Committee on Banking and Insurance

CS/SB 7052 — Insurer Accountability

by Fiscal Policy Committee and Banking and Insurance Committee

The bill contains various provisions intended to increase consumer protection and insurer accountability in this state.

Regarding insurance coverage, the bill:

- Prohibits authorized insurers from cancelling a property insurance policy during any pending claim until the earlier of when the property has been repaired or 1 year after the insurer issues the final claim payment. The bill expands upon current law which prohibits authorized insurers from cancelling a residential property insurance policy until 90 days after repairs are complete for damage resulting from a hurricane or wind loss that is the subject of a state of emergency declared by the Governor and for which the Office of Insurance Regulation has issued an emergency order.
- Protects policyholders whose property insurance company becomes insolvent by requiring Citizens Property Insurance Corporation cover property with open claims handled by the Florida Insurance Guaranty Association.
- Clarifies that if a roof deductible is applied, the prohibition on applying any other deductible under the policy encompasses any other loss to the property caused by the same covered peril.
- Tolls the time period for filing a property insurance claim during a named insured's term of deployment to a combat zone or combat support posting.
- Clarifies legislative intent that ch. 2022-271, L.O.F., passed during Special Session A in December 2022, (SB 2-A [2022] on Property Insurance) shall not be construed to impair any right under an insurance contract in effect on or before the applicable effective date of that chapter law (December 16, 2022).

Regarding rates charged for insurance, the bill:

- Requires property insurance and motor vehicle rate filings to include, and the OIR must consider in reviewing rates, the combined effect of recent legislative reforms.
- Appropriates $500,000 from the Insurance Regulatory Trust Fund for the OIR to obtain an actuarial study to implement this requirement.
- Requires property insurance mitigation discounts be updated at least every 5 years and requires insurers to provide consumer-friendly information on their website describing hurricane mitigation discounts available to policyholders.

Regarding insurer claims handling, the bill:

- Requires liability insurers to follow proper claims handling practices on behalf of their insureds and provides that insurers engaging in a pattern or practice of violations are subject to enhanced enforcement penalties including a 2.0 multiplier of fines.
- Requires residential property insurers to create and use claims-handling manuals that comply with the Insurance Code and, at a minimum, comport to industry standards. The OIR may request a claims handling manual at any time and requires each property insurer

to attest that their claims manuals comply with Florida law and the insurer is able to properly implement their manual.

- Strengthens the Unfair Insurance Trade Practices Act by:
  - Prohibiting alteration or amendment of an adjuster's report without providing a detailed explanation as to why any change that has the effect of reducing the estimate of the loss was made. The insurer must also either create a list of changes and who made the change or retain all versions of the report.
  - Prohibiting officers and directors of impaired or insolvent insurers from receiving a bonus from that insurer or other entity under common ownership with that insurer.

Regarding regulatory oversight of insurers, the bill:

- Creates a statutory requirement that the OIR refer suspected criminal activity to the Department of Financial Services (DFS) or other appropriate law enforcement or prosecutorial entities.
- Requires the OIR to develop a risk-based selection methodology for scheduling examinations of insurers. Such methodology must include:
  - Use of a risk-focused analysis to prioritize financial examinations of insurers when such reporting indicates a decline in the insurer's financial condition.
  - Consideration of:
    - Level of capitalization and identification of unfavorable trends;
    - Negative trends in profitability or cash flow from operations;
    - National Association of Insurance Commissioners Insurance Regulatory Information System ratio results;
    - Risk-based capital and risk-based capital trend test results;
    - The structure and complexity of the insurer;
    - Changes in the insurer's officers or board of directors;
    - Changes in the insurer's business strategy or operations;
    - Findings and recommendations from an examination;
    - Current or pending regulatory actions by the OIR or the DFS;
    - Information obtained from other regulatory agencies or independent organization ratings and reports; and
    - The impact of an insurer's insolvency on policyholders of the insurer and the public generally.
  - Prioritization of property insurers for which the OIR identifies significant concerns about an insurer's solvency.
  - Any other matters the OIR deems necessary to consider for the protection of the public.
- Provides that the OIR must initiate a market conduct examination after a hurricane if, at any time more than 90 days after the end of the hurricane, the insurer:
  - Is among the top 20 percent of insurers based upon a calculation of the ratio of hurricane claim-related consumer complaints made about that insurer to the DFS to the insurer's total number of hurricane-related claims;

  - Is among the top 20 percent of insurers based upon a calculation of the ratio of hurricane claims closed without payment to the insurer's total number of hurricane claims;
  - Has made significant payments to its managing general agent since the hurricane; or
  - Is identified by the OIR as necessitating a market conduct exam for any other reason.
- Specifies factors the OIR may consider in determining whether the continued operation of an insurer may be deemed hazardous to its policyholders, creditors, or the general public. In making such a determination, the OIR may consider, in the totality of the circumstances, any of the following:
  - Adverse findings reported in financial condition or market conduct examination reports, audit reports, or actuarial opinions, reports, or summaries;
  - The National Association of Insurance Commissioners Insurance Regulatory Information Systems and its other financial analysis solvency tools and reports;
  - Whether the insurer has made adequate provisions for the anticipated cash flows required to cover its obligations and expenses;
  - The ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection;
  - Whether the insurer's operating loss in the last twelve-month period is greater than fifty percent of the insurer's remaining surplus;
  - Whether the insurer's operating loss in the last twelve-month period excluding net capital gains, is greater than twenty percent of the insurer's remaining surplus;
  - Whether a reinsurer, obligor, or any entity within the insurer's insurance holding company system, is insolvent, threatened with insolvency or delinquent in payment of its monetary or other obligations, and which may affect the solvency of the insurer;
  - Contingent liabilities, pledges, or guaranties which in the opinion of the OIR may affect the solvency of the insurer;
  - Whether any "affiliate" of an insurer is delinquent in the transmitting to, or payment of, net premiums to the insurer;
  - The age and collectability of receivables;
  - Whether the management of an insurer fails to possess and demonstrate the competence, fitness, and reputation deemed necessary;
  - Whether management of an insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished false or misleading information to the OIR;
  - Whether the insurer has failed to meet financial and holding company filing requirements in the absence of a reason satisfactory to the OIR;
  - Whether management of an insurer has filed or released any false or misleading financial statement, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the insurer;
  - Whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner;
  - Whether the insurer has experienced or will experience in the foreseeable future cash flow or liquidity problems;

  - Whether management has established reserves that do not comply with minimum standards established by state insurance laws, regulations, statutory accounting standards, sound actuarial principals and standards of practice;
  - Whether management persistently engages in material under reserving that results in adverse development;
  - Whether transactions among affiliates, subsidiaries, or controlling persons for which the insurer receives assets or capital gains, or both, do not provide sufficient value, liquidity, or diversity to assure the insurer's ability to meet its outstanding obligations as they mature;
  - The ratio of the annual premium volume to surplus or of its liabilities to surplus in relation to loss experience and/or the kinds of risks insured;
  - Whether the insurer's asset portfolio when viewed in light of current economic conditions and indications of financial or operational leverage is of sufficient value, liquidity or diversity to assure the company's ability to meet its outstanding obligations as they mature;
  - Whether the excess of surplus to policyholders over and above an insurer's statutorily required surplus to policyholders has decreased by more than 50 percent in the preceding 12-month period;
  - Whether residential property insurers have sufficient capital, surplus, and reinsurance to withstand significant weather events, including but not limited to hurricanes;
  - The insurer's required surplus, capital, or capital stock is impaired to an extent prohibited by law;
  - The insurer continues to write new business when it has not maintained the required surplus or capital;
  - The insurer attempts to dissolve or liquidate without first having made provisions, satisfactory to the OIR, for liabilities arising from insurance policies issued by the insurer;
  - Whether an insurer has incurred substantial new debt, has had to rely on frequent or substantial capital infusions, has a highly leveraged balance sheet, or relies increasingly on outside consulting sources;
  - The insurer meets one or more of the grounds in s. 631.051, F.S., for the appointment of the DFS as receiver; or
  - Any other finding determined by the OIR to be hazardous to the insurer's policyholders, creditors, or general public.
- Specifies actions the OIR may take in determining an insurer's financial condition, and specifies actions the OIR may order an insurer to take in an effort to improve the insurer's financial condition.
- Increases maximum administrative fines that may be levied by the OIR on insurers by 250 percent generally, and 500 percent for violations stemming from a state of emergency such as a hurricane.
  - Fines for each nonwillful violation may not exceed $12,500 (up from $5,000) and fines for each willful violation may not exceed $100,000 (up from $40,000). Fines may not exceed an aggregate amount of $50,000 (up from $20,000) for all nonwillful

violations arising out of the same action or an aggregate amount of $500,000 (up from $200,000) for all willful violations arising out of the same action.
    - Fines for "twisting" and for "churning" may not exceed $12,500 (up from $5,000) for each nonwillful violation and may not exceed $187,500 (up from $75,000) for each willful violation. Fines for willfully submitting fraudulent signatures on an application or policy-related document may not exceed $12,500 (up from $5,000) for each nonwillful violation and may not exceed $187,500 (up from $75,000) for each willful violation.
    - Fines for a violation related to a covered loss or claim caused by an emergency for which the Governor declared a state of emergency may not exceed $25,000 for each nonwillful violation and may not exceed $200,000 for each willful violation. Such fines may not exceed an aggregate amount of $100,000 for all nonwillful violations arising out of the same action or an aggregate amount of $1,000,000 for all willful violations arising out of the same action.
- Requires insurers to more promptly respond to the DFS Division of Consumer Services and increases fines for noncompliance. Decreases time for insurers to respond to the DFS Division of Consumer Services from 20 to 14 days and increases fines for noncompliance to $5,000 (up from $2,500) for licensed entities; and increases fines for a licensed individual to a flat $1,000 for each violation (up from $250 for a first violation, $500 for a second violation, and $1,000 for a third and any subsequent violation).
- Requires insurers that violate the Insurance Code to obtain prior approval of forms from the Office of Insurance Regulation (OIR) for three years after the violation.
- Increases staffing for the DFS by appropriating funding for seven full-time equivalent positions.
- Increases staffing at the OIR by appropriating 18 full-time equivalent positions;
- Requires property insurers to report to the OIR any temporary suspension of writing new policies.
- Specifies that insurance fraud referrals may be made to the statewide prosecutor for crimes impacting two or more judicial circuits.
- Requires additional reporting from regulators regarding their enforcement actions.

If approved by the Governor, or allowed to become law without the Governor's signature, these provisions take effect July 1, 2023.
Vote: Senate 39-0; House 113-0