# HOUSE OF REPRESENTATIVES
# FINAL BILL ANALYSIS

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| **BILL #:** | CS/HB 359 | **FINAL HOUSE FLOOR ACTION:** | | | |
| **SUBJECT/SHORT TITLE** | Regulation of Insurance Companies | 117 | **Y's** | 0 | **N's** |
| **SPONSOR(S):** | Commerce Committee; Santiago | **GOVERNOR'S ACTION:** | Approved | | |
| **COMPANION BILLS:** | CS/CS/SB 454 | | | | |

## SUMMARY ANALYSIS

CS/HB 359 passed the House on April 26, 2017. The bill was amended by the Senate on May 4, 2017. The Senate passed the bill, as amended, on May 5, 2017, and returned the bill to the House. The House concurred in the Senate amendment and passed the bill, as amended, on May 5, 2017.

The bill makes the following changes regarding insurance:

- **Property Title Searches** – Adds a provision that renames and expands "ownership and encumbrance reports" (title searches) as "property information reports"; limits the liability of those that prepare property information reports to only the cost of the report, rather than other contractual or negligence remedies; and eliminates form approval by the Office of Insurance Regulation;
- **Florida Hurricane Catastrophe Fund (FHCF) Emergency Assessments** – Makes permanent the exemption from FHCF emergency assessments for medical malpractice insurance that was set to expire on May 31, 2019;
- **Property Insurer Surplus Requirements** – Changes the minimum required surplus to $10 million for a new or current residential property insurer writing renter's insurance, tenant's coverage, or cooperative unit owner insurance to obtain or maintain a certificate of authority to transact insurance in Florida (the current surplus requirement for residential property insurers varies from $5 million to $50 million depending on the insurer's domicile location and whether they are a new or current insurer);
- **Insurer Audit Committees** – Removes the word "solely" from the provision requiring an insurer's board of directors audit committee to be solely made up of independent members;
- **Florida Workers' Compensation Insurance Guaranty Association Assessments (FWCIGA)** – Allows receivables related to FWCIGA assessment recoupment surcharges to be treated as assets;
- **Medical Malpractice Rate Filing** – Removes the requirement that medical malpractice insurers submit an annual base rate filing, regardless of whether the insurer is proposing a rate change, and permits them to file a certification in lieu of a rate filing when no rate change is proposed;
- **Payments for Premium and Insufficient Funds Fee** – Adds payments by "draft" or "electronic check" to the list of acceptable insurance premium payment methods and authorizes most insurers to charge $15, pursuant to policy terms, if an electronic premium payment fails due to insufficient funds (this is in addition to any fees charged by their financial provider) and adds a prohibition on such fees if non-policyholder related fraud or misuse of the policyholder's account caused the failure of payment; and
- **Compliance of Electronic Documents with Insurance Code Requirements** – 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.

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 was approved by the Governor on June 23, 2017, ch. 2017-132, L.O.F., and became effective on that date.

# I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

**Property Title Searches**

Title insurance insures owners of real property or others having an interest in real property, such as lenders, against loss by: encumbrance; defective title; invalidity; or adverse claim to title.[1] Title insurance is a policy issued by a title insurer that, after evaluating a search of title, insures against certain covered risks including: forgery; fraud; liens; and encumbrances on a title. It is usually taken out by the purchaser of property or an entity that is loaning money on a mortgage.

Purchasers of real property and lenders utilize title insurance to protect themselves against claims by others to be the rightful owner of the property. Most lenders require title insurance when they underwrite loans for real property. Title insurance provides a duty by the title insurer to defend against adverse claims on the subject property's title, and also promises to indemnify the policyholder for damage to the lender's security interest created by a cloud on title, unmarketable title, or adverse title that was not discovered by the insurer.[2]

*Owners and Encumbrance Reports*

An "ownership and encumbrance report" (i.e., the report of a title search) discloses certain defined documents imparting constructive notice and appearing in the official records relating to specified real property.[3] Such reports may not directly or indirectly set forth or imply any opinion, warranty, guarantee, insurance, or other similar assurance as to the status of title to real property.[4] Additionally, any ownership and encumbrance report or similar report that is relied on or intended to be relied on by a consumer must be on forms approved by the Office of Insurance Regulation (OIR), and must provide for a maximum liability for incorrect information of not more than $1,000.[5]

*Effect of the Bill*

The bill renames and expands "ownership and encumbrance reports" as "property information reports." It limits the liability of those that prepare property information reports to only the cost of the report, rather than other contractual or negligence remedies. The bill also eliminates form approval by OIR and provides that the provisions of the bill related to property information report do not apply to title opinions issued by an attorney.

**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 are required to enter into reimbursement contracts with FHCF. The purpose

[1] s. 624.608, F.S. Title insurance is also insurance of owners and secured parties of the existence, attachment, perfection and priority of security interests in personal property under the Uniform Commercial Code.
[2] *See*, *e.g.*, AMERICAN LAND TITLE ASSOCIATION (ALTA), http://www.alta.org (last visited May 8, 2017). ALTA is the national trade association of the abstract and title insurance industry. There are currently six basic ALTA policies of title insurance: Lenders, Lenders Leasehold, Owners, Owners Leasehold, Residential, and Construction Loan Policies. AMERICAN LAND TITLE ASSOCIATION, *Title Insurance: A Comprehensive Overview*, http://www.alta.org/press/TitleInsuranceOverview.pdf (last visited May 8, 2017).
[3] s. 627.7843(1), F.S.
[4] s. 627.7843(2), F.S.
[5] s. 627.7843(3), F.S.

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.[6] The Legislature has extended the sunset date in successive three-year increments without interruption since the exemption's creation.[7] 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.

**Property Insurer Surplus Requirements**

New and current residential property insurers are required to maintain a specified minimum surplus to assure financial solvency of the insurer.[8] The current surplus requirement varies from $5 million to $50 million depending on the insurer's domicile location and whether they are a new or current insurer.

*Effect of the Bill*

The bill changes the minimum required surplus to $10 million for a new or current residential property insurer writing renter's insurance, tenant's coverage, or cooperative unit owner insurance to obtain or maintain a certificate of authority to transact insurance in Florida.

**Insurer Audit Committees**

Insurers are required to file an annual statement with OIR.[9] The Board of Directors of the insurer is responsible to hire a certified public accountant to audit the annual statement and appoint an audit committee of the board to liaison with the appointed accountant. The law requires the audit committee be solely composed of directors who are free of any conflicts that may interfere with their independent judgment.[10]

*Effect of the Bill*

The bill removes the word "solely" from the provision requiring an insurer's board of directors audit committee to be solely made up of members that lack a conflict that would interfere with their independent judgment.[11]

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[6] Ch. 2004-27, Laws of Fla.
[7] *See* chs. 2007-90, 2010-141, 2013-60, 2016-132, Laws of Fla.
[8] ss. 624.407 and 624.408, F.S.
[9] s. 624.424, F.S.
[10] s. 624.424(8)(c), F.S.
[11] The effect of removing the word "solely" is unclear as the statute may be interpreted to have the same meaning without this word, i.e., "[t]he audit committee shall be comprised of members who are free from any relationship that, in the opinion of its board of directors, would interfere with the exercise of independent judgment as a committee member." The amended statute does not authorize members that lack independent judgment; rather, it only authorizes those with independent judgment. Additionally, OIR has adopted a rule that conflicts with the current statute. The rule allows audit committees to be formed with members that lack independent judgment. Rule 69O-137.002(14), F.A.C.

## 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.[12] 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.[13]

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.[14] The Florida Workers' Compensation Insurance Guaranty Association (FWCIGA) 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 payments 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[15] 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 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 United States and its territories are required to prepare statutory financial statements and submit them to their state insurance regulators in accordance with statutory accounting principles (SAP),[16] 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

[12] 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).

[13] 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.

[14] 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 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.

[15] 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.

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

objective of solvency regulation, SAP focuses on the balance sheet, rather than the income statement, and emphasizes the insurers' liquidity.[17]

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.[18]

In 2015, the Legislature passed Chapter 2015-167, Laws of Florida, 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 receivable, which is recognized as an admissible asset[19] under statutory accounting principles, to the extent the receivable is likely to be realized. This reflects and clarifies a practice of OIR,[20] 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.

[17] 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."
[18] 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.
[19] NAIC Statement of Statutory Accounting Principles No. 4. http://www.naic.org/cipr_topics/topic_statutory_accounting_principles.htm.
[20] OFFICE OF INSURANCE REGULATION, Supplemental Memorandum to Information Memorandum OIR-06-023M (Dec. 1, 2006), http://www.floir.com/siteDocuments/SupplementalMemo.pdf.

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.[21] 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.[22]

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[23] and the requirement to submit an annual base rate filing.[24] 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 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.[25]

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

[21] s. 627.0645, F.S.
[22] s. 627.0645(3), F.S.
[23] s. 627.062(3)(d), F.S.
[24] s. 627.0645(1)(b), F.S.
[25] s. 627.062, F.S.

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.[26]

**Payments for Premium and Insufficient Funds Fee**

Florida law requires cash payment of insurance premiums.[27] 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[28] or electronic check[29] 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.[30] A premium finance company[31] may charge a fee of $15.00 for checks or drafts that are returned due to insufficient funds.[32] 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.[33] 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 was made by debit card, credit card, electronic funds transfer, or electronic check. However, this fee may not be charged if the payment fails because of misuse or fraud that is not the fault of the policyholder. The insufficient funds fee is not available in the following instances:[34]

- 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,

[26] s. 627.0645(7), F.S.
[27] s. 627.4035, F.S.
[28] 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.
[29] An electronic check is a consumer authorized one-time electronic funds transfer using information from a check. 12 CFR §1005.3(b)2. (2016).
[30] s. 627.162(5), F.S.
[31] s. 627.826, F.S.
[32] s. 627.841(4), F.S.
[33] 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.
[34] ss. 627.401 and 627.4035(2), F.S.

- 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[35] 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.[36]

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.

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.[37]

[35] The Insurance Code is chapters 624-632, 634, 635, 636, 641, 642, 648, and 651, F.S. s. 624.01, F.S.
[36] *See* http://www.thomasphinney.com/2011/03/point-size/ (Last visited Mar. 16, 2017).
[37] OIR will be responsible for administering electronic document compliance under existing form oversight authority.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

Indeterminate. 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.

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.

D. FISCAL COMMENTS:

None.

[38] Florida Office of Insurance Regulation, Agency Analysis of 2017 House Bill 359, p. 5 (Mar. 3, 2017).