FEDERATION OF REGULATORY COUNSEL

FORC JOURNAL OF INSURANCE LAW AND REGULATION

SUMMER 2022 VOL. XXXIII, EDITION 2

THIS ISSUE'S MEMBER AUTHORS:

CYNTHIA J. BORRELLI, ESQ.
Bressler, Amery & Ross, P.C.

DANIEL A. COTTER, ESQ.
Howard & Howard Attorneys PLLC

JAMES S. GKONOS, ESQ.
Saul Ewing Arnstein & Lehr, LLP

FRED E. KARLINSKY, ESQ.
Greenberg Traurig, P.A.

INSIDE THIS ISSUE:

NEW JERSEY'S OUT OF NETWORK CONSUMER PROTECTION, TRANSPARENCY, COST CONTAINMENT, AND ACCOUNTABILITY ACT AS MODIFIED BY THE FEDERAL "NO SURPRISES ACT."

Cynthia J. Borrelli, Esq.
BRESSLER, AMERY & ROSS, P.C.
(973) 514-1200 | cborrelli@bressler.com

Introduction

The Out-Of-Network Consumer Protection, Transparency, Cost Containment, and Accountability Act, P.L. 2018, c. 32 (codified at N.J.S.A. 26:2SS-1 to -20), ("NJ Act"), was enacted on June 1, 2018, and became effective on August 30, 2018. In part, the NJ Act prohibits the practice of balance billing patients and increases transparency in medical billing. The purpose of the law is to protect patients from unexpected or "surprise" medical bills that sometimes arise when a patient unknowingly receives treatment from an out-of-network provider and is then billed for the difference between the provider's billed charges and reimbursement received from payers ***for services performed in emergency room/urgent and/or inadvertent care settings.***

Subsequently, on December 27, 2020, the No Surprises Act ("Federal Act"), as part of the Consolidated Appropriations Act ("CAA") of 2021 (P.L. 116-260)1, was enacted. The Federal Act took effect on January 1, 2022 and applies to health plans issued or renewed on or after January 1, 2022. Like the NJ Act, the Federal Acts establishes consumer protections against surprise billing ***for inadvertent and emergency out-of-network health care services.*** While the New Jersey Department of Banking and Insurance ("Department") issued a Bulletin (Bulletin No. 18-14, November 18, 2018) in lieu of regulations (now promised for nearly 4 years) to implement the NJ Act, with adoption of the Federal Act, the Department has updated its 2018 Bulletin and replaced it with Bulletin NO. 21-14 (December 30, 2021).

When The NJ Act Applies Verses The Federal Act

Generally, the NJ Act applies to fully insured plans, the State Health Benefit plans, and self-funded plans that have opted into being governed by the NJ Act. Beginning January 1, 2022, the new Federal Act will govern self-funded surprise bill claims that have not opted into NJ law and those fully insured claims for services not covered by the NJ Surprise Bill Act, such as post-stabilization care.

To the extent that the NJ Act applies, the Department will continue to enforce the NJ Act consistent with the guidance in Bulletin 18-14 as it relates to plans and circumstances subject to the NJ Act. ***New Jersey law applies so long as it does not prevent application of the Federal Act which merely sets a minimum standard applicable to all health plans, including self-funded plans, federal employee plans, and "grandfathered plans" (as that term is defined in the Affordable Care Act).*** Thus, with respect to federally regulated plans, the federal Departments (DHHS, DOL and Treasury) will enforce the Federal Act, which includes self-funded plans that have not opted into applicable portions of the NJ Act.

The federal Departments also will enforce provisions of the Federal Act with respect to particular services that are not governed by the NJ Act, such as air ambulances, and with respect to services rendered outside New Jersey.

Key Requirements of The NJ Act

The NJ Act outlines new requirements that affect health care professionals in the following areas:

- **Disclosure and notification:** Health care facilities and providers must disclose information regarding network status, medical codes, and estimated fees to patients before scheduling nonemergency procedures or elective services.
- **Balance billing prohibition:** Facilities and providers may no longer bill patients for costs exceeding their in-network deductible, copayment, or coinsurance when billing ***for medically necessary urgent or emergency services or inadvertent OON services.***
- **Mandatory assignment of benefits:** Whenever patients receive inadvertent emergency or OON services, it automatically results in the assigning of the benefits under the patient's carrier to the OON ***provider with no further action required by the patient.***
- **Arbitration process:** When carriers and providers disagree ***on an emergency or urgent medically necessary service or inadvertent OON service and the disputed amount exceeds $1,000, either party may initiate a binding arbitration process*** to resolve the issue if negotiations fail to resolve the payment dispute.
- **Prohibition of cost-sharing waiver:** No OON providers may waive or offer to waive all or a portion of a patient's deductible, coinsurance, or copayment to induce them to choose medical care from that provider. The prohibition does not apply to activities falling under federal safe harbors, which are legal provisions designed to provide protection from liability when meeting specific conditions

Out-of-Network Billing

As a critical tenet of the NJ Act, the Act prohibits providers from billing covered persons for inadvertent and/or involuntary out-of-network services for any amount above the amount resulting from the application of network level cost-sharing to the allowed charge/amount. See N.J.S.A. 26:2SS-7 to -9. ***Notably, covered persons cannot waive their rights under the NJ Act.*** Further, a provider does not render a covered person's decision to proceed with treatment from a provider a choice that "was not made knowingly "simply by disclosing the provider's network status. To the contrary, ***"Knowingly, voluntarily, and specifically selected an out-of-network provider" means that a covered person chose the services of a specific provider, with full knowledge that the provider is out-of-network with respect to the covered person's health benefits plan, under circumstances that indicate that covered person had the opportunity to be serviced by an in-network provider, but instead selected the out-of-network provider.*** See N.J.S.A. 26:2SS-3. Accordingly, waivers provided to covered persons in situations where inadvertent and/or involuntary out-of-network services may be provided does not remove those services from the purview of the Act, and ***thus, providers must not balance bill covered persons for inadvertent and/or involuntary out-of-network services even if those covered persons sign waivers for, or consent to, those services.***

Under the NJ Act, ***"Inadvertent out-of-network services"*** means health care services that are: covered under a managed care health benefits plan that provides a network; and provided by an out-of-network health care provider in the event that a covered person utilizes an in-network health care facility for covered health care services and, for any reason, in-network health care services are unavailable in that facility. ***"Inadvertent out-of-network services" shall include laboratory testing ordered by an in-network health care provider and performed by an out-of-network bio-analytical laboratory.*** See N.J.S.A. 26:2SS-3

While the provision of medically necessary services by an out-of-network urgent care or emergency facility clearly constitutes involuntary out-of-network services to which the arbitration provisions of the NJ Act (described below) will apply, importantly, any admissions into the same out-of-network facility resulting from the involuntary out-of-network services will also be subject to arbitration under the NJ Act up to the point when the covered person can be safely transported to an in-network facility, and including the means of transfer between facilities. Since all plans require providers and covered persons to notify the carrier within a certain number of days upon a facility admission, the carrier will have knowledge of such an involuntary out-of-network admission and be able to engage in utilization management. 6 If during such utilization management, the carrier authorizes a continued stay in the out-of-network facility past the date upon which the covered person can be safely transferred to an in-network facility, the services rendered after that determination will be considered an in-plan exception, and the services will not be subject to arbitration under the NJ Act. If the carrier does not authorize the continued stay in the out-of-network facility and requires transfer, but the covered person elects to stay at the out-of-network facility, the services rendered after the date of safe transfer would be considered voluntary out-of-network services and are not subject to arbitration under the NJ Act.

To the extent that the balance billing protections contained in the Federal Act extend beyond the state law balance billing prohibitions, the Department of Banking and Insurance has announced its intent to refer complaints or balance billing prohibitions to the federal Departments or relevant state regulatory agencies as appropriate.

Cost-Sharing Waivers

As a general rule, an out-of-network health care provider shall not directly or indirectly, knowingly waive, rebate, give, pay, or offer to waive, rebate, give, or pay all or part of a covered person's deductible, copayment, or coinsurance required under the person's health benefits plan as an inducement for the covered person to seek services from such out-of-network health care provider. See N.J.S.A. 26:2SS-15. A pattern of waiving, rebating, giving, or paying all or part of the deductible copayment or coinsurance by a provider shall be considered an inducement.

An out-of-network health care provider may waive, rebate, give, pay, or offer to waive rebate, give, or pay all or part of a covered person's deductible, copayment, or coinsurance required under the person's health benefits plan only **if:**

- the waiver, rebate, gift, payment, or offer falls within any safe harbor under federal laws related to fraud and abuse concerning patient cost-sharing, including as provided in any advisory opinions issued by the Centers for Medicare and Medicaid Services or the Office of Inspector General relating thereto;

OR

- the waiver, rebate, giving, payment, or offer thereof is not offered as part of any advertisement or solicitation; the out-of-network health care provider does not routinely waive, rebate, give, pay, or offer to waive rebate, give, or pay all or part of a covered person's deductible, copayment, or coinsurance required under the person's health benefits plan; and the out-of-network health care provider
    - waives, rebates, gives, pays, or offers to waive rebate, give, or pay all or part of a covered person's deductible, copayment, or coinsurance required under the person's health benefits plan after determining in good faith that the covered person is in financial need; or
    - fails to collect the covered person's deductible, copayment, or coinsurance after making reasonable collection efforts, which reasonable efforts shall not necessarily include initiating collection proceedings.

ID cards

The Federal Act requires that insurance cards issued to enrollees must have the following information:

- the applicable deductibles and out-of-pocket maximum limitations
- telephone number and website address for individuals to use in seeking Assistance. See 86 Fed. Reg. at 36,885. 5 See 86 Fed. Reg. at 36,877.

N.J.A.C. 11:22-8.3 contains certain similar requirements but will be amended to conform with the requirements in the Federal Act, including adding maximum out of pocket maximums and appropriate telephone and website address information. The Department has advised carriers to implement these requirements in good faith at the next opportunity to update Identification Cards.

The requirements contained in Bulletin 18-14 regarding self-funded opt-in information on the identification card remain operative. That Bulletin is linked here. https://www.state.nj.us/dobi/bulletins/blt18_14.pdf

Arbitration

The NJ Act creates an arbitration process pursuant to N.J.S.A. 26:2SS-10. The Federal Act created a separate Independent Dispute Resolution ("IDR") process that took effect January 1, 2022 and applies to nearly all private employer plans and individual insurance. Federal rules related to the IDR process, released on September 30, 2021, www.federalregister.gov/documents/2021/10/07/2021-21441/ establish the federal IDR process that out-of-network providers, including facilities and providers of air ambulance services, plans, ***and issuers in the group and individual markets*** may use to determine the out-of-network rate for applicable items or services after an unsuccessful open negotiation.

Notably, the federal guidance permits the application of the New Jersey law as it relates to state-regulated plans and self-funded plans that opt-in to the state arbitration process. Therefore, the arbitration process established in the NJ Act

will continue to apply to disputes relating to state regulated plans and self-funded plans that opt-in to the NJ Act. The state arbitration process under the NJ Act will continue as provided in Bulletin 18-14, while the federal IDR process will now apply to disputes relating to self-funded plans that did not opt in and in circumstances where the NJ Act does not apply.

Accordingly, a self-funded plan may continue to opt to be subject to the claims processing and arbitration provisions, as provided in Bulletin 18-14. A self-funded plan that previously opted into the New Jersey arbitration by filing an ID card with the Department may opt out of the NJ Act arbitration if it wishes to be subject to the federal IDR established under the Federal Act. ***If a self-funded plan wishes to opt-out of the NJ arbitration, notification should be sent to the Department at least two weeks in advance of such an opt-out taking effect.*** This informational filing should be submitted to the Department at the following email address: lifehealth@dobi.nj.gov.

With respect to out-of-network payment disputes between entities regulated under the NJ Act, such disputes continue to be subject to the state arbitration process. Any disputes between entities not regulated under the NJ Act, ***i.e., between a provider and a self-funded plan that has not opted-in to the NJ Arbitration provisions, and to services not covered by the NJ Act, i.e., air ambulance and services rendered out-of-state, may follow the federal IDR process.***

Under the NJ Act, where carriers and out-of-network health care providers cannot agree upon reimbursement for services, an arbitrator will choose between the parties' final offers. This is often referred to as "baseball or final offer arbitration" because ***the arbitrator must pick one or the other*** and cannot" split the baby" or settle somewhere in between the two offers. See N.J.S.A. 26:2SS-10. The rationale is that if both parties to the dispute understand these rules in advance, each will be reasonable in developing the offers to enhance the chances of the arbitrator selecting the offer.

Carrier Transparency And Disclosure Requirements

Broker Commission Disclosures Under The Federal Act

The Federal Act requires ***carriers*** offering individual health insurance coverage to disclose to enrollees prior to plan selection the amount of any direct or indirect compensation that the plan will pay to the agent or broker associated with that enrollment. This disclosure must also be included on any documentation confirming the enrollment. Issuers must also annually report this information to the Secretary of HHS. Such a requirement must be included in documentation to consumers as soon as possible after January 1, 2022. Each individual market carrier shall submit prior to sending to consumer a specimen of this disclosure document to the Department at the following email address: lifehealth@dobi.nj.gov

Transparency Under The NJ Act

The transparency provisions of the NJ Act apply to all carriers operating in New Jersey with regards to health benefits plans that are issued in New Jersey. Carriers are required to:

- maintain up-to-date website postings of network providers;
- provide clear and detailed information regarding how voluntary out-of-network services are covered for plans that feature out-of-network coverage;
- provide examples of out-of-network costs;
- provide treatment specific information as to estimated costs when requested by a covered person; and
- maintain a telephone hotline to address questions.

Attachment C to Bulletin No. 18-14 is a template ***Summary that carriers can use to provide the transparency disclosures required by the NJ Act.***

The Summary contains the following specific disclosures:

- How the plan covers medically necessary treatment on an emergency or urgent basis by out-of-network health care professionals and facilities, also known as involuntary out-of-network services;
- How the plan covers treatment by an out-of-network healthcare professional for services when a covered person uses an in-network health care facility (e.g. hospital, ambulatory surgery center, etc.) and, for any reason, in-network health care services are unavailable or rendered by out-of-network health care provider in that in-network facility, including laboratory testing ordered by an in-network provider and performed by an out-of-network bio-analytical laboratory;
- ***That a covered person's cost-sharing liability for inadvertent and/or involuntary out-of-network services is limited to the network level cost-sharing under the plan;***
- A description of the ability of carriers to negotiate and settle with out-of-network health care providers to pay less than the amount billed for inadvertent and/or involuntary out of -network services, and how that settlement may increase the covered person's cost-sharing liability above the amount indicated in the initial EOB;
- A description of the right of carriers and out-of-network health care providers to enter into binding arbitration for inadvertent and/or involuntary out-of-network services to determine the amount to be paid by the carrier for the such services where an agreement cannot be reached through negotiation and the provider does not accept the payment with the second EOB, including disclosures that the arbitration award will not increase the covered person's cost-sharing liability above the amount in the second EOB;
- How all plans cover treatment from out-of-network health care providers if in-network health care providers are not available in accordance with the applicable network adequacy standards and that the ability to access a provider through a request for an in-plan exception. Note that the denial of such request is an adverse benefit determination subject to internal and external appeals as discussed in Attachment A;
- If the plan is a preferred provider organization plan ("PPO") or point of service plan ("POS") that covers treatment when a covered person voluntarily seeks to use out-of-network health care providers for the provision of covered services, ***known as voluntary out-of-network treatment***, including: the cost-sharing applicable to voluntary out-of-network treatment and the carrier's basis for calculating the allowed charge/amount;
- How to obtain more information from the carrier regarding whether a provider is in-network, examples of

out-of-network costs, and how to estimate costs for out-of-network treatment for specific Current Procedural Terminology ("CPT") codes; and

- The internet website address(es) and telephone hotline number maintained by the carrier to provide information on out-of-network coverage and issues.

Carriers that elect to create their own disclosures must ensure that the above elements are contained in the disclosures. Carriers are also required to maintain an internet website that provides:

- the same information as set forth above for each health benefits plan offered by the carrier in New Jersey. See N.J.S.A. 26:2SS-6;
- a clear and prominent disclaimer that any estimates or examples provided by the carrier for out-of-network costs do not take into account the amounts that the covered person may have already paid for their cost-sharing liability that accumulate toward the MOOP. See N.J.S.A. 26:2SS-6;
- a clear and prominent disclaimer that out-of-network arbitration is only mandatory with respect to services provided by a provider that is licensed or certified in New Jersey. See N.J.S.A. 26:2SS-3; and
- information that enables prospective members to calculate the anticipated out-of-pocket costs for voluntary out-of-network services in a geographical region or zip code. See N.J.S.A. 26:2SS-6(b)(4). The provision of CPT code-specific disclosures of out-of-network allowed charges/amounts are only required for current covered persons and may be placed on members only portions of the carrier's website. See N.J.S.A. 26:2SS-6(b)(1), (2), (3), (5), and (7).

Carriers must also maintain a telephone hotline that is operated for at least 16 hours per day and staffed with at least one live representative capable of responding to questions about network status and out-of-pocket costs. See N.J.S.A. 26:2SS-6(b)(7).

Conclusions

The NJ Act has changed the landscape for OON medical practitioners regarding their billing practices and procedures. Carriers have also been impacted and need to assure claims payment practices in compliance with the NJ and Federal Acts, as applicable. Both constituencies need to be more knowledgeable and adept at identifying claims subject to the NJ Act and must comply with the time-sensitive requirements for handling these claims.

The time frames for negotiating and arbitrating surprise bill claims according to the statute specify that insurance carriers have 20 days to either pay the bill or notify the provider that the billed amount is excessive. The provider then has 30 days to dispute the proposed payment and negotiate a final reimbursement amount with the carrier.

In the event the payer and the provider are unable to resolve the payment amount, either party may initiate the "baseball-style" binding arbitration whereby the arbitrator must select one of the two final amounts submitted within 30 days.

THE INCREASINGLY COMPLEX LANDSCAPE FOR INSURERS ON PRIVACY

Daniel A. Cotter, Esq.
HOWARD & HOWARD ATTORNEYS PLLC
(312) 456-3674 | dcotter@howardandhoward.com

Insurers have long collected massive amounts of data from consumers, regardless of the line of business written. For decades, insurers have had to provide information about privacy collection practices and procedures and safeguards provided to consumers. In the 1990s, the Health Insurance Portability and Accountability Act (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH) came into effect, and the Gramm-Leach-Bliley Act (GLBA) soon followed. In recent years, New York and the National Association of Insurance Commissioners have promulgated additional privacy and cyber acts that specifically apply to the insurance industry.

However, in addition to the specific privacy acts that apply, the insurance industry also is subject to the emerging landscape of other privacy enactments at the state level. This article briefly summarizes the privacy developments in the insurance industry and then turns to the California Consumer Privacy Act of 2018,[1] as modified by the California Privacy Rights Act of 2020 (collectively, the CPRA), as well as other states' enactments, and the additional issues those present for insurers.[2]

History of Privacy in the United States

It is important to understand the nature of privacy rights in the United States and how those rights might be different than in the European Union or in some states, such as California. The word "privacy" is not found in any of the nation's founding documents. The Declaration of Independence refers to "certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness."[3] The Constitution also does not address privacy per se. The Supreme Court of the United States did find the right to privacy in the "penumbras" of the Constitution. In *Griswold v. Connecticut*[4], a case addressing the issue of whether the Constitution protected the right of marital privacy against state restrictions on a couple's ability to be counseled in the use of contraceptives, the Court, in a 7-2 decision written by Justice William O. Douglas, found that it did protect such a right. Douglas wrote:

> "The foregoing cases suggest that specific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance. See *Poe v. Ullman*, 367 U. S. 497, 367 U. S. 516-522 (dissenting opinion). Various guarantees create zones of privacy. The right of association contained in the penumbra of the First Amendment is one, as we have seen. The Third Amendment, in its prohibition against the quartering of soldiers 'in any house' in time of peace without the consent of the owner, is another facet of that privacy. The Fourth Amendment explicitly affirms the 'right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures.' The Fifth Amendment, in its Self-Incrimination Clause, enables the citizen to create a zone of privacy which government may not force him to surrender to his detriment. The Ninth Amendment provides: 'The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people.' The Fourth and Fifth Amendments were described in *Boyd v. United States*, 116 U. S. 616, 116 U. S. 630, as protection against all governmental invasions 'of the sanctity of a man's home and the privacies of life.' We recently referred in *Mapp v. Ohio*, 367 U. S. 643, 367 U. S. 656, to the Fourth Amendment as creating a 'right to privacy, no less important than any other right carefully and particularly reserved to the people.' See Beaney, The Constitutional Right to Privacy, 1962 Sup. Ct.Rev. 212; Griswold, The Right to be Let Alone, 55 Nw.U.L.Rev. 216 (1960)."[5]

Griswold has been used the last sixty years to protect other privacy rights for citizens of the United States.

Prior to *Griswold*, Louis Brandeis in 1890 wrote a paper, "The Right to Privacy,"[6] with his partner, Samuel Warren, that was published in the Harvard Law Review and was to have a profound effect on the body of jurisprudence going forward. They spoke of a zone of privacy, and Brandeis when he joined the Supreme Court as an associate justice would often advocate and write for findings of zones of privacy in various areas of the law. The Court would adopt his logic, culminating in the *Griswold* case.

Initial Considerations of Privacy

While privacy has not been deemed a fundamental right that is afforded to US citizens by our founding documents, the issue of privacy and protection of information has long been a concern, not only in the United States but worldwide.

A variety of privacy and cyber regulations and laws have been promulgated over the years. The origins and framework for privacy policies has been traced back to a 1980 gathering of the Organisation for Economic Co-operation and Development (OECD), an economic group of 34 countries. In a time when the Internet did not exist and smartphones were decades away in the future, the OECD established a set of principles that should be familiar to anyone who practices at all in privacy.

The Privacy Principles[7]

The OECD established set of principles that form the skeleton of any privacy laws we see today, including the CPRA. The principles established in 1980 for data privacy and protection are:

- Collection Limitation Principle
- Data Quality Principle
- Purpose Specification Principle
- Use Limitation Principle
- Security Safeguards Principle
- Openness Principle
- Individual Participation Principle
- Accountability Principle

The OECD framework and principles were designed taking into account the recognition of the fundamental right to

privacy that exists in many post-World War II constitutions, including the OECD members' constitutions.

The OECD framework would become the backbone or underpinnings for almost all privacy regimes that followed, including in the insurance industry.

State Insurance Regulation of Cybersecurity Programs

Beginning in 2015 or 2016, the NAIC began to take a closer look at cybersecurity and ransomware issues and began to consider a model law for the industry. In 2017, the New York Department of Financial Services (NYDFS) promulgated its program, beating the NAIC to it, and the NAIC soon followed suit.

On March 1, 2017, New York enacted a cybersecurity program.[8] The New York Cybersecurity Regulation applies to anyone "operating under a license, registration, charter, certificate, permit, accreditation or similar authorization" under the banking law, insurance law, or financial services law of the State of New York."

NAIC Model Insurance Data Security Model Law

In late 2017, after much discussion and in large part based on the New York Cybersecurity Regulation, the NAIC adopted the Model Insurance Data Security Model Law.[9] The NAIC model is similar in many ways to the NYDFS model, although it has some variation.

Rather quickly, eight states adopted the NAIC Model Law (often with modifications).[10] In 2020, three additional states adopted the Model Law: Virginia on March 10, 2020;[11] Indiana on March 20, 2020;[12] and, Louisiana on June 11, 2020.[13] In 2021, the number of states adopting the law continued to expand, with Hawaii being the latest, when Governor David Y. Ige signed the bill on June 28, 2021.[14] An additional six states adopted the model law in 2021:

- Maine—March 17, 2021;[15]
- North Dakota—March 2021;[16]
- Iowa—April 30, 2021;[17]
- Tennessee—May 6, 2021;[18]
- Minnesota—June 26, 2021;[19] and
- Wisconsin—July 15, 2021[20].

These actions bring the total number of states adopting the model law to eighteen. Illinois continues to consider adoption of the model, but has not done so to date. As of publication, the number remains 18 states.

Currently, insurance regulators focus on cybersecurity and privacy obligations of those companies that they regulate. We can expect additional states to become part of this continued adoption of the model law.

California Enters The Fray on a Pure Privacy Perspective

Like the European Union constitutions and some state constitutions, the California Constitution contains privacy protections for its residents. The California Constitution provides[21]:

> "All people are by nature free and independent and have inalienable rights. Among these are enjoying and defending life and liberty, acquiring, possessing, and protecting property, and pursuing and obtaining safety, happiness, and privacy."[22]

It is important to understand just how broad the California right to privacy is. California's right to privacy is wider than its federal counterpart in that it protects individuals not only against violations by state and federal government entities, but also against violations by other individuals and private companies. There is a judicial right of action conferred on all Californians for privacy violations. Like many rights in California, the California right to privacy was enacted by ballot measure in November 1972. At the time of the ballot initiative, Ronald Reagan was the Governor of California.

The CCPA

In June 2018, California's governor signed legislation that the California legislature passed, the CCPA.[23] The CCPA provided new privacy rights for California consumers, including:

- The right to know about the personal information a business collects about them and how it is used and shared
- The right to delete personal information collected from them (with some exceptions)
- The right to opt-out of the sale of their personal information -and-
- The right to non-discrimination for exercising their CCPA rights

When enacted, the act was referred to as the "toughest online privacy law" and the most "sweeping data privacy bill" and was compared to the EU General Data Protection Regulation. The bill was enacted hastily in order to thwart efforts for a variety of ballot initiatives. (That would not prevent the initiative from being on the ballot in 2020.)

On January 1, 2020, the landmark legislation went into effect. The CCPA provides groundbreaking protections for consumers in their ability to control the use of their personal data, and is intended to ensure the rights of Californians to: (1) know what personal information is being collected about them; (2) know whether their personal information is sold or disclosed and to whom; (3) say no to the sale of personal information; (4) access their personal information; and (5) receive equal service and price, even if they exercise their privacy rights. The California Attorney General is authorized to bring enforcement actions and set penalties pursuant to the law. And, as part of the implementation and enforcement of the law, the Attorney General was charged with promulgating interpreting regulations on or before July 1, 2020. The CCPA provides a private right of action for consumers, with statutory damages, for violations of the security requirement that result in an unauthorized disclosure of personal information.

On August 14, 2020, the California Office of Administrative Law approved and released the Final Regulations for the CCPA.[24] Before the Final Regulations were approved, the California Attorney General (AG) had already started to take enforcement steps against companies, sending out notices of noncompliance.

While the CCPA set forth the steps and procedures that companies holding consumers' information must take, the Final Regulations set forth in 28 pages what steps companies should take to comply. These steps include:

- Reviewing and updating privacy policy disclosures.
  - All policies should be reviewed and updated to disclose additional data privacy collection, use, disclosure and sale practices, and provide details on the business's verification and processing of requests, and financial incentives the business provides.
- Providing updated notice of collection of personal information.
  - Provide timely notice of collection and use of personal information to employees and consumers online, in-store and via mobile applications, and update that notice as collection practices change. (This is also a focus of Federal Trade Commission enforcement actions in recent years, with significant penalties assessed on those businesses that have practices different from those disclosed.)
- Reviewing and adjusting methods for accepting and responding to consumer requests.
- Ensure consistency with CCPA requirements
  - Ensure that sensitive personal information (i.e., Social Security numbers (SSNs), account passwords, biometric information, etc.) is never disclosed.
- Applying reasonable security controls to responses to consumer requests.
  - Specific security controls and measures are necessary to ensure that personal information provided to a consumer pursuant to a consumer request is subject to reasonable security procedures.
- Adhering to guidelines for verifying consumer requests.
  - The Final Regulations provide guidelines for verifying consumer requests for general as well as specific information.
- Establishing adequate recordkeeping.
  - Businesses must maintain records of CCPA consumer requests in a specific form for at least 24 months.
- Enabling notice to individuals with disabilities.
  - The Final Regulations address ensuring that the required notices regarding the business's privacy practices are reasonably accessible to consumers with disabilities.
- Confirming receipt of consumer requests.
  - Consistent with the CCPA, the Final Regulations require that businesses must respond to consumer requests within ten days of receipt, informing the consumer of the business's verification process and timing for response. Given the AG's recent activity, this likely will be closely monitored by California.

The CCPA and Final Regulations set forth onerous obligations on all companies, including insurers, who do business with California consumers. Anyone doing business in California should closely review the Final Regulations and seek guidance if questions arise. As noted, the California AG is busy addressing issues of noncompliance and more is likely to follow.

Jurisdictional Scope

The CCPA applies to a "business" dealing in the "personal information" of "consumers," with the CCPA broadly defining "personal information." A "consumer" is a natural person who is a "California resident." The CCPA defines personal information as:

> 'Personal information' [(PI)] means information that identifies, relates to, describes, is reasonably capable of being associated with, or could reasonably be linked, directly or indirectly, with a particular consumer or household. Personal information includes, but is not limited to, the following if it identifies, relates to, describes, is reasonably capable of being associated with, or could be reasonably linked, directly or indirectly, with a particular consumer or household:
>
> 1. Identifiers such as name, alias, address, unique personal identifier, IP address, email, account name, SSN, drivers license number, passport number, or other similar identifiers.
> 2. Other PI under California law including physical description, telephone, insurance policy number, financial info, etc.
> 3. Characteristics of protected classifications under California and federal law.
> 4. Commercial information including purchasing history or tendencies.
> 5. Biometric information.
> 6. Internet or other electronic network activity information, including, but not limited to, browsing history, search history, and information regarding a consumer's interaction with an internet website, application, or advertisement.
> 7. Geolocation data.
> 8. Audio, electronic, visual, thermal, olfactory, or similar information.
> 9. Professional or employment-related information.
> 10. Education information, defined as information that is not publicly available personally identifiable information as defined in the Family Educational Rights and Privacy Act.[25]).
> 11. Inferences drawn from any of the information identified in this subdivision to create a profile about a consumer reflecting the consumer's preferences, characteristics, psychological trends, predispositions, behavior, attitudes, intelligence, abilities, and aptitudes."[26]

While the definition is extremely broad, the CCPA does not include in the definition publicly available information or consumer information that is deidentified or aggregate consumer information.

Given the nature of the internet and challenges presented by siloing off California, many consumer facing business have chosen to give CCPA-style rights to all US residents to have a uniform compliance program and to avoid the problem of establishing whether someone is a "California resident."

The Provisions and Applicability

The legislature listed a long set of reasons and purposes for why the CCPA was needed, including reference to the 1972

Constitution change that arose from the ballot initiative. The legislature found (italicization in original):

> The Legislature finds and declares that:
>
> (a) In 1972, California voters amended the California Constitution to include the right of privacy among the 'inalienable' rights of all people. The amendment established a legal and enforceable right of privacy for every Californian. Fundamental to this right of privacy is the ability of individuals to control the use, including the sale, of their personal information.
>
> (b) Since California voters approved the right of privacy, the California Legislature has adopted specific mechanisms to safeguard Californians' privacy, including the Online Privacy Protection Act, the Privacy Rights for California Minors in the Digital World Act, and Shine the Light, a California law intended to give Californians the 'who, what, where, and when' of how businesses handle consumers' personal information.
>
> (c) At the same time, California is one of the world's leaders in the development of new technologies and related industries. Yet the proliferation of personal information has limited Californians' ability to properly protect and safeguard their privacy. It is almost impossible to apply for a job, raise a child, drive a car, or make an appointment without sharing personal information.
>
> (d) As the role of technology and data in the every daily lives of consumers increases, there is an increase in the amount of personal information shared by consumers with businesses. California law has not kept pace with these developments and the personal privacy implications surrounding the collection, use, and protection of personal information.
>
> (e) Many businesses collect personal information from California consumers. They may know where a consumer lives and how many children a consumer has, how fast a consumer drives, a consumer's personality, sleep habits, biometric and health information, financial information, precise geolocation information, and social networks, to name a few categories.
>
> (f) The unauthorized disclosure of personal information and the loss of privacy can have devastating effects for individuals, ranging from financial fraud, identity theft, and unnecessary costs to personal time and finances, to destruction of property, harassment, reputational damage, emotional stress, and even potential physical harm.
>
> (g) In March 2018, it came to light that tens of millions of people had their personal data misused by a data mining firm called Cambridge Analytica. A series of congressional hearings highlighted that our personal information may be vulnerable to misuse when shared on the Internet. As a result, our desire for privacy controls and transparency in data practices is heightened.
>
> (h) People desire privacy and more control over their information. California consumers should be able to exercise control over their personal information, and they want to be certain that there are safeguards against misuse of their personal information. It is possible for businesses both to respect consumers' privacy and provide a high level transparency to their business practices."[27]

Among other things, the CCPA applies to any entity doing business in California that has gross revenues in excess of $25 million per year. If a company meets one of the following thresholds, the CCPA generally applies:

- Annual gross revenues of $25M or more;
- Buys, Receives, Sells, or Shares the PI of 50,000 or more consumers, households, or devices;
- Derives 50% or more of annual revenues from selling consumer's PI.

This broad definition means that many companies, including insurers, fall within the scope of the law. Although the CCPA also has an exemption for information that is already subject to certain federal laws, such as the GLBA and the (HIPAA), these other privacy laws and the CCPA are separate legal frameworks with different scopes, definitions, requirements, rights and remedies.

A key question businesses must address is whether they are "selling" information of consumers. Per the CCPA:

> "Sell," "selling," "sale," or "sold," means selling, renting, releasing, disclosing, disseminating, making available, transferring, or otherwise communicating orally, in writing, or by electronic or other means, a consumer's personal information by the business to another business or a third party for monetary or other valuable consideration.

Whether your organization is "selling" data is a critical question. If so, then the CCPA:

- Requires a Notice of Right to Opt-Out
- Requires additional disclosures in your privacy policy and other documentation
- Requires a "Do Not Sell My Personal Information" link on your homepage
- Requires the creation of an "opt-out" function

The CPRA

As noted, by ballot initiative, the CPRA was adopted. The CPRA expands the rights granted to California consumers under the CCPA and introduces some new privacy rights, including:

- The right to opt out of sharing of personal information. "Sharing" is defined as "sharing…or otherwise communicating orally, in writing, or by electronic or other means, a consumer's personal information by the business to a third party for cross-context behavioral advertising, whether or not for monetary or other valuable consideration," which essentially refers to interest-based advertising.
- The right to opt out of certain uses and disclosures of "sensitive personal information," which refers to personal information that reveals: a consumer's Social Security number, driver's license, state identification card, or passport number; a consumer's account log-in, financial

account, debit card, or credit card number in combination with a security or access code, password or credentials; a consumer's precise geolocation; a consumer's racial or ethnic origin, religious or philosophical beliefs, or union membership; the contents of a consumer's email and text messages, unless the business is the intended recipient of the communications; a consumer's genetic data; a consumer's biometric data, in certain circumstances; a consumer's health data; and data concerning a consumer's sex life or sexual orientation.

- The right to correct inaccurate personal information.
- The right to enhanced transparency about a business's information practices, including information about data retention periods.
- New rights with respect to the use of automated decision-making technology, including for profiling.

The threshold requirements referenced above changed somewhat under the CPRA, the new thresholds are:

- As of January 1 of the calendar year, the company exceeded $25 million in gross revenue in the preceding calendar year.
- The company buys, sells, or shares the personal information of 100,000 or more consumers or households.
- The company derives 50% or more of its annual revenue from selling or sharing consumers' personal information.

If any of the criteria above are satisfied, the company will be deemed a "business" under the CPRA.

The CPRA imposes new obligations on businesses, including requirements related to data retention, data minimization, and purpose limitation, as well as to forward deletion requests not only to service providers but also to contractors and third parties to which the businesses have sold or shared information. This will be a significant obligation. The law also mandates additional provisions that businesses must include in their contracts with service providers, contractors, and other third parties.

The CPRA also creates a new state agency, the California Privacy Protection Agency. Under the CPRA, this agency was authorized to begin exercising rulemaking authority July 1, 2021, or six months after the agency gives notice to the California AG that the agency will commence rulemaking. The CPRA is subject to 22 different categories of regulations, many with subparts, and final regulations must be adopted by July 1, 2022.

Insurer Considerations Under CCPA

At first blush, the CCPA appears to have exemptions that provide insurers with a pass on compliance. These exemptions include:

Health Information[28]. The CCPA exempts "medical information" governed by the Confidentiality of Medical Information Act and "protected health information" collected by a covered entity or business associate under HIPAA. In addition, health care providers and covered entities governed by HIPAA are exempt, to the extent the provider or covered entity maintains patient information in the same manner as medical information/protected health information.[29]

GLBA[30]. The CCPA exempts personal information collected, processed, sold or disclosed pursuant to the federal GLBA and implementing regulations. This exemption does not apply to the provisions granting consumers a private right of action.[31]

Driver's Privacy Protection Act[32]. The CCPA exempts personal information collected, processed, sold or disclosed pursuant to the Driver's Privacy Protection Act. This exemption does not apply to the provisions granting consumers a private right of action[33].

Notwithstanding these beneficial exemptions, insurers should carefully review the partial exemptions. Many insurers engage in information collection, processing and sale activities outside of the GLBA. The definitions in the two statutes are very different, with the CCPA defining personal information and consumer much more broadly than the GLBA. Also, the GLBA exemption does not apply to the private right of action provided under the CCPA. The private right of action allows consumers to seek statutory damages if the consumer's information "is subject to an unauthorized access, exfiltration, theft, or disclosure as a result of the business's violation of the duty to implement and maintain reasonable security procedures and practices.[34]" Despite exemptions, insurers are still subject under the CCPA to potentially significant damages if they experience a data breach.

Further, other jurisdictions have not robustly exempted insurance information to the same extent as the CCPA.

Other States

While California has the most robust laws in place for consumer protection of information, it is not the only state. Other states that have recently enacted broad consumer protection laws include: Colorado[35], Utah[36], Virginia[37], and Connecticut[38]. Many other states in coming months are expected to pass broad legislation. The four other states that have enacted laws similar to California are all relatively consistent, with tweaks among them. One thing that is not as robust as the CCPA is in the insurance exemptions provided above.

Conclusion

Insurers face an increasing amount of privacy obligations on them, from GLBA to the NYDFS and NAIC Model Law, to the increasing number of state enactments that apply to consumer data more generally. In the coming months, more privacy laws will be passed in the states, and insurers will have to keep abreast to comply with the rights of consumers to protections of their data.

---

[1] CAL CIV CODE § 1798.100 - ___.

[2] This article does not address statues such as the Biometric Information Privacy Act of Illinois, and other such statutes.

[3] THE DECLARATION OF INDEPENDENCE para. 2 (U.S. 1976) https://billofrightsinstitute.org/primary-sources/declaration-of-independence?gclid=Cj0KCQjw-pCVBhCFARIsAGMxhAf-rfKUo4UQZnQJSIBHyz4FyERwE6vhB8fgIsnfZg9lC4hLVAM3ujcaAjhLEALw_wcB

[4] 381 U.S. 479 (1965).

[5] *Id.*

[6] Samuel Warren and Louis Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193 (1890).

[7] ACKNOWLEDGEMENTS (oecd.org) https://www.oecd.org/sti/ieconomy/49710223.pdf

[8] N.Y. COMP. CODES R. & REGS. Tit. 23, § 500 (2017).

[9] National Association of Insurance Commissioner, Insurance Data Security Model Law, Model Laws, Regulations, Guidelines and Other Resources (2017), https://content.naic.org/sites/default/files/inline-files/MDL-668.pdf.

[10] The eight states are South Carolina, Ohio, Michigan, Mississippi, Alabama, Connecticut, New Hampshire, and Delaware.

[11] VA. CODE ANN. §§ 38.2-621 to 38.2-629 (2020).

[12] IND. CODE ANN. §§ 27-2-27-1 to 27-2-27-32 (2020).

[13] H.B. 614 (La. 2020).

[14] Act 112, SB 1100 (Haw. 2021); *see* Memorandum from State of Hawaii, Dep't of Com. & Consumer Affs. Ins. Div., Act 112, Relating to Insurance Data Security (July 12, 2021), https://cca.hawaii.gov/ins/files/2021/07/IC-Memo-2021-10L-Ins-Data-Security-Law_signed.pdf.

[15] ME. REV. STAT. ANN. Tit. 24-A, Ch. 24-B; *see also* State of Maine, An Act to Enact the Maine Insurance Data Security Act (Mar. 17, 2021), http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=HP0017&item=2&snum=130.

[16] N.D. CENT. CODE § 26.1-02.2, https://www.legis.nd.gov/cencode/t26-1c02-2.pdf.

[17] Iowa House File 719 (Apr. 30, 2021), https://www.legis.iowa.gov/legislation/BillBook?ga=89&ba=hf719.

[18] Tenn. HB0766 (2021), https://wapp.capitol.tn.gov/apps/BillInfo/Default.aspx?BillNumber=HB0766.

[19] Minn. HF 6 (2021), https://www.revisor.mn.gov/bills/bill.php?b=House&f=HF6&ssn=1&y=2021.

[20] Press Release, Wis. Office of Comm'r of Ins., Governor Evers Signs Law to Enhance Insurance Security Measures (July 15, 2021), https://oci.wi.gov/Pages/PressReleases/20210715CyberBillSigning.aspx (noting Governor's signing of Act 73).

[21] CA CONSt., art. I Declaration of Rights, § 1,

[22] *Id*.

[23] California Consumer Privacy Act of 2018.

[24] Final Regulation Text, Title 11. Law Division 1. Attorney General, Chapter 20. California Consumer Privacy Act Regulations.

[25] 20 U.S.C. Sec. 1232g; 34 C.F.R. Part 99.

[26] CAL. CIV. CODE § 1798.140(o).

[27] Bill Text - AB-1202 Privacy: data brokers. (ca.gov).

[28] .CAL. CIV. CODE § 1798.145(c)(1).

[29] CAL. CIV. CODE §1798.145(c).

[30] CAL. CIV. CODE § 1798.145(e); Gramm-Leach-Bliley Act (Public Law 106-102)

[31] Cal. Civ. Code §1798.145(e).

[32] CAL. CIV. CODE § 1798.145(f).

[33] *Id*.

[34] CAL. CIV. CODE §1798.150.

[35] SB21-190

Protect Personal Data Privacy.

[36] S.B. 227 Consumer Privacy Act.

[37] An Act to amend the Code of Virginia by adding in Title 59.1 a chapter numbered 52, consisting of sections numbered 59.1-571 through 59.1-581, relating to Consumer Data Protection Act.

[38] S.B. No. 6

ESG: The New Corporate Conscience for Insurers

A Practical Guidance® Practice Note by
James S. Gkonos, Saul Ewing Arnstein & Lehr, LLP

James S. Gkonos
Saul Ewing Arnstein & Lehr, LLP

This practice note explains the concept of ESG and its components, discusses the impact that ESG is having on insurers, summarizes the insurance industry's initial responses to ESG, and outlines compliance initiatives insurers should consider when addressing emerging ESG statutory and regulatory requirements.

Prior to the pandemic, "ESG" was barely a whisper, let alone the buzzword that it has evolved into today. Yet, many companies still inquire as to whether ESG is a "thing." ESG is here, and yes, Virginia, it is definitely a "thing." As an acronym, "ESG" stands for its component parts:

Environmental

Social

Governance

ESG has as its underpinnings the confluence of the growing concern about climate change and its effect on businesses, and the changing predilections of the newer generations, such as Millennials (the generation born between 1981 and 1996), Gen Z (the generation born between 1997 and 2012), and even Gen X (the generation born between 1965 and 1980).

For more information about ESG, see Environmental, Social, and Governance (ESG) Resource Kit.

Environmental – Climate Change

Climate change was the initial driver of what we now know as ESG. A Munich Re report showed the dramatic rise in catastrophe losses due to climate change. See Hurricanes, Cold Waves, Tornadoes: Weather Disasters in USA Dominate Natural Disaster Losses in 2021, Munich Re (Jan. 10, 2022). Such losses were $16.7 billion in 2010, rose to $111 billion in 2017 (Hurricanes Harvey, Irma, and Maria), increased to $166 billion in 2019 (with only $57 billion insured), and incrementally increased to $210 billion in 2020 (with only $82 billion insured). This dramatic increase in losses caused all businesses to focus on the effect of climate change in their operations and plans as time has progressed. In the Global Risks Report 2022 by the World Economic Forum (Jan. 11, 2022), respondents to the report's survey identified climate action failure and extreme weather as the two most severe risks to be encountered by the world economy.

The insurance business world was already recognizing the need to address climate change before the pandemic. However, a number of insurance companies, international brokers, and ratings agencies recently have been pushing climate change initiatives. In 2019, Zurich Insurance Group signed up to the Business Ambition pledge to reduce global temperature increases to under 1.5°C and has recently pledged to reduce emissions from operations by 70% by 2029. In 2020, Aviva committed to reduce its carbon footprint to net zero by 2040. Swiss Re has committed to achieving net zero emissions for its own operations by 2030, and committed to reduce carbon intensity by 35%

for corporate bonds and its equity portfolio by 2025. In 2021, Lloyd's of London committed to attaining operational and attributable gas emissions to net zero by 2050 at the latest. Also in 2019, Chubb Ltd. initiated its coal policy by which it promised to end new policies for companies that generate more than 30% revenues from thermal coal mining and to phase out existing coverage for those companies in the next year or two. In 2021, Chubb ended coverage on a pipeline project, the Trans Mountain tar sands expansion project. In the same time frame, Liberty Mutual Group committed to cut 50% of its scope one and scope two greenhouse gas (based on 2019 levels) by 2030. Marsh & McClennan initiated a D&O insurance initiative that would reward clients who met certain ESG criteria with enhanced terms and conditions. At least four major carriers have joined the initiative, including AIG, Berkshire Hathaway, Sompo International, and Zurich North America. Finally, AIG announced that it would no longer provide underwriting services and investments for the construction of any new coal-fired power plants, thermal coal mines, or oil sands. These are just a few of many such examples.

Social – Investor and Customer Pressure

In addition to concerns about the effect on climate change, the rise of the Millennials and Gen Z / Gen X as investors and customers has also impacted the focus on ESG factors. These younger generations are already having an impact in the way that insurance is sold and delivered as confirmed by the proliferation of technology ("Insurtech") companies and products. The effect of these generational views is also a driving factor in the ascendency of ESG. A CNBC report shows that sustainable investments by Millennials grew ten-fold from 2015 ($5 billion) to 2020 ($51.1 billion). See Alicia Adamczyk, Millennials Spurred Growth in Sustainable Investing for Years; Now, all Generations are Interested in ESG Options (May 21, 2021). A related study also showed that close to one-third of Millennials often use ESG-related investments, as compared to 19% of Gen Z, 16% of Gen X, and 2% of Baby Boomers. See Millennials are a Driving Factor in the Growth Behind ESG Investments, EFT Trends and Nasdaq (May 25, 2021). Many Millennials and Gen Zs seem to have common views on issues such as climate change and race. Millennials comprised 72.1 million people in the United States in 2019. Gen Z totaled 25.9% of the U.S. population that year.

In addition to their own wealth and investments, these two groups are likely to inherit approximately $30 trillion dollars from their older generation parents. Studies of Millennials have shown that:

- 86% are interested in impact investing
- 89% expect their financial advisors to vet a company's ESG factors and history before making an investment recommendation –and–
- 76% consider climate change to be a serious threat to society

Similarly, studies of Gen Z's show:

- 80% factor ESG into investment decisions
- Gen Z's are more likely to buy sustainable brands and are willing to pay more to do so –and–
- 28% see climate change as one of their greatest concerns

See Tiffany Robertson, Millennial and Gen Z Investors Grow to Embrace ESG Issues, The Impactivate (Dec. 7. 2021).

Given the potential impact of these potential investors and customers, it is therefore no surprise that the financial sector, including insurance companies, have begun to focus on the effect of ESG factors on their business.

The investment markets have mirrored the priorities of these younger generations. Another 2021 study found that:

- ESG assets under management could grow to $53 trillion—approximately one-third of all assets under management
- Europe accounted in 2020 for half of ESG assets, but the United States may overtake Europe by as early as 2022
- ESG exchange-traded funds would surpass $190 billion by the end of 2021 and could be as high as $1 trillion by 2025
- ESG debt market as of the end of 2020 was about $2.2 trillion, but was expected to grow to $11 trillion by 2025 –and–
- Organic growth of ESG debt is unlikely to slow and will be driven by companies, development projects, and central banks alike

See ESG assets may hit $53 trillion by 2025, a third of global AUM (Feb. 23, 2021).

As the younger generations attain more wealth, it appears that these trends will continue to develop.

Governance

An increase in the focus of governance is nothing new to the insurance sector. The initiation of the Corporate Governance Annual Disclosure Model Act (CGAD) and the Own Risk and Solvency Assessment Model Act (ORSA) as a part of the governance framework by the National

Association of Insurance Commissioners (NAIC) are only recent instances of an increased focus by regulators on the governance and forward-looking management necessary for insurance companies. While the "G" in ESG is not new, it does emphasize that the recognition of environmental and social factors in the business analysis is meaningless if it is not made a part of the fabric of a company's plans through adequate top-down governance.

See NAIC Model Laws, Regulations and Guidelines 305-1, §§ 1–10 and NAIC Model Laws, Regulations and Guidelines 305-1, State Adoption and NAIC Model Laws, Regulations and Guidelines 505-1, §§ 1–11 and NAIC Model Laws, Regulations and Guidelines 505-1, State Adoption.

For details about Corporate Governance Annual Disclosures and Own Risk and Solvency Assessments across the 50 states, see these topics in the drop down menu on the Insurance Practical Guidance **State Law Comparison Tool**.

Rating Agency Reaction

As these trends in climate change and generational shifts in investment focus were developing, rating companies also were endorsing ESG principles into their rating methodologies. In recent reporting, DBRS Morningstar announced that it is more formally including 17 ESG factors into its rating process:

> The assessment of environmental risks is a major component of DBRS Morningstar's analysis for the property and casualty (P&C) insurance business.

Five of those factors relate to the environment.

In that same report, the firm's head of global structured finance research further elaborated:

> What we're doing now is we're bringing these ESG factors forward and out so that they are identified and discussed [formally] in the ratings process. Where we find that one of these factors is involved and influential in determining our ratings, we will then be identifying that and detailing that in our press releases and ratings reports.

In an online letter directed to its clients, BlackRock Institutions announced its commitment to evaluating ESG "with the same rigor that it analyses traditional measures such as credit and liquidity risk."

At the end of 2020, AM Best reported that

> AM Best has refined its Best Credit Rating Methodology (BCRM) to enhance transparency as to how it contemplates ESG risks as part of the credit rating analysis. AM Best will continue addressing climate risk, innovation and enterprise risk management in the assignment of a rating.

See AM Best Clarifies How Insurers'' ESG Risks Are Considered in Credit Rating Process (December 21, 2020).

Consistent with its prior announcement, in 2021 AM Best reported that ESG factors were considered one of the drivers of 13% of its global ratings for the 12-month period ending in March 2021. AM Best indicated that in the majority of those cases, environment factors were the ESG driver.

See Impact of ESG Factors on AM Best's Rating Actions, AM Best (July 14, 2021).

Further, while Milliman is not a rating agency, it noted in a 2020 whitepaper that

> ESG considerations cannot be overlooked by insurers in today's environment, given the growing prominence of such issues. As awareness of sustainability increasingly influences customer demand and as regulatory attention to this area grows, insurers must ensure their positions on ESG matters are clear and that management are aligned to them. This will be increasingly important not only in order to maintain brand and reputation, but also to remain competitive as customer demand evolves.

See Claire Booth, Amy Nicholson, and Natasha Singhal, ESG Considerations in the Insurance Industry, Milliman (July 15, 2020) at page 8.

Regulatory Actions

An overview of the actions of insurance regulators around the world is really a tale of two cities. In the United States, regulator reaction has been slow to develop. In the European Union, the regulator activity has been very robust and world-leading.

U.S. Regulatory Actions

The U.S. regulatory reaction has been slow and primarily exploratory in nature. The Securities and Exchange Commissions has begun reviewing these issues and has:

- Requested comment on climate disclosure
- Enhanced its focus on climate-related disclosure in public company filings –and–
- Created an enforcement task force focused on climate and ESG issues

See SEC Response to Climate and ESG Risks and Opportunities (Oct. 26, 2021).

In a speech to the 2021 Society of Corporate Governance National Conference, SEC Commissioner Allison Herren Lee commented:

> We should consider whether public pledges on ESG issues are actually backed up by corporate action. That's part of my message . . . that substantive consideration of ESG should be meaningfully integrated into board oversight . . . [a]nd why I've previously suggested that our disclosure regime should provide investors with adequate information to test public pledges like these.

See A changing boardroom climate: insurance planning with ESG in mind (Sept. 24, 2021).

However, the SEC has not taken any formal action with regard to ESG principles.

Similarly, the National Association of Insurance Commissioners does not appear to have taken any action regarding ESG principles than to seek data from insurers on their disclosure of climate change risks. However, at least one state—New York—through its Department of Financial Services, has required that financial institutions, including insurers, must "start integrating the financial risks from climate change into their governance frameworks, risk management processes, and business strategies." Further, the department requires that such institutions

> conduct a risk assessment of the physical and transition risks of climate change, whether directly impacting them, or indirectly due to the disruptive consequences of climate change in the communities they serve and on their customers, such as business disruptions, out-migrations, loss of income and higher default rates, supply chain other disruptions, and changes in investor and consumer sentiments, and start developing strategic plans, including an outline of such risks, the impact on their balance sheets, and steps to be taken to mitigate such risks.

See New York Department of Financial Services Industry letter, Climate Change and Financial Risks (Oct. 29, 2020).

It is not clear what, if any, action the New York Department of Financial Services has taken to date to enforce this industry directive.

European Union

Unlike the United States, the European Union and such countries as United Kingdom have taken robust regulatory action. As it did with data security and privacy, the European Union has taken a leading role in setting standards for financial institutions to analyze and report ESG factors affecting their businesses. While it would take a practice note far longer than this to effectively describe in detail the specifics of the European Union regulatory scheme, a summary of the critical elements follows.

The Sustainable Finance Disclosure Regulation (SFDR) became effective on March 10, 2021. See Regulation EU 2019/2088. The regulation set forth the basic standards for sustainability-related disclosures in the financial services sector, which includes insurance companies. The aim of the SFDR is to provide investors with "accurate, fair, clear, not misleading" ESG information about products in the financial services sector. The SFDR complements the previous Non-Financial Reporting Directive (NFRD), (see Regulation 2014/95/EU), which required large companies to report on how their business affects the environment and the people they employ, as well as their customers. The NFRD was replaced and updated by the Corporate Sustainability Reporting Directive (CSRD), (see COM/2021/189) which introduces tougher reporting requirements and audits of ESG-related information. This group of regulations is supplemented and amended by the EU Taxonomy Regulation, Regulation 2020/852/EU, which provided the conceptual framework and vocabulary for the reporting requirements. To provide further clarity to the regulations, the Taxonomy Regulation permitted European Supervisory Authority (ESA's) draft regulatory technical standards (RTS) for additional disclosures on products using "environmental" taxonomy. Several draft RTS have been circulated for discussion, with the latest and proposed final RTS in October 2021. The RTS were expected to have an application date of July 1, 2022, but that date was later moved to January 1, 2023.

The SFDR imposed three types of disclosure requirements:

- Entity-level principal adverse impact assessments
- Pre-contractual and website product disclosure –and–
- Periodic product disclosure

As to the entity-level principal adverse impact assessments, companies are required to measure the adverse impact against certain core environmental (e.g., carbon emissions, energy consumption from nonrenewable sources) and social (e.g., gender pay gap, board gender diversity) indicators. Companies must compare the indicators against the prior year's assessment and identify the policies used to identify and prioritize the adverse impacts. The RTS initially contained 32 mandatory indicators and 18 additional indicators of which companies must report as against at least two.

The second SFDR reporting criteria, pre-contractual and website product disclosure, requires companies to show that their products promote environmental or social characteristics, or have sustainable investments

or reductions in carbon emissions as their objective. The required disclosures include the planned proportion of sustainable investments (and the split between environmentally and socially sustainable investments), an explanation of how the investments comply with the "do not significantly harm" principle set out in the SFDR and Taxonomy Regulation, and a list of the indicators used to measure the attainment of the environmentally and socially sustainable investments. The final RTS is supposed to provide a template for the presentation of this information. Finally, the SFDR and RTS require certain information to be provided on a company or firm's website, including how environmental, social, and sustainability indicators are tracked during the life of a product, the methodologies used to measure the attainment of the environmental or social characteristics, the data sources used, and any limitations to the methodologies and data.

The third SFDR reporting requirement relates to financial products promoting environmental and social characteristics. The information required to be reported includes the degree to which attainment of social and environmental characteristics occurred during the period, a list of the largest investments of the financial product, a breakdown of total investments, and actions taken within the reporting period to achieve the social and environmental characteristics.

EU reporting companies not only have to deal with this very complex set of reporting requirements, but also a new set of vocabulary as well. EU firms now have to become conversant with a whole new set of terms. As noted above, the EU Taxonomy Regulation provided the reporting framework and vocabulary for the SFDR. One main reporting and vocabulary item was for companies to report on whether their activities were "environmentally sustainable."

The Taxonomy Regulation requires that the activity substantially contributes to one or more of 12 different environmental objectives, which include:

- Climate change mitigation (e.g., reduces greenhouse gas emissions, uses renewable or carbon-neutral fuels)
- Sustainable use and protection of water and marine resources (e.g., protecting or restoring the marine environment)
- Transition to a circular economy (e.g., reusability, recyclability, or prolonging use of products)
- Preventing/controlling pollution –and–
- Protecting/restoring biodiversity and ecosystems

In addition, in order to be environmentally sustainable, the activity must do no significant harm to the environmental objectives (DNSH) and comply with minimum social safeguards (e.g., relating to human rights and international labor standards).

While EU companies are still trying to understand the ground rules, reporting formats, and myriads of acronyms of the SFDR, NFRD, CSRD, and the EU Taxonomy Regulation, the European Commission continues to move forward with other ESG initiatives, which could extend the application of ESG principles. Proposals are on the table to add climate change mitigation and adaptation covering nuclear and gas activities, provide additional framework around sustainable use and protection of water resources, increased disclosure obligations under the SFDR, extension of the NFRD to smaller companies, strengthening the enforcement of environmental criminal law, and encouraging investment in green bonds. Moreover, the EU Commission has signaled that it plans to submit draft legislation in 2022 for a mandatory supply chain due diligence law that would require EU businesses to investigate and mitigate the risk of forced labor in their operations and supply chains.

The summary above of EU activity on ESG is a brief and high level view of a complex and evolving regulatory scheme. What is clear, however, is that the EU is taking a very proactive view of ESG and is making recognition, reporting, and mitigation of ESG issues mandatory and a part of the fabric of everyday corporate life.

What Are U.S. Companies Doing?

As is evident from the initial question as to whether ESG is a "thing," there is a substantial amount of confusion regarding what companies are doing and should do. A 2021 study by PriceWaterhouseCoopers (PWC) showed that 75% of companies were only at the beginning of consideration of ESG issues. However, approximately 90% of S&P 500 companies published sustainability reports in 2019. See Annual Corporate Directors Survey, PriceWaterhouseCoopers (2021). Further, a recent article about a September 2021 survey conducted by OCEG (a corporate governance advocacy nonprofit) reported that while 78% of the respondents (530 corporate executives) thought ESG will have an impact on brand and reputation, only 48% thought ESG would affect their company's financial outcome. Of those same executives, 28% had no confidence that their organizations had mature, well-documented ESG capabilities. Thirty percent felt that they had minimal confidence in their company's ESG programs. Only nine percent were highly confident in their ESG capabilities. Notwithstanding the lack of confidence in the ESG planning capabilities, over 50% of the respondents

indicated that their companies already or will consider ESG factors in evaluating compensation for their executives. See Jessica DiNapoli, Most executives think their ESG programs fall short, survey finds (Sept. 15, 2021).

One of the critical issues facing companies is the lack of regulatory guidance and/or uniform reporting standards. This lack of uniformity and guidance was cited by companies as the top barrier to ESG reporting effectiveness in the PWC study. Similarly, over 70% of insurers and reinsurers in an AM Best survey called for more direction from regulators on ESG. See Best's Special Report: US Insurers Seeing Need to Adapt to Evolving ESG Demands, Survey Finds, Best's News & Research Service (Oct. 29, 2021). Indeed, the state attorneys general from New York and California have both written letters to the Securities and Exchange Commission asking for more guidance on ESG. This lack of uniformity is also an issue in the EU, where the final RTS purporting to provide a final framework and template to the SFDR are still under review and the implementation dates pushed off another year until 2023.

As with all corporate initiatives, companies must balance the initiative against growth and profitability targets. Quantification of potential return on investment of ESG goals is key and many companies are not confident in their forecasting ability. Adding to the potential inadequacy of forecasting is the lack of complete and consistent data. In the EU where the standards, while not finalized, are much more advanced and defined, data availability is incomplete and inconsistent. Data vendors do not have all the same data and vendor consensus is not very high. There is neither a great degree of standardization nor transparency to the methodologies used to score ESG elements. There are low levels of correlation due to individual and different calculation methodologies to determine ESG compliance. Compounding the problem is that ESG data providers are not regulated. See Adrian Whelan, SFDR Base Camp Reached: Now Comes the Hard Part, Brown Brothers Harriman (Mar. 29, 2021). With a near total lack of regulatory direction, the likelihood is that the issues of lack of data uniformity and scarcity is incrementally more problematic in the United States.

What Should U.S. Insurance Companies Do?

Notwithstanding the lack of action by U.S. regulators, ESG is clearly here to stay and must be dealt with by U.S. insurance companies. If the history of capital and privacy regulation repeats itself, the likelihood is that U.S. regulation ultimately will be closer to its EU counterpart than not. Even if U.S. regulation does not require material ESG disclosures, the competitive effect of European companies making such disclosures required by the EU, will effectively draft U.S. companies to make similar disclosures. Accordingly, U.S. companies should pay attention to the developments of ESG regulation in the EU.

Companies should start the process of developing ESG plans. Management should, if it has not already, reconsider its overall strategy and its view of the future to incorporate ESG principles and disclosure. A comprehensive analysis of ESG factors in the insurance business should be prepared. Law firms and consultants are available to assist in this process and consultants can be used to supplement company expertise. Many consultants and law firms are strengthening their bench strength to assist clients. For example, PWC announced that it intended to expand its ESG capabilities, hiring as many as 10,000 new personnel in this effort. Whether in conjunction with consultants and law firms, or not, insurance companies should incorporate ESG risk criteria in their underwriting and risk analysis.

It is not enough that companies begin to think about and incorporate ESG into their business plans. ESG targets have to be benchmarked, disclosed, and tracked over time and their success prioritized. The success of the business plans will be dependent upon the persistence and drive of senior management, who must dedicate adequate resources to the ESG initiatives. U.S. companies should begin to consider ESG-related disclosures and transparency. Companies should beware, however, of "greenwashing" (materially overstating or misrepresenting environmental or sustainability characteristics) as such statements will likely be heavily scrutinized by regulators. Consequently, any such disclosures will have to be backed by objective and reasonable information.

The evolution of ESG and its impact on the business plans and disclosures made by U.S. insurance companies is in its infancy and should be watched carefully by companies that do not want to be left behind or find themselves at a competitive disadvantage.

Related Content

Practice Notes

- Solvency Regulation Framework for United States Insurers
- Environmental Insurance as M&A Risk Management Tool
- Insurance M&A Transactions
- Political Risk Insurance: A Lender's Guide
- Political Risk Insurance: Issues to Consider When Submitting a Claim

Resource Kits

- Environmental, Social, and Governance (ESG) Resource Kit
- Insurance Regulatory Compliance Resource Kit
- International Insurance Issues Resource Kit

State Law Comparison Tool Topics

- Corporate Governance Annual Disclosures
- Own Risk and Solvency Assessment (ORSA)

James S. Gkonos, Counsel, Saul Ewing Arnstein & Lehr, LLP

Jim Gkonos focuses his practice of almost 40 years on insurance and reinsurance regulatory matters, contract and treaty interpretation and reinsurance disputes. As a former division general counsel of a large domestic property and casualty carrier, Jim has significant experience with the regulatory issues facing domestic carriers. Jim advises insurance and reinsurance companies on issues such as InsurTech, cybersecurity regulation, licensing, appointments, and compliance with the regulations applicable to the day-to-day operations of insurance companies, including corporate governance, cybersecurity, rates, advertising and social media. Jim also has substantial experience on issues relating to financial guarantees, surety bonds, and the intersection between insurance and the capital markets.

Jim also drafts reinsurance agreements and handles reinsurance disputes. He is a certified reinsurance arbitrator. He advises clients on the drafting of life and property and casualty reinsurance agreements, structures securitized international financial transactions backed by insurance guarantees, and advises clients on structuring reinsurance transactions involving SPVs and backed by capital market investments. In his previous role as division general counsel, he was responsible for drafting and interpreting the reinsurance treaties placed annually by the division and was involved in the commutation of hundreds of reinsurance treaties.

Jim also previously served for nine years as senior counsel advising the rehabilitator of one of the largest insurance insolvencies in the United States - *Mutual Fire Marine and Inland Insurance Company, In Rehabilitation*. As a result of his substantial experience with insurance insolvencies and runoffs, he frequently represents clients who have issues with insurance companies in runoff and liquidation. He also has substantial international experience in the restructure of financially impaired, insolvent or bankrupt entities. Jim also handled substantial litigation in the United Kingdom, Japan, China, Argentina, Brazil and the Virgin Islands and brings more than 30 years of domestic litigation experience to the Insurance Practice.

SPECIAL SESSION RECAP: FLORIDA LAWMAKERS TAKE ACTION TO ADDRESS THE STATE'S PROPERTY INSURANCE CRISIS

Fred E. Karlinsky, Esq.
GREENBERG TRAURIG, P.A.
(954) 768-8278 | karlinskyf@gtlaw.com

Timothy F. Stanfield, Esq.
GREENBERG TRAURIG, P.A.
(850) 425-8547 | stanfieldt@gtlaw.com

Christian Brito, Esq.
GREENBERG TRAURIG, P.A.
(954) 768-8279 | britoc@gtlaw.com

On April 26, 2022, Governor Ron DeSantis signed a proclamation calling on the Florida Legislature to convene for a special session to address the State's property insurance market crisis. The formal call from the Governor requested that the Legislature consider critical legislation which would focus on property insurance and reinsurance, changes to the Florida building code to improve affordability of property insurance, the Florida Office of Insurance Regulation, civil remedies, and appropriations

State of the Florida Marketplace

It is no secret that Florida's property insurance market is in crisis. Florida homeowners are faced with rising premiums, declining coverage, and fewer carrier alternatives. In some of the most extreme circumstances, some policyholders have found themselves scrambling to find coverage after receiving cancellation notices from their insurance carriers. As a result, the State's publicly-funded insurer of last resort, Citizens Property Insurance Corporation ("Citizens"), has grown to insure 883,333 policyholders as of May 2022—an increase of 273,195 policies since May of 2021. These figures highlight a concerning trend. Citizens' in-force policy count is quickly and consistently rising from its recent historic low of 419,475 in-force policies in October 2019 and is inching closer to the 1,000,000+ policy count figures that were prevalent from 2006 until January 2014. This comes as no surprise to industry experts who have watched as Citizens increasingly becomes the only choice for many Florida consumers as a result of carriers leaving the market.

It would be easy to simply blame Florida's historically challenging property insurance market on geographic and environmental causes, but the truth is that the crisis is largely man-made.

As was widely reported last session and was quoted in a letter from Commissioner David Altmaier to Chairman Blaise Ingoglia, Florida accounted for 76% of the nation's homeowner's insurance lawsuits[1]. However, Florida only accounts for 8% of the nation's homeowner's insurance claims according to a report from the Florida Office of Insurance Regulation ("FOIR").

The litigious environment in Florida has led to an increasing number of insolvencies in the past several years. Since 2014 eight property insurance companies have become insolvent and placed into liquidation by FOIR. In the last four months alone, four insurance companies writing homeowners coverage in Florida have gone insolvent, while numerous others have non-renewed policies or ceased writing new business in Florida, leaving tens of thousands of policyholders seeking coverage with limited options in the marketplace. In the last 60 days, at least one property insurer, Federated National, has gone into regulatory supervision due to an unacceptable financial stability rating, requiring them to cancel at least 70,000 policies. With the lack of capacity in the private market Citizens has become the only option for many Floridians.

During previous market downturns, Florida carriers were supported by capital infusions from investors that were willing to continue investing in Florida despite the hardships faced by carriers in the statewide marketplace. However, with the exception of Slide Insurance Company's assumption of St. John's Insurance Company's book of business, replacement capacity is not available to most struggling carriers this time around. Many view that as a signal that the current losses are too severe for the marketplace to handle on its own and new capital will wait on the sidelines until the Legislature takes further action.

2022 Special Session 2D

Despite not tackling the issues facing Florida's property insurance marketplace in the 2022 regular legislative session, the Legislature met on May 23 through May 25, 2022 to address Florida's property insurance crisis. Ultimately, legislators adopted an expansive property insurance reform package which was signed into law by Governor Ron DeSantis on May 26 2022.

SB 2D seeks to provide stability to the property insurance marketplace with a reinsurance program to provide much needed capacity, antifraud measures aimed at reducing frivolous roof claims, attorney's fee reforms intended to reduce excess litigation, and provisions to assist consumers in maintain coverage.

SB 2D created the Reinsurance to Assist Policyholders (RAP) Program. The RAP Program is a $2 billion reimbursement layer of reinsurance for hurricane losses directly below the mandatory layer of the Florida Hurricane Catastrophe Fund (FHCF). The FHCF mandatory retention is $8.5 billion for the 2022-2023 contract year. Any insurer that is a participating insurer in the Florida Hurricane Catastrophe Fund (FHCF) on June 1, 2022 is considered eligible for the RAP Program. Insurers found to be in "unsound financial condition" by the Insurance Commissioner are prohibited from participation. On June 15, 2022 the Florida Office of Insurance Regulation ("FOIR") found no insurers to be in "unsound financial condition". The bill provides that Citizens Property Insurance Corporation and joint underwriting associations are ineligible to participate in the RAP Program.

The RAP program will reimburse 90 percent of each insurer's covered losses and 10 percent of their loss adjustment expenses up to each individual insurer's limit of coverage for the two hurricanes causing the largest losses for that insurer during the contract year. Insurers will not be charged a premium for RAP Program coverage but must make a filing with FOIR to reflect the savings to policyholders created by the RAP coverage. Each insurer's limit of the $2 billion in RAP coverage is their pro-rata market share among all insurers that participate in the

RAP program. For example, an insurer with five percent of the risk reinsured by RAP coverage would have a limit of coverage of $100 million.

All eligible insurers must participate in the RAP program for one year. Insurers that do not have private reinsurance within the RAP layer of coverage for the 2022-2023 contract year must participate during the 2022-2023 contract year. An eligible insurer that has any private reinsurance that duplicates RAP coverage for the 2022-2023 contract year must notify the State Board of Administration of the private reinsurance and must defer participation in the RAP program until the 2023-2024 contract year.

Solicitation of policyholders by unscrupulous contractors to file unnecessary roof claims has been identified as a major driver of losses. SD 2D now prohibits contractors from making written or electronic communications that encourage or induce a consumer to contact a contractor or public adjuster for the purposes of making a property insurance claim for roof damage unless the solicitation provides specified notices providing information about insurance fraud.

Litigation cost, particularly one-way attorney's fees paid by insurers to the plaintiff's lawyers, has been a significant driver of loss costs in the Florida marketplace. SB 2D continued the legislature's work of addressing attorney's fee reform that was started in 2019 with AOB reform and in 2021 with first party claims in SB 76. SB 2D addressed bad faith claims by requiring that a policyholder must establish a property insurer breached the insurance contract in order to prevail in a bad faith claim.

SB 2D continued reforms related to litigation brought by vendors that have entered into an Assignment of Benefits ("AOB") agreement with a policyholder. The bill prohibits an AOB vendor from recovering one-way attorney fees. Further, the bill amends the definition of "assignment agreement" to include assignments executed by a party that inspects the property and specifies that public adjuster fees are not an assignment agreement. The bill further clarifies the requirement to provide a Notice of Intent to Initiate Litigation before filing suit related to an Assignment of Benefit (AOB). Finally, the bill requires that a valid AOB must specify that the assignee will hold harmless the assignor from all liabilities, including attorney fees. It is believed by many in the industry that these reforms are an important step in reducing frivolous AOB litigation and the associated loss costs.

SB 2D also creates a new standard for the award of an attorney fee multiplier in property insurance litigation. The bill creates a presumption that in property insurance cases, attorney fee awards based on the Lodestar methodology are sufficient and reasonable. Attorney fee multipliers may now only be awarded under rare and exceptional circumstances with evidence that competent counsel could not be hired in a reasonable manner.

Additionally, SB 2D provides insurers recourse when a claimant fails to file a Notice of Intent to Litigate prior to filing a lawsuit against the insurer. The bill provides that courts may now award attorney fees to an insurer when a first-party claimant's property insurance suit is dismissed without prejudice for failure to provide a Notice of Intent to Initiate Litigation.

SB 2D contains provisions that will assist policyholders in maintaining private market property insurance coverage. Property insurers may now offer consumers an optional separate roof deductible of up to two percent of the Coverage A limit of the policy or 50 percent of the cost to replace the roof. Policyholders that select the roof deductible must receive a premium credit or discount. The roof deductible will not apply to a total loss, a loss caused by a hurricane, a loss resulting from the puncture a roof deck or a roof loss requiring the repair of less than 50 percent of the roof.

Further, consumers are receiving protections from strict roof underwriting guidelines. SB 2D prohibits insurers from canceling or non-renewing policies solely due to the roof being 15 years old or older. In addition, if consumers with roofs that are 15 years old or older obtain an inspection from an authorized provider showing their roof has at least 5 years of life an insurer cannot cancel or non-renew their policy due solely to the age of their roofs.

New claims handling mandates related to insurer communication have been adopted in SB 2D. The bill provides that for claims other than those subject to a hurricane deductible, an insurer must conduct any physical inspection within 45 days after its receipt of the proof of loss statements. Insurers must now notify policyholders of their right to receive any detailed report created by an adjuster that estimates the amount of the loss. Further, insurers must provide a reasonable explanation of the claim decision in relation to the insurance policy, facts, and law. If the insurer makes a claim payment that is less than the amount contained in an adjuster's estimate of the loss, the insurer must explain the discrepancy in the amounts.

In order to assist consumers in maintaining their home in an insurable condition, SB 2D appropriates $150 million to the My Safe Florida Home Program to provide hurricane mitigation inspections and matching grants for the performance of hurricane retrofitting on homestead single family homes located in the wind-borne debris region set forth in the Florida Building Code with a value of $500,000 or less. The My Safe Florida Home Program will also provide financial incentives for Florida residents to obtain free home inspections to identify mitigation measures.

Additionally, SB 2D creates the Property Insurer Stability Unit within the Office of Insurance Regulation (OIR) to aid in the detection and prevention of insurer insolvencies in the homeowners' and condominium unit owners' insurance market. The unit will:

- Provide enhanced monitoring when the OIR identifies significant concerns about the condition of the insurer;
- Conduct targeted market conduct exams when there is reason to believe an insurer may be in an unsound financial condition;
- Closely monitor insurer financial data;
- Conduct annual catastrophe stress tests of domestic insurers;
- Update wind mitigation credits;
- Review the causes of insolvency and business practices of insurers referred to the Division of Rehabilitation and Liquidation within the Department of Financial Services; and

- Twice annually, provide a report on the status of the homeowner and condominium unit owner insurance market.

In addition, in the event of an insolvency involving a domestic property insurer, the Department of Financial Services must:

- Begin an analysis of the history and causes of the insolvency no later than the initiation of delinquency proceedings against the insurer;
- Review the OIR's regulatory oversight of the insurer;
- Submit an initial report analyzing the history and causes of the insolvency no later than two months after the initiation of the delinquency proceeding;
- Provide a special report within 10 days of identifying any condition or practice that may lead to insolvency in the property insurance marketplace; and
- Submit a final report analyzing the history and causes of the insolvency and the OIR's regulatory oversight within 30 days of the conclusion of the insolvency proceeding.

SB 4D contains provisions to address the cost of roof claims and roof replacement. Prior to the adoption of this bill, the Florida Building Code required that not more than 25 percent of the total roof area of any existing building or structure could be repaired, replaced, or recovered in any 12-month period unless the entire existing roofing system was replaced to conform to most recent requirements of the building code. This requirement led to the unnecessary full replacement of roofs in many instances. The bill creates an exception to this provision. SB 4D requires that when 25 percent or more of a roofing system or roof section is being repaired, replaced, or recovered, only the portion of the roofing system or roof section undergoing such work must be constructed in accordance with the current Florida Building Code in effect at that time. It is believed that this provision will allow for more roof repairs and fewer full roof replacements, which should ultimately reduce insurer loss cost related to roofing claims.

What Comes Next

The adoption of SB 2D and SB 4D are steps in the right direction. However, there is much work still ahead. Continued attorney's fee and tort reform is critical to reinvigorating the Florida property insurance marketplace and improving the overall business environment. Both Citizens Property Insurance Corporation and the Florida Hurricane Catastrophe Fund are effective and necessary facilities to support the Florida marketplace. However, the competitive nature of Citizens' rates belies its purpose as a market of last resort and the current reinsurance market has highlighted the need for more flexibility at the Cat Fund. Policyholders will hopefully see the effects of the laws after it goes through the insurance policy life cycle, which takes about 18 months, but more turbulence should be expected in the interim.

---

[1] Commissioner David Altmaier, OFFICE OF INSURANCE REGULATION (2021).

It's not easy to earn a FORC shield. It takes years of experience in insurance regulatory law, recommendations from many insurance industry leaders, and a rigorous vetting by insurance industry experts. If you are looking for the high standards and expertise of a FORC lawyer, search the FORC Member Directory at www.FORC.org.

– ABOUT FORC –

The Federation of Regulatory Counsel is a professional association of insurance regulatory lawyers formed in 1988 for the purpose of raising the standard of excellence in the practice of regulatory law.

FORC PUBLICATIONS

Expertise shared by respected and accomplished FORC counsel

- **FORC JOURNAL** - A compelling assortment of articles pertaining to regulatory law and the insurance industry.
- **FORC ALERTS** - Brief, focused, and relevant state and national updates to keep you apprised of current insurance regulatory news.

Peruse FORC's vast online collection of authoritative and topical articles that analyze timely issues affecting the insurance industry. Subscribe to the FORC Journal and Alerts at www.FORC.org.

FORC MEMBERS

National Network of Skilled Insurance Regulatory Attorneys

- Fully vetted by the FORC Admissions Committee with an intensive application process including interviews with candidates and insurance industry executives from unrelated companies who have attested to their skill and competency.
- Licensed qualified attorneys with a minimum of five, but typically decades, of insurance regulatory law experience.
- A member in good standing in at least one state bar association.
- Focused on insurance regulatory law and bill more than fifty percent of their time to insurance regulatory matters.
- Recommended by three FORC members, or three additional attorneys, which are acquainted with and/or have had professional dealings with the member.
- Capable of performing related services in two or more categories of insurance law practice including insurance business transactions, legislation, litigation and regulation.
- Knowledgeable in the industry which is confirmed by authorship in the FORC Journal of Insurance Law and Regulation and other industry publications.
- Connected to other FORC insurance regulatory attorneys throughout the country to use as additional resources.

FEDERATION OF REGULATORY COUNSEL

Dedicated to Excellence in the Practice of Regulatory Law

For a full member list of insurance and financial regulatory counsel visit:
www.FORC.org

FEDERATION OF REGULATORY COUNSEL
4248 Park Glen Road | Minneapolis, MN 55416
T: (952) 928-4656 | F: (952) 767-0767 | info@forc.org