CHAMBER ACTION

Senate House

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Representative Duggan offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Section 624.115, Florida Statutes, is created to read:

624.115 Referral of criminal violations.—If, during an investigation or examination, the office has the reasonable belief that any criminal law of this state has or may have been violated, the office shall refer any relevant records and information to the Division of Investigative and Forensic Services, state or federal law enforcement, or prosecutorial agencies, as applicable, and shall provide investigative

assistance to those agencies, as required.

Section 2. Paragraph (b) of subsection (10) of section 624.307, Florida Statutes, is amended to read:

624.307 General powers; duties.—

(10)

(b) Any person licensed or issued a certificate of authority by the department or the office shall respond, in writing or electronically, to the division within 14 ~~20~~ days after receipt of a written request for documents and information from the division concerning a consumer complaint. The response must address the issues and allegations raised in the complaint and include any requested documents concerning the consumer complaint not subject to attorney-client or work-product privilege. The division may impose an administrative penalty for failure to comply with this paragraph of up to $5,000 ~~$2,500~~ per violation upon any entity licensed by the department or the office ~~and $250 for the first violation, $500 for the second violation,~~ and up to $1,000 per ~~for the third or subsequent~~ violation by ~~upon~~ any individual licensed by the department or the office.

Section 3. Present subsection (4) of section 624.315, Florida Statutes, is redesignated as subsection (5), and a new subsection (4) is added to that section, to read:

624.315 Annual reports; quarterly reports ~~report~~.—

(4)(a) The office shall create a report detailing all

actions of the office to enforce insurer compliance with this code and all rules and orders of the office or department during the previous year. For each of the following, the report must detail the insurer or other licensee or registrant against whom such action was taken; whether the office found any violation of law or rule by such party, and, if so, detail such violation; and the resolution of such action, including any penalties imposed by the office. The report must be published on the website of the office and submitted to the commission, the President of the Senate, the Speaker of the House of Representatives, and the legislative committees with jurisdiction over matters of insurance on or before January 31 of each year. The report must include, but need not be limited to:

1. The revocation, denial, or suspension of any license or registration issued by the office.

2. All actions taken pursuant to s. 624.310.

3. Fines imposed by the office for violations of this code.

4. Consent orders entered into by the office.

5. Examinations and investigations conducted and completed by the office pursuant to ss. 624.316 and 624.3161.

6. Investigations conducted and completed, by line of insurance, for which the office found violations of law or rule but did not take enforcement action.

(b) Each quarter, the office shall create a report detailing all actions of the office to enforce insurer compliance during the previous quarter. The report must include, but need not be limited to, the subjects that must be included in the annual report under paragraph (a). The report must be submitted to the commission, the President of the Senate, the Speaker of the House of Representatives, and the legislative committees with jurisdiction over matters of insurance. The report is due on or before April 30, July 31, October 31, and January 31, respectively, for the immediately preceding quarter. The report due January 31 may be included within the annual report required under paragraph (a).

(c) The office need not include within any report required under this subsection information that would violate any confidentiality provision included within any agreement, order, or consent order entered into or adopted by the office.

Section 4. Paragraph (a) of subsection (2) of section 624.316, Florida Statutes, is amended, and subsections (3) and (4) are added to that section, to read:

624.316 Examination of insurers.—

(2)(a) Except as provided in paragraph (f), the office may examine each insurer as often as may be warranted for the protection of the policyholders and in the public interest, but must, at a minimum, examine:

1. High-risk insurers at least once every 3 years.

2. Average- and low-risk insurers at least once every ~~and shall examine each domestic insurer not less frequently than once every~~ 5 years.

The examination shall cover the number of fiscal years since the last examination ~~preceding 5 fiscal years~~ of the insurer, except for examinations of low-risk insurers, in which case the examination need only cover at least the preceding 5 fiscal years, and shall be commenced within 12 months after the end of the most recent fiscal year being covered by the examination. The examination may cover any period of the insurer's operations since the last previous examination. The examination may include examination of events subsequent to the end of the most recent fiscal year and the events of any prior period that affect the present financial condition of the insurer.

(3) The office shall create, and the commission shall adopt by rule, a risk-based selection methodology for scheduling examinations of insurers subject to this section. Except as otherwise specified in subsection (2), this requirement does not restrict the authority of the office to conduct examinations under this section as often as it deems advisable. Such methodology must include all of the following:

(a) Use of a risk-focused analysis to prioritize financial examinations of insurers when such reporting indicates a decline in the insurer's financial condition.

(b) Consideration of:

1. The level of capitalization and identification of unfavorable trends;

2. Negative trends in profitability or cash flow from operations;

3. National Association of Insurance Commissioners Insurance Regulatory Information System ratio results;

4. Risk-based capital and risk-based capital trend test results;

5. The structure and complexity of the insurer;

6. Changes in the insurer's officers or board of directors;

7. Changes in the insurer's business strategy or operations;

8. Findings and recommendations from an examination made pursuant to this section or s. 624.3161;

9. Current or pending regulatory actions by the office or the department;

10. Information obtained from other regulatory agencies or independent organization ratings and reports; and

11. The impact of an insurer's insolvency on policyholders of the insurer and the public generally.

(c) Prioritization of property insurers for which the office identifies significant concerns about an insurer's solvency pursuant to s. 627.7154.

(d) Any other matters the office deems necessary to consider for the protection of the public.

(4) The office shall present any proposed rules implementing this section to the commission no later than October 1, 2023. In addition to the methodology required by this section, such rule or rules must include a plan to implement the examination schedule in subsection (2). To facilitate the development of the methodology for scheduling examinations pursuant to this section, the commission may also adopt by rule the National Association of Insurance Commissioners Financial Analysis Handbook, to the extent that the handbook is consistent with and does not negate the requirements of this section.

Section 5. Subsection (7) of section 624.3161, Florida Statutes, is amended, and subsections (8) and (9) are added to that section, to read:

624.3161 Market conduct examinations.—

(7) Notwithstanding subsection (1), any authorized insurer transacting residential property insurance business in this state:

(a) May be subject to an additional market conduct examination after a hurricane if, at any time more than 90 days after the end of the hurricane, the insurer:

~~(a)~~ is among the top 20 percent of insurers based upon a calculation of the ratio of hurricane-related property insurance claims filed to the number of property insurance policies in

force;

(b) Must be subject to a market conduct examination after a hurricane if, at any time more than 90 days after the end of the hurricane, the insurer:

1. Is among the top 20 percent of insurers based upon a calculation of the ratio of hurricane claim-related consumer complaints made about that insurer to the department to the insurer's total number of hurricane-related claims;

2. Is among the top 20 percent of insurers based upon a calculation of the ratio of hurricane claims closed without payment to the insurer's total number of hurricane claims on policies providing wind or windstorm coverage;

3.~~(c)~~ Has made significant payments to its managing general agent since the hurricane; or

4.~~(d)~~ Is identified by the office as necessitating a market conduct exam for any other reason.

All relevant criteria under this section and s. 624.316 shall be applied to the market conduct examination under this subsection. Such an examination must be initiated within 18 months after the landfall of a hurricane that results in an executive order or a state of emergency issued by the Governor. The requirements of this subsection do not limit the authority of the office to conduct at any time a market conduct examination of a property insurer in the aftermath of a hurricane. This subsection does

not require the office to conduct multiple market conduct examinations of the same insurer when multiple hurricanes make landfall in this state in a single calendar year. An examination of an insurer under this subsection must also include an examination of its managing general agent as if it were the insurer.

(8) The office shall create, and the commission shall adopt by rule, a selection methodology for scheduling and conducting market conduct examinations of insurers and other entities regulated by the office. This requirement does not restrict the authority of the office to conduct market conduct examinations as often as it deems necessary. Such selection methodology must prioritize market conduct examinations of insurers and other entities regulated by the office to whom any of the following conditions applies:

(a) An insurance regulator in another state has initiated or taken regulatory action against the insurer or entity regarding an act or omission of such insurer or entity which, if committed in this state, would constitute a violation of the laws of this state or any rule or order of the office or department.

(b) Given the insurer's market share in this state, the department or the office has received a disproportionate number of the following types of claims-handling complaints against the insurer:

1. Failure to timely communicate with respect to claims;

2. Failure to timely pay claims;

3. Untimely payments giving rise to the payment of statutory interest;

4. Failure to adjust and pay claims in accordance with the terms and conditions of the policy or contract and in compliance with state law;

5. Violations of part IX of chapter 626, the Unfair Insurance Trade Practices Act;

6. Failure to use licensed and duly appointed claims adjusters;

7. Failure to maintain reasonable claims records; or

8. Failure to adhere to the company's claims-handling manual.

(c) The results of a National Association of Insurance Commissioners Market Conduct Annual Statement indicate that the insurer is a negative outlier with regard to particular metrics.

(d) There is evidence that the insurer is violating or has violated the Unfair Insurance Trade Practices Act.

(e) The insurer meets the criteria in subsection (7).

(f) Any other conditions the office deems necessary for the protection of the public.

The office shall present the proposed rule required by this subsection to the commission no later than October 1, 2023. In

addition to the methodology required by this subsection, the rule must provide criteria for how the office, in coordination with the department, will determine what constitutes a disproportionate number of claims-handling complaints described in paragraph (b).

(9) If the office concludes through an examination pursuant to this section that an insurer providing liability coverage in this state exhibits a pattern or practice of violations of the Florida Insurance Code during any investigation or examination of the insurer, the office must review the insurer's claims-handling practices to determine if the insurer should be subject to the enhanced enforcement penalties of this subsection.

(a) A liability insurer may be subject to enhanced enforcement penalties if the office reviews the insurer's claims-handling practices and finds a pattern or practice of the insurer failing to do the following when responding to claims under an insurance policy, after receiving actual notice of such claims:

1. Assign a licensed and appointed insurance adjuster to investigate whether coverage is provided under the policy and diligently attempt to resolve any questions concerning the extent of the insured's coverage.

2. Evaluate the claim fairly, honestly, and with due regard for the interests of the insured based on available

information.

3. Request from the insured or claimant additional relevant information the insurer reasonably deems necessary to evaluate whether to settle a claim.

4. Conduct all oral and written communications with the insured with honesty and candor.

5. Make reasonable efforts to explain to persons not represented by counsel matters requiring expertise beyond the level normally expected of a layperson with no training in insurance or claims-handling issues.

6. Retain all written and recorded communications and create and retain a summary of all verbal communications in a reasonable manner for a period of not less than 2 years after the later of the entry of a final judgment against the insured in excess of policy limits or, if an extracontractual claim is made, the conclusion of that claim and any related appeals.

7. Within 30 days after a request, provide the insured with all communications related to the insurer's handling of the claim which are not privileged as to the insured.

8. Provide, upon request and at the insurer's expense, reasonable accommodations necessary to communicate effectively with an insured covered under the Americans with Disabilities Act.

9. When handling a third-party claim, communicate each of the following to the insured:

a. The identity of any other person or entity the insurer has reason to believe may be liable.

b. The insurer's final and completed estimate of the claim.

c. The possibility of an excess judgment.

d. The insured's right to secure personal counsel at his or her own expense.

e. That the insured should cooperate with the insurer, including providing information required by the insurer because of a settlement opportunity or in accordance with the policy.

f. Any formal settlement demands or offers to settle by the claimant and any offers to settle on behalf of the insured.

10. Respond to any request for insurance information in compliance with s. 626.9372 or s. 627.4137, as applicable.

11. Seek to obtain a general release of each insured in making any settlement offer to a third-party claimant.

12. Take reasonable measures to preserve any documentary, photographic, and forensic evidence as needed for the defense of the liability claim if it appears likely that the insured's liability exposure is greater than policy limits and the insurer fails to secure a general release in favor of the insured.

13. Comply with subsections (1) and (2), if applicable.

14. Comply with the Unfair Insurance Trade Practices Act.

(b) As used in this subsection, the term "actual notice" means the insurer's receipt of notice of an incident or a loss

that could give rise to a covered claim that is communicated to the insurer or an agent of the insurer:

1. By any manner permitted by the policy or other documents provided to the insured by the insurer;

2. Through the claims link on the insurer's website; or

3. Through the e-mail address designated by the insurer under s. 624.422.

(c) In reviewing claims-handling practices, it is relevant whether the insured, claimant, and any representative of the insured or claimant were acting reasonably toward the insurer in furnishing information regarding the claim, in making demands of the insurer, in setting deadlines, and in attempting to settle the claim. Such matters include whether:

1. The insured cooperated with the insurer in the defense of the claim and in making settlements by taking reasonable actions requested by the claimant or required by the policy which are necessary to assist the insurer in settling a covered claim, including:

a. Executing affidavits regarding the facts within the insured's knowledge regarding the covered loss; and

b. Providing documents, including, if reasonably necessary to settle a covered claim valued in excess of policy limits and upon the request of the claimant, a summary of the insured's assets, liabilities, obligations, and other insurance policies that may provide coverage for the claim and the name and contact

information of the insured's employer when the insured is a natural person who was acting in the course and scope of employment when the incident giving rise to the claim occurred.

2. The claimant and any claimant's representative:

a. Acted honestly in furnishing information regarding the claim;

b. Acted reasonably in setting deadlines; and

c. Refrained from taking actions that may be reasonably expected to prevent an insurer from accepting the settlement demand, such as providing insufficient detail within the demand, providing unreasonable deadlines for acceptance of the demand, or including unreasonable conditions to settlement.

(d) In addition to authorized penalties for a liability insurer that the office has determined has a pattern or practice of violations of the Florida Insurance Code at the conclusion of any investigation or examination, the office may impose enhanced enforcement penalties for insurer claims-handling practices that fail to meet the review standards of this subsection. Such enhanced enforcement penalties include, but are not limited to, administrative fines that are subject to a 2.0 multiplier and fines that exceed the limits on fine amounts and aggregate fine amounts provided for under this code.

(e) This subsection does not create a civil cause of action, a civil remedy under s. 624.155, or an unfair trade practice under s. 626.9541.

Section 6. Section 624.4211, Florida Statutes, is amended to read:

624.4211 Administrative fine in lieu of suspension or revocation.—

(1) If the office finds that one or more grounds exist for the discretionary revocation or suspension of a certificate of authority issued under this chapter, the office may, in lieu of such revocation or suspension, impose a fine upon the insurer.

(2)(a) With respect to a ~~any~~ nonwillful violation, such fine may not exceed:

1. Twenty-five thousand dollars per violation, up to an aggregate amount of $100,000 for all nonwillful violations arising out of the same action, related to a covered loss or claim caused by an emergency for which the Governor declared a state of emergency pursuant to s. 252.36.

2. Twelve thousand five hundred dollars ~~$5,000~~ per violation, up to~~. In no event shall such fine exceed~~ an aggregate amount of $50,000 ~~$20,000~~ for all other nonwillful violations arising out of the same action.

(b) If an insurer discovers a nonwillful violation, the insurer shall correct the violation and, if restitution is due, make restitution to all affected persons. Such restitution shall include interest at 12 percent per year from either the date of the violation or the date of inception of the affected person's policy, at the insurer's option. The restitution may be a credit

against future premiums due, provided that interest accumulates until the premiums are due. If the amount of restitution due to any person is $50 or more and the insurer wishes to credit it against future premiums, it shall notify such person that she or he may receive a check instead of a credit. If the credit is on a policy that is not renewed, the insurer shall pay the restitution to the person to whom it is due.

(3)(a) With respect to a ~~any~~ knowing and willful violation of a lawful order or rule of the office or commission or a provision of this code, the office may impose a fine upon the insurer in an amount not to exceed:

1. Two hundred thousand dollars for each such violation, up to an aggregate amount of $1 million for all knowing and willful violations arising out of the same action, related to a covered loss or claim caused by an emergency for which the Governor declared a state of emergency pursuant to s. 252.36.

2. One hundred thousand dollars ~~$40,000~~ for each such violation, up to~~. In no event shall such fine exceed~~ an aggregate amount of $500,000 ~~$200,000~~ for all other knowing and willful violations arising out of the same action.

(b) In addition to such fines, the insurer shall make restitution when due in accordance with subsection (2).

(4) The failure of an insurer to make restitution when due as required under this section constitutes a willful violation of this code. However, if an insurer in good faith is uncertain

as to whether any restitution is due or as to the amount of such restitution, it shall promptly notify the office of the circumstances; and the failure to make restitution pending a determination thereof shall not constitute a violation of this code.

Section 7. Section 624.4301, Florida Statutes, is created to read:

624.4301 Notice of temporary discontinuance of writing new residential property insurance policies.—

(1) Any authorized insurer, before temporarily suspending writing new residential property insurance policies in this state, must give notice to the office of the insurer's reasons for such action, the effective dates of the temporary suspension, and the proposed communication to its agents. Such notice must be provided on a form approved by the office and adopted by the commission. The insurer shall submit such notice to the office the earlier of 20 business days before the effective date of the temporary suspension of writing or 5 business days before notifying its agents of the temporary suspension of writing. The insurer must provide any other information requested by the office related to the insurer's temporary suspension of writing. The requirements of this section do not:

(a) Apply to a temporary suspension of writing new business made in response to:

1. A hurricane that may make landfall in this state if such temporary suspension ceases within 72 hours after hurricane conditions are no longer present in this state; or

2. Any other natural emergency as defined in s. 252.34(8) which impacts one or more counties and is the subject of a declared state of emergency by any local, state, or federal authority, if such temporary suspension applies only to the affected counties and ceases within 72 hours after such natural emergency is no longer present in those counties.

(b) Require such insurers to obtain the approval of the office before temporarily suspending writing new residential property insurance policies in this state.

(2) The commission may adopt rules to administer this section.

Section 8. Section 624.805, Florida Statutes, is created to read:

624.805 Hazardous insurer standards; office's evaluation and enforcement authority; immediate final order.—

(1) In determining whether the continued operation of any authorized insurer transacting business in this state may be deemed to be hazardous to its policyholders or creditors or to the general public, the office may consider, in the totality of the circumstances of such insurer, any of the following:

(a) Adverse findings reported in financial condition or market conduct examination reports, audit reports, or actuarial

opinions, reports, or summaries.

(b) The National Association of Insurance Commissioners Insurance Regulatory Information System and its other financial analysis solvency tools and reports.

(c) Whether the insurer has made adequate provisions, according to presently accepted actuarial standards of practice, for the anticipated cash flows required to cover its contractual obligations and related expenses.

(d) The ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection for the insurer's remaining surplus after taking into account the insurer's cash flow and the lines of insurance written, as well as the financial condition of the assuming reinsurer.

(e) Whether the insurer's operating loss in the last 12-month period, including, but not limited to, net capital gain or loss, change in nonadmitted assets, and cash dividends paid to shareholders is greater than 50 percent of the insurer's remaining surplus as regards policyholders in excess of the minimum required.

(f) Whether the insurer's operating loss in the last 12-month period, excluding net capital gains, is greater than 20 percent of the insurer's remaining surplus as regards policyholders in excess of the minimum required.

(g) Whether a reinsurer, an obligor, or any entity within

the insurer's insurance holding company system is insolvent, threatened with insolvency, or delinquent in payment of its monetary or other obligations, and which in the opinion of the office may affect the solvency of the insurer.

(h) Contingent liabilities, pledges, or guaranties that individually or collectively involve a total amount that in the opinion of the office may affect the solvency of the insurer.

(i) Whether any affiliate, as defined in s. 624.10(1), of the insurer is delinquent in the transmitting to, or payment of, net premiums to the insurer.

(j) The age and collectability of receivables.

(k) Whether the management of the insurer, including officers, directors, or any other person who directly or indirectly controls the operation of the insurer, fails to possess and demonstrate the competence, fitness, and reputation deemed necessary to serve the insurer in such position.

(l) Whether management of the insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished false or misleading information to the office concerning an inquiry.

(m) Whether the insurer has failed to meet financial and holding company filing requirements in the absence of a reason satisfactory to the office.

(n) Whether management of the insurer has filed any false or misleading sworn financial statement, has released a false or

misleading financial statement to lending institutions or to the general public, has made a false or misleading entry, or has omitted an entry of material amount in the books of the insurer.

(o) Whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner.

(p) Whether the insurer has experienced, or will experience in the foreseeable future, cash flow or liquidity problems.

(q) Whether management has established reserves that do not comply with minimum standards established by state insurance laws and regulations, statutory accounting standards, sound actuarial principles, and standards of practice.

(r) Whether management persistently engages in material under-reserving that results in adverse development.

(s) Whether transactions among affiliates, subsidiaries, or controlling persons for which the insurer receives assets or capital gains, or both, do not provide sufficient value, liquidity, or diversity to assure the insurer's ability to meet its outstanding obligations as they mature.

(t) The ratio of the annual premium volume to surplus or of its liabilities to surplus in relation to loss experience, the kinds of risks insured, or both.

(u) Whether the insurer's asset portfolio, when viewed in light of current economic conditions and indications of

financial or operational leverage, is of sufficient value, liquidity, or diversity to assure the company's ability to meet its outstanding obligations as they mature.

(v) Whether the excess of surplus as regards policyholders above the insurer's statutorily required surplus as regards policyholders has decreased by more than 50 percent in the preceding 12-month period.

(w) As to a residential property insurer, whether it has sufficient capital, surplus, and reinsurance to withstand significant weather events, including, but not limited to, hurricanes.

(x) Whether the insurer's required surplus, capital, or capital stock is impaired to an extent prohibited by law.

(y) Whether the insurer continues to write new business when it has not maintained the required surplus or capital.

(z) Whether the insurer moves to dissolve or liquidate without first having made provisions satisfactory to the office for liabilities arising from insurance policies issued by the insurer.

(aa) Whether the insurer has incurred substantial new debt, has had to rely on frequent or substantial capital infusions, or has a highly leveraged balance sheet.

(bb) Whether the insurer relies increasingly on other entities, including, but not limited to, affiliates, third-party administrators, managing general agents, or management

564 companies.
565 (cc) Whether the insurer meets one or more of the grounds
566 in s. 631.051 for the appointment of the department as receiver.
567 (dd) Any other finding determined by the office to be
568 hazardous to the insurer's policyholders or creditors or to the
569 general public.
570 (2) For the purposes of making a determination of an
571 insurer's financial condition under the Florida Insurance Code,
572 the office may:
573 (a) Disregard any credit or amount receivable resulting
574 from transactions with a reinsurer that is insolvent, impaired,
575 or otherwise subject to a delinquency proceeding;
576 (b) Make appropriate adjustments, including disallowance
577 to asset values attributable to investments in or transactions
578 with parents, subsidiaries, or affiliates, consistent with the
579 National Association of Insurance Commissioners Accounting
580 Practices and Procedures Manual and state laws and rules;
581 (c) Refuse to recognize the stated value of accounts
582 receivable if the ability to collect receivables is highly
583 speculative in view of the age of the account or the financial
584 condition of the debtor; or
585 (d) Increase the insurer's liability, in an amount equal
586 to any contingent liability, pledge, or guarantee not otherwise
587 included, if there is a substantial risk that the insurer will
588 be called upon to meet the obligation undertaken within the next

12-month period.

(3) If the office determines that the continued operations of an insurer authorized to transact business in this state may be hazardous to its policyholders or creditors or to the general public, the office may issue an order requiring the insurer to do any of the following:

(a) Reduce the total amount of present and potential liability for policy benefits by procuring additional reinsurance.

(b) Reduce, suspend, or limit the volume of business being accepted or renewed.

(c) Reduce expenses by specified methods or amounts.

(d) Increase the insurer's capital and surplus.

(e) Suspend or limit the declaration and payment of dividends by an insurer to its stockholders or to its policyholders.

(f) File reports in a form acceptable to the office concerning the market value of the insurer's assets.

(g) Limit or withdraw from certain investments or discontinue certain investment practices to the extent the office deems necessary.

(h) Document the adequacy of premium rates in relation to the risks insured.

(i) File, in addition to regular annual statements, interim financial reports on a form prescribed by the commission

and adopted by the National Association of Insurance Commissioners.

(j) Correct corporate governance practice deficiencies and adopt and use governance practices acceptable to the office.

(k) Provide a business plan acceptable to the office in order to continue to transact business in this state.

(l) Notwithstanding any other law limiting the frequency or amount of rate adjustments, adjust rates for any non-life insurance product written by the insurer which the office considers necessary to improve the financial condition of the insurer.

(4) This section may not be interpreted to limit the powers granted to the office by any laws of this state, nor may it be interpreted to supersede any laws of this state.

(5) The office may, pursuant to ss. 120.569 and 120.57, in its discretion and without advance notice or hearing, issue an immediate final order to any insurer requiring the actions listed in subsection (3).

Section 9. Subsection (11) of section 624.81, Florida Statutes, is amended to read:

624.81 Notice to comply with written requirements of office; noncompliance.—

~~(11) The commission may adopt rules to define standards of hazardous financial condition and corrective action substantially similar to that indicated in the National~~

~~Association of Insurance Commissioners' 1997 "Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition," which are necessary to implement the provisions of this part.~~

Section 10. Section 624.865, Florida Statutes, is created to read:

624.865 Rulemaking.—The commission may adopt rules to administer ss. 624.80-624.87.

Section 11. Paragraph (c) of subsection (3) of section 626.207, Florida Statutes, is amended to read:

626.207 Disqualification of applicants and licensees; penalties against licensees; rulemaking authority.—

(3) An applicant who has been found guilty of or has pleaded guilty or nolo contendere to a crime not included in subsection (2), regardless of adjudication, is subject to:

(c) A 7-year disqualifying period for all misdemeanors directly related to the financial services business or any misdemeanor directly related to any violation of the Florida Insurance Code.

Section 12. Subsections (2) and (3) of section 626.9521, Florida Statutes, are amended to read:

626.9521 Unfair methods of competition and unfair or deceptive acts or practices prohibited; penalties.—

(2) Except as provided in subsection (3), any person who violates any provision of this part is subject to a fine in an

amount not greater than $12,500 ~~$5,000~~ for each nonwillful violation and not greater than $100,000 ~~$40,000~~ for each willful violation. Fines under this subsection imposed against an insurer may not exceed an aggregate amount of $50,000 ~~$20,000~~ for all nonwillful violations arising out of the same action or an aggregate amount of $500,000 ~~$200,000~~ for all willful violations arising out of the same action. The fines may be imposed in addition to any other applicable penalty.

(3)(a) If a person violates s. 626.9541(1)(l), the offense known as "twisting," or violates s. 626.9541(1)(aa), the offense known as "churning," the person commits a misdemeanor of the first degree, punishable as provided in s. 775.082, and an administrative fine not greater than $12,500 ~~$5,000~~ shall be imposed for each nonwillful violation or an administrative fine not greater than $187,500 ~~$75,000~~ shall be imposed for each willful violation. To impose an administrative fine for a willful violation under this paragraph, the practice of "churning" or "twisting" must involve fraudulent conduct.

(b) If a person violates s. 626.9541(1)(ee) by willfully submitting fraudulent signatures on an application or policy-related document, the person commits a felony of the third degree, punishable as provided in s. 775.082, and an administrative fine ~~not greater than $5,000 shall be imposed for each nonwillful violation or an administrative fine~~ not greater than $187,500 ~~$75,000~~ shall be imposed for each ~~willful~~

violation.

(c) If a person violates any provision of this part and such violation is related to a covered loss or covered claim caused by an emergency for which the Governor declared a state of emergency pursuant to s. 252.36, such person is subject to a fine in an amount not greater than $25,000 for each nonwillful violation and not greater than $200,000 for each willful violation. Fines imposed under this paragraph may not exceed an aggregate amount of $100,000 for all nonwillful violations arising out of the same action or an aggregate amount of $1 million for all willful violations arising out of the same action.

(d) Administrative fines under paragraphs (a) and (b) ~~this subsection~~ may not exceed an aggregate amount of $125,000 ~~$50,000~~ for all nonwillful violations arising out of the same action or an aggregate amount of $625,000 ~~$250,000~~ for all willful violations arising out of the same action.

Section 13. Paragraphs (i) and (w) of subsection (1) of section 626.9541, Florida Statutes, are amended to read:

626.9541 Unfair methods of competition and unfair or deceptive acts or practices defined.—

(1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS.—The following are defined as unfair methods of competition and unfair or deceptive acts or practices:

(i) *Unfair claim settlement practices.*—

1. Attempting to settle claims on the basis of an application, when serving as a binder or intended to become a part of the policy, or any other material document which was altered without notice to, or knowledge or consent of, the insured;

2. A material misrepresentation made to an insured or any other person having an interest in the proceeds payable under such contract or policy, for the purpose and with the intent of effecting settlement of such claims, loss, or damage under such contract or policy on less favorable terms than those provided in, and contemplated by, such contract or policy;

3. Committing or performing with such frequency as to indicate a general business practice any of the following:

a. Failing to adopt and implement standards for the proper investigation of claims;

b. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

c. Failing to acknowledge and act promptly upon communications with respect to claims;

d. Denying claims without conducting reasonable investigations based upon available information;

e. Failing to affirm or deny full or partial coverage of claims, and, as to partial coverage, the dollar amount or extent of coverage, or failing to provide a written statement that the claim is being investigated, upon the written request of the

insured within 30 days after proof-of-loss statements have been completed;

f. Failing to promptly provide a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a claim or for the offer of a compromise settlement;

g. Failing to promptly notify the insured of any additional information necessary for the processing of a claim;

h. Failing to clearly explain the nature of the requested information and the reasons why such information is necessary; ~~or~~

i. Failing to pay personal injury protection insurance claims within the time periods required by s. 627.736(4)(b). The office may order the insurer to pay restitution to a policyholder, medical provider, or other claimant, including interest at a rate consistent with the amount set forth in s. 55.03(1), for the time period within which an insurer fails to pay claims as required by law. Restitution is in addition to any other penalties allowed by law, including, but not limited to, the suspension of the insurer's certificate of authority; or

j. Altering or amending an insurance adjuster's report without:

(I) Providing a detailed explanation as to why any change that has the effect of reducing the estimate of the loss was made; and

(II) Including on the report or as an addendum to the report a detailed list of all changes made to the report and the identity of the person who ordered each change; or

(III) Retaining all versions of the report, and including within each such version, for each change made within such version of the report, the identity of each person who made or ordered such change; or

4. Failing to pay undisputed amounts of partial or full benefits owed under first-party property insurance policies within 60 days after an insurer receives notice of a residential property insurance claim, determines the amounts of partial or full benefits, and agrees to coverage, unless payment of the undisputed benefits is prevented by factors beyond the control of the insurer as defined in s. 627.70131(5).

(w) *Soliciting or accepting new or renewal insurance risks by insolvent or impaired insurer or receipt of certain bonuses by an officer or director of an insolvent insurer prohibited; penalty.*—

1. Whether or not delinquency proceedings as to the insurer have been or are to be initiated, but while such insolvency or impairment exists, no director or officer of an insurer, except with the written permission of the office, shall authorize or permit the insurer to solicit or accept new or renewal insurance risks in this state after such director or officer knew, or reasonably should have known, that the insurer

was insolvent or impaired.

2. Regardless of whether delinquency proceedings as to the insurer have been or are to be initiated, but while such insolvency or impairment exists, a director or an officer of an impaired insurer may not receive a bonus from such insurer, nor may such director or officer receive a bonus from a holding company or an affiliate that shares common ownership or control with such insurer.

3. As used in this paragraph, the term:

a. "Bonus" means a payment, in addition to an officer's or a director's usual compensation, which is in addition to any amounts contracted for or otherwise legally due.

b. "Impaired" includes impairment of capital or surplus, as defined in s. 631.011(12) and (13).

4.~~2.~~ Any such director or officer, upon conviction of a violation of this paragraph, commits ~~is guilty of~~ a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 14. Subsection (6) of section 626.989, Florida Statutes, is amended, and subsection (10) is added to that section, to read:

626.989 Investigation by department or Division of Investigative and Forensic Services; compliance; immunity; confidential information; reports to division; division investigator's power of arrest.—

(6)(a) Any person, other than an insurer, agent, or other person licensed under the code, or an employee thereof, having knowledge or who believes that a fraudulent insurance act or any other act or practice which, upon conviction, constitutes a felony or a misdemeanor under the code, or under s. 817.234, is being or has been committed may send to the Division of Investigative and Forensic Services a report or information pertinent to such knowledge or belief and such additional information relative thereto as the department may request. Any professional practitioner licensed or regulated by the Department of Business and Professional Regulation, except as otherwise provided by law, any medical review committee as defined in s. 766.101, any private medical review committee, and any insurer, agent, or other person licensed under the code, or an employee thereof, having knowledge or who believes that a fraudulent insurance act or any other act or practice which, upon conviction, constitutes a felony or a misdemeanor under the code, or under s. 817.234, is being or has been committed shall send to the Division of Investigative and Forensic Services a report or information pertinent to such knowledge or belief and such additional information relative thereto as the department may require.

(b) The Division of Investigative and Forensic Services shall review such information or reports and select such information or reports as, in its judgment, may require further

investigation. It shall then cause an independent examination of the facts surrounding such information or report to be made to determine the extent, if any, to which a fraudulent insurance act or any other act or practice which, upon conviction, constitutes a felony or a misdemeanor under the code, or under s. 817.234, is being committed.

(c) The Division of Investigative and Forensic Services shall report any alleged violations of law which its investigations disclose to the appropriate licensing agency and state attorney or other prosecuting agency having jurisdiction, including, but not limited to, the statewide prosecutor for crimes that impact two or more judicial circuits in this state, with respect to any such violation, as provided in s. 624.310. ~~If prosecution by the state attorney or other prosecuting agency having jurisdiction with respect to such violation is not begun within 60 days of the division's report,~~ The state attorney or other prosecuting agency having jurisdiction with respect to such violation shall inform the division of any ~~the~~ reasons why prosecution of such violation was:

1. Not begun within 60 days after the division's report; or

2. Declined ~~for the lack of prosecution~~.

(10) The Division of Investigative and Forensic Services Bureau of Insurance Fraud shall prepare and submit a performance report to the President of the Senate and the Speaker of the

House of Representatives by September 1 of each year. The annual report must include, but need not be limited to:

(a) The total number of initial referrals received, cases opened, cases presented for prosecution, cases closed, and convictions resulting from cases presented for prosecution by the Bureau of Insurance Fraud, by type of insurance fraud and circuit.

(b) The number of referrals received from insurers, the office, and the Division of Consumer Services of the department, and the outcome of those referrals.

(c) The number of investigations undertaken by the Bureau of Insurance Fraud which were not the result of a referral from an insurer and the outcome of those referrals.

(d) The number of investigations that resulted in a referral to a regulatory agency and the disposition of those referrals.

(e) The number of cases presented by the Bureau of Insurance Fraud which local prosecutors or the statewide prosecutor declined to prosecute and the reasons provided for declining prosecution.

(f) A summary of the annual report required under s. 626.9896.

(g) The total number of employees assigned to the Bureau of Insurance Fraud, delineated by location of staff assigned, and the number and location of employees assigned to the Bureau

of Insurance Fraud who were assigned to work other types of fraud cases.

(h) The average caseload and turnaround time by type of case for each investigator.

(i) The training provided during the year to insurance fraud investigators.

Section 15. Subsections (1), (3), and (4) of section 627.0629, Florida Statutes, are amended to read:

627.0629 Residential property insurance; rate filings.—

(1) It is the intent of the Legislature that insurers provide savings to consumers who install or implement windstorm damage mitigation techniques, alterations, or solutions to their properties to prevent windstorm losses. A rate filing for residential property insurance must include actuarially reasonable discounts, credits, or other rate differentials, or appropriate reductions in deductibles, for properties on which fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm have been installed or implemented. The fixtures or construction techniques must include, but are not limited to, fixtures or construction techniques that enhance roof strength, roof covering performance, roof-to-wall strength, wall-to-floor-to-foundation strength, opening protection, and window, door, and skylight strength. Credits, discounts, or other rate differentials, or appropriate reductions in deductibles, for fixtures and

914 construction techniques that meet the minimum requirements of
915 the Florida Building Code must be included in the rate filing.
916 The office shall determine the discounts, credits, other rate
917 differentials, and appropriate reductions in deductibles that
918 reflect the full actuarial value of such revaluation, which may
919 be used by insurers in rate filings. Effective October 1, 2023,
920 each insurer subject to the requirements of this section must
921 provide information on the insurer's website describing the
922 hurricane mitigation discounts available to policyholders. Such
923 information must be accessible on, or through a hyperlink
924 located on, the home page of the insurer's website or the
925 primary page of the insurer's website for property insurance
926 policyholders or applicants for such coverage in this state. On
927 or before January 1, 2025, and every 5 years thereafter, the
928 office shall reevaluate and update the fixtures or construction
929 techniques demonstrated to reduce the amount of loss in a
930 windstorm and the discounts, credits, other rate differentials,
931 and appropriate reductions in deductibles that reflect the full
932 actuarial value of such fixtures or construction techniques. The
933 office shall adopt rules and forms necessitated by such
934 reevaluation.
935 (3) A rate filing ~~made on or after July 1, 1995,~~ for
936 mobile home owner insurance must include appropriate discounts,
937 credits, or other rate differentials for mobile homes
938 constructed to comply with American Society of Civil Engineers

Standard ANSI/ASCE 7-88, adopted by the United States Department of Housing and Urban Development on July 13, 1994, and that also comply with all applicable tie-down requirements provided by state law.

(4) The Legislature finds that separate consideration and notice of hurricane insurance premiums will assist consumers by providing greater assurance that hurricane premiums are lawful and by providing more complete information regarding the components of property insurance premiums. ~~Effective January 1, 1997,~~ A rate filing for residential property insurance shall be separated into two components, rates for hurricane coverage and rates for all other coverages. A premium notice reflecting a rate implemented on the basis of such a filing shall separately indicate the premium for hurricane coverage and the premium for all other coverages.

Section 16. Paragraph (ll) is added to subsection (6) of section 627.351, Florida Statutes, to read:

627.351 Insurance risk apportionment plans.—

(6) CITIZENS PROPERTY INSURANCE CORPORATION.—

(ll) The corporation may not determine that a risk is ineligible for coverage with the corporation solely because such risk has unrepaired damage caused by a covered loss that is the subject of a claim that has been filed with the Florida Insurance Guaranty Association. This paragraph applies to a risk until the earlier of 24 months after the date the Florida

Insurance Guaranty Association began servicing such claim or the Florida Insurance Guaranty Association closes the claim.

Section 17. Subsection (4) of section 627.410, Florida Statutes, is amended to read:

627.410 Filing, approval of forms.—

(4) The office may, by order, exempt from the requirements of this section for so long as it deems proper any insurance document or form or type thereof as specified in such order, to which, in its opinion, this section may not practicably be applied, or the filing and approval of which are, in its opinion, not desirable or necessary for the protection of the public. The office may not exempt from the requirements of this section the insurance documents or forms of any insurer, against whom the office enters a final order determining that such insurer violated any provision of this code, for a period of 36 months after the date of such order, and such forms may not be deemed approved under subsection (2).

Section 18. Section 627.4108, Florida Statutes, is created to read:

627.4108 Claims-handling manuals; submission; attestation.—

(1) Each authorized residential property insurer conducting business in this state must create and use a claims-handling manual that provides guidelines and procedures and that complies with the requirements of this code and, at a minimum,

comports to usual and customary industry claims-handling practices. Such manual must include guidelines and procedures for:

(a) Initially receiving and acknowledging initial receipt of the claim and reviewing and evaluating the claim;

(b) Communicating with policyholders, beginning with the receipt of the claim and continuing until closure of the claim;

(c) Setting the claim reserve;

(d) Investigating the claim, including conducting inspections of the property that is the subject of the claim;

(e) Making preliminary estimates and estimates of the covered damages to the insured property and communicating such estimates to the policyholder;

(f) The payment, partial payment, or denial of the claim and communicating such claim decision to the policyholder;

(g) Closing claims; and

(h) Any aspect of the claims-handling process which the office determines should be included in the claims-handling manual in order to:

1. Comply with the laws of this state or rules or orders of the office or department;

2. Ensure that the claims-handling manual, at a minimum, comports with usual and customary industry claims-handling guidelines; or

3. Protect policyholders of the insurer or the general

public.

(2) At any time, the office may request that a residential property insurer submit a physical or electronic copy of the insurer's currently applicable, or otherwise specifically requested, claims-handling manuals. Upon receiving such a request, a residential property insurer must submit to the office within 5 business days:

(a) A true and correct copy of each claims-handling manual requested; and

(b) An attestation, on a form prescribed by the commission, that certifies:

1. That the insurer has provided a true and correct copy of each currently applicable, or otherwise specifically requested, claims-handling manual; and

2. The timeframe for which each submitted claims-handling manual was or is in effect.

(3)(a) Annually, each authorized residential property insurer must certify and attest, on a form prescribed by the commission, that:

1. Each of the insurer's current claims-handling manuals complies with the requirements of this code and comports to, at a minimum, usual and customary industry claims-handling practices; and

2. The insurer maintains adequate resources available to implement the requirements of each of its claims-handling

manuals at all times, including during natural disasters and catastrophic events.

(b) Such attestation must be submitted to the office:

1. On or before August 1, 2023; and

2. Annually thereafter, on or before May 1 of each calendar year.

(4) The commission is authorized, and all conditions are deemed met, to adopt emergency rules under s. 120.54(4), for the purpose of implementing this section. Notwithstanding any other law, emergency rules adopted under this section are effective for 6 months after adoption and may be renewed during the pendency of procedures to adopt permanent rules addressing the subject of the emergency rules.

Section 19. Paragraph (d) of subsection (2) of section 627.4133, Florida Statutes, is amended to read:

627.4133 Notice of cancellation, nonrenewal, or renewal premium.—

(2) With respect to any personal lines or commercial residential property insurance policy, including, but not limited to, any homeowner, mobile home owner, farmowner, condominium association, condominium unit owner, apartment building, or other policy covering a residential structure or its contents:

(d)1. ~~Upon a declaration of an emergency pursuant to s. 252.36 and the filing of an order by the Commissioner of~~

~~Insurance Regulation,~~ An authorized insurer may not cancel or nonrenew a personal residential or commercial residential property insurance policy covering a dwelling or residential property located in this state:

a. For a period of 90 days after the dwelling or residential property has been repaired, if such property ~~which~~ has been damaged as a result of a hurricane or wind loss that is the subject of the declaration of emergency pursuant to s. 252.36 and the filing of an order by the Commissioner of Insurance Regulation ~~for a period of 90 days after the dwelling or residential property has been repaired~~. ~~A structure is deemed to be repaired when substantially completed and restored to the extent that it is insurable by another authorized insurer that is writing policies in this state.~~

b. Until the earlier of when the dwelling or residential property has been repaired or 1 year after the insurer issues the final claim payment, if such property was damaged by any covered peril and sub-subparagraph a. does not apply.

2. However, an insurer or agent may cancel or nonrenew such a policy prior to the repair of the dwelling or residential property:

a. Upon 10 days' notice for nonpayment of premium; or

b. Upon 45 days' notice:

(I) For a material misstatement or fraud related to the claim;

(II) If the insurer determines that the insured has unreasonably caused a delay in the repair of the dwelling; or

(III) If the insurer has paid policy limits.

3. If the insurer elects to nonrenew a policy covering a property that has been damaged, the insurer shall provide at least 90 days' notice to the insured that the insurer intends to nonrenew the policy 90 days after the dwelling or residential property has been repaired. Nothing in this paragraph shall prevent the insurer from canceling or nonrenewing the policy 90 days after the repairs are complete for the same reasons the insurer would otherwise have canceled or nonrenewed the policy but for the limitations of subparagraph 1. The Financial Services Commission may adopt rules, and the Commissioner of Insurance Regulation may issue orders, necessary to implement this paragraph.

4. This paragraph shall also apply to personal residential and commercial residential policies covering property that was damaged as the result of Hurricane Ian or Hurricane Nicole ~~Tropical Storm Bonnie, Hurricane Charley, Hurricane Frances, Hurricane Ivan, or Hurricane Jeanne~~.

5. For purposes of this paragraph:

a. A structure is deemed to be repaired when substantially completed and restored to the extent that it is insurable by another authorized insurer writing policies in this state.

b. The term "insurer" means an authorized insurer.

Section 20. Paragraph (a) of subsection (10) of section 627.701, Florida Statutes, is amended to read:

627.701 Liability of insureds; coinsurance; deductibles.—

(10)(a) Notwithstanding any other provision of law, an insurer issuing a personal lines residential property insurance policy may include in such policy a separate roof deductible that meets all of the following requirements:

1. The insurer has complied with the offer requirements under subsection (7) regarding a deductible applicable to losses from perils other than a hurricane.

2. The roof deductible may not exceed the lesser of 2 percent of the Coverage A limit of the policy or 50 percent of the cost to replace the roof.

3. The premium that a policyholder is charged for the policy includes an actuarially sound credit or premium discount for the roof deductible.

4. The roof deductible applies only to a claim adjusted on a replacement cost basis.

5. The roof deductible does not apply to any of the following events:

a. A total loss to a primary structure in accordance with the valued policy law under s. 627.702 which is caused by a covered peril.

b. A roof loss resulting from a hurricane as defined in s. 627.4025(2)(c).

c. A roof loss resulting from a tree fall or other hazard that damages the roof and punctures the roof deck.

d. A roof loss requiring the repair of less than 50 percent of the roof.

If a roof deductible is applied, no other deductible under the policy may be applied to the loss or to any other loss to the property caused by the same covered peril.

Section 21. Subsection (2) of section 627.70132, Florida Statutes, is amended to read:

627.70132 Notice of property insurance claim.—

(2) A claim or reopened claim, but not a supplemental claim, under an insurance policy that provides property insurance, as defined in s. 624.604, including a property insurance policy issued by an eligible surplus lines insurer, for loss or damage caused by any peril is barred unless notice of the claim was given to the insurer in accordance with the terms of the policy within 1 year after the date of loss. A supplemental claim is barred unless notice of the supplemental claim was given to the insurer in accordance with the terms of the policy within 18 months after the date of loss. The time limitations of this subsection are tolled during any term of deployment to a combat zone or combat support posting which materially affects the ability of a named insured who is a servicemember as defined in s. 250.01 to file a claim,

supplemental claim, or reopened claim.

Section 22. Paragraph (d) of subsection (2) and paragraph (b) of subsection (3) of section 628.8015, Florida Statutes, are amended to read:

628.8015 Own-risk and solvency assessment; corporate governance annual disclosure.—

(2) OWN-RISK AND SOLVENCY ASSESSMENT.—

(d) Exemption.—

1. An insurer is exempt from the requirements of this subsection if:

a. The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program, of less than $500 million; or

b. The insurer is a member of an insurance group and the insurance group has annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program, of less than $1 billion.

2. If an insurer is:

a. Exempt under sub-subparagraph 1.a., but the insurance group of which the insurer is a member is not exempt under sub-subparagraph 1.b., the ORSA summary report must include every

insurer within the insurance group. The insurer may satisfy this requirement by submitting more than one ORSA summary report for any combination of insurers if any combination of reports includes every insurer within the insurance group.

b. Not exempt under sub-subparagraph 1.a., but the insurance group of which it is a member is exempt under sub-subparagraph 1.b., the insurer must submit to the office the ORSA summary report applicable only to that insurer.

3. The office may require an exempt insurer to maintain a risk management framework, conduct an ORSA, and file an ORSA summary report:

a. Based on unique circumstances, including, but not limited to, the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests;

b. If the insurer has risk-based capital for a company action level event pursuant to s. 624.4085(3), meets one or more of the standards of an insurer deemed to be in hazardous financial condition <u>under s. 624.805</u> ~~as defined in rules adopted by the commission pursuant to s. 624.81(11)~~, or exhibits qualities of an insurer in hazardous financial condition as determined by the office; or

c. If the office determines it is in the best interest of the state.

4. If an exempt insurer becomes disqualified for an

exemption because of changes in premium as reported on the most recent annual statement of the insurer or annual statements of the insurers within the insurance group of which the insurer is a member, the insurer must comply with the requirements of this section effective 1 year after the year in which the insurer exceeded the premium thresholds.

(3) CORPORATE GOVERNANCE ANNUAL DISCLOSURE.—

(b) Disclosure requirement.—

1.a. An insurer, or insurer member of an insurance group, of which the office is the lead state regulator, as determined by the procedures in the most recent National Association of Insurance Commissioners Financial Analysis Handbook, shall submit a corporate governance annual disclosure to the office by June 1 of each calendar year. The initial corporate governance annual disclosure must be submitted by December 31, 2018.

b. An insurer or insurance group not required to submit a corporate governance annual disclosure under sub-subparagraph a. shall do so at the request of the office, but not more than once per calendar year. The insurer or insurance group shall notify the office of the proposed submission date within 30 days after the request of the office.

c. Before December 31, 2018, the office may require an insurer or insurance group to provide a corporate governance annual disclosure:

(I) Based on unique circumstances, including, but not

limited to, the type and volume of business written, the ownership and organizational structure, federal agency requests, and international supervisor requests;

(II) If the insurer has risk-based capital for a company action level event pursuant to s. 624.4085(3), meets one or more of the standards of an insurer deemed to be in hazardous financial condition under s. 624.805 ~~as defined in rules adopted pursuant to s. 624.81(11)~~, or exhibits qualities of an insurer in hazardous financial condition as determined by the office;

(III) If the insurer is the member of an insurer group of which the office acts as the lead state regulator as determined by the procedures in the most recent National Association of Insurance Commissioners Financial Analysis Handbook; or

(IV) If the office determines that it is in the best interest of the state.

2. The chief executive officer or corporate secretary of the insurer or the insurance group must sign the corporate governance annual disclosure attesting that, to the best of his or her knowledge and belief, the insurer has implemented the corporate governance practices and provided a copy of the disclosure to the board of directors or the appropriate board committee.

3.a. Depending on the structure of its system of corporate governance, the insurer or insurance group may provide corporate governance information at one of the following levels:

(I) The ultimate controlling parent level;

(II) An intermediate holding company level; or

(III) The individual legal entity level.

b. The insurer or insurance group may make the corporate governance annual disclosure at:

(I) The level used to determine the risk appetite of the insurer or insurance group;

(II) The level at which the earnings, capital, liquidity, operations, and reputation of the insurer are collectively overseen and the supervision of those factors is coordinated and exercised; or

(III) The level at which legal liability for failure of general corporate governance duties would be placed.

An insurer or insurance group must indicate the level of reporting used and explain any subsequent changes in the reporting level.

4. The review of the corporate governance annual disclosure and any additional requests for information shall be made through the lead state as determined by the procedures in the most recent National Association of Insurance Commissioners Financial Analysis Handbook.

5. An insurer or insurance group may comply with this paragraph by cross-referencing other existing relevant and applicable documents, including, but not limited to, the ORSA

summary report, Holding Company Form B or F filings, Securities and Exchange Commission proxy statements, or foreign regulatory reporting requirements, if the documents contain information substantially similar to the information described in paragraph (c). The insurer or insurance group shall clearly identify and reference the specific location of the relevant and applicable information within the corporate governance annual disclosure and attach the referenced document if it has not already been filed with, or made available to, the office.

6. Each year following the initial filing of the corporate governance annual disclosure, the insurer or insurance group shall file an amended version of the previously filed corporate governance annual disclosure indicating changes that have been made. If changes have not been made in the previously filed disclosure, the insurer or insurance group should so indicate.

Section 23. Chapter 2022-271, Laws of Florida, shall not be construed to impair any right under an insurance contract in effect on or before the effective date of that chapter law. To the extent that chapter 2022-271, Laws of Florida, affects a right under an insurance contract, that chapter law applies to an insurance contract issued or renewed after the applicable effective date provided by the chapter law. This section is intended to clarify existing law and is remedial in nature.

Section 24. (1) Every residential property insurer and every motor vehicle insurer rate filing made with the Office of

Insurance Regulation on or after July 1, 2023, must reflect the projected savings or reduction in claim frequency, claim severity, and loss adjustment expenses, including for attorney fees, payment of attorney fees to claimants, and any other reduction actuarially indicated, due to the combined effect of the applicable provisions of chapters 2021-77, 2022-268, 2022-271, and 2023-15, Laws of Florida, in order to ensure that rates for such insurance accurately reflect the risk of providing such insurance.

(2) The Office of Insurance Regulation must consider in its review of such rate filings the projected savings or reduction in claim frequency, claim severity, and loss adjustment expenses, including for attorney fees, payment of attorney fees to claimants, and any other reduction actuarially indicated, due to the combined effect of the applicable provisions of chapters 2021-77, 2022-268, 2022-271, and 2023-15, Laws of Florida. The office may develop methodology and data that incorporate generally accepted actuarial techniques and standards to be used in its review of rate filings governed by this section. The office may contract with an appropriate vendor to advise the office in developing such methodology and data to consider. Such methodology and data are not intended to create a mandatory minimum rate decrease for all residential property insurers and motor vehicle insurers, respectively, but rather to ensure that the rates for such coverage meet the requirements of

s. 627.062, Florida Statutes, and thus are not excessive, inadequate, or unfairly discriminatory and allow such insurers a reasonable rate of return.

(3) This section does not apply to rate filings made pursuant to s. 627.062(2)(k), Florida Statutes.

(4) For the 2023-2024 fiscal year, the sum of $500,000 in nonrecurring funds is appropriated from the Insurance Regulatory Trust Fund in the Department of Financial Services to the Office of Insurance Regulation to implement this section.

Section 25. For the 2023-2024 fiscal year, 18 full-time equivalent positions with associated salary rate of 1,116,500 are authorized and the sum of $1,879,129 in recurring funds and $185,086 in nonrecurring funds is appropriated from the Insurance Regulatory Trust Fund to the Office of Insurance Regulation to implement this act.

Section 26. For the 2023-2024 fiscal year, seven full-time equivalent positions with associated salary rate of 350,000 are authorized and the sum of $574,036 in recurring funds and $33,467 in nonrecurring funds is appropriated from the Insurance Regulatory Trust Fund to the Department of Financial Services to implement this act.

Section 27. This act shall take effect July 1, 2023.

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

Remove everything before the enacting clause and insert:

A bill to be entitled

An act relating to insurer accountability; creating s. 624.115, F.S.; specifying a requirement for the Office of Insurance Regulation in referring criminal violations; amending s. 624.307, F.S.; authorizing electronic responses to certain requests from the Division of Consumer Services of the Department of Financial Services concerning consumer complaints; revising the timeframe in which responses must be made; revising administrative penalties; amending s. 624.315, F.S.; requiring the office to annually and quarterly create and publish specified reports relating to the enforcement of insurer compliance; requiring the office to submit such reports to the Financial Services Commission and the Legislature by specified dates; amending s. 624.316, F.S.; revising the minimum intervals in which the office must examine certain insurers; revising periods that examinations must cover; requiring the office to create a specified methodology for scheduling examinations of insurers; specifying requirements for such methodology; providing construction; specifying requirements for the office in proposing rules to the commission; authorizing the commission to adopt rules; amending s.

624.3161, F.S.; revising requirements and conditions for certain insurer market conduct examinations after a hurricane; requiring the office to create, and the commission to adopt by rule, a specified selection methodology for examinations; specifying requirements for such methodology; specifying rulemaking requirements; specifying requirements, procedures, and conditions for the office's review of a liability insurer's claims-handling practices and the imposition of enhanced enforcement penalties; defining the term "actual notice"; providing construction; amending s. 624.4211, F.S.; revising administrative fines the office may impose in lieu of revocation or suspension; creating s. 624.4301, F.S.; specifying requirements for residential property insurers temporarily suspending writing new policies in notifying the office; providing applicability and construction; authorizing the commission to adopt rules; creating s. 624.805, F.S.; specifying factors the office may consider in determining whether the continued operation of an insurer may be deemed to be hazardous to its policyholders or creditors or to the general public; specifying actions the office may take in determining an insurer's financial condition; authorizing the office to issue an order requiring a

hazardous insurer to take specified actions; providing construction; authorizing the office to issue immediate final orders; amending s. 624.81, F.S.; deleting certain rulemaking authority of the commission; creating s. 624.865, F.S.; authorizing the commission to adopt certain rules; amending s. 626.207, F.S.; revising a condition for disqualification of an insurance representative applicant or licensee; amending s. 626.9521, F.S.; revising and specifying applicable fines for unfair methods of competition and unfair or deceptive acts or practices; amending s. 626.9541, F.S.; adding an unfair claim settlement practice by an insurer; prohibiting an officer or a director of an impaired insurer from receiving a bonus from such insurer or from certain holding companies or affiliates; defining the term "bonus"; providing a criminal penalty; amending s. 626.989, F.S.; revising a reporting requirement for the department's Division of Investigative and Forensic Services; revising a requirement for state attorneys or other prosecuting agencies having jurisdiction to inform the division under certain circumstances; requiring the division to submit an annual performance report to the Legislature; specifying requirements for the report;

amending s. 627.0629, F.S.; specifying requirements for residential property insurers in providing certain hurricane mitigation discount information to policyholders in a specified manner; specifying requirements for the office in reevaluating and updating certain fixtures and construction techniques; deleting obsolete dates; amending s. 627.351, F.S.; prohibiting Citizens Property Insurance Corporation from determining that a risk is ineligible for coverage solely on a specified basis; providing applicability; amending s. 627.410, F.S.; prohibiting the office from exempting specified insurers from form filing requirements for a specified period; providing construction; creating s. 627.4108, F.S.; specifying requirements for residential property insurers in creating and using claims-handling manuals; authorizing the office to request submission of such manuals; providing requirements for such submissions; requiring authorized insurers to annually submit a certified attestation to the office; authorizing the commission to adopt emergency rules; amending s. 627.4133, F.S.; revising prohibitions on insurers against the cancellation or nonrenewal of property insurance policies; revising applicability; providing construction; defining the term "insurer"; amending s.

627.701, F.S.; providing that if a roof deductible is applied under a personal lines residential property insurance policy, no other deductible under the policy may be applied to any other loss to the property caused by the same covered peril; amending s. 627.70132, F.S.; providing for the tolling of certain timeframes for filing notices of property insurance claims by named insureds who are servicemembers under specified circumstances; amending s. 628.8015, F.S.; conforming provisions to changes made by the act; providing construction relating to chapter 2022-271, Laws of Florida; requiring residential property insurers and motor vehicle insurer rate filings to reflect certain projected savings and reductions in expenses; specifying requirements for the office in reviewing rate filings; authorizing the office to develop certain methodology and data and contract with a vendor for a certain purpose; providing applicability; providing appropriations; providing an effective date.