HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 359 Insurance
SPONSOR(S): Commerce Committee; Santiago
TIED BILLS: **IDEN./SIM. BILLS:** CS/CS/SB 454

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee	13 Y, 0 N	Lloyd	Luczynski
2) Commerce Committee	20 Y, 0 N, As CS	Lloyd	Hamon

SUMMARY ANALYSIS

The bill makes the following changes regarding insurance:

- **Florida Hurricane Catastrophe Fund (FHCF) Emergency Assessments** – medical malpractice insurance is exempt from FHCF emergency assessment until May 31, 2019. The bill repeals the sunset of the exemption. The exemption becomes permanent, rather than expiring on May 31, 2019.

- **Florida Workers' Compensation Insurance Guaranty Association Assessments** – While receivables related to recoupment of Florida Insurance Guaranty Association (FIGA) assessments are an "asset" for purposes of statutory accounting principles, the same does not apply to such receivables related to Florida Workers' Compensation Insurance Guaranty Association (FWCIGA) assessments. The bill allows receivables related to FWCIGA assessment recoupment surcharges to be treated as assets in the same manner that is currently provided for FIGA assessment related receivables.

- **Medical Malpractice Rate Filing** – Medical malpractice insurers are required to make annual base rate filings. The bill removes the requirement to submit an annual base rate filing, regardless of whether the insurer is proposing a rate change, and substitutes the procedure that applies to all other property and casualty insurers who are required to make an annual base rate filing. It permits medical malpractice insurers to file a certification in lieu of a rate filing when no rate change is proposed.

- **Payments for Premium and Insufficient Funds Fee** – Florida law requires payment of premiums by certain methods. The bill adds payments by "draft" or "electronic check" to the list of acceptable payment methods. In certain instances, a property, casualty, or surety insurer, a premium finance company, or a motor vehicle insurer may charge a fee to the insured if their payment fails due to insufficient funds (this is in addition to any fees charged by their financial provider). The bill authorizes most insurers to charge $15, pursuant to policy terms, if an electronic premium payment fails due to insufficient funds.

- **Compliance of Electronic Documents with Insurance Code Requirements** – The Insurance Code establishes content, readability and formatting requirements for a wide variety of documents used in the transaction of insurance. The bill provides that electronic documents will satisfy certain standards applicable to paper documents if the elements have reasonably similar proportions or emphasis in their electronic format and context or are displayed in a reasonably conspicuous manner.

- **Motor Vehicle Insurance Policy Exclusions** – While motor vehicle insurers may exclude specified vehicles from coverage under a policy, they cannot exclude named individuals if coverage is required by law. The bill authorizes an insurer to specifically exclude named individuals from private passenger motor vehicle insurance coverages, except for periods when the named excluded individual is not operating a covered vehicle, it is unfairly discriminatory, or it is inconsistent with filed underwriting guidelines.

The bill has no impact on state or local government revenues or expenditures. It has positive and negative impacts on the private sector.

The bill is effective upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Florida Hurricane Catastrophe Fund Emergency Assessments

The Florida Hurricane Catastrophe Fund (FHCF) is a tax-exempt trust fund created in 1993 as a form of reinsurance for residential property insurers. The FHCF is administered by the State Board of Administration and reimburses property insurers for a selected percentage of hurricane losses to residential property above the insurer's retention (deductible). As a condition of doing business in Florida, property insurers required to enter into reimbursement contracts with FHCF. The purpose of the FHCF is to protect and advance the state's interest in maintaining insurance capacity in Florida by providing reimbursements to insurers for a portion of their catastrophic hurricane losses.

Revenue bonds are issued by the FHCF to pay claims when the FHCF's funds are inadequate. These bonds are funded by emergency assessments levied by the FHCF against property and casualty insurance premiums paid by policyholders; however, workers' compensation, accident and health, federal flood, and medical malpractice premiums are exempt from the emergency assessments. The Legislature created the exemption for medical malpractice insurance in 2004, subject to sunset repeal in 2007.[1] The Legislature has extended the sunset date in successive three-year increments without interruption since the exemption's creation.[2] The exemption currently is scheduled to be repealed on May 31, 2019, and medical malpractice insurance will be subject to emergency assessments beginning June 1, 2019.

Effect of the Bill

The bill repeals the provision that sunsets the exemption for medical malpractice insurance from FHCF emergency assessments. The exemption becomes permanent, rather than expiring on May 31, 2019.

Florida Workers' Compensation Insurance Guaranty Association Assessments

Insurance Guaranty Associations – Background

Chapter 631, F.S., relating to insurer insolvency and guaranty payments, governs the receivership process for insurance companies in Florida.[3] Federal law specifies that insurance companies cannot file for bankruptcy. Instead, they are either "rehabilitated" or "liquidated" by the state. In Florida, the Division of Rehabilitation and Liquidation of the Department of Financial Services (DFS) is responsible for rehabilitating or liquidating insurance companies.[4]

Florida operates five insurance guaranty funds to ensure that policyholders of liquidated insurers are protected with respect to insurance premiums paid and settlement of outstanding claims, up to limits provided by law.[5] The Florida Workers' Compensation Insurance Guaranty Association (FWCIGA)

[1] Ch. 2004-27, Laws of Fla.
[2] *See* chs. 2007-90, 2010-141, 2013-60, 2016-132, Laws of Fla.
[3] The Bankruptcy Code expressly provides that "a domestic insurance company" may not be the subject of a federal bankruptcy proceeding. 11 U.S.C. § 109(b)(2). The exclusion of insurers from the federal bankruptcy court process is consistent with federal policy generally allowing states to regulate the business of insurance. *See* 15 U.S.C. §§ 1011- 1012 (McCarran-Ferguson Act).
[4] Typically, insurers are put into liquidation when the company is insolvent whereas insurers are put into rehabilitation for numerous reasons, one of which is an unsound financial condition. The goal of rehabilitation is to return the insurer to a sound financial condition. The goal of liquidation, however, is to dissolve the insurer. *See* s. 631.051, F.S., for the grounds for rehabilitation and s. 631.061, F.S., for the grounds for liquidation.
[5] The Florida Life and Health Insurance Guaranty Association generally is responsible for claims settlement and premium refunds for health and life insurers who are insolvent. The Florida Health Maintenance Organization Consumer Assistance Plan offers assistance to members of insolvent health maintenance organizations, and the Florida Workers' Compensation Insurance Guaranty Association is directed by law to protect policyholders of insolvent workers' compensation insurers. The Florida Self-Insurers Guaranty Association protects policyholders of insolvent individual self-insured employers for workers' compensation claims. The Florida Insurance Guaranty

serves to protect workers' compensation policyholders and claimants from workers' compensation insurer insolvency.

A guaranty association generally is a not-for-profit corporation created by law directed to protect policyholders from financial losses and delays in claim payment and settlement due to the insolvency of an insurance company. A guaranty association accomplishes its mission by assuming responsibility for settling claims and refunding unearned premiums[6] to policyholders. Assets of the insolvent insurers are marshaled to fund claims against the guaranty association for liabilities of the insolvent insurer. When these assets are insufficient to meet claim liabilities, the guaranty association may request and the Office of Insurance Regulation (OIR) may order an assessment to fund the deficiency. Insurers are required by law to participate in guaranty associations as a condition of transacting business in Florida.

Accounting for Guaranty Association Assessments

Most insurers authorized to do business in the U.S. and its territories are required to prepare statutory financial statements to their state insurance regulators in accordance with statutory accounting principles (SAP),[7] which differs from generally acceptable accounting principles (GAAP) in a number of ways. While GAAP provides information useful to investors and other users of financial reporting (such as banks, credit rating agencies, and the U.S. Securities & Exchange Commission), SAP is developed in accordance with the concepts of consistency, recognition and conservatism, and assists state insurance departments with the regulation of the solvency of insurance companies. The ultimate objective of solvency regulation is to ensure that policyholder, contract holder and other legal obligations are met when they come due and that companies maintain capital and surplus at all times and in such forms as required by statute to provide a margin of safety. With the objective of solvency regulation, SAP focuses on the balance sheet, rather than the income statement, and emphasizes the insurers' liquidity.[8]

Under both GAAP and SAP, an insurer recognizes a liability when a FWCIGA assessment is imposed (which reduces the insurer's surplus and net worth). However, a timing difference exists between the two principles for the recognition of an asset relating to the future recoveries of policy surcharges:

- GAAP does not treat the assessments recoverable from future premium writings as an asset, and thus results in an immediate reduction in equity and earnings in the period a FWCIGA assessment is billed. However, the equity reduction is eliminated the following year as the assessments are recouped from policyholders.
- On the other hand, SAP allows insurers to recognize the assessment amount likely to be recovered from future premium surcharges as an asset, which in turn offsets or eliminates the negative effect on statutory surplus, subject to certain conditions. SAP does not permit an asset to be recognized if the assessment is to be recovered from future rate structures, and limits asset recognition for accrued assessment liabilities to the extent that amount to be recovered is from in-force premiums only.[9]

In 2015, the Legislature passed Ch. 2015-167, L.O.F., which provided that the definition of "asset" for the purposes of determining an insurer's financial condition includes Florida Insurance Guaranty Association (FIGA) assessments that are levied (*before* policy surcharges are collected) result in a

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Association is responsible for paying claims for insolvent insurers for most remaining lines of insurance, including residential and commercial property, automobile insurance, and liability insurance, among others.

[6] The term "unearned premium" refers to that portion of a premium that is paid in advance, typically for six months or one year, and which is still owed on the unexpired portion of the policy.

[7] OIR requires insurers to file annual SAP statements and independently audited financial reports. s. 624.424, F.S.

[8] NAIC & THE CENTER FOR INSURANCE POLICY AND RESEARCH, *Statutory Accounting Principles*, http://www.naic.org/cipr_topics/topic_statutory_accounting_principles.htm (last visited on Mar. 18, 2017). Section 625.01115, F.S., provides that "statutory accounting principles" means "accounting principles as defined in the National Association of Insurance Commissioners Accounting Practices and Procedures Manual as of March 2002 and subsequent amendments thereto if the amendments remains substantially consistent."

[9] Statements of Statutory Accounting Principles, No. 35R, Guaranty Fund and Other Assessments (SSAP 35R); *see also* Thomas Howell Ferguson, P.A., *Accounting for Guaranty Fund Assessments Memorandum*, Dec. 3, 2013.

receivable, which is recognized as an admissible asset[10] under statutory accounting principles, to the extent the receivable is likely to be realized. This reflects and clarifies a practice of OIR,[11] and eliminates the negative effect on statutory surplus of guaranty fund assessments. The asset must be established and recorded separately from the liability. The insurer must reduce the amount recorded as an asset if it cannot fully recoup the assessment amount because of a reduction in writings or withdrawal from the market. For assessments that are paid *after* policy surcharges are collected pursuant to the monthly installment option, the recognition of assets is based on actual premium written offset by the obligation to FIGA.

Effect of the Bill

The bill allows receivables related to FWCIGA assessment recoupment surcharges to be treated as assets in the same manner that is currently provided for FIGA assessment related receivables.

Medical Malpractice Rate Filing

Part I of ch. 627, F.S., the "Rating Law," sets forth the rating requirements for property, casualty, and surety insurance. Its primary purpose is to ensure that rates are not excessive, inadequate, or unfairly discriminatory" (collectively known as the "rate standards"). OIR has responsibility to review and approve or disapprove rates charged by insurance companies to ensure compliance with the rate standards. Rates are disapproved if they do not meet the rate standards.

Insurers that file rates for approval with OIR have the option of utilizing two procedures: "file and use" or "use and file." Under file and use:

- Insurers are required to file rates 90 days before the proposed effective date, and
- OIR must finalize its review by issuing a notice of intent to approve or disapprove within 90 days after receipt of the filing; otherwise the filing is deemed approved.

Under use and file, insurers:

- Can file their rates 30 days after the rate filing is implemented, and
- May implement the filing prior to approval, but may be ordered by OIR to refund to the policyholder any portion of the rate ultimately found by OIR to be excessive.

Every insurer writing any line of property or casualty insurance, except workers' compensation, employer's liability and specified commercial property and casualty insurance, must make an annual base rate filing for each line of insurance written that is subject to rate review and approval.[12] If no rate change is proposed, the insurer may submit a certification from an actuary, in lieu of the base rate filing, which states that the existing rate is actuarially sound and is not inadequate.[13]

Rating requirements for medical malpractice insurance are divided into two categories. The first category (i.e., medical malpractice insurance for a facility other than a hospital, nursing home, or assisted living and medical malpractice insurance for a health care practitioner other than a dentist, physician, chiropractor, podiatrist, pharmacist, or pharmacy technician) is exempt from the rate filing and review requirements[14] and the requirement to submit an annual base rate filing.[15] However, this category of medical malpractice insurance remains subject to the rate standards. An insurer offering coverage under this category must notify OIR within 30 days after the effective date of a rate change. Notice is limited to the name of the insurer, the type or kind of insurance, and the statewide percentage

[10] NAIC Statement of Statutory Accounting Principles No. 4. http://www.naic.org/cipr_topics/topic_statutory_accounting_principles.htm.
[11] OFFICE OF INSURANCE REGULATION, Supplemental Memorandum to Information Memorandum OIR-06-023M (Dec. 1, 2006). http://www.floir.com/siteDocuments/SupplementalMemo.pdf.
[12] s. 627.0645, F.S.
[13] s. 627.0645(3), F.S.
[14] s. 627.062(3)(d), F.S.
[15] s. 627.0645(1)(b), F.S.

change in rates. Such a filing is commonly referred to as an informational filing. OIR, at its discretion, may review the rates for compliance with the statutory requirements.

By contrast, medical malpractice insurance in the second category (i.e., all other types of medical malpractice insurance) remain subject to the standard rate filing and review requirements. The law further requires an insurer who writes coverage in this category to make an annual base rate filing whether or not the insurer is proposing a rate change. The filing must be sworn to by at least two executive officers of the insurer.[16]

Unlike other property and casualty insurers, medical malpractice insurers do not have the option of submitting, in lieu of the base rate filing, a certification from an actuary that the existing rate is actuarially sound and is not inadequate.

Effect of the Bill

The bill changes the annual base rate filing requirement for medical malpractice insurers that are subject to full rate filing and review. The bill removes the requirement to submit an annual base rate filing, regardless of whether the insurer is proposing a rate change, and substitutes the procedure that applies to all other property and casualty insurers who are required to make an annual base rate filing, but allowed to make a certification, in lieu of a filing. This gives medical malpractice insurers the option of filing a certification in lieu of a rate filing when no rate change is proposed. The bill retains the requirement for any filing to be sworn to by at least two executive officers of the insurer. OIR retains the right to review a rate at any time.[17]

Payments for Premium and Insufficient Funds Fee

Florida law requires cash payment of insurance premiums.[18] Acceptable forms of payment are coins, currency, checks, or money orders or by using a debit card, credit card, automatic electronic funds transfer, or payroll deduction. For motor vehicle insurance, consumers are also allowed to use a draft[19] or electronic check[20] to pay insurance premiums.

In certain instances, an insurer may charge a fee to the insured if their payment fails due to insufficient funds (this is in addition to any fees charged by their financial provider). If a check or draft for payment to a property, casualty, or surety insurer, including a workers' compensation insurer, is returned due to insufficient funds, the insurer may charge a fee of $20.00 or 5 percent of the payment, whichever is greater.[21] A premium finance company[22] may charge a fee of $15.00 for checks or drafts that are returned due to insufficient funds.[23] Also, a motor vehicle insurer may charge an insufficient funds fee of up to $15 if a payment of premium by debit card, credit card, electronic funds transfer, or electronic check is returned, declined, or cannot be processed.

Effect of the Bill

The bill adds "drafts" and "electronic checks" to the list of acceptable payment methods for premium payment. It also creates a generally applicable authority for insurers to charge a $15.00 insufficient funds fee, subject to an exception.[24] Insurers may charge this fee pursuant to policy terms whenever a premium payment fails due to insufficient funds, is declined, or cannot be processed and the payment

[16] s. 627.062, F.S.
[17] s. 627.0645(7), F.S.
[18] s. 627.4035, F.S.
[19] A draft is a negotiable instrument that orders the payment of a fixed amount of money. s. 673.1041, F.S. Examples of drafts include checks, cashier's checks, teller's checks, and documentary drafts.
[20] An electronic check is a consumer authorized one-time electronic funds transfer using information from a check. 12 CFR §1005.3(b)2. (2016).
[21] s. 627.162(5), F.S.
[22] s. 627.826, F.S.
[23] s. 627.841(4), F.S.
[24] Current law provides that property, casualty, and surety insurers may charge an insufficient fund fee of $20 or 5 percent of the payment, whichever is greater, for an insufficient check or draft. s. 627.162(5), F.S.

was made by debit card, credit card, electronic funds transfer, or electronic check. The insufficient funds fee is not available in following instances:[25]

- Reinsurance,
- Policies or contracts not issued for delivery in this state nor delivered in this state,
- Wet marine and transportation insurance,
- Title insurance,
- Credit life or credit disability insurance,
- Reinsurance agreements,
- Pension plans,
- Premium loans, whether or not subject to an automatic provision,
- Dividends, whether to purchase additional paid-up insurance or to shorten the dividend payment period,
- Salary deduction plans,
- Preauthorized check plans,
- Waivers of premiums on disability,
- Nonforfeiture provisions affording benefits under supplementary contracts; or
- Such other methods of paying for life insurance as may be permitted by the commission pursuant to rule or regulation.

The bill deletes the provision of law authorizing motor vehicle insurance consumers to pay premiums using a draft or electronic check and their insurers to charge an insufficient funds fee to avoid redundancy or conflict with the new provision described above.

Compliance of Electronic Documents with Insurance Code Requirements

The Insurance Code[26] establishes content, readability and formatting requirements for a wide variety of documents used in the transaction of insurance. Many of these requirements are focused on documents provided to or relied upon by the public and protect consumers by making the document readable, accessible, understandable, and consistent from insurer to insurer. Such requirements can take the form of minimum readability levels, inclusion of specified notices, and look and feel type standards, such as requiring text to be all capital, bold-type, contrasting color, or minimum point sizes. However, as technology facilitates greater use of electronic delivery of documents, some of these requirements, while important to consumer protection, do not translate well when paper documents are converted or presented in an electronic format. Statutorily required minimum point size text is a prime example.

The specified point size of type is a measure of physical size on a printed page. It is related to typeface printing and the characteristics of type set text. It does not necessarily identify the physical size of the character itself. Rather, it describes a maximum height parameter within the complete font type collection. One point in physical type face is 1/72 of an inch, thus 12-point font is 12/72 of an inch. Point size does not directly translate to graphical display size in electronics. Electronic graphical display size is measured in picture elements, popularly known as pixels. Different size displays contain different numbers of pixels. Accordingly, specifying the point size of electronic text presents challenges that can require a high degree of technical precision.[27]

When displayed on a graphical display, required format elements, such as point size, can be difficult for the content provider to program and are subject to change by the end user. Display properties of a desktop computer monitor can be adjusted by the user to display images in different resolutions and sizes. Displays on touch screen devices, such as smart phones, tablets, and touch screen desktop monitors, can be quickly resized through simple touches and gestures. Changing the display size makes minimum point size requirements functionally meaningless.

[25] ss. 627.401 and 627.4035(2), F.S.
[26] The Insurance Code is chapters 624-632, 634, 635, 636, 641, 642, 648, and 651, F.S. s. 624.01, F.S.
[27] See http://www.thomasphinney.com/2011/03/point-size/ (Last visited Mar. 16, 2017).

Additionally, when an insurance form is converted into software content, it can be broken down into multiple parts that are displayed in sequence and read in isolation, as compared to a paper form, which contains all required information in context with the other elements of the document. When broken down into a software application or content, required notices may lose their context or emphasis that is readily apparent when received on paper. Current rules of OIR do not appear to address the application of statutory standards designed for paper documents to their electronic versions.

Effect of the Bill

The bill provides a means for electronic insurance documents to be measured in comparison to paper based document standards. The electronic document will satisfy certain standards applicable to paper documents if the elements have reasonably similar proportions or emphasis in their electronic format and context or are displayed in a reasonably conspicuous manner.[28]

Motor Vehicle Insurance Policy Exclusions

Motor vehicle coverage requirements are established under part XI of ch. 627, F.S., Motor Vehicle and Casualty Insurance Contracts, and ch. 324, F.S., the Financial Responsibility Law of 1955. Owners and operators of motor vehicles must maintain the ability to respond in damages at specified minimum amounts for personal injury protection, bodily injury or death, and property damage.

Coverage of a specific motor vehicle owned by the insured may be excluded when it is not insured under the policy.[29] A policyholder may choose not to insure particular motor vehicles that are not registered, covered under another policy, or that result in unwanted premium. Neither the policyholder nor the insurer can exclude individuals required to be covered by law. Among other insureds, personal injury protection insurance is required to cover persons operating the insured motor vehicle and relatives residing in the same household[30] as the named insured (i.e., policyholder).[31] A motor vehicle liability policy providing coverage for bodily injury, death, and property damage is required to provide coverage for individuals that are named on the policy and anyone operating a motor vehicle listed on the policy doing so with the express or implied permission of the insured motor vehicle owner.[32]

An insurer is permitted to cancel a motor vehicle insurance policy if the named insured or any operator who resides in the same household or customarily operates a motor vehicle insured under the policy has her or his driver license revoked or suspended.[33] An insured motor vehicle that is operated by an individual that is excluded from coverage or without the express or implied consent of the insured vehicle's owner is an uninsured/underinsured motor vehicle for purposes of uninsured/underinsured motor vehicle coverage (UM coverage).[34]

There is no authority under the motor vehicle insurance laws for an insurer to exclude coverage of a named individual. Rather, the insurer must choose not to write a policy in order to avoid specific individuals.[35] However, unfair discrimination is prohibited.[36] This results in consumers who reside with another individual that is a high insurance risk being denied opportunities to purchase motor vehicle insurance or having to pay more because they live with individuals that the policyholder or insurer would like to exclude from the policy. Additionally, policyholders may have their policy cancelled if the license or registration of a co-resident is suspended or revoked.

[28] OIR will be responsible for administering electronic document compliance under existing form oversight authority.
[29] s. 627.736(2), F.S.
[30] "Relative residing in the same household" means a relative of any degree by blood or by marriage who usually makes her or his home in the same family unit, whether or not temporarily living elsewhere. s. 627.732(6), F.S.
[31] ss. 627.736(1) and (4)(e) and 627.7407(5)(b), F.S.
[32] s. 324.151(1), F.S.
[33] ss. 627.7275 and 627.728, F.S.
[34] s. 627.727, F.S.
[35] s. 627.736(2), F.S.
[36] ss. 626.9541(1)(g) and 627.728(4)(c), F.S.

Effect of the Bill

The bill authorizes insurers to exclude named individuals from coverage under a private passenger motor vehicle insurance policy. Once excluded, the individual would not be covered for damages that occur while operating the insured motor vehicle. The bill prohibits exclusion for periods when the named excluded individual is not operating a motor vehicle covered under the policy, if the exclusion is unfairly discriminatory, as determined by OIR, and if the exclusion is inconsistent with the underwriting guidelines filed by the insurer with OIR.

B. SECTION DIRECTORY:

Section 1. Amends s. 215.555, F.S., relating to Florida Hurricane Catastrophe Fund.

Section 2. Amends s. 625.012, F.S., relating to "assets" defined.

Section 3. Amends s. 627.062, F.S., relating to rate standards.

Section 4. Amends s. 627.0645, F.S., relating to annual filings.

Section 5. Amends s. 627.4035, F.S., relating to cash payment of premiums; claims.

Section 6. Amend s. 627.421, F.S., relating to delivery of policy.

Section 7. Amend s. 627.7295, F.S., relating to motor vehicle insurance contracts.

Section 8. Creates s. 627.747, F.S., relating to named driver exclusion.

Section 9. Provides an effective date of upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Indeterminate. The provisions of the bill authorizing motor vehicle insurers to exclude coverage of named individuals may require the Department of Highway Safety and Motor Vehicles to revise rules and update software systems.[37] OIR reports that the provisions regarding medical malpractice insurance base rate filing will require software system changes at minimal cost that can be absorbed through current resources.[38]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

[37] An agency analysis was not requested of the Department of Highway Safety and Motor Vehicles.
[38] Florida Office of Insurance Regulation, Agency Analysis of 2017 House Bill 359, p. 5 (Mar. 3, 2017).

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Exempting medical malpractice insurance from the FHCF assessment base will cause policyholders of the other types of property and casualty insurance included in the assessment base to pay higher assessments if revenue bonds are issued by the FHCF after June 1, 2019.

Medical malpractice insurers will be positively impacted by avoiding the burden of making annual base rate filings when they choose to certify their rates instead.

Insurers will be positively impacted by new options for payment of premium and collection of insufficient funds fees, but consumers will be negatively impacted by these fees.

Insurers and consumers will be positively impacted by increased opportunities for electronic delivery of documents.

Consumers will be positively impacted by increased availability and/or lowered premiums of motor vehicle insurance written with named driver exclusions. However, high risk consumers may experience increased application denials or premiums when mandatory coverage requirements are overridden by the exclusion authority provided by the bill.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On April 6, 2017, the Commerce Committee considered the bill, adopted three amendments, and reported the bill favorably as a committee substitute. The amendments made the following changes to the bill:

- Authorized the Florida Workers' Compensation Insurance Guaranty Association to recognize assessments that are collected and remitted as installment payments as assets, consistent with the provision of the bill recognizing assessment surcharges following a one-time payment as assets and current law applicable to the Florida Insurance Guaranty Association.
- Avoided a potential conflict with current law by clarifying that the insufficient fund fee authorized by the bill does not apply to property, casualty, or surety insurers, which may charge a higher fee that is separately authorized in statute.
- Clarified provisions of the bill related to named driver exclusions.

The staff analysis has been updated to reflect the committee substitute.