By the Committees on Fiscal Policy; and Banking and Insurance

594-04106-23 20237052c1

1 A bill to be entitled
2 An act relating to insurer accountability; amending s.
3 624.307, F.S.; authorizing electronic responses to
4 certain requests from the Division of Consumer
5 Services of the Department of Financial Services
6 concerning consumer complaints; revising the timeframe
7 in which responses must be made; revising
8 administrative penalties; amending s. 624.315, F.S.;
9 requiring the Office of Insurance Regulation to
10 annually and quarterly create and publish specified
11 reports relating to the enforcement of insurer
12 compliance; requiring the office to submit such
13 reports to the Financial Services Commission and the
14 Legislature by specified dates; amending s. 624.316,
15 F.S.; requiring the office to create a specified
16 methodology for scheduling examinations of insurers;
17 specifying requirements for such methodology;
18 providing construction; authorizing the commission to
19 adopt rules; amending s. 624.3161, F.S.; revising
20 requirements and conditions for certain insurer market
21 conduct examinations after a hurricane; providing
22 construction; requiring the office to create, and the
23 commission to adopt by rule, a specified selection
24 methodology for examinations; specifying requirements
25 for such methodology; specifying rulemaking
26 requirements; amending s. 624.4211, F.S.; revising
27 administrative fines the office may impose in lieu of
28 revocation or suspension; creating s. 624.4301, F.S.;
29 specifying requirements for residential property

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30 insurers temporarily suspending writing new policies
31 in notifying the office; authorizing the commission to
32 adopt rules; creating s. 624.805, F.S.; specifying
33 factors the office may consider in determining whether
34 the continued operation of an insurer may be deemed to
35 be hazardous to its policyholders or creditors or to
36 the general public; specifying actions the office may
37 take in determining an insurer's financial condition;
38 authorizing the office to issue an order requiring a
39 hazardous insurer to take specified actions; providing
40 construction; authorizing the office to issue
41 immediate final orders; amending s. 624.81, F.S.;
42 deleting certain rulemaking authority of the
43 commission; creating s. 624.865, F.S.; authorizing the
44 commission to adopt certain rules; amending s.
45 628.8015, F.S.; conforming provisions to changes made
46 by the act; amending s. 626.207, F.S.; revising a
47 condition for disqualification of an insurance
48 representative applicant or licensee; amending s.
49 626.9521, F.S.; revising and specifying applicable
50 fines for unfair methods of competition and unfair or
51 deceptive acts or practices; amending s. 626.9541,
52 F.S.; adding an unfair claim settlement practice by an
53 insurer; prohibiting an officer or a director of an
54 impaired insurer from receiving a bonus from such
55 insurer or from certain holding companies or
56 affiliates; defining the term "bonus"; providing a
57 criminal penalty; amending s. 626.989, F.S.; revising
58 a reporting requirement for the department's Division

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59 of Investigative and Forensic Services; requiring the
60 division to submit an annual performance report to the
61 Legislature; specifying requirements for the report;
62 amending s. 627.0629, F.S.; specifying requirements
63 for residential property insurers in providing certain
64 hurricane mitigation discount information to
65 policyholders in a specified manner; specifying
66 requirements for the office in reevaluating and
67 updating certain fixtures and construction techniques;
68 deleting obsolete dates; amending s. 627.351, F.S.;
69 prohibiting Citizens Property Insurance Corporation
70 from determining that a risk is ineligible for
71 coverage solely on a specified basis; providing
72 applicability; amending s. 627.410, F.S.; prohibiting
73 the office from exempting specified insurers from form
74 filing requirements for a specified period; providing
75 construction; creating s. 627.4108, F.S.; specifying
76 requirements for residential property insurers in
77 creating and using claims-handling manuals;
78 authorizing the office to request submission of such
79 manuals; providing requirements for such submissions;
80 requiring authorized insurers to annually submit a
81 certified attestation to the office; authorizing the
82 commission to adopt emergency rules; amending s.
83 627.4133, F.S.; revising prohibitions on insurers
84 against the cancellation or nonrenewal of property
85 insurance policies; revising applicability; providing
86 construction; defining the term “insurer”; amending s.
87 627.426, F.S.; specifying duties of a liability

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88 insurer upon receiving actual notice of certain
89 incidents or losses; defining the term "actual
90 notice"; providing construction; specifying penalties;
91 amending s. 627.701, F.S.; providing that if a roof
92 deductible is applied under a personal lines
93 residential property insurance policy, no other
94 deductible under the policy may be applied to any
95 other loss to the property caused by the same covered
96 peril; amending s. 627.70132, F.S.; providing for the
97 tolling of certain timeframes for filing notices of
98 property insurance claims for servicemembers under
99 specified circumstances; providing construction
100 relating to chapter 2022-271, Laws of Florida;
101 requiring residential property insurers and motor
102 vehicle insurer rate filings to reflect certain
103 projected savings and reductions in expenses;
104 specifying requirements for the office in reviewing
105 rate filings; authorizing the office to develop
106 certain methodology and data and contract with a
107 vendor for a certain purpose; providing applicability;
108 providing appropriations; providing an effective date.
109
110 Be It Enacted by the Legislature of the State of Florida:
111
112 Section 1. Paragraph (b) of subsection (10) of section
113 624.307, Florida Statutes, is amended to read:
114 624.307 General powers; duties.—
115 (10)
116 (b) Any person licensed or issued a certificate of

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117 authority by the department or the office shall respond, in
118 writing or electronically, to the division within 14 ~~20~~ days
119 after receipt of a written request for documents and information
120 from the division concerning a consumer complaint. The response
121 must address the issues and allegations raised in the complaint
122 and include any requested documents concerning the consumer
123 complaint not subject to attorney-client or work-product
124 privilege. The division may impose an administrative penalty for
125 failure to comply with this paragraph of up to $5,000 ~~$2,500~~ per
126 violation upon any entity licensed by the department or the
127 office ~~and $250 for the first violation, $500 for the second~~
128 ~~violation,~~ and up to $1,000 per ~~for the third or subsequent~~
129 violation by ~~upon~~ any individual licensed by the department or
130 the office.
131 Section 2. Present subsection (4) of section 624.315,
132 Florida Statutes, is redesignated as subsection (5), and a new
133 subsection (4) is added to that section, to read:
134 624.315 Annual reports; quarterly reports ~~report~~.—
135 (4)(a) The office shall create a report detailing all
136 actions of the office to enforce insurer compliance with this
137 code and all rules and orders of the office or department during
138 the previous year. For each of the following, the report must
139 detail the insurer or other licensee or registrant against whom
140 such action was taken; whether the office found any violation of
141 law or rule by such party, and, if so, detail such violation;
142 and the resolution of such action, including any penalties
143 imposed by the office. The report must be published on the
144 website of the office and submitted to the commission, the
145 President of the Senate, the Speaker of the House of

146 Representatives, and the legislative committees with
147 jurisdiction over matters of insurance on or before January 31
148 of each year. The report must include, but need not be limited
149 to:
150 1. The revocation, denial, or suspension of any license or
151 registration issued by the office.
152 2. All actions taken pursuant to s. 624.310.
153 3. Fines imposed by the office for violations of this code.
154 4. Consent orders entered into by the office.
155 5. Examinations and investigations conducted and completed
156 by the office pursuant to ss. 624.316 and 624.3161.
157 6. Investigations conducted and completed, by line of
158 insurance, for which the office found violations of law or rule
159 but did not take enforcement action.
160 (b) Each quarter, the office shall create a report
161 detailing all actions of the office to enforce insurer
162 compliance during the previous quarter. The report must include,
163 but not be limited to, the subjects that must be included in the
164 annual report under paragraph (a). The report must be submitted
165 to the commission, the President of the Senate, the Speaker of
166 the House of Representatives, and the legislative committees
167 with jurisdiction over matters of insurance. The report is due
168 on or before April 30, July 31, October 31, and January 31,
169 respectively, for the immediately preceding quarter. The report
170 due January 31 may be included within the annual report required
171 under paragraph (a).
172 (c) The office need not include within any report required
173 under this subsection information that would violate any
174 confidentiality provision included within any agreement, order,

175 or consent order entered into or promulgated by the office.
176 Section 3. Subsections (3) and (4) are added to section
177 624.316, Florida Statutes, to read:
178 624.316 Examination of insurers.—
179 (3) The office shall create, and the commission shall adopt
180 by rule, a risk-based selection methodology for scheduling
181 examinations of insurers subject to this section. This
182 requirement does not restrict the authority of the office to
183 conduct examinations under this section as often as it deems
184 advisable. Such methodology must include all of the following:
185 (a) Use of a risk-focused analysis to prioritize financial
186 examinations of insurers when such reporting indicates a decline
187 in the insurer's financial condition.
188 (b) Consideration of:
189 1. Level of capitalization and identification of
190 unfavorable trends;
191 2. Negative trends in profitability or cash flow from
192 operations;
193 3. National Association of Insurance Commissioners
194 Insurance Regulatory Information System ratio results;
195 4. Risk-based capital and risk-based capital trend test
196 results;
197 5. The structure and complexity of the insurer;
198 6. Changes in the insurer's officers or board of directors;
199 7. Changes in the insurer's business strategy or
200 operations;
201 8. Findings and recommendations from an examination made
202 pursuant to s. 624.316 or s. 624.3161;
203 9. Current or pending regulatory actions by the office or

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204 the department;
205 10. Information obtained from other regulatory agencies or
206 independent organization ratings and reports; and
207 11. The impact of an insurer's insolvency on policyholders
208 of the insurer and the public generally.
209 (c) Prioritization of property insurers for which the
210 office identifies significant concerns about an insurer's
211 solvency pursuant to s. 627.7154.
212 (d) Any other matters the office deems necessary to
213 consider for the protection of the public.
214 (4) To facilitate the development of the methodology for
215 scheduling examinations pursuant to this section, the commission
216 may adopt by rule the National Association of Insurance
217 Commissioners Financial Analysis Handbook, to the extent that
218 the handbook is consistent with and does not negate the
219 requirements of this section.
220 Section 4. Subsection (7) of section 624.3161, Florida
221 Statutes, is amended, and subsection (8) is added to that
222 section, to read:
223 624.3161 Market conduct examinations.—
224 (7) Notwithstanding subsection (1), any authorized insurer
225 transacting residential property insurance business in this
226 state:
227 (a) May be subject to an additional market conduct
228 examination after a hurricane if, at any time more than 90 days
229 after the end of the hurricane, the insurer~~:~~
230 ~~(a)~~ is among the top 20 percent of insurers based upon a
231 calculation of the ratio of hurricane-related property insurance
232 claims filed to the number of property insurance policies in

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233 force;

234 (b) Must be subject to a market conduct examination after a

235 hurricane if, at any time more than 90 days after the end of the

236 hurricane, the insurer:

237 1. Is among the top 20 percent of insurers based upon a

238 calculation of the ratio of hurricane claim-related consumer

239 complaints made about that insurer to the department to the

240 insurer's total number of hurricane-related claims;

241 2. Is among the top 20 percent of insurers based upon a

242 calculation of the ratio of hurricane claims closed without

243 payment to the insurer's total number of hurricane claims;

244 3.(c) Has made significant payments to its managing general

245 agent since the hurricane; or

246 4.(d) Is identified by the office as necessitating a market

247 conduct exam for any other reason.

248

249 All relevant criteria under this section and s. 624.316 shall be

250 applied to the market conduct examination under this subsection.

251 Such an examination must be initiated within 18 months after the

252 landfall of a hurricane that results in an executive order or a

253 state of emergency issued by the Governor. The requirements of

254 this subsection do not limit the authority of the office to

255 conduct at any time a market conduct examination of a property

256 insurer in the aftermath of a hurricane. This subsection does

257 not require the office to conduct multiple market conduct

258 examinations of the same insurer when multiple hurricanes make

259 landfall in this state in a single calendar year. An examination

260 of an insurer under this subsection must also include an

261 examination of its managing general agent as if it were the

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262 insurer.
263 (8) The office shall create, and the commission shall adopt
264 by rule, a selection methodology for scheduling and conducting
265 market conduct examinations of insurers and other entities
266 regulated by the office. This requirement does not restrict the
267 authority of the office to conduct market conduct examinations
268 as often as it deems necessary. Such selection methodology must
269 prioritize market conduct examinations of insurers and other
270 entities regulated by the office to whom any of the following
271 conditions applies:
272 (a) An insurance regulator in another state has initiated
273 or taken regulatory action against the insurer or entity
274 regarding an act or omission of such insurer which, if committed
275 in this state, would constitute a violation of the laws of this
276 state or any rule or order of the office or department.
277 (b) Given the insurer's market share in this state, the
278 department or the office has received a disproportionate number
279 of the following types of claims-handling complaints against the
280 insurer:
281 1. Failure to timely communicate with respect to claims;
282 2. Failure to timely pay claims;
283 3. Untimely payments giving rise to the payment of
284 statutory interest;
285 4. Failure to adjust and pay claims in accordance with the
286 terms and conditions of the policy or contract and in compliance
287 with state law;
288 5. Violations of part IX of chapter 626, the Unfair
289 Insurance Trade Practices Act;
290 6. Failure to use licensed and duly appointed claims

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291 adjusters;
292 7. Failure to maintain reasonable claims records; or
293 8. Failure to adhere to the company's claims-handling
294 manual.
295 (c) The results of a National Association of Insurance
296 Commissioners Market Conduct Annual Statement indicate that the
297 insurer is a negative outlier with regard to particular metrics.
298 (d) There is evidence that the insurer is violating or has
299 violated the Unfair Insurance Trade Practices Act.
300 (e) The insurer meets the criteria in subsection (7).
301 (f) Any other conditions the office deems necessary for the
302 protection of the public.
303
304 The office shall present the proposed rule required by this
305 subsection to the commission no later than October 1, 2023. In
306 addition to the methodology required by this subsection, the
307 rule must provide criteria for how the office, in coordination
308 with the department, will determine what constitutes a
309 disproportionate number of claims-handling complaints described
310 in paragraph (b).
311 Section 5. Section 624.4211, Florida Statutes, is amended
312 to read:
313 624.4211 Administrative fine in lieu of suspension or
314 revocation.—
315 (1) If the office finds that one or more grounds exist for
316 the discretionary revocation or suspension of a certificate of
317 authority issued under this chapter, the office may, in lieu of
318 such revocation or suspension, impose a fine upon the insurer.
319 (2)(a) With respect to a any nonwillful violation, such

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320 fine may not exceed:
321 1. Twenty-five thousand dollars per violation, up to an
322 aggregate amount of $100,000 for all nonwillful violations
323 arising out of the same action, related to a covered loss or
324 claim caused by an emergency for which the Governor declared a
325 state of emergency pursuant to s. 252.36.
326 2. Twelve thousand five hundred dollars ~~$5,000~~ per
327 violation, up to~~. In no event shall such fine exceed~~ an
328 aggregate amount of $50,000 ~~$20,000~~ for all other nonwillful
329 violations arising out of the same action.
330 (b) If an insurer discovers a nonwillful violation, the
331 insurer shall correct the violation and, if restitution is due,
332 make restitution to all affected persons. Such restitution shall
333 include interest at 12 percent per year from either the date of
334 the violation or the date of inception of the affected person’s
335 policy, at the insurer’s option. The restitution may be a credit
336 against future premiums due, provided that interest accumulates
337 until the premiums are due. If the amount of restitution due to
338 any person is $50 or more and the insurer wishes to credit it
339 against future premiums, it shall notify such person that she or
340 he may receive a check instead of a credit. If the credit is on
341 a policy that is not renewed, the insurer shall pay the
342 restitution to the person to whom it is due.
343 (3)(a) With respect to a ~~any~~ knowing and willful violation
344 of a lawful order or rule of the office or commission or a
345 provision of this code, the office may impose a fine upon the
346 insurer in an amount not to exceed:
347 1. Two hundred thousand dollars for each such violation, up
348 to an aggregate amount of $1 million for all knowing and willful

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349 violations arising out of the same action, related to a covered
350 loss or claim caused by an emergency for which the Governor
351 declared a state of emergency pursuant to s. 252.36.
352 2. One hundred thousand dollars ~~$40,000~~ for each such
353 violation, up to~~. In no event shall such fine exceed~~ an
354 aggregate amount of $500,000 ~~$200,000~~ for all other knowing and
355 willful violations arising out of the same action.
356 (b) In addition to such fines, the insurer shall make
357 restitution when due in accordance with subsection (2).
358 (4) The failure of an insurer to make restitution when due
359 as required under this section constitutes a willful violation
360 of this code. However, if an insurer in good faith is uncertain
361 as to whether any restitution is due or as to the amount of such
362 restitution, it shall promptly notify the office of the
363 circumstances; and the failure to make restitution pending a
364 determination thereof shall not constitute a violation of this
365 code.
366 Section 6. Section 624.4301, Florida Statutes, is created
367 to read:
368 624.4301 Notice of temporary discontinuance of writing new
369 residential property insurance policies.—
370 (1) Any authorized insurer, before temporarily suspending
371 writing new residential property insurance policies in this
372 state, must give notice to the office of the insurer’s reasons
373 for such action, the effective dates of the temporary
374 suspension, and the proposed communication to its agents. Such
375 notice must be provided on a form approved by the office and
376 adopted by the commission. The insurer shall submit such notice
377 to the office the earlier of 20 business days before the

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378 effective date of the temporary suspension of writing or 5
379 business days before notifying its agents of the temporary
380 suspension of writing. The insurer must provide any other
381 information requested by the office related to the insurer’s
382 temporary suspension of writing. The requirements of this
383 section do not apply to a temporary suspension of writing new
384 business made in response to a hurricane that may make landfall
385 in this state if such temporary suspension ceases within 72
386 hours after hurricane conditions are no longer present in this
387 state.
388 (2) The commission may adopt rules to administer this
389 section.
390 Section 7. Section 624.805, Florida Statutes, is created to
391 read:
392 624.805 Hazardous insurer standards; office’s evaluation
393 and enforcement authority; immediate final order.—
394 (1) In determining whether the continued operation of any
395 insurer transacting business in this state may be deemed to be
396 hazardous to its policyholders or creditors or to the general
397 public, the office may consider, in the totality of the
398 circumstances of such insurer, any of the following:
399 (a) Adverse findings reported in financial condition or
400 market conduct examination reports, audit reports, or actuarial
401 opinions, reports, or summaries.
402 (b) The National Association of Insurance Commissioners
403 Insurance Regulatory Information System and its other financial
404 analysis solvency tools and reports.
405 (c) Whether the insurer has made adequate provisions,
406 according to presently accepted actuarial standards of practice,

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407 for the anticipated cash flows required to cover its contractual
408 obligations and related expenses.
409 (d) The ability of an assuming reinsurer to perform and
410 whether the insurer's reinsurance program provides sufficient
411 protection for the insurer's remaining surplus after taking into
412 account the insurer's cash flow and the classes of business
413 written, as well as the financial condition of the assuming
414 reinsurer.
415 (e) Whether the insurer's operating loss in the last 12-
416 month period, including, but not limited to, net capital gain or
417 loss, change in nonadmitted assets, and cash dividends paid to
418 shareholders is greater than 50 percent of the insurer's
419 remaining surplus as regards policyholders in excess of the
420 minimum required.
421 (f) Whether the insurer's operating loss in the last 12-
422 month period, excluding net capital gains, is greater than 20
423 percent of the insurer's remaining surplus as regards
424 policyholders in excess of the minimum required.
425 (g) Whether a reinsurer, an obligor, or any entity within
426 the insurer's insurance holding company system is insolvent,
427 threatened with insolvency, or delinquent in payment of its
428 monetary or other obligations, and which in the opinion of the
429 office may affect the solvency of the insurer.
430 (h) Contingent liabilities, pledges, or guaranties that
431 individually or collectively involve a total amount that in the
432 opinion of the office may affect the solvency of the insurer.
433 (i) Whether any affiliate, as defined in s. 624.10(1), of
434 the insurer is delinquent in the transmitting to, or payment of,
435 net premiums to the insurer.

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436 (j) The age and collectability of receivables.

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

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

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

449 (n) Whether management of the insurer has filed any false
450 or misleading sworn financial statement, has released a false or
451 misleading financial statement to lending institutions or to the
452 general public, has made a false or misleading entry, or has
453 omitted an entry of material amount in the books of the insurer.

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

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

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

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

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465 (s) Whether transactions among affiliates, subsidiaries, or
466 controlling persons for which the insurer receives assets or
467 capital gains, or both, do not provide sufficient value,
468 liquidity, or diversity to assure the insurer's ability to meet
469 its outstanding obligations as they mature.
470 (t) The ratio of the annual premium volume to surplus or of
471 its liabilities to surplus in relation to loss experience, the
472 kinds of risks insured, or both.
473 (u) Whether the insurer's asset portfolio, when viewed in
474 light of current economic conditions and indications of
475 financial or operational leverage, is of sufficient value,
476 liquidity, or diversity to assure the company's ability to meet
477 its outstanding obligations as they mature.
478 (v) Whether the excess of surplus as regards policyholders
479 above the insurer's statutorily required surplus as regards
480 policyholders has decreased by more than 50 percent in the
481 preceding 12-month period.
482 (w) As to a residential property insurer, whether it has
483 sufficient capital, surplus, and reinsurance to withstand
484 significant weather events, including, but not limited to,
485 hurricanes.
486 (x) Whether the insurer's required surplus, capital, or
487 capital stock is impaired to an extent prohibited by law.
488 (y) Whether the insurer continues to write new business
489 when it has not maintained the required surplus or capital.
490 (z) Whether the insurer moves to dissolve or liquidate
491 without first having made provisions satisfactory to the office
492 for liabilities arising from insurance policies issued by the
493 insurer.

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494 (aa) Whether the insurer has incurred substantial new debt,
495 has had to rely on frequent or substantial capital infusions,
496 has a highly leveraged balance sheet, or relies increasingly on
497 other entities, including, but not limited to, affiliates,
498 third-party administrators, managing general agents, or
499 management companies.
500 (bb) Whether the insurer meets one or more of the grounds
501 in s. 631.051 for the appointment of the department as receiver.
502 (cc) Any other finding determined by the office to be
503 hazardous to the insurer's policyholders or creditors or to the
504 general public.
505 (2) For the purposes of making a determination of an
506 insurer's financial condition under the Florida Insurance Code,
507 the office may:
508 (a) Disregard any credit or amount receivable resulting
509 from transactions with a reinsurer that is insolvent, impaired,
510 or otherwise subject to a delinquency proceeding;
511 (b) Make appropriate adjustments, including disallowance to
512 asset values attributable to investments in or transactions with
513 parents, subsidiaries, or affiliates, consistent with the
514 National Association of Insurance Commissioners Accounting
515 Practices and Procedures Manual and state laws and rules;
516 (c) Refuse to recognize the stated value of accounts
517 receivable if the ability to collect receivables is highly
518 speculative in view of the age of the account or the financial
519 condition of the debtor; or
520 (d) Increase the insurer's liability, in an amount equal to
521 any contingent liability, pledge, or guarantee not otherwise
522 included, if there is a substantial risk that the insurer will

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523 be called upon to meet the obligation undertaken within the next
524 12-month period.
525 (3) If the office determines that the continued operations
526 of an insurer authorized to transact business in this state may
527 be hazardous to its policyholders or creditors or to the general
528 public, the office may issue an order requiring the insurer to
529 do any of the following:
530 (a) Reduce the total amount of present and potential
531 liability for policy benefits by procuring additional
532 reinsurance.
533 (b) Reduce, suspend, or limit the volume of business being
534 accepted or renewed.
535 (c) Reduce general insurance and commission expenses by
536 specified methods or amounts.
537 (d) Increase the insurer's capital and surplus.
538 (e) Suspend or limit the declaration and payment of
539 dividends by an insurer to its stockholders or to its
540 policyholders.
541 (f) File reports in a form acceptable to the office
542 concerning the market value of the insurer's assets.
543 (g) Limit or withdraw from certain investments or
544 discontinue certain investment practices to the extent the
545 office deems necessary.
546 (h) Document the adequacy of premium rates in relation to
547 the risks insured.
548 (i) File, in addition to regular annual statements, interim
549 financial reports on a form prescribed by the commission and
550 adopted by the National Association of Insurance Commissioners.
551 (j) Correct corporate governance practice deficiencies and

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552 adopt and use governance practices acceptable to the office.
553 (k) Provide a business plan to the office in order to
554 continue to transact business in this state.
555 (l) Notwithstanding any other law limiting the frequency or
556 amount of rate adjustments, adjust rates for any non-life
557 insurance product written by the insurer which the office
558 considers necessary to improve the financial condition of the
559 insurer.
560 (4) This section may not be interpreted to limit the powers
561 granted to the office by any laws of this state, nor may it be
562 interpreted to supersede any laws of this state.
563 (5) The office may, pursuant to ss. 120.569 and 120.57, in
564 its discretion and without advance notice or hearing, issue an
565 immediate final order to any insurer requiring the actions
566 listed in subsection (3).
567 Section 8. Subsection (11) of section 624.81, Florida
568 Statutes, is amended to read:
569 624.81 Notice to comply with written requirements of
570 office; noncompliance.—
571 ~~(11) The commission may adopt rules to define standards of~~
572 ~~hazardous financial condition and corrective action~~
573 ~~substantially similar to that indicated in the National~~
574 ~~Association of Insurance Commissioners’ 1997 “Model Regulation~~
575 ~~to Define Standards and Commissioner’s Authority for Companies~~
576 ~~Deemed to be in Hazardous Financial Condition,” which are~~
577 ~~necessary to implement the provisions of this part.~~
578 Section 9. Section 624.865, Florida Statutes, is created to
579 read:
580 624.865 Rulemaking.—The commission may adopt rules to

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581 administer ss. 624.80-624.87. Such rules must protect the
582 interests of insureds, claimants, insurers, and the public.
583 Section 10. Paragraph (d) of subsection (2) and paragraph
584 (b) of subsection (3) of section 628.8015, Florida Statutes, are
585 amended to read:
586 628.8015 Own-risk and solvency assessment; corporate
587 governance annual disclosure.—
588 (2) OWN-RISK AND SOLVENCY ASSESSMENT.—
589 (d) *Exemption.*—
590 1. An insurer is exempt from the requirements of this
591 subsection if:
592 a. The insurer has annual direct written and unaffiliated
593 assumed premium, including international direct and assumed
594 premium, but excluding premiums reinsured with the Federal Crop
595 Insurance Corporation and the National Flood Insurance Program,
596 of less than $500 million; or
597 b. The insurer is a member of an insurance group and the
598 insurance group has annual direct written and unaffiliated
599 assumed premium, including international direct and assumed
600 premium, but excluding premiums reinsured with the Federal Crop
601 Insurance Corporation and the National Flood Insurance Program,
602 of less than $1 billion.
603 2. If an insurer is:
604 a. Exempt under sub-subparagraph 1.a., but the insurance
605 group of which the insurer is a member is not exempt under sub-
606 subparagraph 1.b., the ORSA summary report must include every
607 insurer within the insurance group. The insurer may satisfy this
608 requirement by submitting more than one ORSA summary report for
609 any combination of insurers if any combination of reports

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610 includes every insurer within the insurance group.
611 b. Not exempt under sub-subparagraph 1.a., but the
612 insurance group of which it is a member is exempt under sub-
613 subparagraph 1.b., the insurer must submit to the office the
614 ORSA summary report applicable only to that insurer.
615 3. The office may require an exempt insurer to maintain a
616 risk management framework, conduct an ORSA, and file an ORSA
617 summary report:
618 a. Based on unique circumstances, including, but not
619 limited to, the type and volume of business written, ownership
620 and organizational structure, federal agency requests, and
621 international supervisor requests;
622 b. If the insurer has risk-based capital for a company
623 action level event pursuant to s. 624.4085(3), meets one or more
624 of the standards of an insurer deemed to be in hazardous
625 financial condition under s. 624.805 ~~as defined in rules adopted~~
626 ~~by the commission pursuant to s. 624.81(11)~~, or exhibits
627 qualities of an insurer in hazardous financial condition as
628 determined by the office; or
629 c. If the office determines it is in the best interest of
630 the state.
631 4. If an exempt insurer becomes disqualified for an
632 exemption because of changes in premium as reported on the most
633 recent annual statement of the insurer or annual statements of
634 the insurers within the insurance group of which the insurer is
635 a member, the insurer must comply with the requirements of this
636 section effective 1 year after the year in which the insurer
637 exceeded the premium thresholds.
638 (3) CORPORATE GOVERNANCE ANNUAL DISCLOSURE.—

639 (b) *Disclosure requirement.*—
640 1.a. An insurer, or insurer member of an insurance group,
641 of which the office is the lead state regulator, as determined
642 by the procedures in the most recent National Association of
643 Insurance Commissioners Financial Analysis Handbook, shall
644 submit a corporate governance annual disclosure to the office by
645 June 1 of each calendar year. The initial corporate governance
646 annual disclosure must be submitted by December 31, 2018.
647 b. An insurer or insurance group not required to submit a
648 corporate governance annual disclosure under sub-subparagraph a.
649 shall do so at the request of the office, but not more than once
650 per calendar year. The insurer or insurance group shall notify
651 the office of the proposed submission date within 30 days after
652 the request of the office.
653 c. Before December 31, 2018, the office may require an
654 insurer or insurance group to provide a corporate governance
655 annual disclosure:
656 (I) Based on unique circumstances, including, but not
657 limited to, the type and volume of business written, the
658 ownership and organizational structure, federal agency requests,
659 and international supervisor requests;
660 (II) If the insurer has risk-based capital for a company
661 action level event pursuant to s. 624.4085(3), meets one or more
662 of the standards of an insurer deemed to be in hazardous
663 financial condition under s. 624.805 ~~as defined in rules adopted~~
664 ~~pursuant to s. 624.81(11)~~, or exhibits qualities of an insurer
665 in hazardous financial condition as determined by the office;
666 (III) If the insurer is the member of an insurer group of
667 which the office acts as the lead state regulator as determined

668 by the procedures in the most recent National Association of
669 Insurance Commissioners Financial Analysis Handbook; or
670 (IV) If the office determines that it is in the best
671 interest of the state.
672 2. The chief executive officer or corporate secretary of
673 the insurer or the insurance group must sign the corporate
674 governance annual disclosure attesting that, to the best of his
675 or her knowledge and belief, the insurer has implemented the
676 corporate governance practices and provided a copy of the
677 disclosure to the board of directors or the appropriate board
678 committee.
679 3.a. Depending on the structure of its system of corporate
680 governance, the insurer or insurance group may provide corporate
681 governance information at one of the following levels:
682 (I) The ultimate controlling parent level;
683 (II) An intermediate holding company level; or
684 (III) The individual legal entity level.
685 b. The insurer or insurance group may make the corporate
686 governance annual disclosure at:
687 (I) The level used to determine the risk appetite of the
688 insurer or insurance group;
689 (II) The level at which the earnings, capital, liquidity,
690 operations, and reputation of the insurer are collectively
691 overseen and the supervision of those factors is coordinated and
692 exercised; or
693 (III) The level at which legal liability for failure of
694 general corporate governance duties would be placed.
695
696 An insurer or insurance group must indicate the level of

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697 reporting used and explain any subsequent changes in the
698 reporting level.
699 4. The review of the corporate governance annual disclosure
700 and any additional requests for information shall be made
701 through the lead state as determined by the procedures in the
702 most recent National Association of Insurance Commissioners
703 Financial Analysis Handbook.
704 5. An insurer or insurance group may comply with this
705 paragraph by cross-referencing other existing relevant and
706 applicable documents, including, but not limited to, the ORSA
707 summary report, Holding Company Form B or F filings, Securities
708 and Exchange Commission proxy statements, or foreign regulatory
709 reporting requirements, if the documents contain information
710 substantially similar to the information described in paragraph
711 (c). The insurer or insurance group shall clearly identify and
712 reference the specific location of the relevant and applicable
713 information within the corporate governance annual disclosure
714 and attach the referenced document if it has not already been
715 filed with, or made available to, the office.
716 6. Each year following the initial filing of the corporate
717 governance annual disclosure, the insurer or insurance group
718 shall file an amended version of the previously filed corporate
719 governance annual disclosure indicating changes that have been
720 made. If changes have not been made in the previously filed
721 disclosure, the insurer or insurance group should so indicate.
722 Section 11. Paragraph (c) of subsection (3) of section
723 626.207, Florida Statutes, is amended to read:
724 626.207 Disqualification of applicants and licensees;
725 penalties against licensees; rulemaking authority.—

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726 (3) An applicant who has been found guilty of or has
727 pleaded guilty or nolo contendere to a crime not included in
728 subsection (2), regardless of adjudication, is subject to:
729 (c) A 7-year disqualifying period for all misdemeanors
730 directly related to the financial services business or any
731 violation of the Florida Insurance Code.
732 Section 12. Subsections (2) and (3) of section 626.9521,
733 Florida Statutes, are amended to read:
734 626.9521 Unfair methods of competition and unfair or
735 deceptive acts or practices prohibited; penalties.—
736 (2) Except as provided in subsection (3), any person who
737 violates any provision of this part is subject to a fine in an
738 amount not greater than $12,500 ~~$5,000~~ for each nonwillful
739 violation and not greater than $100,000 ~~$40,000~~ for each willful
740 violation. Fines under this subsection imposed against an
741 insurer may not exceed an aggregate amount of $50,000 ~~$20,000~~
742 for all nonwillful violations arising out of the same action or
743 an aggregate amount of $500,000 ~~$200,000~~ for all willful
744 violations arising out of the same action. The fines may be
745 imposed in addition to any other applicable penalty.
746 (3)(a) If a person violates s. 626.9541(1)(l), the offense
747 known as "twisting," or violates s. 626.9541(1)(aa), the offense
748 known as "churning," the person commits a misdemeanor of the
749 first degree, punishable as provided in s. 775.082, and an
750 administrative fine not greater than $12,500 ~~$5,000~~ shall be
751 imposed for each nonwillful violation or an administrative fine
752 not greater than $187,500 ~~$75,000~~ shall be imposed for each
753 willful violation. To impose an administrative fine for a
754 willful violation under this paragraph, the practice of

755 “churning” or “twisting” must involve fraudulent conduct.
756 (b) If a person violates s. 626.9541(1)(ee) by willfully
757 submitting fraudulent signatures on an application or policy-
758 related document, the person commits a felony of the third
759 degree, punishable as provided in s. 775.082, and an
760 administrative fine not greater than $12,500 ~~$5,000~~ shall be
761 imposed for each nonwillful violation or an administrative fine
762 not greater than $187,500 ~~$75,000~~ shall be imposed for each
763 willful violation.
764 (c) If a person violates any provision of this part and
765 such violation is related to a covered loss or covered claim
766 caused by an emergency for which the Governor declared a state
767 of emergency pursuant to s. 252.36, such person is subject to a
768 fine in an amount not greater than $25,000 for each nonwillful
769 violation and not greater than $200,000 for each willful
770 violation. Fines imposed under this paragraph against an insurer
771 may not exceed an aggregate amount of $100,000 for all
772 nonwillful violations arising out of the same action or an
773 aggregate amount of $1 million for all willful violations
774 arising out of the same action.
775 (d) Administrative fines under paragraphs (a) and (b) ~~this~~
776 ~~subsection~~ may not exceed an aggregate amount of $125,000
777 ~~$50,000~~ for all nonwillful violations arising out of the same
778 action or an aggregate amount of $625,000 ~~$250,000~~ for all
779 willful violations arising out of the same action.
780 Section 13. Paragraphs (i) and (w) of subsection (1) of
781 section 626.9541, Florida Statutes, are amended to read:
782 626.9541 Unfair methods of competition and unfair or
783 deceptive acts or practices defined.—

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784 (1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE
785 ACTS.—The following are defined as unfair methods of competition
786 and unfair or deceptive acts or practices:
787 (i) *Unfair claim settlement practices.*—
788 1. Attempting to settle claims on the basis of an
789 application, when serving as a binder or intended to become a
790 part of the policy, or any other material document which was
791 altered without notice to, or knowledge or consent of, the
792 insured;
793 2. A material misrepresentation made to an insured or any
794 other person having an interest in the proceeds payable under
795 such contract or policy, for the purpose and with the intent of
796 effecting settlement of such claims, loss, or damage under such
797 contract or policy on less favorable terms than those provided
798 in, and contemplated by, such contract or policy;
799 3. Committing or performing with such frequency as to
800 indicate a general business practice any of the following:
801 a. Failing to adopt and implement standards for the proper
802 investigation of claims;
803 b. Misrepresenting pertinent facts or insurance policy
804 provisions relating to coverages at issue;
805 c. Failing to acknowledge and act promptly upon
806 communications with respect to claims;
807 d. Denying claims without conducting reasonable
808 investigations based upon available information;
809 e. Failing to affirm or deny full or partial coverage of
810 claims, and, as to partial coverage, the dollar amount or extent
811 of coverage, or failing to provide a written statement that the
812 claim is being investigated, upon the written request of the

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813 insured within 30 days after proof-of-loss statements have been
814 completed;
815 f. Failing to promptly provide a reasonable explanation in
816 writing to the insured of the basis in the insurance policy, in
817 relation to the facts or applicable law, for denial of a claim
818 or for the offer of a compromise settlement;
819 g. Failing to promptly notify the insured of any additional
820 information necessary for the processing of a claim;
821 h. Failing to clearly explain the nature of the requested
822 information and the reasons why such information is necessary;
823 ~~or~~
824 i. Failing to pay personal injury protection insurance
825 claims within the time periods required by s. 627.736(4)(b). The
826 office may order the insurer to pay restitution to a
827 policyholder, medical provider, or other claimant, including
828 interest at a rate consistent with the amount set forth in s.
829 55.03(1), for the time period within which an insurer fails to
830 pay claims as required by law. Restitution is in addition to any
831 other penalties allowed by law, including, but not limited to,
832 the suspension of the insurer's certificate of authority; or
833 j. Altering or amending an insurance adjuster's report
834 without:
835 (I) Providing a detailed explanation as to why any change
836 that has the effect of reducing the estimate of the loss was
837 made; and
838 (II) Including on the report or as an addendum to the
839 report a detailed list of all changes made to the report and the
840 identity of the person who ordered each change; or
841 (III) Retaining all versions of the report, and including

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842 within each such version, for each change made within such
843 version of the report, the identity of each person who made or
844 ordered such change; or
845 4. Failing to pay undisputed amounts of partial or full
846 benefits owed under first-party property insurance policies
847 within 60 days after an insurer receives notice of a residential
848 property insurance claim, determines the amounts of partial or
849 full benefits, and agrees to coverage, unless payment of the
850 undisputed benefits is prevented by factors beyond the control
851 of the insurer as defined in s. 627.70131(5).
852 (w) *Soliciting or accepting new or renewal insurance risks*
853 *by insolvent or impaired insurer or receipt of certain bonuses*
854 *by an officer or director of an insolvent insurer prohibited;*
855 *penalty.*—
856 1. Whether or not delinquency proceedings as to the insurer
857 have been or are to be initiated, but while such insolvency or
858 impairment exists, no director or officer of an insurer, except
859 with the written permission of the office, shall authorize or
860 permit the insurer to solicit or accept new or renewal insurance
861 risks in this state after such director or officer knew, or
862 reasonably should have known, that the insurer was insolvent or
863 impaired.
864 2. Regardless of whether delinquency proceedings as to the
865 insurer have been or are to be initiated, but while such
866 insolvency or impairment exists, a director or an officer of an
867 impaired insurer may not receive a bonus from such insurer, nor
868 may such director or officer receive a bonus from a holding
869 company or an affiliate that shares common ownership or control
870 with such insurer.

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871 3. As used in this paragraph, the term:
872 a. “Bonus” means a payment, in addition to an officer’s or
873 a director’s usual compensation, which is in addition to any
874 amounts contracted for or otherwise legally due.
875 b. “Impaired” includes impairment of capital or surplus, as
876 defined in s. 631.011(12) and (13).
877 4.~~2.~~ Any such director or officer, upon conviction of a
878 violation of this paragraph, commits ~~is guilty of~~ a felony of
879 the third degree, punishable as provided in s. 775.082, s.
880 775.083, or s. 775.084.
881 Section 14. Subsection (6) of section 626.989, Florida
882 Statutes, is amended, and subsection (10) is added to that
883 section, to read:
884 626.989 Investigation by department or Division of
885 Investigative and Forensic Services; compliance; immunity;
886 confidential information; reports to division; division
887 investigator’s power of arrest.—
888 (6)(a) Any person, other than an insurer, agent, or other
889 person licensed under the code, or an employee thereof, having
890 knowledge or who believes that a fraudulent insurance act or any
891 other act or practice which, upon conviction, constitutes a
892 felony or a misdemeanor under the code, or under s. 817.234, is
893 being or has been committed may send to the Division of
894 Investigative and Forensic Services a report or information
895 pertinent to such knowledge or belief and such additional
896 information relative thereto as the department may request. Any
897 professional practitioner licensed or regulated by the
898 Department of Business and Professional Regulation, except as
899 otherwise provided by law, any medical review committee as

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900 defined in s. 766.101, any private medical review committee, and
901 any insurer, agent, or other person licensed under the code, or
902 an employee thereof, having knowledge or who believes that a
903 fraudulent insurance act or any other act or practice which,
904 upon conviction, constitutes a felony or a misdemeanor under the
905 code, or under s. 817.234, is being or has been committed shall
906 send to the Division of Investigative and Forensic Services a
907 report or information pertinent to such knowledge or belief and
908 such additional information relative thereto as the department
909 may require.
910 (b) The Division of Investigative and Forensic Services
911 shall review such information or reports and select such
912 information or reports as, in its judgment, may require further
913 investigation. It shall then cause an independent examination of
914 the facts surrounding such information or report to be made to
915 determine the extent, if any, to which a fraudulent insurance
916 act or any other act or practice which, upon conviction,
917 constitutes a felony or a misdemeanor under the code, or under
918 s. 817.234, is being committed.
919 (c) The Division of Investigative and Forensic Services
920 shall report any alleged violations of law which its
921 investigations disclose to the appropriate licensing agency and
922 state attorney or other prosecuting agency having jurisdiction,
923 including, but not limited to, the statewide prosecutor for
924 crimes that impact two or more judicial circuits in this state,
925 with respect to any such violation, as provided in s. 624.310.
926 If prosecution by the state attorney or other prosecuting agency
927 having jurisdiction with respect to such violation is not begun
928 within 60 days of the division’s report, the state attorney or

929 other prosecuting agency having jurisdiction with respect to
930 such violation shall inform the division of the reasons for the
931 lack of prosecution.
932 (10) The Division of Investigative and Forensic Services
933 Bureau of Insurance Fraud shall prepare and submit a performance
934 report to the President of the Senate and the Speaker of the
935 House of Representatives by January 1 of each year. The annual
936 report must include, but need not be limited to:
937 (a) The total number of initial referrals received, cases
938 opened, cases presented for prosecution, cases closed, and
939 convictions resulting from cases presented for prosecution by
940 the Bureau of Insurance Fraud, by type of insurance fraud and
941 circuit.
942 (b) The number of referrals received from insurers, the
943 office, and the Division of Consumer Services of the department,
944 and the outcome of those referrals.
945 (c) The number of investigations undertaken by the Bureau
946 of Insurance Fraud which were not the result of a referral from
947 an insurer and the outcome of those referrals.
948 (d) The number of investigations that resulted in a
949 referral to a regulatory agency and the disposition of those
950 referrals.
951 (e) The number of cases presented by the Bureau of
952 Insurance Fraud which local prosecutors or the statewide
953 prosecutor declined to prosecute and the reasons provided for
954 declining prosecution.
955 (f) A summary of the annual report required under s.
956 626.9896.
957 (g) The total number of employees assigned to the Bureau of

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958 Insurance Fraud, delineated by location of staff assigned, and
959 the number and location of employees assigned to the Bureau of
960 Insurance Fraud who were assigned to work other types of fraud
961 cases.
962 (h) The average caseload and turnaround time by type of
963 case for each investigator.
964 (i) The training provided during the year to insurance
965 fraud investigators.
966 Section 15. Subsections (1), (3), and (4) of section
967 627.0629, Florida Statutes, are amended to read:
968 627.0629 Residential property insurance; rate filings.—
969 (1) It is the intent of the Legislature that insurers
970 provide savings to consumers who install or implement windstorm
971 damage mitigation techniques, alterations, or solutions to their
972 properties to prevent windstorm losses. A rate filing for
973 residential property insurance must include actuarially
974 reasonable discounts, credits, or other rate differentials, or
975 appropriate reductions in deductibles, for properties on which
976 fixtures or construction techniques demonstrated to reduce the
977 amount of loss in a windstorm have been installed or
978 implemented. The fixtures or construction techniques must
979 include, but are not limited to, fixtures or construction
980 techniques that enhance roof strength, roof covering
981 performance, roof-to-wall strength, wall-to-floor-to-foundation
982 strength, opening protection, and window, door, and skylight
983 strength. Credits, discounts, or other rate differentials, or
984 appropriate reductions in deductibles, for fixtures and
985 construction techniques that meet the minimum requirements of
986 the Florida Building Code must be included in the rate filing.

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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 October 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

1016 providing greater assurance that hurricane premiums are lawful
1017 and by providing more complete information regarding the
1018 components of property insurance premiums. ~~Effective January 1,~~
1019 ~~1997,~~ A rate filing for residential property insurance shall be
1020 separated into two components, rates for hurricane coverage and
1021 rates for all other coverages. A premium notice reflecting a
1022 rate implemented on the basis of such a filing shall separately
1023 indicate the premium for hurricane coverage and the premium for
1024 all other coverages.
1025 Section 16. Paragraph (ll) is added to subsection (6) of
1026 section 627.351, Florida Statutes, to read:
1027 627.351 Insurance risk apportionment plans.—
1028 (6) CITIZENS PROPERTY INSURANCE CORPORATION.—
1029 <u>(ll) The corporation may not determine that a risk is</u>
1030 <u>ineligible for coverage with the corporation solely because such</u>
1031 <u>risk has unrepaired damage caused by a covered loss that is the</u>
1032 <u>subject of a claim that has been filed with the Florida</u>
1033 <u>Insurance Guaranty Association. This paragraph applies to a risk</u>
1034 <u>until the earlier of 36 months after the date the Florida</u>
1035 <u>Insurance Guaranty Association began servicing such claim or the</u>
1036 <u>Florida Insurance Guaranty Association closes the claim.</u>
1037 Section 17. Subsection (4) of section 627.410, Florida
1038 Statutes, is amended to read:
1039 627.410 Filing, approval of forms.—
1040 (4) The office may, by order, exempt from the requirements
1041 of this section for so long as it deems proper any insurance
1042 document or form or type thereof as specified in such order, to
1043 which, in its opinion, this section may not practicably be
1044 applied, or the filing and approval of which are, in its

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1045 opinion, not desirable or necessary for the protection of the
1046 public. The office may not exempt from the requirements of this
1047 section the insurance documents or forms of any insurer, against
1048 whom the office enters a final order determining that such
1049 insurer violated any provision of this code, for a period of 36
1050 months after the date of such order, and may not be deemed
1051 approved under subsection (2).
1052 Section 18. Section 627.4108, Florida Statutes, is created
1053 to read:
1054 627.4108 Claims-handling manuals; submission; attestation.—
1055 (1) Each authorized residential property insurer conducting
1056 business in this state must create and use a claims-handling
1057 manual that provides guidelines and procedures and that complies
1058 with the requirements of this code and comports to usual and
1059 customary industry claims-handling practices. Such manual must
1060 include guidelines and procedures for:
1061 (a) Initially receiving and acknowledging initial receipt
1062 of the claim and reviewing and evaluating the claim;
1063 (b) Communicating with policyholders, beginning with the
1064 receipt of the claim and continuing until closure of the claim;
1065 (c) Setting the claim reserve;
1066 (d) Investigating the claim, including conducting
1067 inspections of the property that is the subject of the claim;
1068 (e) Making preliminary estimates and estimates of the
1069 covered damages to the insured property and communicating such
1070 estimates to the policyholder;
1071 (f) The payment, partial payment, or denial of the claim
1072 and communicating such claim decision to the policyholder;
1073 (g) Closing claims; and

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1074 (h) Any aspect of the claims-handling process which the
1075 office determines should be included in the claims-handling
1076 manual in order to:
1077 1. Comply with the laws of this state or rules or orders of
1078 the office or department;
1079 2. Ensure the claims-handling manual comports with usual
1080 and customary industry claims-handling guidelines; or
1081 3. Protect policyholders of the insurer or the general
1082 public.
1083 (2) At any time, the office may request that a residential
1084 property insurer submit a physical or electronic copy of the
1085 insurer’s currently applicable, or otherwise specifically
1086 requested, claims-handling manuals. Upon receiving such a
1087 request, a residential property insurer must submit to the
1088 office within 5 business days:
1089 (a) A true and correct copy of each claims-handling manual
1090 requested; and
1091 (b) An attestation, on a form prescribed by the commission,
1092 that certifies:
1093 1. That the insurer has provided a true and correct copy of
1094 each currently applicable, or otherwise specifically requested,
1095 claims-handling manual; and
1096 2. The timeframe for which each submitted claims-handling
1097 manual was or is in effect.
1098 (3)(a) Annually, each authorized residential property
1099 insurer must certify and attest, on a form prescribed by the
1100 commission, that:
1101 1. Each of the insurer’s current claims-handling manuals
1102 complies with the requirements of this code and comports to

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1103 usual and customary industry claims-handling practices; and
1104 2. The insurer maintains adequate resources available to
1105 implement the requirements of each of its claims-handling
1106 manuals at all times, including during natural disasters and
1107 catastrophic events.
1108 (b) Such attestation must be submitted to the office:
1109 1. On or before August 1, 2023; and
1110 2. Annually thereafter, on or before May 1 of each calendar
1111 year.
1112 (4) The commission is authorized, and all conditions are
1113 deemed met, to adopt emergency rules under s. 120.54(4), for the
1114 purpose of implementing this section. Notwithstanding any other
1115 law, emergency rules adopted under this section are effective
1116 for 6 months after adoption and may be renewed during the
1117 pendency of procedures to adopt permanent rules addressing the
1118 subject of the emergency rules.
1119 Section 19. Paragraph (d) of subsection (2) of section
1120 627.4133, Florida Statutes, is amended to read:
1121 627.4133 Notice of cancellation, nonrenewal, or renewal
1122 premium.—
1123 (2) With respect to any personal lines or commercial
1124 residential property insurance policy, including, but not
1125 limited to, any homeowner, mobile home owner, farmowner,
1126 condominium association, condominium unit owner, apartment
1127 building, or other policy covering a residential structure or
1128 its contents:
1129 (d)1. ~~Upon a declaration of an emergency pursuant to s.~~
1130 ~~252.36 and the filing of an order by the Commissioner of~~
1131 ~~Insurance Regulation,~~ An authorized insurer may not cancel or

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1132 nonrenew a personal residential or commercial residential
1133 property insurance policy covering a dwelling or residential
1134 property located in this state:
1135 a. For a period of 90 days after the dwelling or
1136 residential property has been repaired, if such property ~~which~~
1137 has been damaged as a result of a hurricane or wind loss that is
1138 the subject of the declaration of emergency pursuant to s.
1139 252.36 and the filing of an order by the Commissioner of
1140 Insurance Regulation ~~for a period of 90 days after the dwelling~~
1141 ~~or residential property has been repaired~~. ~~A structure is deemed~~
1142 ~~to be repaired when substantially completed and restored to the~~
1143 ~~extent that it is insurable by another authorized insurer that~~
1144 ~~is writing policies in this state.~~
1145 b. Until the earlier of when the dwelling or residential
1146 property has been repaired or 1 year after the insurer issues
1147 the final claim payment, if such property was damaged by any
1148 covered peril and sub-subparagraph a. does not apply.
1149 2. However, an insurer or agent may cancel or nonrenew such
1150 a policy prior to the repair of the dwelling or residential
1151 property:
1152 a. Upon 10 days' notice for nonpayment of premium; or
1153 b. Upon 45 days' notice:
1154 (I) For a material misstatement or fraud related to the
1155 claim;
1156 (II) If the insurer determines that the insured has
1157 unreasonably caused a delay in the repair of the dwelling; or
1158 (III) If the insurer has paid policy limits.
1159 3. If the insurer elects to nonrenew a policy covering a
1160 property that has been damaged, the insurer shall provide at

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1161 least 90 days' notice to the insured that the insurer intends to
1162 nonrenew the policy 90 days after the dwelling or residential
1163 property has been repaired. Nothing in this paragraph shall
1164 prevent the insurer from canceling or nonrenewing the policy 90
1165 days after the repairs are complete for the same reasons the
1166 insurer would otherwise have canceled or nonrenewed the policy
1167 but for the limitations of subparagraph 1. The Financial
1168 Services Commission may adopt rules, and the Commissioner of
1169 Insurance Regulation may issue orders, necessary to implement
1170 this paragraph.
1171 4. This paragraph shall also apply to personal residential
1172 and commercial residential policies covering property that was
1173 damaged as the result of Hurricane Ian or Hurricane Nicole
1174 ~~Tropical Storm Bonnie, Hurricane Charley, Hurricane Frances,~~
1175 ~~Hurricane Ivan, or Hurricane Jeanne~~.
1176 5. For purposes of this paragraph:
1177 a. A structure is deemed to be repaired when substantially
1178 completed and restored to the extent that it is insurable by
1179 another authorized insurer writing policies in this state.
1180 b. The term "insurer" means an authorized insurer.
1181 Section 20. Subsection (3) is added to section 627.426,
1182 Florida Statutes, to read:
1183 627.426 Claims administration.—
1184 (3)(a) Upon receiving actual notice of an incident or a
1185 loss that could give rise to a covered liability claim under an
1186 insurance policy, each liability insurer must do all of the
1187 following:
1188 1. Assign a licensed and appointed insurance adjuster to
1189 investigate the extent of the insured's probable exposure and

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1190 diligently attempt to resolve any questions concerning the
1191 existence or extent of the insured's coverage.
1192 2. Evaluate the claim fairly, honestly, and with due regard
1193 for the interests of the insured based on available information;
1194 consider the extent of the claimant's recoverable damages; and
1195 consider the information in a reasonable and prudent manner.
1196 3. Request from the insured or claimant additional relevant
1197 information the insurer reasonably deems necessary to evaluate
1198 whether to settle a claim.
1199 4. Conduct all oral and written communications with the
1200 insured with honesty and candor.
1201 5. Make reasonable efforts to explain to persons not
1202 represented by counsel matters requiring expertise beyond the
1203 level normally expected of a layperson with no training in
1204 insurance or claims-handling issues.
1205 6. Retain all written and recorded communications and
1206 create and retain a summary of all verbal communications in a
1207 reasonable manner for a period of not less than 5 years after
1208 the later of the entry of a judgment against the insured in
1209 excess of policy limits becoming final or the conclusion of the
1210 extracontractual claim, if any, including any related appeals.
1211 7. Within 30 days after a request, provide the insured with
1212 all communications related to the insurer's handling of the
1213 claim which are not privileged as to the insured.
1214 8. Provide, upon request and at the insurer's expense,
1215 reasonable accommodations necessary to communicate effectively
1216 with an insured covered under the Americans with Disabilities
1217 Act.
1218 9. Communicate to an insured all of the following within 15

1219 days after notice of the existence of a third-party claim:
1220 a. The identity of any other person or entity the insurer
1221 has reason to believe may be liable.
1222 b. The insurer’s evaluation of the claim, given the facts
1223 known by the insurer at that time.
1224 c. The likelihood and possible extent of an excess
1225 judgment.
1226 d. Steps the insured can take to avoid exposure to an
1227 excess judgment, including the right to secure personal counsel
1228 at the insured’s expense.
1229 e. The insured’s duty to cooperate with the insurer,
1230 including any specific requests required because of a settlement
1231 opportunity or by the insurer in accordance with the policy, the
1232 purpose of the required cooperation, and the consequences of
1233 refusing to cooperate.
1234 f. Any settlement demands or offers.
1235 10. Initiate settlement negotiations by tendering its
1236 policy limits to the claimant in exchange for a general release
1237 of the insured if the facts available to the insurer indicate
1238 that the insured’s liability is likely to exceed the policy
1239 limits.
1240 11. Give fair consideration to a settlement offer that is
1241 not unreasonable under the facts available to the insurer and
1242 settle in exchange for a general release of the insured, if
1243 possible, when a reasonably prudent person, faced with the
1244 prospect of paying the total probable exposure of the insured,
1245 would do so. The insurer shall provide reasonable assistance to
1246 the insured to comply with the insured’s obligations to
1247 cooperate and act reasonably to attempt to satisfy any

1248 conditions of a claimant’s settlement offer. If it is not
1249 possible to settle a liability claim within the available policy
1250 limits in exchange for a general release of the insured, the
1251 insurer shall act reasonably to attempt to minimize the excess
1252 exposure to the insured.
1253 12. Attempt to minimize the magnitude of possible excess
1254 judgments against the insured when multiple claims arise out of
1255 a single occurrence and the combined value of all claims exceeds
1256 the total of all applicable policy limits. The insurer is
1257 entitled to great discretion to decide how much to offer each
1258 respective claimant in its attempt to settle with such claimant
1259 in exchange for a general release of the insured. This
1260 subparagraph may not be interpreted to prevent an insurer from
1261 using either process provided under s. 624.155(6). An insurer
1262 does not violate this subsection simply because it is unable to
1263 settle all claims in a multiple claimant case.
1264 13. Attempt to settle the claim in exchange for a general
1265 release of all insureds against whom a claim may be presented if
1266 a loss creates the potential for a third-party claim against
1267 more than one insured. If it is not possible to settle in
1268 exchange for a general release of all insureds, the insurer, in
1269 consultation with the insureds, must attempt to enter into
1270 reasonable settlements of claims against certain insureds in
1271 exchange for a general release of such insureds to the exclusion
1272 of other insureds.
1273 14. Respond to any request for insurance information in
1274 compliance with s. 626.9372 or s. 627.4137, as applicable.
1275 15. Take reasonable measures to preserve evidence, for a
1276 reasonable period of time, which is needed for the defense of

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1277 the liability claim if it appears the insured’s probable
1278 exposure is greater than policy limits.
1279 16. Comply with subsections (1) and (2), if applicable.
1280 17. Comply with the Unfair Insurance Trade Practices Act.
1281 (b) As used in this subsection, the term “actual notice”
1282 means the insurer’s receipt of notice of an incident or a loss
1283 that could give rise to a covered claim that is communicated to
1284 the insurer or an agent of the insurer:
1285 1. By any manner permitted by the policy or other documents
1286 provided to the insured by the insurer;
1287 2. Through the claims link on the insurer’s website; or
1288 3. Through the e-mail address designated by the insurer
1289 under s. 624.422.
1290 (c) In determining whether an insurer violated this
1291 subsection, it is relevant whether the insured, claimant, and
1292 any representative of the insured or claimant was acting in good
1293 faith toward the insurer in furnishing information regarding the
1294 claim, in making demands of the insurer, in setting deadlines,
1295 and in attempting to settle the claim. Such matters include
1296 whether:
1297 1. The insured met its duty to cooperate with the insurer
1298 in the defense of the claim and in making settlements by taking
1299 reasonable actions requested by the claimant or required by the
1300 policy which are necessary to assist the insurer in settling a
1301 covered claim, including:
1302 a. Executing affidavits regarding the facts within the
1303 insured’s knowledge regarding the covered loss; and
1304 b. Providing documents, including if reasonably necessary
1305 to settle a covered claim valued in excess of policy limits and

1306 upon the request of the claimant, a summary of the insured's
1307 assets, liabilities, obligations, other insurance policies that
1308 may provide coverage for the claim, and the name and contact
1309 information of the insured's employer when the insured is a
1310 natural person who was acting in the course and scope of
1311 employment when the incident giving rise to the claim occurred.
1312 2. The claimant and any claimant's representative:
1313 a. Acted honestly in furnishing information regarding the
1314 claim;
1315 b. Acted reasonably in setting deadlines; and
1316 c. Refrained from taking actions that may be reasonably
1317 expected to prevent an insurer from accepting the settlement
1318 demand, such as providing insufficient detail within the demand,
1319 providing unreasonable deadlines for acceptance of the demand,
1320 or including unreasonable conditions to settlement.
1321 (d) Any violation of this subsection, when found by the
1322 office in any investigation or examination, constitutes a
1323 violation of the Florida Insurance Code and is subject to any
1324 applicable enforcement provisions therein. Administrative fines
1325 imposed for violations of this subsection are subject to a 2.0
1326 multiplier and may exceed the limits on fine amounts and
1327 aggregate fine amounts provided for under this code.
1328 (e) This subsection does not create a civil cause of
1329 action, nor does it abrogate or diminish any civil cause of
1330 action currently existing in statutory or common law.
1331 (f) Any proceedings, determinations, or enforcement actions
1332 taken by the office against an insurer for violations of this
1333 subsection are not admissible in any civil action.
1334 Section 21. Paragraph (a) of subsection (10) of section

1335 627.701, Florida Statutes, is amended to read:

1336 627.701 Liability of insureds; coinsurance; deductibles.—

1337 (10)(a) Notwithstanding any other provision of law, an
1338 insurer issuing a personal lines residential property insurance
1339 policy may include in such policy a separate roof deductible
1340 that meets all of the following requirements:

1341 1. The insurer has complied with the offer requirements
1342 under subsection (7) regarding a deductible applicable to losses
1343 from perils other than a hurricane.

1344 2. The roof deductible may not exceed the lesser of 2
1345 percent of the Coverage A limit of the policy or 50 percent of
1346 the cost to replace the roof.

1347 3. The premium that a policyholder is charged for the
1348 policy includes an actuarially sound credit or premium discount
1349 for the roof deductible.

1350 4. The roof deductible applies only to a claim adjusted on
1351 a replacement cost basis.

1352 5. The roof deductible does not apply to any of the
1353 following events:

1354 a. A total loss to a primary structure in accordance with
1355 the valued policy law under s. 627.702 which is caused by a
1356 covered peril.

1357 b. A roof loss resulting from a hurricane as defined in s.
1358 627.4025(2)(c).

1359 c. A roof loss resulting from a tree fall or other hazard
1360 that damages the roof and punctures the roof deck.

1361 d. A roof loss requiring the repair of less than 50 percent
1362 of the roof.

1363

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1364 If a roof deductible is applied, no other deductible under the
1365 policy may be applied to the loss or to any other loss to the
1366 property caused by the same covered peril.
1367 Section 22. Subsection (2) of section 627.70132, Florida
1368 Statutes, is amended to read:
1369 627.70132 Notice of property insurance claim.—
1370 (2) A claim or reopened claim, but not a supplemental
1371 claim, under an insurance policy that provides property
1372 insurance, as defined in s. 624.604, including a property
1373 insurance policy issued by an eligible surplus lines insurer,
1374 for loss or damage caused by any peril is barred unless notice
1375 of the claim was given to the insurer in accordance with the
1376 terms of the policy within 1 year after the date of loss. A
1377 supplemental claim is barred unless notice of the supplemental
1378 claim was given to the insurer in accordance with the terms of
1379 the policy within 18 months after the date of loss. The time
1380 limitations of this subsection are tolled during any term of
1381 deployment to a combat zone or combat support posting which
1382 materially affects the ability of a servicemember as defined in
1383 s. 250.01 to file a claim, supplemental claim, or reopened
1384 claim.
1385 Section 23. Chapter 2022-271, Laws of Florida, shall not be
1386 construed to impair any right under an insurance contract in
1387 effect on or before the effective date of that chapter law. To
1388 the extent that chapter 2022-271, Laws of Florida, affects a
1389 right under an insurance contract, that chapter law applies to
1390 an insurance contract issued or renewed after the effective date
1391 of that chapter law. This section is intended to clarify
1392 existing law and is remedial in nature.

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1393 Section 24. (1) Every residential property insurer and
1394 every motor vehicle insurer rate filing made or pending with the
1395 Office of Insurance Regulation on or after July 1, 2023, must
1396 reflect the projected savings or reduction in claim frequency,
1397 claim severity, and loss adjustment expenses, including for
1398 attorney fees, payment of attorney fees to claimants, and any
1399 other reduction actuarially indicated, due to the combined
1400 effect of the applicable provisions of chapters 2021-77, 2022-
1401 268, 2022-271, and 2023-15, Laws of Florida, in order to ensure
1402 that rates for such insurance accurately reflect the risk of
1403 providing such insurance.
1404 (2) The Office of Insurance Regulation must consider in its
1405 review of such rate filings the projected savings or reduction
1406 in claim frequency, claim severity, and loss adjustment
1407 expenses, including for attorney fees, payment of attorney fees
1408 to claimants, and any other reduction actuarially indicated, due
1409 to the combined effect of the applicable provisions of chapters
1410 2021-77, 2022-268, 2022-271, and 2023-15, Laws of Florida. The
1411 office may develop methodology and data that incorporate
1412 generally accepted actuarial techniques and standards to be used
1413 in its review of rate filings governed by this section. The
1414 office may contract with an appropriate vendor to advise the
1415 office in developing such methodology and data to consider. Such
1416 methodology and data are not intended to create a mandatory
1417 minimum rate decrease for all motor vehicle insurers and
1418 property insurers, respectively, but rather to ensure that the
1419 rates for such coverage meet the requirements of s. 627.062,
1420 Florida Statutes, and thus are not excessive, inadequate, or
1421 unfairly discriminatory and allow such insurers a reasonable

1422 rate of return.

1423 (3) This section does not apply to rate filings made

1424 pursuant to s. 627.062(2)(k), Florida Statutes.

1425 (4) For the 2023-2024 fiscal year, the sum of $500,000 in

1426 nonrecurring funds is appropriated from the Insurance Regulatory

1427 Trust Fund in the Department of Financial Services to the Office

1428 of Insurance Regulation to implement this section.

1429 Section 25. For the 2023-2024 fiscal year, 18 full-time

1430 equivalent positions with associated salary rate of 1,116,500

1431 are authorized and the sum of $1,879,129 in recurring funds and

1432 $185,086 in nonrecurring funds is appropriated from the

1433 Insurance Regulatory Trust Fund to the Office of Insurance

1434 Regulation to implement this act.

1435 Section 26. For the 2023-2024 fiscal year, seven full-time

1436 equivalent positions with associated salary rate of 350,000 are

1437 authorized and the sum of $574,036 in recurring funds and

1438 $33,467 in nonrecurring funds is appropriated from the Insurance

1439 Regulatory Trust Fund to the Department of Financial Services to

1440 implement this act.

1441 Section 27. This act shall take effect July 1, 2023.