By the Committee on Banking and Insurance

597-03563-23 20237052__

A bill to be entitled

An act relating to insurer accountability; 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.; specifying reporting requirements for the Office of Insurance Regulation's internal auditor in the office's annual report relating to the enforcement of insurer compliance; creating s. 624.3152, F.S.; specifying requirements for the office to report quarterly to the Legislature relating to the enforcement of insurer compliance; amending s. 624.316, F.S.; requiring the office to create a specified methodology for scheduling examinations of insurers; specifying requirements for such methodology; providing construction; amending s. 624.3161, F.S.; providing that authorized property insurers must, rather than may, be subject to an additional market conduct examination after a hurricane if specified conditions are met; revising the applicability of such conditions; requiring the office to create, and the Financial Services Commission to adopt by rule, a specified methodology for scheduling examinations of insurers; specifying requirements for such methodology; providing construction; amending s. 624.4211, F.S.; revising

administrative fines the office may impose in lieu of revocation or suspension; amending s. 624.424, F.S.; revising reporting requirements for insurers that pay financial consideration or payment to affiliates; revising factors the office must consider in determining whether such financial consideration or payment is fair and reasonable; specifying reporting requirements for insurers relating to agreements with affiliates; creating s. 624.4301, F.S.; specifying requirements for insurers temporarily suspending writing new policies in notifying the office; 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 to authorize or permit the insurer to pay a bonus to any officer or director of the insurer; defining the term "bonus"; providing a criminal penalty; amending s. 626.9743, F.S.; revising applicability of provisions relating to motor vehicle insurance claim settlement practices; specifying requirements, procedures, and authorized actions for insurers relating to communications, investigations, estimates, and recordkeeping; defining the terms "factors beyond the control of the insurer" and

"insurer"; specifying required notices by insurers; specifying requirements and procedures for insurers in paying or denying claims; providing construction and applicability; amending s. 626.989, F.S.; revising a reporting requirement for the department's Division of Investigative and Forensic Services; 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; amending s. 627.410, F.S.; prohibiting the office from exempting specified insurers from form filing requirements; creating s. 627.4108, F.S.; providing legislative intent; specifying requirements for insurers in submitting claims-handling manuals to the office; authorizing the office to conduct examinations; 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. 627.426, F.S.; requiring the office to ensure that each liability insurer, upon receiving certain notice, takes specified actions; providing construction; 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 for servicemembers; amending s. 627.7019, F.S.; providing that surplus lines insurers are subject to the commission's rulemaking authority as to requirements of insurers after natural disasters; amending s. 627.782, F.S.; revising rate filing requirements for title insurers; providing that the office, rather than the commission, must review premium rates; providing construction relating to chapter 2022-271, Laws of Florida; requiring residential property insurers and motor vehicle insurer rate filings to reflect certain savings and reductions in expenses; specifying requirements for the office in reviewing rate filings; authorizing the office to develop certain factors and contract with a vendor for a certain purpose; providing appropriations; providing an effective date.

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

Section 1. 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 2. 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 report.—

(4) The internal auditor of the office shall detail all actions of the office to enforce insurer compliance 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 Governor, the President of the Senate, and the Speaker of the House of Representatives on or before February 15 of each year. The report must include, but need not be limited to:

(a) The revocation, denial, or suspension of any license or registration issued by the office.

(b) All actions taken pursuant to s. 624.310.

(c) Fines imposed by the office for violations of this code.

(d) Consent orders entered into by the office.

(e) Examinations and investigations conducted and completed by the office pursuant to ss. 624.316 and 624.3161.

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

Section 3. Section 624.3152, Florida Statutes, is created to read:

624.3152 Quarterly report of enforcement activity.—Each quarter, the office shall create a report detailing all actions of the office to enforce insurer compliance. 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. 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 is due on or before April 30, July 31, October 31, and January 31, respectively, for the immediately preceding quarter. 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.

Section 4. Subsection (3) is added to section 624.316, Florida Statutes, to read:

624.316 Examination of insurers.—

(3) The office shall create a risk-based selection methodology for scheduling examinations of insurers subject to this section. This requirement does not restrict the authority of the office to conduct market conduct examinations as often as it deems advisable. Such methodology must include:

(a) Use of currently required risk-based capital reports to prioritize financial examinations of insurers when such reporting indicates a decline in the insurer’s financial condition.

(b) Consideration of any downgrade or threatened downgrade in the insurer’s financial strength rating.

(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 conditions the office deems necessary for the protection of the public.

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

624.3161 Market conduct examinations.—

(7) Notwithstanding subsection (1), any authorized insurer transacting property insurance business in this state must ~~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) Is among the top 20 percent of insurers based upon a calculation of the ratio of consumer complaints made to the department to hurricane-related claims;

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

(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. This requirement does not limit in any way the authority of the office to conduct at any time a market conduct examination of a property insurer in the aftermath of a hurricane. 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 risk-based 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. Under such selection methodology, the office must initiate a market conduct examination if any of the following conditions exist relating to an insurer or other entity regulated by the office:

(a) An insurance regulator in another state has initiated or taken regulatory action against the insurer or entity, including, but not limited to:

1. A licensure denial, suspension, or revocation;

2. Imposition of administrative fines; or

3. Issuance of a cease and desist order, consent order, or other order regarding actions or omissions of the insurer or entity.

(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 the Unfair Insurance Trade Practices Act in part IX of chapter 626;

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 the insurer is a negative outlier with regard to particular metrics.

(d) There is evidence the insurer is engaged in a pattern or practice of violations of 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.

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. Subsection (13) of section 624.424, Florida Statutes, is amended to read:

624.424 Annual statement and other information.—

(13)(a) Each insurer doing business in this state which pays a fee, commission, or other financial consideration or payment to any affiliate directly or indirectly must ~~is required upon request to~~ provide to the office documentation supporting that such ~~any information the office deems necessary. The~~ fee, commission, or other financial consideration or payment to any affiliate is ~~must be~~ fair and reasonable for each service being

provided by contract. In determining whether the fee, commission, or other financial consideration or payment is fair and reasonable, the office shall consider, at a minimum, the following:

1. The actual cost of each service provided by an affiliate;

2. The cost of that service, if provided by a nonaffiliate;

3. The relative financial condition of the insurer and of the managing general agent;

4. The level of holding company debt and how that debt is serviced;

5. The amount of dividends paid by the managing general agent and for what purpose; and

6. Whether the terms of the written contract benefit the insurer and are in the best interest of policyholders.

(b) For each agreement with an affiliate in force on July 1, 2023, each insurer shall provide to the office no later than October 1, 2023, the cost incurred by the affiliate to provide each service, the amount charged to the insurer for each service, and the dollar amount of fees forgiven, waived, or reimbursed by the affiliate for the two most recent preceding years. If the total dollar amount charged to the insurer was greater than the total cost to provide services for either year, the insurer must explain how it determined the fee was fair and reasonable. For any proposed contract with an affiliate effective after July 1, 2023, the insurer may include a proposal for the same services by an unaffiliated third party to support that the fee, commission, or other financial consideration or payment to the affiliate is fair and reasonable ~~among other~~

~~things, the actual cost of the service being provided~~.

Section 8. Section 624.4301, Florida Statutes, is created to read:

624.4301 Notice of temporary discontinuance of writing new policies.—Any insurer, before temporarily suspending writing new policies in this state, must give written 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. 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.

Section 9. 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 violation of the Florida Insurance Code.

Section 10. 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 $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.

(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 under this paragraph imposed against an insurer 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 11. 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 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. Any change that has the effect of reducing the estimate of the loss must include a detailed explanation why such change was made; 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 or payment of certain bonuses by insolvent or impaired 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 authorize or permit the insurer to pay a bonus to any officer or director of the 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, that 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 12. Section 626.9743, Florida Statutes, is amended to read:

626.9743 Claim settlement practices relating to motor vehicle insurance.—

(1) This section shall apply to the adjustment and settlement of first- and third-party personal and commercial motor vehicle insurance claims.

(2)(a) Upon an insurer's receiving a communication with respect to a claim, the insurer shall within 7 calendar days review and acknowledge receipt of such communication unless

payment is made within that period of time or unless the failure to acknowledge is caused by factors beyond the control of the insurer. If the acknowledgment is not in writing, a notification indicating acknowledgement must be made in the insurer's claim file and dated. A communication made to or by a representative of an insurer with respect to a claim constitutes communication to or by the insurer.

(b) Such acknowledgment must be responsive to the communication. If the communication constitutes notification of a claim, unless the acknowledgment reasonably advises the claimant that the claim appears not to be covered by the insurer, the acknowledgment must provide necessary claim forms and instructions, including an appropriate telephone number.

(3)(a) Unless otherwise provided by the policy of insurance or by law, within 7 days after an insurer receives proof-of-loss statements, the insurer shall begin such investigation as is reasonably necessary unless the failure to begin such investigation is caused by factors beyond the control of the insurer.

(b) If such investigation involves a physical inspection of the motor vehicle, the licensed adjuster assigned by the insurer must provide the policyholder with a printed or electronic document containing his or her name and state adjuster license number. An insurer must conduct any such physical inspection within 7 days after its receipt of the proof-of-loss statements.

(c) Any subsequent communication with the policyholder regarding the claim must also include the name and license number of the adjuster communicating about the claim. Communication of the adjuster's name and license number may be

included with other information provided to the policyholder.

(d) An insurer may use electronic methods to investigate the loss. Such electronic methods may include any method that provides the insurer with clear color pictures or video documenting the loss, including, but not limited to, electronic photographs or video recordings of the loss and video conferencing between the adjuster and the policyholder which includes video recording of the loss. The insurer may also allow the policyholder to use such methods to assist in the investigation of the loss. An insurer may void the insurance policy if the policyholder or any other person at the direction of the policyholder, with intent to injure, defraud, or deceive any insurer, commits insurance fraud by providing false, incomplete, or misleading information concerning any fact or thing material to a claim using electronic methods. The use of electronic methods to investigate the loss does not prohibit an insurer from assigning a licensed adjuster to physically inspect the motor vehicle.

(e) The insurer must send the policyholder a copy of any detailed estimate of the amount of the loss within 7 days after the estimate is generated by the insurer's adjuster. This paragraph does not require that an insurer create a detailed estimate of the amount of the loss if such estimate is not reasonably necessary as part of the claim investigation.

(4) An insurer shall maintain:

(a) A record or log of each adjuster who communicates with the policyholder as provided in paragraphs (3)(b) and (c) and provide a list of such adjusters to the insured, the office, or the department upon request.

(b) Claim records, including dates of:

1. Any claim-related communication made between the insurer and the policyholder or the policyholder's representative;

2. The insurer's receipt of the policyholder's proof of loss statement;

3. Any claim-related request for information made by the insurer to the policyholder or the policyholder's representative;

4. Any claim-related inspections of the property made by the insurer, including physical inspections and inspections made by electronic means;

5. Any detailed estimate of the amount of the loss generated by the insurer's adjuster;

6. The beginning and end of any tolling period provided for in subsection (8); and

7. The insurer's payment or denial of the claim.

(5) For purposes of this section, the term:

(a) "Factors beyond the control of the insurer" means:

1. Any of the following events which is the basis for the office issuing an order finding that such event renders all or specified residential property insurers reasonably unable to meet the requirements of this section in specified locations, and ordering that such insurer or insurers may have additional time as specified by the office to comply with the requirements of this section: a state of emergency declared by the Governor under s. 252.36, a breach of security that must be reported under s. 501.171(3), or an information technology issue. The office may not extend the period for payment or denial of a claim for more than 30 additional days.

2. Actions by the policyholder or the policyholder's representative which constitute fraud, lack of cooperation, or intentional misrepresentation regarding the claim for which benefits are owed when such actions reasonably prevent the insurer from complying with any requirement of this section.

(b) "Insurer" means any motor vehicle insurer.

(6)(a) When providing a preliminary or partial estimate of damage regarding a claim, an insurer shall include with the estimate the following statement printed in at least 12-point bold, uppercase type: "THIS ESTIMATE REPRESENTS OUR CURRENT EVALUATION OF THE COVERED DAMAGES TO YOUR INSURED PROPERTY AND MAY BE REVISED AS WE CONTINUE TO EVALUATE YOUR CLAIM. IF YOU HAVE QUESTIONS, CONCERNS, OR ADDITIONAL INFORMATION REGARDING YOUR CLAIM, WE ENCOURAGE YOU TO CONTACT US."

(b) When providing a payment on a claim which is not the full and final payment for the claim, an insurer shall include with the payment the following statement printed in at least 12-point bold, uppercase type: "WE ARE CONTINUING TO EVALUATE YOUR CLAIM INVOLVING YOUR INSURED PROPERTY AND MAY ISSUE ADDITIONAL PAYMENTS. IF YOU HAVE QUESTIONS, CONCERNS, OR ADDITIONAL INFORMATION REGARDING YOUR CLAIM, WE ENCOURAGE YOU TO CONTACT US."

(7) Within 60 days after an insurer receives notice of an initial or supplemental motor vehicle claim from a first- or third-party claimant, the insurer shall pay or deny such claim or a portion of the claim unless the failure to pay is caused by factors beyond the control of the insurer. The insurer shall provide a reasonable explanation in writing to the policyholder of the basis in the insurance policy, in relation to the facts

or applicable law, for the payment, denial, or partial denial of a claim. If the insurer's claim payment is less than specified in any insurer's detailed estimate of the amount of the loss, the insurer must provide a reasonable explanation in writing of the difference to the policyholder. Any payment of an initial or supplemental claim or portion of such claim made 60 days after the insurer receives notice of the claim, or made after the expiration of any additional timeframe provided to pay or deny a claim or a portion of a claim made pursuant to an order of the office finding factors beyond the control of the insurer, whichever is later, bears interest at the rate set forth in s. 55.03. Interest begins to accrue from the date the insurer receives notice of the claim. This subsection may not be waived, voided, or nullified by the terms of the insurance policy. If there is a right to prejudgment interest, the insured must select whether to receive prejudgment interest or interest under this subsection. Interest is payable when the claim or portion of the claim is paid. Failure to comply with this subsection constitutes a violation of this code. However, failure to comply with this subsection does not form the sole basis for a private cause of action.

(8) The requirements of this section are tolled:

(a) During the pendency of any mediation proceeding under s. 627.745 or any alternative dispute resolution proceeding provided for in the insurance contract. The tolling period ends upon the end of the mediation or alternative dispute resolution proceeding.

(b) Upon the failure of a policyholder or a representative of the policyholder to provide material claims information

requested by the insurer within 10 days after the request was received. The tolling period ends upon the insurer's receipt of the requested information. Tolling under this paragraph applies only to requests sent by the insurer to the policyholder or a representative of the policyholder at least 15 days before the insurer is required to pay or deny the claim or a portion of the claim under subsection (7).

(9) This section also applies to surplus lines insurers and surplus lines insurance authorized under ss. 626.913-626.937 providing motor vehicle coverage.

(10) ~~(2)~~ An insurer may not, when liability and damages owed under the policy are reasonably clear, recommend that a third-party claimant make a claim under his or her own policy solely to avoid paying the claim under the policy issued by that insurer. However, the insurer may identify options to a third-party claimant relative to the repair of his or her vehicle.

(11) ~~(3)~~ An insurer that elects to repair a motor vehicle and specifically requires a particular repair shop for vehicle repairs shall cause the damaged vehicle to be restored to its physical condition as to performance and appearance immediately prior to the loss at no additional cost to the insured or third-party claimant other than as stated in the policy.

(12) ~~(4)~~ An insurer may not require the use of replacement parts in the repair of a motor vehicle which are not at least equivalent in kind and quality to the damaged parts prior to the loss in terms of fit, appearance, and performance.

(13) ~~(5)~~ When the insurance policy provides for the adjustment and settlement of first-party motor vehicle total losses on the basis of actual cash value or replacement with

another of like kind and quality, the insurer shall use one of the following methods:

(a) The insurer may elect a cash settlement based upon the actual cost to purchase a comparable motor vehicle, including sales tax, if applicable pursuant to subsection (17) ~~(9)~~. Such cost may be derived from:

1. When comparable motor vehicles are available in the local market area, the cost of two or more such comparable motor vehicles available within the preceding 90 days;

2. The retail cost as determined from a generally recognized used motor vehicle industry source such as:

a. An electronic database if the pertinent portions of the valuation documents generated by the database are provided by the insurer to the first-party insured upon request; or

b. A guidebook that is generally available to the general public if the insurer identifies the guidebook used as the basis for the retail cost to the first-party insured upon request; or

3. The retail cost using two or more quotations obtained by the insurer from two or more licensed dealers in the local market area.

(b) The insurer may elect to offer a replacement motor vehicle that is a specified comparable motor vehicle available to the insured, including sales tax if applicable pursuant to subsection (17) ~~(9)~~, paid for by the insurer at no cost other than any deductible provided in the policy and betterment as provided in subsection (14) ~~(6)~~. The offer must be documented in the insurer’s claim file. For purposes of this subsection, a comparable motor vehicle is one that is made by the same manufacturer, of the same or newer model year, and of similar

body type and that has similar options and mileage as the insured vehicle. Additionally, a comparable motor vehicle must be in as good or better overall condition than the insured vehicle and available for inspection within a reasonable distance of the insured's residence.

(c) When a motor vehicle total loss is adjusted or settled on a basis that varies from the methods described in paragraph (a) or paragraph (b), the determination of value must be supported by documentation, and any deductions from value must be itemized and specified in appropriate dollar amounts. The basis for such settlement shall be explained to the claimant in writing, if requested, and a copy of the explanation shall be retained in the insurer's claim file.

(d) Any other method agreed to by the claimant.

(14) ~~(6)~~ When the amount offered in settlement reflects a reduction by the insurer because of betterment or depreciation, information pertaining to the reduction shall be maintained with the insurer's claim file. Deductions shall be itemized and specific as to dollar amount and shall accurately reflect the value assigned to the betterment or depreciation. The basis for any deduction shall be explained to the claimant in writing, if requested, and a copy of the explanation shall be maintained with the insurer's claim file.

(15) ~~(7)~~ Every insurer shall, if partial losses are settled on the basis of a written estimate prepared by or for the insurer, supply the insured a copy of the estimate upon which the settlement is based.

(16) ~~(8)~~ Every insurer shall provide notice to an insured before termination of payment for previously authorized storage

charges, and the notice shall provide 72 hours for the insured to remove the vehicle from storage before terminating payment of the storage charges.

(17)~~(9)~~ If sales tax will necessarily be incurred by a claimant upon replacement of a total loss or upon repair of a partial loss, the insurer may defer payment of the sales tax unless and until the obligation has actually been incurred.

(18)~~(10)~~ Nothing in this section shall be construed to authorize or preclude enforcement of policy provisions relating to settlement disputes.

Section 13. 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 the reasons 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 January 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 14. 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 construction techniques that meet the minimum requirements of the Florida Building Code must be included in the rate filing.

The office shall determine the discounts, credits, other rate differentials, and appropriate reductions in deductibles that reflect the full actuarial value of such revaluation, which may be used by insurers in rate filings. Effective July 1, 2023, each insurer subject to the requirements of this section must provide information on the insurer's website describing the hurricane mitigation discounts available to policyholders. Such information must be accessible on, or through a hyperlink located on, the home page of the insurer's website or the primary page of the insurer's website for property insurance policyholders or applicants for such coverage in this state. On or before January 1, 2025, and every 5 years thereafter, the office shall reevaluate and update the fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm and the discounts, credits, other rate differentials, and appropriate reductions in deductibles that reflect the full actuarial value of such fixtures or construction techniques. The office shall adopt rules and forms necessitated by such reevaluation.

(3) A rate filing ~~made on or after July 1, 1995,~~ for mobile home owner insurance must include appropriate discounts, credits, or other rate differentials for mobile homes 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 15. 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.

Section 16. 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.

Section 17. Section 627.4108, Florida Statutes, is created to read:

627.4108 Submission of claims-handling manuals; attestation.—

(1) This section is intended to ensure that insurers are able to properly handle insurance claims, particularly during natural disasters, catastrophes, and other emergencies.

(2) Each authorized insurer and eligible surplus lines insurer conducting business in this state shall submit any and all claims-handling manuals to the office:

(a) On or before August 1, 2023;

(b) Annually thereafter, on or before May 1 of each calendar year; and

(c) Within 30 days after any updates or amendments to such manual.

(3) The insurer shall include with each such submission an attestation on a form prescribed by the commission, stating that:

(a) The insurer’s claims-handling manual complies with the requirements of this code and comports to usual and customary industry claims-handling practices; and

(b) The insurer maintains adequate resources available to implement the requirements of its claims-handling manual at all times, including during extreme catastrophic events.

(4) The office may, as often as it deems necessary, conduct market conduct examinations under s. 624.3161 of insurers to

ensure compliance with this section.

(5) 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 18. 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 or surplus lines 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 dwelling or residential property has been repaired, if such property was damaged by any covered peril and the provisions of sub-subparagraph a. do 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. "Insurer" means an authorized insurer or an eligible surplus lines insurer.

Section 19. Subsection (3) is added to section 627.426, Florida Statutes, to read:

627.426 Claims administration.—

(3)(a) The office shall ensure that each liability insurer, upon receiving actual notice of an incident or a loss that could give rise to a covered liability claim under an insurance policy:

1. Assigns a duly licensed and appointed insurance adjuster to investigate the extent of the insured's probable exposure and diligently attempts to resolve any questions concerning the existence or extent of the insured's coverage.

2. Based on available information, ethically evaluates every claim fairly, honestly, and with due regard for the interests of the insured; considers the extent of the claimant's recoverable damages; and considers the information in a reasonable and prudent manner.

3. Requests from the insured or claimant additional

relevant information the insurer reasonably deems necessary to evaluate whether to settle a claim.

4. Conducts all oral and written communications with the insured with the utmost honesty and complete candor.

5. Makes 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. Retains all written communications and notes and retains a summary of all verbal communications in a reasonable manner for a period of not less than 5 years after the later of the entry of a judgment against the insured in excess of policy limits becomes final or the conclusion of the extracontractual claim, if any, including any related appeals.

7. Provides the insured, upon request, with all communications related to the insurer's handling of the claim which are not privileged as to the insured.

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

9. In handling third-party claims, communicates to an insured all of the following:

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

b. The insurer's evaluation of the claim.

c. The likelihood and possible extent of an excess judgment.

d. Steps the insured can take to avoid exposure to an excess judgment, including the right to secure personal counsel

at the insured's expense.

e. The insured's duty to cooperate with the insurer, including any specific requests required because of a settlement opportunity or by the insurer in accordance with the policy, the purpose of the required cooperation, and the consequences of refusing to cooperate; and any settlement demands or offers.

10. If, after the expiration of the safe harbor periods in s. 624.155(4) or (6), as applicable, the facts available to the insurer indicate that the insured's liability is likely to exceed the policy limits, initiates settlement negotiations by tendering its policy limits to the claimant in exchange for a general release of the insured.

11. Gives fair consideration to a settlement offer that is not unreasonable under the facts available to the insurer and settle, if possible, when a reasonably prudent person, faced with the prospect of paying the total probable exposure of the insured, would do so. The insurer shall provide reasonable assistance to the insured to comply with the insured's obligations to cooperate and act reasonably to attempt to satisfy any conditions of a claimant's settlement offer. If it is not possible to settle a liability claim within the available policy limits, the insurer shall act reasonably to attempt to minimize the excess exposure to the insured.

12. When multiple claims arise out of a single occurrence, the combined value of all claims exceeds the total of all applicable policy limits, and the claimants are unwilling to globally settle within the policy limits, thereafter attempts to minimize the magnitude of possible excess judgments against the insured. The insurer is entitled to great discretion to decide

how much to offer each respective claimant in its attempt to protect the insured. The insurer may, in its effort to minimize the excess liability of the insured, use its discretion to offer the full available policy limits to one or more claimants to the exclusion of other claimants and may leave the insured exposed to some liability after all the policy limits are paid. An insurer does not violate this section simply because it is unable to settle all claims in a multiple claimant case.

13. When a loss creates the potential for a third-party claim against more than one insured, attempts to settle the claim on behalf of all insureds against whom a claim may be presented. If it is not possible to settle on behalf of all insureds, the insurer, in consultation with the insureds, must attempt to enter into reasonable settlements of claims against certain insureds to the exclusion of other insureds.

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

15. Where it appears the insured's probable exposure is greater than policy limits, takes reasonable measures to preserve, for a reasonable period of time, evidence that is needed for the defense of the liability claim.

16. Complies with s. 627.426, if applicable.

17. Complies with any provision of the Unfair Insurance Trade Practices Act.

(b) Violations of this section constitute violations of the Florida Insurance Code and are subject to any applicable enforcement provisions therein.

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 federal or state active duty which materially affects the ability of a servicemember as defined in s. 250.01 to file a claim, supplemental claim, or reopened claim.

Section 22. Section 627.7019, Florida Statutes, is amended to read:

627.7019 Standardization of requirements applicable to insurers after natural disasters.—

(1) The commission shall adopt by rule, pursuant to s. 120.54(1)-(3), standardized requirements that may be applied to insurers and surplus lines insurers as a consequence of a hurricane or other natural disaster. The rules shall address the following areas:

(a) Claims reporting requirements.

(b) Grace periods for payment of premiums and performance of other duties by insureds.

(c) Temporary postponement of cancellations and nonrenewals.

(2) The rules adopted under this section shall require the office to issue an order within 72 hours after the occurrence of a hurricane or other natural disaster specifying, by line of insurance, which of the standardized requirements apply, the geographic areas in which they apply, the time at which applicability commences, and the time at which applicability terminates.

(3) Any emergency rule adopted under s. 120.54(4) which is in conflict with any provision of the rules adopted under this section must be by unanimous vote of the commission.

Section 23. Section 627.782, Florida Statutes, is amended to read:

627.782 Adoption of rates.—

(1) Rates for title insurance are subject to the rating provisions of this section. Title insurers shall file with the office under the procedures set forth in s. 627.062(2)(a)1. or 2. rates, rating schedules, rating manuals, premium credits or discount schedules, and surcharge schedules, and changes thereto, ~~code, the commission must adopt a rule specifying the premium~~ to be charged in this state ~~by title insurers~~ for the respective types of title insurance contracts and, for policies issued through agents or agencies, the percentage of such premium ~~required~~ to be retained by the title insurer ~~which shall not be less than 30 percent~~. However, in a transaction subject to the Real Estate Settlement Procedures Act of 1974, 12 U.S.C.

ss. 2601 et seq., as amended, no portion of the premium attributable to providing a primary title service shall be paid to or retained by any person who does not actually perform or is not liable for the performance of such service.

(2) In reviewing ~~adopting~~ premium rates, the office ~~commission~~ must give due consideration to the following:

(a) The title insurers' loss experience and prospective loss experience under closing protection letters and policy liabilities.

(b) A reasonable margin for underwriting profit and contingencies, including contingent liability under s. 627.7865, sufficient to allow title insurers, agents, and agencies to earn a rate of return on their capital that will attract and retain adequate capital investment in the title insurance business and maintain an efficient title insurance delivery system.

(c) Past expenses and prospective expenses for administration and handling of risks.

(d) Liability for defalcation.

(e) Other relevant factors.

(3) Rates may be grouped by classification or schedule and may differ as to class of risk assumed.

(4) Rates may not be excessive, inadequate, or unfairly discriminatory.

(5) The premium applies to each $100 of insurance issued to an insured.

(6) ~~The premium rates apply throughout this state.~~

~~(7) The commission shall, in accordance with the standards provided in subsection (2), review the premium as needed, but not less frequently than once every 3 years, and shall, based~~

~~upon the review required by this subsection, revise the premium if the results of the review so warrant.~~

~~(8)~~ Each title insurance agency and insurer licensed to do business in this state and each insurer's direct or retail business in this state shall maintain and submit information, including revenue, loss, and expense data, as the office determines necessary to assist in the analysis of title insurance premium rates, title search costs, and the condition of the title insurance industry in this state. Such information shall be transmitted to the office annually by May 31 of the year after the reporting year. The commission shall adopt rules relating to the collection and analysis of the data from the title insurance industry.

Section 24. 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 effective date of that chapter law. This section is intended to clarify existing law and is remedial in nature.

Section 25. (1) Every residential property insurer and every motor vehicle insurer rate filing made or pending with the Office of Insurance Regulation on or after July 1, 2023, must reflect the 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 provide rate relief to policyholders as soon as practicable.

(2) The Office of Insurance Regulation must consider in its review of such rate filings the 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 a factor or factors using 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 determining such factor or factors.

(3) 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 26. For the 2023-2024 fiscal year, five positions with associated salary rate of 325,000 and the sum of $494,774 in recurring funds and $23,410 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.