applies to records held before, on, or after the effective date of the exemption. Unless renewed or saved from repeal by the Legislature, the exemption will expire on October 2, 2022.

Subsection (2) of the bill sets forth the rationale for keeping the provisions exempt from the public records laws. It provides the public disclosure of this information would allow criminal elements to use such information to identify fraud prevention or detection strategies employed by insurers and use this information to commit insurance fraud. It would also allow persons suspected of fraud to be alerted to a potential or ongoing investigation and alter their behavior to impede an investigation. It provides that information already in the possession of the DFS is retroactively protected by the exemption. Finally, the Legislature found that public disclosure of information relating to the number and type of claims, as well as the dollar amount of such claims, could injure a business in the marketplace by providing its competitors with detailed insights into the claim investigative process, thereby diminishing the advantage that the business maintains over competitors that do not possess such information. Without this exemption, insurers might refrain from providing accurate, unbiased information to the department.

Effective date: June 27, 2017
Chapter No. 2017-179, LOF