

Insurance & Banking Subcommittee

Wednesday, November 6, 2019
3:30 pm – 5:30 pm
Sumner Hall (404 HOB)

Jose Oliva
Speaker

Byron Donalds
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Insurance & Banking Subcommittee

Start Date and Time:	Wednesday, November 06, 2019 03:30 pm
End Date and Time:	Wednesday, November 06, 2019 05:30 pm
Location:	Sumner Hall (404 HOB)
Duration:	2.00 hrs

Consideration of the following bill(s):

HB 269 Loss Run Statements by Perez
HB 329 Insurance Guaranty Associations by Smith, D.

Pursuant to rule 7.11, the deadline for amendments to bills on the agenda by non-appointed members shall be 6:00 p.m., Tuesday, November 5, 2019.

By Request of Chair Donalds, all Insurance & Banking Subcommittee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Tuesday, November 5, 2019.

NOTICE FINALIZED on 10/30/2019 3:47PM by Harrell.Lindsey

The Florida House of Representatives

Commerce Committee

Insurance & Banking Subcommittee

Jose R. Oliva
Speaker

Byron Donalds
Chair

AGENDA

November 6, 2019
404 House Office Building
3:30 PM – 5:30 PM

I. Call to Order & Roll Call

II. Consideration of the following bills:

A. HB 269 Loss Run Statements by Perez

B. HB 329 Insurance Guaranty Associations by Smith, D.

III. Adjournment

303 House Office Building, 402 South Monroe Street, Tallahassee, Florida 32399-1300
(850) 717-4871 Fax: (850) 413-0419

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 269 Loss Run Statements
SPONSOR(S): Perez
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee		Fortenberry	Cooper
2) Government Operations & Technology Appropriations Subcommittee			
3) Commerce Committee			

SUMMARY ANALYSIS

A loss run statement is a report from an insurer that shows how many claims a specific insured has filed under that insured's policy during a particular period of time. It may be provided to a prospective insurer when an insured is shopping for a new insurance policy so that the prospective insurer can determine whether write a policy for the prospective insured and what premium to charge for that policy. Loss run statements typically contain claims history for three to five years.

While insureds may request loss run statements for any line of insurance, insureds seeking new general commercial line policies often request these statement to shop for new insurance. Some insurers have existing loss runs systems that allow their insureds to log into a portal and to obtain their own detailed reports on claims. However, other insurers, may provide insureds with loss run statements that they have created upon request or direct the insureds to obtain such statements from their agents of record.

Often, personal lines loss history can be obtained from public sources, but these publicly available reports may not be completely accurate. Additionally, commercial and health insurance data are not readily available from public sources. While insurers routinely provide loss run information to insureds, Florida has no existing statutory framework regarding when or how insurers much provide this information to insureds. Approximately 11 other states currently have statutory requirements for insurers providing loss run statements to insureds.

The overall effect of the bill is to establish a statutory framework for an insurance practice that routinely occurs. The bill defines "loss run statement" as a report generated and maintained by an insurer that shows the history of insurance claims by an insured during a particular policy period. The bill defines "provide" as electronically sending a document, or allowing access through an electronic portal to review or generate a document.

The bill provides that, for all lines of insurance, an insurer shall provide a loss run statement to an insured within 15 calendar days after receipt of a written request. The loss run statement provided must be a five-year loss run history for five continuous years before the year in which the insured makes the request, or the complete loss run history if it is less than five years. The bill requires that the insurer notify the insured's agent of record that it provided the loss run statement to the insured at the time that the insurer provided it. The bill also prohibits an insurer from charging an insured for the first loss run statement that an insured requests each year. The bill imposes identical requirements to provide loss run statements to insureds whether the insurers are authorized insurers, eligible surplus lines insurers, or unauthorized insurers permitted to issue policies.

The bill has no impact on state or local government revenues and expenditures. It also may have a positive direct economic impact on the private sector.

This bill has an effective date of January 1, 2021.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

A loss run statement[1] is a report from an insurer that shows how many claims a specific insured has filed under that insured's policy during a particular period of time.[2] This report can be provided to a prospective insurer when an insured is shopping for a new insurance policy.[3] The prospective insurer can use the loss run statement to review the types, frequency, and dollar value of prior claims in order to determine whether write a policy for the prospective insured and what premium to charge for that policy.[4] Prospective insurers often want to review loss run statements showing a loss run history from three to five years to make decisions about writing insurance policies.[5]

While insureds may request loss run statements for any line of insurance, insureds seeking new general liability, business owner's, commercial property, commercial auto insurance, or workers' compensation insurance, often request them to shop for new insurance[6] upon cancelation or nonrenewal of a policy by an insurer or when the insured chooses to shop for new insurance at the time a policy is up for renewal. Some insurers, especially those providing commercial lines coverage or workers' compensation insurance, have existing loss runs systems that allow their insureds to log into a portal and to obtain their own detailed reports on claims.[7] However, other insurers, in these and other lines of insurance, may provide insureds with loss run statements that they have created upon request or direct the insureds to obtain such statements from their agents of record.

Often, personal lines loss history can be obtained from public sources. A Comprehensive Loss Underwriting Exchange, or CLUE, report is a claims report generated by the consumer-reporting agency, LexisNexis.[8] A CLUE report contains claims information reported by insurers for all personal auto and personal property claims in which they pay money, set up a file for a possible claim, or deny a claim.[9] Yet, CLUE reports and other publicly available reports, may not be completely accurate.[10] Additionally, commercial and health insurance data are not readily available from public sources.

While insurers routinely provide loss run information to insureds, Florida has no existing statutory framework regarding when or how insurers much provide this information to insureds. Approximately 11 other states currently have statutory requirements for insurers providing loss run statements to insureds.[11]

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[1] Loss run statements are also referred to as loss runs or loss run reports.
[2] Insureon, https://www.insureon.com/insurance-glossary/loss-runs (last visited Oct. 31, 2019).
[3] *Id.*
[4] *Id.*
[5] *Id.*
[6] *Id.*
[7] *See, e.g.,* MSIG Loss Runs, https://www.msigusa.com/loss-runs/ and StarStone, http://myaccount.starstoneworkcomp.com/index.htm (last visited Oct. 31, 2019).
[8] Office of the Insurance Commissioner Washington State, https://www.insurance.wa.gov/clue-comprehensive-loss-underwriting-exchange (last visited Oct. 31, 2019).
[9] *Id.*
[10] Information reported by Florida Association of Insurance Agents, which is a nonprofit trade association and a proponent of this bill.
[11] *See, e.g.*, Okla. Stat. Ann. 36, §1204.1, which provides that loss runs or claims history must be made available within 30 days of a written request, and Ky. Rev. Stat. Ann. §304.20-100, which provides that a five-year loss run history must be made available within 20 days following a written request.

Effect of the Bill

The overall effect of the bill is to establish a statutory framework for a practice that routinely occurs in the insurance industry. The bill defines "loss run statement" as a report that is generated and maintained by an insurer, and shows the history of insurance claims by an insured during a particular policy period. The bill defines "provide" as electronically sending a document, or allowing access through an electronic portal to review or generate a document.

The bill provides that, for all lines of insurance, an insurer shall provide a loss run statement to an insured within 15 calendar days after receipt of a written request from that insured. The loss run statement that the insurer provides must be a five-year loss run history for five continuous years before the year in which the insured makes the request, or the complete loss run history if it is less than five years. The bill requires that the insurer notify the insured's agent of record that it provided the loss run statement to the insured at the time that the insurer provided it. The bill also prohibits an insurer from charging an insured for the first loss run statement that an insured requests each year.

The bill imposes identical requirements on insurers to provide loss run statements to insureds regardless of whether the insurers are authorized insurers[12], eligible surplus lines insurers[13], or unauthorized insurers permitted by the Florida Office of Insurance Regulation (OIR) to issue insurers policies under certain circumstances[14].

B. SECTION DIRECTORY:

Section 1. Creates s. 626.9202, F.S., relating to loss run statements for all lines of insurance.

Section 2. Creates s. 627.4605, F.S., relating to loss run statements for all lines of insurance.

Section 3. Provides an effective date of January 1, 2021.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

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[12] An authorized insurer is one authorized by a certificate of authority issued by OIR to transact insurance business in Florida. S. 624.09, F.S.

[13] Chapter 626, part VIII, F.S., sets forth the criteria under which surplus lines carriers may write insurance policies in Florida.

[14] Section 626.918(5) and (6), F.S., establishes the circumstances under which an otherwise unauthorized insurer may issue an insurance policy in Florida.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Because most insurers likely already provide loss run statements to insureds upon request or via an electronic portal, or they can easily create them, the bill codifies an existing practice and should not place a financial burden upon insurers. The bill may benefit consumers as they may be able to obtain premium discounts if they are able to use loss run statements to show prospective insurers that they have no claim history for a certain period of time.

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:

The bill neither authorizes nor requires administrative rulemaking.

C. DRAFTING ISSUES OR OTHER COMMENTS:

OIR has pointed out in its analysis of the bill that "provide" is defined only to include electronic access or delivery.[15] Because s. 627.421(1), F.S., allows insureds to receive "policy documents" via mail, the bill may conflict with existing law if loss run statements are considered "policy documents."

OIR also pointed out that, under s. 627.291, F.S., a workers' compensation insurer is permitted to charge a "reasonable charge" to provide an insured with "pertinent information" requested.[16] OIR interprets "pertinent information" under this section to include a loss run statement.[17] Therefore, the prohibition in the bill against charging an insured for the first loss run statement requested within a year may conflict with this statute if an insured requests a loss run statement for a workers' compensation insurance policy.

Lines 33 and 60 of the bill contain the phrase "loss run history," which is not a defined term within the statutes created by the bill. Perhaps a better phrase might be "claims history" because statement is defined to be a history of claims.[18]

Lines 42 and 67 of the bill contain the phrase "per year." It is unclear whether this means per calendar year or on a rolling 12-month basis beginning when an insured makes a request for a loss run statement.

In its analysis, OIR further noted that s. 627.4605, F.S., one of the statutes created by the bill, is proposed to be placed in ch. 627, part II, F.S., which pertains the insurance contract.[19] OIR suggests

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[15] Florida Office of Insurance Regulation, Agency Analysis of 2020 House Bill 269, p. 5 (Oct. 31, 2019).
[16] *Id.*
[17] *Id.*
[18] *Id.*

that the statute created might be more appropriately placed in ch. 627, part I, F.S., which pertains to rates and rating organizations, because loss run statements are used for rating purposes.[20]

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[19] *Id.*
[20] *Id.*

A bill to be entitled

An act relating to loss run statements; creating ss. 626.9202 and 627.4065, F.S.; providing definitions; requiring eligible surplus lines insurers, specified unauthorized insurers, and authorized insurers to provide loss run statements to insureds within a specified timeframe; providing the loss run statement history requirements; providing notification requirements; prohibiting fees under certain circumstances; providing applicability; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 626.9202, Florida Statutes, is created to read:

626.9202 Loss run statements for all lines of insurance.—

(1) As used in this section, the term:

(a) "Loss run statement" means a report that:

1. Is generated and maintained by an insurer; and

2. Shows the history of insurance claims that an insured has had during an insurance policy period.

(b) "Provide" means to electronically send a document, or to allow access through an electronic portal to view or generate a document.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

(2)(a) Notwithstanding any other provision of law, an eligible surplus lines insurer or an unauthorized insurer permitted by the office to issue an insurance policy under s. 626.918(5) and (6) shall provide a loss run statement to an insured within 15 calendar days after receipt of the insured's written request.

(b) The loss run statement provided under paragraph (a) must be a 5-year loss run history for 5 continuous years before the year in which the request is made or, if the history is less than 5 years, a complete loss run history.

(3) At the time the loss run statement is provided, the eligible surplus lines insurer or unauthorized insurer shall also notify the surplus lines agent of record that the loss run statement was provided to the insured.

(4) The eligible surplus lines insurer or unauthorized insurer may not charge a fee to prepare and provide one loss run statement per year in accordance with subsection (2).

(5) This section applies to all lines of insurance.

Section 2. Section 627.4065, Florida Statutes, is created to read:

627.4065 Loss run statements for all lines of insurance.—

(1) As used in this section, the term:

(a) "Loss run statement" means a report that:

1. Is generated and maintained by an insurer; and

2. Shows the history of insurance claims that an insured

has had during an insurance policy period.

(b) "Provide" means to electronically send a document, or to allow access through an electronic portal to view or generate a document.

(2)(a) Notwithstanding any other provision of law, an authorized insurer shall provide a loss run statement to an insured within 15 calendar days after receipt of the insured's written request.

(b) The loss run statement provided under paragraph (a) must be a 5-year loss run history for 5 continuous years before the year in which the request is made or, if the history is less than 5 years, a complete loss run history.

(3) At the time the loss run statement is provided, the insurer shall also notify the agent of record that the loss run statement was provided to the insured.

(4) The insurer may not charge a fee to prepare and provide one loss run statement per year in accordance with subsection (2).

(5) This section applies to all lines of insurance.

Section 3. This act shall take effect January 1, 2021.

INSURANCE & BANKING SUBCOMMITTEE

HB 269 by Rep. Perez
Loss Run Statements

AMENDMENT SUMMARY
November 6, 2019

Amendment 1 by Rep. Perez (strike-all): The strike-all amendment:

- Maintains the intent of the current version of the bill and makes the following modifications and clarifications:
  - Changes the definition of "loss run statement" so that it more precisely defines what must be included in a loss run statement. In addition, it specifies what is not included.
  - Establishes that any insurer is only required to provide an insured with a loss run statement once per policy period.
  - Establishes that no insurer shall be required to provide loss reserve information as part of a loss run statement.
  - Places provisions relating to authorized insurers in a different location in statutes than the bill.
  - Makes various formatting and technical changes.

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	____	(Y/N)
ADOPTED AS AMENDED	____	(Y/N)
ADOPTED W/O OBJECTION	____	(Y/N)
FAILED TO ADOPT	____	(Y/N)
WITHDRAWN	____	(Y/N)
OTHER		

Committee/Subcommittee hearing bill: Insurance & Banking Subcommittee

Representative Perez offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Section 626.9202, Florida Statutes, is created to read:

626.9202 Loss run statements for all lines of insurance.—

(1) As used in this section, the term:

(a) "Loss run statement" means a report that contains the policy number, the period of coverage, the number of claims, the paid losses on all claims, and the date of each loss. The term does not include supporting claim file documentation, including, but not limited to, copies of claim files, investigation

reports, evaluation statements, insureds' statements, and documents protected by a common law or statutory privilege.

(b) "Provide" means to electronically send a document, or to allow access through an electronic portal to view or generate a document.

(2) Notwithstanding any other law, an insurer shall provide a loss run statement to an insured within 15 calendar days after receipt of the insured's written request, but in no event more frequently than once per policy period.

(3) At the time the loss run statement is provided to the insured, the insurer shall notify the agent of record that the loss run statement was provided to the insured.

(4) A loss run statement provided pursuant to this section must contain a claims history with the insurer for the preceding 5 years or, if the claims history is less than 5 years, a complete claims history with the insurer.

(5) Notwithstanding any other provision of this section, an insurer may not be required to provide loss reserve information.

(6) Notwithstanding any other law, an insurer may not charge any fee to prepare and provide annually one loss run statement in accordance with this section.

Section 2. Section 627.0622, Florida Statutes, is created to read:

627.0622 Loss run statements for all lines of insurance.—

(1) As used in this section, the term:

(a) "Loss run statement" means a report that contains the policy number, the period of coverage, the number of claims, the paid losses on all claims, and the date of each loss. The term does not include supporting claim file documentation, including, but not limited to, copies of claim files, investigation reports, evaluation statements, insureds' statements, and documents protected by a common law or statutory privilege.

(b) "Provide" means to electronically send a document, or to allow access through an electronic portal to view or generate a document.

(2) Notwithstanding any other law, an insurer shall provide a loss run statement to an insured within 15 calendar days after receipt of the insured's written request, but in no event more frequently than once per policy period.

(3) At the time the loss run statement is provided to the insured, the insurer shall notify the agent of record that the loss run statement was provided to the insured.

(4) A loss run statement provided pursuant to this section must contain a claims history with the insurer for the preceding 5 years or, if the claims history is less than 5 years, a complete claims history with the insurer.

(5) Notwithstanding any other provision of this section, an insurer may not be required to provide loss reserve information.

(6) Notwithstanding any other law, an insurer may not charge any fee to prepare and provide annually one loss run statement in accordance with this section.

Section 3. This act shall take effect January 1, 2021.

T I T L E A M E N D M E N T

Remove everything before the enacting clause and insert:

A bill to be entitled

An act relating to loss run statements; creating ss. 626.9202 and 627.0622, F.S.; providing definitions; requiring insurers to provide loss run statements to insureds within a specified timeframe; providing notification requirements; providing claims history requirements for loss run statements; prohibiting insurers from being required to provide loss reserve information; prohibiting fees under certain circumstances; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 329 Insurance Guaranty Associations
SPONSOR(S): Smith, D.
TIED BILLS: **IDEN./SIM. BILLS:** SB 540

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee		Fortenberry	Cooper
2) Government Operations & Technology Appropriations Subcommittee			
3) Commerce Committee			

SUMMARY ANALYSIS

Florida law provides for guaranty associations to ensure policyholders of insolvent insurers are protected with respect to insurance premiums paid and settlement of outstanding claims. Florida has four guaranty associations including the Florida Insurance Guaranty Association (FIGA) and the Florida Workers' Compensation Insurance Guaranty Association (FWCIGA).

FIGA assumes the rights and duties of insolvent Florida insurers, including claims adjusting. Claims filed with a liquidated foreign insurer are referred to that state's guaranty association for handling. FIGA handles claims involving insolvent Florida insurers and claims on Florida policies issued by liquidated foreign insurers. It may be efficient for the employees of another state's guaranty association to be involved in adjusting a Florida claim. The bill allows those employees to adjust Florida claims without being licensed adjusters, if authorized by the contract between FIGA and the other state's guaranty association. It also allows FIGA employees to adjust claims without being licensed adjusters.

If an insurer's assets are insufficient to pay all claims, FIGA can issue post-insolvency assessments against property and casualty insurers to obtain funds to pay the remaining claims. The bill clarifies that the assessment due from member insurers will be a uniform percentage of premium collected instead of based on a proportion of the total net direct written premium for the prior calendar year. The bill establishes that assessment installment payments made by FIGA members may be made quarterly rather than monthly.

FWCIGA assumes the right and duties of the insolvent Florida workers' compensation insurers or self-insurance funds and pays the claims of its policyholders. FWCIGA is funded through the liquidation of insolvent insurers, potentially including a portion of the estates of insolvent insurers in other states. FWCIGA has the authority to levy assessments on workers' compensation insurers if insolvent insurers' estates are insufficient to pay claims. This bill provides additional changes to the assessment methods that were amended significantly in 2016 to conform them to workers' compensation industry standards.

The bill clarifies the method by which assessments are levied against insurers and collected by FWCIGA related to policy deductibles and to retrospectively rated policies. The bill provides the authority for FWCIGA to audit reports from insurers regarding the payments made to FWCIGA and the amounts collected from policyholders. It provides that assessments paid that are required to be remitted by the insurer prior to surcharging policyholders constitute advances of funds to FWCIGA to allow for proper accounting treatment. The bill also makes other technical and structural changes to the statutes controlling FIGA and FWCIGA.

This bill does not impact local or state government revenues or expenditures. It has positive and negative direct economic impacts on the private sector.

This bill has an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Guaranty Associations

Under federal law, insurance companies cannot file for bankruptcy.[1] Instead, they are either rehabilitated or liquidated by their state of domicile. Florida law establishes the system for the treatment of impaired or insolvent insurers[2] in Florida and sets up guaranty payments where necessary.[3] Florida law provides for guaranty associations to ensure policyholders of insolvent insurers are protected with respect to insurance premiums paid and settlement of outstanding claims, up to limits provided by law.[4] A guaranty association is a not-for-profit corporation created by law and directed to protect policyholders from financial losses and delays in claims payment and settlements due to the insolvency of an insurer.[5] Insurers are required to participate in the guaranty associations as a condition of transacting insurance business in Florida. Florida operates four guaranty associations including the Florida Insurance Guaranty Association (FIGA)[6] and the Florida Workers' Compensation Insurance Guaranty Association (FWCIGA)[7].

Florida Insurance Guaranty Association

FIGA provides a "mechanism for the payment of covered claims under certain insurance policies to avoid" delay and financial loss due to the financial insolvency of an insurer.[8] It issues guaranty fund payments and provides related services for all lines of property and casualty insurance with certain exceptions.[9] When a Florida property and casualty insurer becomes insolvent, FIGA takes over the claims of that insurer and pays the claims of its policyholders, ensuring that policyholders are not left with unpaid claims. FIGA obtains funds to pay the claims of insolvent insurers located in Florida from the liquidation of the assets of insolvent insurers by the Division of Rehabilitation and Liquidation (the Division) in the Florida Department of Financial Services (DFS) and from the liquidation of assets of insolvent insurers located outside Florida that transact insurance business in Florida.[10]

If an insurer's assets are insufficient to pay all claims, FIGA can also issue post-insolvency assessments against property and casualty insurers to obtain funds to pay the remaining claims.[11] Currently, the Florida statute setting forth FIGA's duties and powers states that assessments on members of FIGA are "initially estimated in the proportion that each insurer's net direct written premiums [in Florida] in the classes protected by the account bears to the total of said net direct written premiums received [in Florida] by all such insurers for the preceding calendar year for the kinds of insurance included in such account."[12] Furthermore, each insurer assessed must be provided with at

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[1] 11 U.S.C. § 109(b)(2).
[2] An "insolvent insurer" means an insurer that was authorized to transact insurance in this state, either at the time the policy was issued or when the insured event occurred, and against which an order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction if such order has become final by the exhaustion of appellate review. S. 631.904(4), F.S.
[3] Ch. 631, F.S.
[4] *Id.*
[5] *See e.g.,* ss. 631.51 and 631.902, F.S.
[6] Ch. 631, part II, F.S.
[7] Ch. 631, part V, F.S.
[8] S. 631.51, F.S.
[9] S. 631.52, F.S.
[10] *See* s. 631.061, F.S. for grounds for liquidation. *See* s. 631.025, F.S., for an overview of persons subject to proceedings initiated by the Division.
[11] S. 631.57, F.S.
[12] S. 631.57(3)(a), F.S. Stated differently, an insurer's assessment amount would be estimated by determining its part of the whole of the premium written for the prior year for the kinds of insurance included in a certain account and multiplying that proportion by the entire assessment amount to be collected. For example, if FIGA was assessing its auto insurance account, an auto insurer's

least 30 days' written notice as to the date the initial assessment payment is due.[13] When FIGA issues an assessment, it has the option to require that member insurers pay the assessment in a single payment or to allow the member insurers to pay assessment payments in monthly installments, with the first installment being due at the end of the monthly following the levy of an assessment.[14]

When an insolvent insurer is liquidated in Florida, FIGA assumes the claims and is "deemed the insurer to the extent of its obligation on...covered claims, and,...shall have all rights, duties, defenses, and obligations of the insolvent insurer as if the insurer had not become insolvent."[15] Additionally, FIGA has the right to employ the necessary staff to handle claims and perform other duties for the association.[16] In general, when an insolvent insurer located in another state is liquidated, the claims in that state are referred to its guaranty association for claims handling. However, FIGA handles claims that exist on policies issued in Florida by insolvent foreign insurers.[17] Due to the nature of the claims process and the involvement of more than one state's guaranty association in these claims, it may be appropriate and efficient for an employee of another state's guaranty association to adjust a Florida claim.

Effect of the Bill

Adjusting

The bill allows employees of FIGA to adjust losses for FIGA if those employees hold a license in Florida that allows them to adjust losses or if they held such a license within the last ten years.[18] It also allows FIGA to authorize employees of any state guaranty association whose insurance regulators are members of the National Association of Insurance Commissioners to adjust Florida claims for FIGA.[19] While the bill does not require that the employee adjusting losses be a licensed insurance adjuster in Florida, the employee must maintain appropriate experience and training to adjust claims, and the authorization for the state guaranty association's employee to adjust losses must be included in the contract between FIGA and the state guaranty association whose employee is doing the adjusting. This provision of the bill will allow FIGA and other states' guaranty associations to efficiently provide continuity of claims handling and adjusting claims within Florida and when claims cross state lines.

Assessments

The bill removes the word "net" from "net direct written premium" to use the more common industry terminology of "direct written premium." It also eliminates dividends paid or credited to policyholders from being subtracted from the premium amount when direct written premiums are calculated. To simplify the explanation of the way in which a FIGA member insurer's assessment amount is calculated, the bill eliminates the language from s. 631.57(3)(a), F.S., that requires a determination of each insurer's proportion of net direct written premiums to the total of net direct written premiums received during the preceding calendar year for the kinds of insurance included within an account. Instead, the assessment due will be a uniform percentage of premium collected.

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assessment would be estimated by determining its share of the entire auto insurance premium written during the prior year and multiplying that by the total assessment amount to be collected.

[13] S. 631.57(3)(a), F.S.

[14] S. 631.57(3)(e)3 and (f)2, F.S.

[15] S. 631.57, F.S.

[16] *Id.*

[17] A foreign insurer is one formed under the laws of any state, district, territory, or commonwealth of the United States other than Florida. S. 624.06, F.S.

[18] DFS has indicated that the licensure status of the person determining the amount of loss (i.e., adjusting a claim) has no bearing on the contractual obligations of the insurer from a regulatory standpoint. Therefore, an insured whose claim is being handled by FIGA by virtue of an insurer insolvency and whose claim was adjusted by an unlicensed employee of FIGA or another state's guaranty association does not lose any rights or remedies should that insured dispute the amount of loss as determined by the adjuster. Email from Greg Thomas, Director Division of Agents and Agency Services, Department of Financial Services, RE: HB 429 (Feb. 14, 2019).

[19] *Id.*

For clarity, the bill moves the portion of s. 631.57(3)(a), F.S., which requires that FIGA provide each insurer with at least 30 days' written notice as to the date the initial assessment payment is due to s. 631.57(3)(f)1.b, F.S. Notice of an initial payment due date would not apply when the assessment is being paid in a single payment. The bill establishes that when FIGA allows for assessments to be paid in installments, those payments maybe be made in quarterly, rather than monthly installments. The bill also provides for other technical and structural changes and conforms statutory cross-references as needed.

Florida Workers' Compensation Insurance Guaranty Association

FWCIGA "provides a mechanism for the payment of covered claims under chapter 440 to avoid" delay and financial loss to claimants due to the insolvency of a workers' compensation insurer.[20] FWCIGA services workers' compensation claims against insolvent workers' compensation insurers[21] and self-insurance funds.[22] When a workers' compensation insurer or self-insurance fund becomes insolvent, FWCIGA takes over the claims of that insurer and pays the claims of its policyholders, ensuring that policyholders are not left with unpaid claims. Like FIGA, FWCIGA is funded through the liquidation of insolvent insurers, including a portion of the estates of insolvent insurers in other states. If the assets of the liquidated insurer are insufficient to pay claims, FWCIGA in conjunction with the Office of Insurance Regulation (OIR), may order assessments of workers' compensation insurers and self-insurance funds writing workers' compensation coverage in Florida.[23] FWCIGA levied assessments from its inception in 1998 through 2005.[24] On June 18, 2019, the FWCIGA Board of Directors certified the need for a 1.0% assessment on its member insurers.[25] Subsequently, OIR issued a 1.0% assessment levy on all new and renewal workers' compensation policies with effective dates beginning January 1, 2020, through December 31, 2020.[26] These assessment payments will be due to FWCIGA quarterly after applying and collecting a 1.0% surcharge to all workers' compensation and excess workers' compensation policies.[27]

Method of Assessment

In 2016, the method of assessment for FWCIGA was amended to be more consistent with the methods used to levy assessments on the other Florida guaranty associations.[28] Since the 2016 amendments, the law has provided for two methods by which FWCIGA can collect assessments from workers' compensation insurers and self-insurance funds.[29] FWCIGA may choose to fund an assessment by either of the following methods:[30]

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[20] S. 631.902, F.S.

[21] "'Insurer' means an insurance carrier or self-insurance fund authorized to insure under chapter 440. For purposes of this act, "insurer" does not include a qualified local government self-insurance fund, as defined in s. 624.4622, or an individual self-insurer as defined in s. 440.385." S. 631.904(5), F.S.

[22] "'Self-insurance fund' means a group self-insurance fund authorized under s. 624.4621, a commercial self-insurance fund writing workers' compensation insurance authorized under s. 624.462, or an assessable mutual insurer authorized under s. 628.6011. For purposes of this act, the term "self-insurance fund" does not include a qualified local government self-insurance fund, as defined in s. 624.4622, an independent educational institution self-insurance fund as defined in s. 624.4623, an electric cooperative self-insurance fund as described in s. 624.4626, or an individual self-insurer as defined in s. 440.385." S. 631.904(6), F.S.

[23] S. 631.914, F.S.

[24] Florida Workers' Compensation Insurance Guaranty Association, *Assessments*, https://fwciga.org/assessments (last visited Oct. 30, 2019).

[25] *Id.* Pursuant to s. 631.914(4)(a), F.S., an insurer may be exempted from an assessment if, in the opinion of OIR, the assessment would impair the solvency of the insurer.

[26] *Id.*

[27] *Id.*

[28] Ch. 16-170, Laws of Fla.

[29] *See* s. 631.914, F.S.

[30] *See id.*

- Single payment, subject to true-up (pay and recover)[31] – under this method, the insurer pays the assessment to the FWCIGA and then recovers its payment from its insureds through policy surcharges. The assessment payment is due and payable no earlier than 30 days following written notice of the assessment order. For accounting purposes, the billed surcharges are a receivable and an asset for the purposes of the National Association of Insurance Commissioners' Statement of Statutory Accounting Principles Number 4[32] and would be recorded separately from the liability for OIR reports.
- Installment (collect and remit) – under this method, the insurer would bill the insured for the surcharge as policies are written and remit the collected surcharges to the FWCIGA quarterly.[33]

The insurer is required to submit a reconciliation report within 120 days following the end of the 12 month assessment recovery period showing the amount initially paid and the amount of the surcharge collected.[34] This results in a "true-up" of the actual assessment amount if the initial calculation and payment was too low or too high.[35]

Calculation of Insurer Assessment Amount

OIR, upon certification of need by FWCIGA, levies assessments on each insurer "initially estimated in the proportion that the insurer's net direct written premiums" in Florida bear to the total net direct premiums received in Florida by all workers' compensation insurers during the previous calendar year.[36] The assessments levied against insurers and self-insurance funds are computed based upon the net direct written premium amounts set forth in Florida for workers' compensation insurance without consideration for any discount in premium or credit for deductibles.[37]

The assessment is limited to 2 percent of an insurer's or self-insurance fund's net direct written premium in any given calendar year.[38] If the assessment is insufficient to meet FWCIGA's funding need for payments owing to claimants in a calendar year, then, upon certification by FWCIGA, OIR shall levy assessments of up to an additional 1.5 percent of the insurer's net direct written premiums in Florida.[39] Insurers and self-insurance funds must report to FWCIGA the amount of initial payment or installment payments made to FWCIGA and the amount collected from policyholders.[40] The reporting must occur within 120 days after the 12-month assessment period and annually thereafter for 3 years.[41]

Effect of the Bill

The bill clarifies the method by which assessments are levied against insurers and collected by FWCIGA, by providing that OIR shall levy the uniform surcharge percentage on all policies of the same kind or line as it considered in determining an insurer's assessment liability, along with an insurer using this method to fully recoup assessments from policyholders.

The bill clarifies that no insurer's direct written premium calculated for the purposes of determining its premium subject to surcharge will be reduced by any discount or credit for deductibles in any policy.

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[31] S. 631.914(1)(d), F.S.
[32] *See* National Association of Insurance Commissioners & The Center for Insurance Policy and Research, *Statutory Accounting Principles*, http://www.naic.org/cipr_topics/topic_statutory_accounting_principles.htm (last visited Oct. 30, 2019).
[33] S. 631.914(1)(d), F.S.
[34] S. 631.914(1)(d)3., F.S.
[35] *Id.*
[36] S. 631.914(1)(a), F.S.
[37] *Id.*
[38] *Id.*
[39] S. 631.914(1)(c), F.S.
[40] S. 631.914(1)(a)d.3., F.S.
[41] *Id.*

It also does not reduce an insurer's direct written premium calculated for the purposes of determining the insurer's premium subject to surcharge for any premium adjustment on retrospectively rated policies.[42]

The bill provides the authority for FWCIGA to audit the reports from insurers regarding the payments made to FWCIGA and the amounts collected from policyholders. It provides that assessments paid by workers' compensation insurers constitute advances of funds to FWCIGA under certain circumstances to allow for proper accounting treatment.

The bill removes the word "net" from "net direct written premium" to use the more common industry terminology of "direct written premium." The bill provides for other technical and structural changes and conforms statutory cross-references as needed.

B. SECTION DIRECTORY:

Section 1. Creates s. 626.8621, F.S., relating to adjustments by guaranty association employees.

Section 2. Amends s. 631.54, F.S., relating to definitions.

Section 3. Amends s. 631.57, F.S., relating to powers and duties of the association.

Section 4. Amends s. 625.012, F.S., relating to "assets" defined.

Section 5. Amends s. 631.59, F.S., relating to duties and powers of department and office.

Section 6. Amends s. 631.59, F.S., relating to board of directors.

Section 7. Amends s. 631.914, F.S., relating to assessments.

Section 8. Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

[42] A retrospectively rated policy in one with a rating plan that adjusts the premium to reflect current loss experience of an insured. IRMI, *Retrospective Rating*, https://www.irmi.com/term/insurance-definitions/retrospective-rating (last visited Oct. 30, 2019).

Changing the method by which FWCIGA calculates assessments may increase costs for certain employers and decrease costs for others based on the changes to treatment of premium discounts and credits, or premium adjustments in calculating assessments. However, the modification to the calculation does not change the total amount assessed by FWCIGA.

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:

The bill neither authorizes nor requires administrative rulemaking.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to insurance guaranty associations; creating s. 626.8621, F.S.; authorizing an employee of the Florida Insurance Guaranty Association or an employee of a guaranty association of another state to adjust losses for the Florida Insurance Guaranty Association if certain conditions are met; amending s. 631.54, F.S.; defining the term "direct written premiums" rather than the term "net direct written premiums"; amending s. 631.57, F.S.; deleting a provision specifying the manner in which the Office of Insurance Regulation initially estimates assessments levied on insurers; deleting a provision specifying the timeline to address notices of such assessments; conforming provisions to changes made by the act; requiring certain assessments to be made quarterly rather than monthly; revising the calculation of insurers' initial payments to the association; amending ss. 625.012, 631.59, and 631.912, F.S.; conforming provisions to changes made by the act; amending s. 631.914, F.S.; revising requirements for the office in levying workers' compensation insurers; providing that an insurer's direct written premium may not be reduced by certain amounts for the purposes of determining insurer assessments or policy surcharges;

authorizing the Florida Workers' Compensation Insurance Guaranty Association to audit certain reports; revising requirements for remitting policy surcharges and assessments; providing that assessments paid by an insurer constitute advances of funds to the association under certain circumstances; revising the requirements for the insurers' reconciliation reports to the Florida Workers' Compensation Insurance Guaranty Association; revising construction; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 626.8621, Florida Statutes, is created to read:

626.8621 Adjustments by guaranty association employees.—

(1) An employee of the Florida Insurance Guaranty Association, created under part II of chapter 631, may adjust losses for the association if such employee holds, or has held within the past 10 years, licensure in this state which allows for the adjustment of such losses.

(2) An employee of a guaranty association established by another state and whose insurance regulators are members of the National Association of Insurance Commissioners may adjust losses for the Florida Insurance Guaranty Association. The

authorization for such employees to adjust losses must be included in a contract with the Florida Insurance Guaranty Association and the employee's guaranty association or association's authorized representative. The Florida Insurance Guaranty Association shall contract only for employees of other state guaranty associations who maintain the appropriate experience and training for adjusting such claims.

Section 2. Subsection (9) of section 631.54, Florida Statutes, is amended to read:

631.54 Definitions.—As used in this part:

(9) "~~Net~~ Direct written premiums" means direct gross premiums written in this state on insurance policies to which this part applies, less return premiums thereon ~~and dividends paid or credited to policyholders~~ on such direct business. The term ~~"Net direct written premiums"~~ does not include premiums on contracts between insurers or reinsurers.

Section 3. Paragraphs (a), (e), and (f) of subsection (3) of section 631.57, Florida Statutes, are amended to read:

631.57 Powers and duties of the association.—

(3)(a) To the extent necessary to secure funds for the respective accounts for the payment of covered claims, to pay the reasonable costs to administer such accounts, and to secure funds for the account specified in s. 631.55(2)(b) or to retire indebtedness, including, without limitation, the principal, redemption premium, if any, and interest on, and related costs

of issuance of, bonds issued under s. 631.695 and the funding of reserves and other payments required under the bond resolution or trust indenture pursuant to which such bonds have been issued, the office, upon certification of the board of directors, shall levy assessments, in accordance with subparagraph (f)1. or subparagraph (f)2.~~, initially estimated in the proportion that each insurer's net direct written premiums in this state in the classes protected by the account bears to the total of said net direct written premiums received in this state by all such insurers for the preceding calendar year for the kinds of insurance included within such account.~~ Assessments shall be remitted to and administered by the board of directors in the manner specified by the approved plan and paragraph (f). ~~Each insurer so assessed shall have at least 30 days' written notice as to the date the initial assessment payment is due and payable.~~ Every assessment shall be a uniform percentage. The assessments levied against any insurer may not exceed in any one calendar year more than 2 percent of that insurer's ~~net~~ direct written premiums in this state for the kinds of insurance included within such account.

(e)1. In addition to assessments authorized in paragraph (a), and to the extent necessary to secure the funds for the account specified in s. 631.55(2)(b) for the direct payment of covered claims of insurers rendered insolvent by the effects of a hurricane and to pay the reasonable costs to administer such

claims, or to retire indebtedness, including, without limitation, the principal, redemption premium, if any, and interest on, and related costs of issuance of, bonds issued under s. 631.695 and the funding of any reserves and other payments required under the bond resolution or trust indenture pursuant to which such bonds have been issued, the office, upon certification of the board of directors, shall levy emergency assessments upon insurers holding a certificate of authority. The emergency assessments levied against any insurer may not exceed in any one calendar year more than 2 percent of that insurer's ~~net~~ written premiums in this state for the kinds of insurance within the account specified in s. 631.55(2)(b).

2. Emergency assessments authorized under this paragraph shall be levied by the office upon insurers in accordance with paragraph (f), upon certification as to the need for such assessments by the board of directors. If the board participates in the issuance of bonds in accordance with s. 631.695, emergency assessments shall be levied in each year that bonds issued under s. 631.695 and secured by such emergency assessments are outstanding in amounts up to such 2-percent limit as required in order to provide for the full and timely payment of the principal of, redemption premium, if any, and interest on, and related costs of issuance of, such bonds. The emergency assessments are assigned and pledged to the municipality, county, or legal entity issuing bonds under s.

631.695 for the benefit of the holders of such bonds in order to provide for the payment of the principal of, redemption premium, if any, and interest on such bonds, the cost of issuance of such bonds, and the funding of any reserves and other payments required under the bond resolution or trust indenture pursuant to which such bonds have been issued, without further action by the association, the office, or any other party. If bonds are issued under s. 631.695 and the association determines to secure such bonds by a pledge of revenues received from the emergency assessments, such bonds, upon such pledge of revenues, shall be secured by and payable from the proceeds of such emergency assessments, and the proceeds of emergency assessments levied under this paragraph shall be remitted directly to and administered by the trustee or custodian appointed for such bonds.

3. Emergency assessments used to defease bonds issued under this part may be payable in a single payment or, at the option of the association, may be payable in quarterly ~~12 monthly~~ installments with the first installment being due and payable at the end of the month after an emergency assessment is levied and subsequent installments being due by the end of each succeeding month.

4. If emergency assessments are imposed, the report required by s. 631.695(7) must include an analysis of the revenues generated from the emergency assessments imposed under

this paragraph.

5. If emergency assessments are imposed, the references in sub-subparagraph (1)(a)3.b. and s. 631.695(2) and (7) to assessments levied under paragraph (a) must include emergency assessments imposed under this paragraph.

6. If the board of directors participates in the issuance of bonds in accordance with s. 631.695, an annual assessment under this paragraph shall continue while the bonds issued with respect to which the assessment was imposed are outstanding, including any bonds the proceeds of which were used to refund bonds issued pursuant to s. 631.695, unless adequate provision has been made for the payment of the bonds in the documents authorizing the issuance of such bonds.

(f)1. The association, office, and insurers remitting assessments pursuant to paragraph (a) or paragraph (e) must comply with the following:

a. In the order levying an assessment, the office shall specify the actual percentage amount to be collected uniformly from all the policyholders of insurers subject to the assessment and the date on which the assessment year begins, which may not begin before 90 days after the association board certifies such an assessment.

b. Insurers shall make an initial payment to the association before the beginning of the assessment year on or before the date specified in the order of the office. Each

insurer shall have at least 30 days' written notice as to the date on which the initial assessment payment is due and payable.

c. Insurers that have written insurance in the calendar year before the year in which the assessment is certified by the board shall make an initial payment based on the ~~net~~ direct written premium in this state for the classes protected by the account ~~amount~~ from the previous calendar year as set forth in the insurer's annual statement, multiplied by the uniform percentage of premium specified in the order issued by the office. Insurers that have not written insurance in the previous calendar year in any of the lines under the account which are being assessed, but which are writing insurance as of, or after, the date the board certifies the assessment to the office, shall pay an amount based on a good faith estimate of the amount of ~~net~~ direct written premium anticipated to be written in the subject lines of business for the assessment year, multiplied by the uniform percentage of premium specified in the order issued by the office.

d. Insurers shall file a reconciliation report with the association which indicates the amount of the initial payment to the association before the assessment year, whether such amount was based on ~~net~~ direct written premium contained in a previous calendar year annual statement or a good faith projection, the amount actually collected during the assessment year, and such other information contained on a form adopted by the association

and provided to the insurers in advance. If the insurer collected from policyholders more than the amount initially paid, the insurer shall pay the excess amount to the association. If the insurer collected from policyholders an amount which is less than the amount initially paid to the association, the association shall credit the insurer that amount against future assessments. Such payment reconciliation report, and any payment of excess amounts collected from policyholders, shall be completed and remitted to the association within 90 days after the end of the assessment year. The association shall send a final reconciliation report on all insurers to the office within 120 days after each assessment year.

e. Insurers remitting reconciliation reports under this paragraph to the association are subject to s. 626.9541(1)(e).

2. For assessments required under paragraph (a) or paragraph (e), the association may use a quarterly ~~monthly~~ installment method instead of the method described in sub-subparagraphs 1.b. and c. or in combination thereof based on the association's projected cash flow. If the association projects that it has cash on hand for the payment of anticipated claims in the applicable account for at least 6 months, the board may make an estimate of the assessment needed and may recommend to the office the assessment percentage that may be collected as a quarterly ~~monthly~~ assessment. The office may, in the order

levying the assessment on insurers, specify that the assessment is due and payable quarterly ~~monthly~~ as the funds are collected from insureds throughout the assessment year, in which case the assessment shall be a uniform percentage of premium collected during the assessment year and shall be collected from all policyholders with policies in the classes protected by the account. All insurers shall collect the assessment without regard to whether the insurers reported premium in the year preceding the assessment. Insurers are not required to advance funds if the association and the office elect to use the quarterly ~~monthly~~ installment option. All funds collected shall be retained by the association for the payment of current or future claims. This subparagraph does not alter the obligation of an insurer to remit assessments levied pursuant to this subsection to the association.

Section 4. Paragraph (b) of subsection (15) of section 625.012, Florida Statutes, is amended to read:

625.012 "Assets" defined.—In any determination of the financial condition of an insurer, there shall be allowed as "assets" only such assets as are owned by the insurer and which consist of:

(15)

(b) Assessments levied as ~~monthly~~ installments pursuant to s. 631.57(3)(e)3. or s. 631.914 which are paid after policy surcharges are collected so that the recognition of assets is

based on actual premium written offset by the obligation to the Florida Insurance Guaranty Association or the Florida Workers' Compensation Insurance Guaranty Association, Incorporated.

Section 5. Subsection (3) of section 631.59, Florida Statutes, is amended to read:

631.59 Duties and powers of department and office.—

(3) The office shall, upon request of the board of directors, provide the association with a statement of the ~~net~~ direct written premiums of each member insurer.

Section 6. Subsection (1) of section 631.912, Florida Statutes, is amended to read:

631.912 Board of directors.—

(1) The board of directors of the corporation shall consist of 11 persons, 1 of whom is the insurance consumer advocate appointed under s. 627.0613 or designee and 1 of whom is designated by the Chief Financial Officer. The department shall appoint to the board 6 persons selected by private carriers from among the 20 workers' compensation insurers with the largest amount of ~~net~~ direct written premium as determined by the department, and 2 persons selected by the self-insurance funds. The Governor shall appoint one person who has commercial insurance experience. At least two of the private carriers shall be foreign carriers authorized to do business in this state. The board shall elect a chairperson from among its members. The Chief Financial Officer may remove any board member for cause.

Each board member shall be appointed to serve a 4-year term and may be reappointed. A vacancy on the board shall be filled for the remaining period of the term in the same manner by which the original appointment was made.

Section 7. Subsections (1), (2), and (3) of section 631.914, Florida Statutes, are amended to read:

631.914 Assessments.—

(1)(a) To the extent necessary to secure the funds for the payment of covered claims, and also to pay the reasonable costs to administer the same, the Office of Insurance Regulation, upon certification by the board, shall levy assessments on each insurer ~~initially estimated in the proportion that the insurer's net direct written premiums in this state bears to the total of said net direct written premiums received in this state by all such workers' compensation insurers for the preceding calendar year~~. Assessments levied against insurers and self-insurance funds pursuant to this paragraph must be computed and levied on the basis of ~~the full policy premium value on~~ the ~~net~~ direct written premium amount as set forth in the state for workers' compensation insurance ~~without consideration of any applicable discount or credit for deductibles~~. An insurer's direct written premium calculated for the purposes of determining the insurer's assessment or policy surcharge may not be reduced by any discount or credit for deductibles in a policy or by any premium adjustment to a retrospectively rated policy. Insurers and self-

insurance funds must report premiums in compliance with this paragraph, and the association may audit the reports. Assessments shall be remitted to and administered by the board of directors in the manner specified by the approved plan of operation and paragraph (d). ~~Each assessment shall be a uniform percentage applicable to the net direct written premiums of each insurer writing workers' compensation insurance.~~ Assessments levied against insurers and self-insurance funds shall not exceed in any calendar year more than 2 percent of that insurer's ~~net~~ direct written premiums in this state for workers' compensation insurance.

(c)~~(b)~~ The office shall levy the uniform surcharge percentage on all policies of the same kind or line as were considered by the office in determining the assessment liability of the insurer. Member insurers shall collect policy surcharges at a uniform percentage rate on new and renewal policies issued and effective during the period of 12 months beginning on January 1, April 1, July 1, or October 1, whichever is the first day of the following calendar quarter as specified in an order issued by the office ~~directing insurers to pay an assessment to the association~~. The policy surcharge may not begin until 90 days after the board of directors certifies the assessment.

(b)~~(c)~~ If assessments otherwise authorized in paragraph (a) are insufficient to make all payments on reimbursements then owing to claimants in a calendar year, then upon certification

by the board, the office shall levy additional assessments of up to 1.5 percent of the insurer's ~~net~~ direct written premiums in this state.

(d) The association may use an installment method to require the insurer to remit the policy surcharge ~~assessment~~ as collected ~~premium is written~~ or may require the insurer to remit the assessment to the association before collecting the policy ~~policyholder~~ surcharge. ~~If the assessment is remitted before the surcharge is collected, the assessment remitted must be based on an estimate of the assessment due based on the proportion of each insurer's net direct written premium in this state for the preceding calendar year as described in paragraph (a) and adjusted following the end of the 12-month period during which the assessment is levied.~~

1. If the association elects to use the installment method, the office may, in the order levying the assessment on insurers, specify that the policy surcharge ~~assessment~~ is due and payable quarterly as collected ~~premium is written~~ throughout the assessment year. Insurers shall collect policy surcharges at a uniform percentage rate specified by order as described in paragraph (c) ~~(b)~~. Insurers are not required to advance funds if the association and the office elect to use the installment option. Assessments levied under this subparagraph are paid after policy surcharges are collected, and the recognition of assets is based on actual policy surcharges collected ~~premium~~

~~written~~ offset by the obligation to the association.

2. If the association elects to require insurers to remit the assessment before surcharging the policy ~~policyholder~~, the following shall apply:

a. On or before the date specified in the order of the office, insurers shall make an initial payment to the association of the percentage specified in the order multiplied by the insurer's direct written premiums received in this state for the preceding calendar year for the kinds of insurance included within such account before the beginning of the assessment year.

b.~~a.~~ The levy order shall provide each insurer so assessed at least 30 days' written notice of the date the initial assessment payment is due and payable by the insurer.

c.~~b.~~ Insurers shall collect policy surcharges at a uniform percentage rate specified by the order, as described in paragraph (c) ~~(b)~~.

d.~~c.~~ Assessments levied under this subparagraph and ~~are~~ paid by an insurer constitute advances of funds from the insurer to the association ~~before policy surcharges are billed~~ and result in a receivable for policy surcharges to be billed in the future. The amount of billed policy surcharges, to the extent it is likely that it will be realized, meets the definition of an admissible asset as specified in the National Association of Insurance Commissioners' Statement of Statutory Accounting

Principles No. 4. The asset shall be established and recorded separately from the liability. If an insurer is unable to fully recoup the amount of the assessment, the amount recorded as an asset shall be reduced to the amount reasonably expected to be recouped.

3. Insurers must submit a reconciliation report to the association within 120 days after the end of the 12-month assessment period and annually thereafter for a period of 3 years. The report must indicate the amount of the initial payment or installment payments made to the association and the amount of policy surcharges collected ~~written premium pursuant to paragraph (a)~~ for the assessment year. If the insurer's reconciled ~~assessment~~ obligation is more than the amount paid to the association, the insurer shall pay the excess policy surcharges collected to the association. If the insurer's reconciled ~~assessment~~ obligation is less than the initial amount paid to the association, the association shall return the overpayment to the insurer.

(2) Policy surcharges collected ~~Assessments levied~~ under this section are not premium and are not subject to any premium tax, fees, or commissions. Insurers shall treat the failure of an insured to pay policy ~~assessment-related~~ surcharges as a failure to pay premium. An insurer is not liable for any uncollectible policy ~~assessment-related~~ surcharges levied pursuant to this section.

(3) Assessments levied under this section may be levied only upon insurers. This section does not create a cause of action by a policyholder with respect to the levying of an assessment or a policyholder's duty to pay assessment-related policy surcharges.

Section 8. This act shall take effect July 1, 2020.