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LEGISLATIVE ACTION

Senate	.	House
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Senator Hutson moved the following:

1 **Senate Amendment (with title amendment)**
2
3 Delete everything after the enacting clause
4 and insert:
5 Section 1. Section 624.115, Florida Statutes, is created to
6 read:
7 624.115 Referral of criminal violations.—If, during an
8 investigation or examination, the office has reason to believe
9 that any criminal law of this state has or may have been
10 violated, the office shall refer any relevant records and
11 information to the Division of Investigative and Forensic

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12 Services, state or federal law enforcement, or prosecutorial
13 agencies, as applicable, and shall provide investigative
14 assistance to those agencies as required.
15 Section 2. Paragraph (b) of subsection (10) of section
16 624.307, Florida Statutes, is amended to read:
17 624.307 General powers; duties.—
18 (10)
19 (b) Any person licensed or issued a certificate of
20 authority by the department or the office shall respond, in
21 writing or electronically, to the division within 14 ~~20~~ days
22 after receipt of a written request for documents and information
23 from the division concerning a consumer complaint. The response
24 must address the issues and allegations raised in the complaint
25 and include any requested documents concerning the consumer
26 complaint not subject to attorney-client or work-product
27 privilege. The division may impose an administrative penalty for
28 failure to comply with this paragraph of up to $5,000 ~~$2,500~~ per
29 violation upon any entity licensed by the department or the
30 office ~~and $250 for the first violation, $500 for the second~~
31 ~~violation,~~ and up to $1,000 per ~~for the third or subsequent~~
32 violation by ~~upon~~ any individual licensed by the department or
33 the office.
34 Section 3. Present subsection (4) of section 624.315,
35 Florida Statutes, is redesignated as subsection (5), and a new
36 subsection (4) is added to that section, to read:
37 624.315 Annual reports; quarterly reports ~~report~~.—
38 (4)(a) The office shall create a report detailing all
39 actions of the office to enforce insurer compliance with this
40 code and all rules and orders of the office or department during

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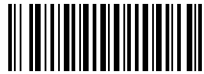
41 the previous year. For each of the following, the report must
42 detail the insurer or other licensee or registrant against whom
43 such action was taken; whether the office found any violation of
44 law or rule by such party, and, if so, detail such violation;
45 and the resolution of such action, including any penalties
46 imposed by the office. The report must be published on the
47 website of the office and submitted to the commission, the
48 President of the Senate, the Speaker of the House of
49 Representatives, and the legislative committees with
50 jurisdiction over matters of insurance on or before January 31
51 of each year. The report must include, but need not be limited
52 to:
53 1. The revocation, denial, or suspension of any license or
54 registration issued by the office.
55 2. All actions taken pursuant to s. 624.310.
56 3. Fines imposed by the office for violations of this code.
57 4. Consent orders entered into by the office.
58 5. Examinations and investigations conducted and completed
59 by the office pursuant to ss. 624.316 and 624.3161.
60 6. Investigations conducted and completed, by line of
61 insurance, for which the office found violations of law or rule
62 but did not take enforcement action.
63 (b) Each quarter, the office shall create a report
64 detailing all actions of the office to enforce insurer
65 compliance during the previous quarter. The report must include,
66 but need not be limited to, the subjects that must be included
67 in the annual report under paragraph (a). The report must be
68 submitted to the commission, the President of the Senate, the
69 Speaker of the House of Representatives, and the legislative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70 committees with jurisdiction over matters of insurance. The
71 report is due on or before April 30, July 31, October 31, and
72 January 31, respectively, for the immediately preceding quarter.
73 The report due January 31 may be included within the annual
74 report required under paragraph (a).
75 (c) The office need not include within any report required
76 under this subsection information that would violate any
77 confidentiality provision included within any agreement, order,
78 or consent order entered into or adopted by the office.
79 Section 4. Paragraph (a) of subsection (2) of section
80 624.316, Florida Statutes, is amended, and subsections (3) and
81 (4) are added to that section, to read:
82 624.316 Examination of insurers.—
83 (2)(a) Except as provided in paragraph (f), the office may
84 examine each insurer as often as may be warranted for the
85 protection of the policyholders and in the public interest, but
86 must, at a minimum, examine:
87 1. High-risk insurers at least once every 3 years.
88 2. Average- and low-risk insurers at least once every ~~and~~
89 ~~shall examine each domestic insurer not less frequently than~~
90 ~~once every~~ 5 years.
91
92 The examination shall cover the number of fiscal years since the
93 last examination ~~preceding 5 fiscal years~~ of the insurer, except
94 for examinations of low-risk insurers, in which case the
95 examination need only cover at least the preceding 5 fiscal
96 years, and shall be commenced within 12 months after the end of
97 the most recent fiscal year being covered by the examination.
98 The examination may cover any period of the insurer’s operations

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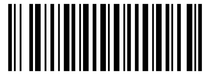
99 since the last previous examination. The examination may include
100 examination of events subsequent to the end of the most recent
101 fiscal year and the events of any prior period that affect the
102 present financial condition of the insurer.
103 (3) The office shall create, and the commission shall adopt
104 by rule, a risk-based selection methodology for scheduling
105 examinations of insurers subject to this section. Except as
106 otherwise specified in subsection (2), this requirement does not
107 restrict the authority of the office to conduct examinations
108 under this section as often as it deems advisable. Such
109 methodology must include all of the following:
110 (a) Use of a risk-focused analysis to prioritize financial
111 examinations of insurers when such reporting indicates a decline
112 in the insurer's financial condition.
113 (b) Consideration of:
114 1. The level of capitalization and identification of
115 unfavorable trends;
116 2. Negative trends in profitability or cash flow from
117 operations;
118 3. National Association of Insurance Commissioners
119 Insurance Regulatory Information System ratio results;
120 4. Risk-based capital and risk-based capital trend test
121 results;
122 5. The structure and complexity of the insurer;
123 6. Changes in the insurer's officers or board of directors;
124 7. Changes in the insurer's business strategy or
125 operations;
126 8. Findings and recommendations from an examination made
127 pursuant to this section or s. 624.3161;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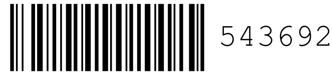
128 9. Current or pending regulatory actions by the office or
129 the department;
130 10. Information obtained from other regulatory agencies or
131 independent organization ratings and reports; and
132 11. The impact of an insurer's insolvency on policyholders
133 of the insurer and the public generally.
134 (c) Prioritization of property insurers for which the
135 office identifies significant concerns about an insurer's
136 solvency pursuant to s. 627.7154.
137 (d) Any other matters the office deems necessary to
138 consider for the protection of the public.
139 (4) The office shall present any proposed rules
140 implementing this section to the commission no later than
141 October 1, 2023. In addition to the methodology required by this
142 section, such rule or rules must include a plan to implement the
143 examination schedule in subsection (2). To facilitate the
144 development of the methodology for scheduling examinations
145 pursuant to this section, the commission may also adopt by rule
146 the National Association of Insurance Commissioners Financial
147 Analysis Handbook, to the extent that the handbook is consistent
148 with and does not negate the requirements of this section.
149 Section 5. Subsection (7) of section 624.3161, Florida
150 Statutes, is amended, and subsections (8) and (9) are added to
151 that section, to read:
152 624.3161 Market conduct examinations.—
153 (7) Notwithstanding subsection (1), any authorized insurer
154 transacting residential property insurance business in this
155 state:
156 (a) May be subject to an additional market conduct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157 examination after a hurricane if, at any time more than 90 days
158 after the end of the hurricane, the insurer:
159 (a) is among the top 20 percent of insurers based upon a
160 calculation of the ratio of hurricane-related property insurance
161 claims filed to the number of property insurance policies in
162 force;
163 (b) Must be subject to a market conduct examination after a
164 hurricane if, at any time more than 90 days after the end of the
165 hurricane, the insurer:
166 1. Is among the top 20 percent of insurers based upon a
167 calculation of the ratio of hurricane claim-related consumer
168 complaints made about that insurer to the department to the
169 insurer's total number of hurricane-related claims;
170 2. Is among the top 20 percent of insurers based upon a
171 calculation of the ratio of hurricane claims closed without
172 payment to the insurer's total number of hurricane claims on
173 policies providing wind or windstorm coverage;
174 3.(c) Has made significant payments to its managing general
175 agent since the hurricane; or
176 4.(d) Is identified by the office as necessitating a market
177 conduct exam for any other reason.
178
179 All relevant criteria under this section and s. 624.316 shall be
180 applied to the market conduct examination under this subsection.
181 Such an examination must be initiated within 18 months after the
182 landfall of a hurricane that results in an executive order or a
183 state of emergency issued by the Governor. The requirements of
184 this subsection do not limit the authority of the office to
185 conduct at any time a market conduct examination of a property

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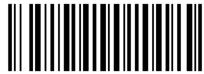
186 insurer in the aftermath of a hurricane. This subsection does
187 not require the office to conduct multiple market conduct
188 examinations of the same insurer when multiple hurricanes make
189 landfall in this state in a single calendar year. An examination
190 of an insurer under this subsection must also include an
191 examination of its managing general agent as if it were the
192 insurer.
193 (8) The office shall create, and the commission shall adopt
194 by rule, a selection methodology for scheduling and conducting
195 market conduct examinations of insurers and other entities
196 regulated by the office. This requirement does not restrict the
197 authority of the office to conduct market conduct examinations
198 as often as it deems necessary. Such selection methodology must
199 prioritize market conduct examinations of insurers and other
200 entities regulated by the office to whom any of the following
201 conditions applies:
202 (a) An insurance regulator in another state has initiated
203 or taken regulatory action against the insurer or entity
204 regarding an act or omission of such insurer or entity which, if
205 committed in this state, would constitute a violation of the
206 laws of this state or any rule or order of the office or
207 department.
208 (b) Given the insurer's market share in this state, the
209 department or the office has received a disproportionate number
210 of the following types of claims-handling complaints against the
211 insurer:
212 1. Failure to timely communicate with respect to claims;
213 2. Failure to timely pay claims;
214 3. Untimely payments giving rise to the payment of

 543692

215 statutory interest;
216 4. Failure to adjust and pay claims in accordance with the
217 terms and conditions of the policy or contract and in compliance
218 with state law;
219 5. Violations of part IX of chapter 626, the Unfair
220 Insurance Trade Practices Act;
221 6. Failure to use licensed and duly appointed claims
222 adjusters;
223 7. Failure to maintain reasonable claims records; or
224 8. Failure to adhere to the company's claims-handling
225 manual.
226 (c) The results of a National Association of Insurance
227 Commissioners Market Conduct Annual Statement indicate that the
228 insurer is a negative outlier with regard to particular metrics.
229 (d) There is evidence that the insurer is violating or has
230 violated the Unfair Insurance Trade Practices Act.
231 (e) The insurer meets the criteria in subsection (7).
232 (f) Any other conditions the office deems necessary for the
233 protection of the public.
234
235 The office shall present the proposed rule required by this
236 subsection to the commission no later than October 1, 2023. In
237 addition to the methodology required by this subsection, the
238 rule must provide criteria for how the office, in coordination
239 with the department, will determine what constitutes a
240 disproportionate number of claims-handling complaints described
241 in paragraph (b).
242 (9) If the office concludes through an examination pursuant
243 to this section that an insurer providing liability coverage in

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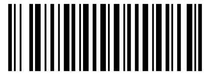
244 this state exhibits a pattern or practice of violations of the
245 Florida Insurance Code during any investigation or examination
246 of the insurer, the office must review the insurer's claims-
247 handling practices to determine if the insurer should be subject
248 to the enhanced enforcement penalties of this subsection.
249 (a) A liability insurer may be subject to enhanced
250 enforcement penalties if the office reviews the insurer's
251 claims-handling practices and finds a pattern or practice of the
252 insurer failing to do the following when responding to covered
253 liability claims under an insurance policy, after receiving
254 actual notice of such claims:
255 1. Assign a licensed and appointed insurance adjuster to
256 investigate whether coverage is provided under the policy and
257 diligently attempt to resolve any questions concerning the
258 extent of the insured's coverage.
259 2. Evaluate the claim fairly, honestly, and with due regard
260 for the interests of the insured based on available information.
261 3. Request from the insured or claimant additional relevant
262 information the insurer reasonably deems necessary to evaluate
263 whether to settle a claim.
264 4. Conduct all oral and written communications with the
265 insured with honesty and candor.
266 5. Make reasonable efforts to explain to persons not
267 represented by counsel matters requiring expertise beyond the
268 level normally expected of a layperson with no training in
269 insurance or claims-handling issues.
270 6. Retain all written and recorded communications and
271 create and retain a summary of all verbal communications in a
272 reasonable manner for a period of not less than 2 years after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273 the later of the entry of a final judgment against the insured
274 in excess of policy limits or, if an extracontractual claim is
275 made, the conclusion of that claim and any related appeals.
276 7. Within 30 days after a request, provide the insured with
277 all communications related to the insurer's handling of the
278 claim which are not privileged as to the insured.
279 8. Provide, upon request and at the insurer's expense,
280 reasonable accommodations necessary to communicate effectively
281 with an insured covered under the Americans with Disabilities
282 Act.
283 9. When handling a third-party claim, communicate each of
284 the following to the insured:
285 a. The identity of any other person or entity the insurer
286 has reason to believe may be liable.
287 b. The insurer's final and completed estimate of the claim.
288 c. The possibility of an excess judgment.
289 d. The insured's right to secure personal counsel at his or
290 her own expense.
291 e. That the insured should cooperate with the insurer,
292 including providing information required by the insurer because
293 of a settlement opportunity or in accordance with the policy.
294 f. Any formal settlement demands or offers to settle by the
295 claimant and any offers to settle on behalf of the insured.
296 10. Respond to any request for insurance information in
297 compliance with s. 626.9372 or s. 627.4137, as applicable.
298 11. Seek to obtain a general release of each insured in
299 making any settlement offer to a third-party claimant.
300 12. Take reasonable measures to preserve any documentary,
301 photographic, and forensic evidence as needed for the defense of

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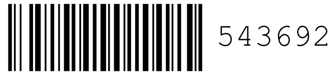
302 the liability claim if it appears likely that the insured's
303 liability exposure is greater than policy limits and the insurer
304 fails to secure a general release in favor of the insured.
305 13. Comply with subsections (1) and (2), if applicable.
306 14. Comply with the Unfair Insurance Trade Practices Act.
307 (b) As used in this subsection, the term "actual notice"
308 means the insurer's receipt of notice of an incident or a loss
309 that could give rise to a covered claim that is communicated to
310 the insurer or an agent of the insurer:
311 1. By any manner permitted by the policy or other documents
312 provided to the insured by the insurer;
313 2. Through the claims link on the insurer's website; or
314 3. Through the e-mail address designated by the insurer
315 under s. 624.422.
316 (c) In reviewing claims-handling practices, it is relevant
317 whether the insured, claimant, and any representative of the
318 insured or claimant were acting reasonably toward the insurer in
319 furnishing information regarding the claim, in making demands of
320 the insurer, in setting deadlines, and in attempting to settle
321 the claim. Such matters include whether:
322 1. The insured cooperated with the insurer in the defense
323 of the claim and in making settlements by taking reasonable
324 actions requested by the claimant or required by the policy
325 which are necessary to assist the insurer in settling a covered
326 claim, including:
327 a. Executing affidavits regarding the facts within the
328 insured's knowledge regarding the covered loss; and
329 b. Providing documents, including, if reasonably necessary
330 to settle a covered claim valued in excess of policy limits and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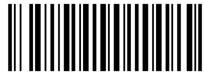
331 upon the request of the claimant, a summary of the insured's
332 assets, liabilities, obligations, and other insurance policies
333 that may provide coverage for the claim and the name and contact
334 information of the insured's employer when the insured is a
335 natural person who was acting in the course and scope of
336 employment when the incident giving rise to the claim occurred.
337 2. The claimant and any claimant's representative:
338 a. Acted honestly in furnishing information regarding the
339 claim;
340 b. Acted reasonably in setting deadlines; and
341 c. Refrained from taking actions that may be reasonably
342 expected to prevent an insurer from accepting the settlement
343 demand, such as providing insufficient detail within the demand,
344 providing unreasonable deadlines for acceptance of the demand,
345 or including unreasonable conditions to settlement.
346 (d) In addition to authorized penalties for a liability
347 insurer that the office has determined has a pattern or practice
348 of violations of the Florida Insurance Code at the conclusion of
349 any investigation or examination, the office may impose enhanced
350 enforcement penalties for insurer claims-handling practices that
351 fail to meet the review standards of this subsection. Such
352 enhanced enforcement penalties include, but are not limited to,
353 administrative fines that are subject to a 2.0 multiplier and
354 fines that exceed the limits on fine amounts and aggregate fine
355 amounts provided for under this code.
356 (e) This subsection does not create a civil cause of
357 action, a civil remedy under s. 624.155, or an unfair trade
358 practice under 626.9541.
359 Section 6. Section 624.4211, Florida Statutes, is amended

 543692

360 to read:
361 624.4211 Administrative fine in lieu of suspension or
362 revocation.—
363 (1) If the office finds that one or more grounds exist for
364 the discretionary revocation or suspension of a certificate of
365 authority issued under this chapter, the office may, in lieu of
366 such revocation or suspension, impose a fine upon the insurer.
367 (2)(a) With respect to a ~~any~~ nonwillful violation, such
368 fine may not exceed:
369 1. Twenty-five thousand dollars per violation, up to an
370 aggregate amount of $100,000 for all nonwillful violations
371 arising out of the same action, related to a covered loss or
372 claim caused by an emergency for which the Governor declared a
373 state of emergency pursuant to s. 252.36.
374 2. Twelve thousand five hundred dollars ~~$5,000~~ per
375 violation, up to~~. In no event shall such fine exceed~~ an
376 aggregate amount of $50,000 ~~$20,000~~ for all other nonwillful
377 violations arising out of the same action.
378 (b) If an insurer discovers a nonwillful violation, the
379 insurer shall correct the violation and, if restitution is due,
380 make restitution to all affected persons. Such restitution shall
381 include interest at 12 percent per year from either the date of
382 the violation or the date of inception of the affected person’s
383 policy, at the insurer’s option. The restitution may be a credit
384 against future premiums due, provided that interest accumulates
385 until the premiums are due. If the amount of restitution due to
386 any person is $50 or more and the insurer wishes to credit it
387 against future premiums, it shall notify such person that she or
388 he may receive a check instead of a credit. If the credit is on

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389 a policy that is not renewed, the insurer shall pay the
390 restitution to the person to whom it is due.
391 (3)(a) With respect to a ~~any~~ knowing and willful violation
392 of a lawful order or rule of the office or commission or a
393 provision of this code, the office may impose a fine upon the
394 insurer in an amount not to exceed:
395 1. Two hundred thousand dollars for each such violation, up
396 to an aggregate amount of $1 million for all knowing and willful
397 violations arising out of the same action, related to a covered
398 loss or claim caused by an emergency for which the Governor
399 declared a state of emergency pursuant to s. 252.36.
400 2. One hundred thousand dollars ~~$40,000~~ for each such
401 violation, up to~~. In no event shall such fine exceed~~ an
402 aggregate amount of $500,000 ~~$200,000~~ for all other knowing and
403 willful violations arising out of the same action.
404 (b) In addition to such fines, the insurer shall make
405 restitution when due in accordance with subsection (2).
406 (4) The failure of an insurer to make restitution when due
407 as required under this section constitutes a willful violation
408 of this code. However, if an insurer in good faith is uncertain
409 as to whether any restitution is due or as to the amount of such
410 restitution, it shall promptly notify the office of the
411 circumstances; and the failure to make restitution pending a
412 determination thereof shall not constitute a violation of this
413 code.
414 Section 7. Section 624.4301, Florida Statutes, is created
415 to read:
416 624.4301 Notice of temporary discontinuance of writing new
417 residential property insurance policies.—

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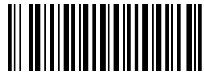
418 (1) Any authorized insurer, before temporarily suspending
419 writing new residential property insurance policies in this
420 state, must give notice to the office of the insurer’s reasons
421 for such action, the effective dates of the temporary
422 suspension, and the proposed communication to its agents. Such
423 notice must be provided on a form approved by the office and
424 adopted by the commission. The insurer shall submit such notice
425 to the office the earlier of 20 business days before the
426 effective date of the temporary suspension of writing or 5
427 business days before notifying its agents of the temporary
428 suspension of writing. The insurer must provide any other
429 information requested by the office related to the insurer’s
430 temporary suspension of writing. The requirements of this
431 section do not:
432 (a) Apply to a temporary suspension of writing new business
433 made in response to:
434 1. A hurricane that may make landfall in this state if such
435 temporary suspension ceases within 72 hours after hurricane
436 conditions are no longer present in this state; or
437 2. Any other natural emergency as defined in s. 252.34(8)
438 which impacts one or more counties and is the subject of a
439 declared state of emergency by any local, state, or federal
440 authority, if such temporary suspension applies only to the
441 affected counties and ceases within 72 hours after such natural
442 emergency is no longer present in those counties.
443 (b) Require such insurers to obtain the approval of the
444 office before temporarily suspending writing new residential
445 property insurance policies in this state.
446 (2) The commission may adopt rules to administer this

 543692

447 section.
448 Section 8. Section 624.805, Florida Statutes, is created to
449 read:
450 624.805 Hazardous insurer standards; office's evaluation
451 and enforcement authority; immediate final order.—
452 (1) In determining whether the continued operation of any
453 authorized insurer transacting business in this state may be
454 deemed to be hazardous to its policyholders or creditors or to
455 the general public, the office may consider, in the totality of
456 the circumstances of such insurer, any of the following:
457 (a) Adverse findings reported in financial condition or
458 market conduct examination reports, audit reports, or actuarial
459 opinions, reports, or summaries.
460 (b) The National Association of Insurance Commissioners
461 Insurance Regulatory Information System and its other financial
462 analysis solvency tools and reports.
463 (c) Whether the insurer has made adequate provisions,
464 according to presently accepted actuarial standards of practice,
465 for the anticipated cash flows required to cover its contractual
466 obligations and related expenses.
467 (d) The ability of an assuming reinsurer to perform and
468 whether the insurer's reinsurance program provides sufficient
469 protection for the insurer's remaining surplus after taking into
470 account the insurer's cash flow and the lines of insurance
471 written, as well as the financial condition of the assuming
472 reinsurer.
473 (e) Whether the insurer's operating loss in the last 12-
474 month period, including, but not limited to, net capital gain or
475 loss, change in nonadmitted assets, and cash dividends paid to

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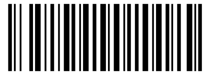
476 shareholders is greater than 50 percent of the insurer's
477 remaining surplus as regards policyholders in excess of the
478 minimum required.
479 (f) Whether the insurer's operating loss in the last 12-
480 month period, excluding net capital gains, is greater than 20
481 percent of the insurer's remaining surplus as regards
482 policyholders in excess of the minimum required.
483 (g) Whether a reinsurer, an obligor, or any entity within
484 the insurer's insurance holding company system is insolvent,
485 threatened with insolvency, or delinquent in payment of its
486 monetary or other obligations, and which in the opinion of the
487 office may affect the solvency of the insurer.
488 (h) Contingent liabilities, pledges, or guaranties that
489 individually or collectively involve a total amount that in the
490 opinion of the office may affect the solvency of the insurer.
491 (i) Whether any affiliate, as defined in s. 624.10(1), of
492 the insurer is delinquent in the transmitting to, or payment of,
493 net premiums to the insurer.
494 (j) The age and collectability of receivables.
495 (k) Whether the management of the insurer, including
496 officers, directors, or any other person who directly or
497 indirectly controls the operation of the insurer, fails to
498 possess and demonstrate the competence, fitness, and reputation
499 deemed necessary to serve the insurer in such position.
500 (l) Whether management of the insurer has failed to respond
501 to inquiries relative to the condition of the insurer or has
502 furnished false or misleading information to the office
503 concerning an inquiry.
504 (m) Whether the insurer has failed to meet financial and

 543692

505 holding company filing requirements in the absence of a reason
506 satisfactory to the office.
507 (n) Whether management of the insurer has filed any false
508 or misleading sworn financial statement, has released a false or
509 misleading financial statement to lending institutions or to the
510 general public, has made a false or misleading entry, or has
511 omitted an entry of material amount in the books of the insurer.
512 (o) Whether the insurer has grown so rapidly and to such an
513 extent that it lacks adequate financial and administrative
514 capacity to meet its obligations in a timely manner.
515 (p) Whether the insurer has experienced, or will experience
516 in the foreseeable future, cash flow or liquidity problems.
517 (q) Whether management has established reserves that do not
518 comply with minimum standards established by state insurance
519 laws and regulations, statutory accounting standards, sound
520 actuarial principles, and standards of practice.
521 (r) Whether management persistently engages in material
522 under-reserving that results in adverse development.
523 (s) Whether transactions among affiliates, subsidiaries, or
524 controlling persons for which the insurer receives assets or
525 capital gains, or both, do not provide sufficient value,
526 liquidity, or diversity to assure the insurer's ability to meet
527 its outstanding obligations as they mature.
528 (t) The ratio of the annual premium volume to surplus or of
529 its liabilities to surplus in relation to loss experience, the
530 kinds of risks insured, or both.
531 (u) Whether the insurer's asset portfolio, when viewed in
532 light of current economic conditions and indications of
533 financial or operational leverage, is of sufficient value,

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534 liquidity, or diversity to assure the company's ability to meet
535 its outstanding obligations as they mature.
536 (v) Whether the excess of surplus as regards policyholders
537 above the insurer's statutorily required surplus as regards
538 policyholders has decreased by more than 50 percent in the
539 preceding 12-month period.
540 (w) As to a residential property insurer, whether it has
541 sufficient capital, surplus, and reinsurance to withstand
542 significant weather events, including, but not limited to,
543 hurricanes.
544 (x) Whether the insurer's required surplus, capital, or
545 capital stock is impaired to an extent prohibited by law.
546 (y) Whether the insurer continues to write new business
547 when it has not maintained the required surplus or capital.
548 (z) Whether the insurer moves to dissolve or liquidate
549 without first having made provisions satisfactory to the office
550 for liabilities arising from insurance policies issued by the
551 insurer.
552 (aa) Whether the insurer has incurred substantial new debt,
553 has had to rely on frequent or substantial capital infusions,
554 has a highly leveraged balance sheet.
555 (bb) Whether the insurer relies increasingly on other
556 entities, including, but not limited to, affiliates, third-party
557 administrators, managing general agents, or management
558 companies.
559 (cc) Whether the insurer meets one or more of the grounds
560 in s. 631.051 for the appointment of the department as receiver.
561 (dd) Any other finding determined by the office to be
562 hazardous to the insurer's policyholders or creditors or to the

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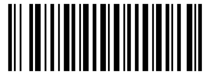
563 general public.
564 (2) For the purposes of making a determination of an
565 insurer's financial condition under the Florida Insurance Code,
566 the office may:
567 (a) Disregard any credit or amount receivable resulting
568 from transactions with a reinsurer that is insolvent, impaired,
569 or otherwise subject to a delinquency proceeding;
570 (b) Make appropriate adjustments, including disallowance to
571 asset values attributable to investments in or transactions with
572 parents, subsidiaries, or affiliates, consistent with the
573 National Association of Insurance Commissioners Accounting
574 Practices and Procedures Manual and state laws and rules;
575 (c) Refuse to recognize the stated value of accounts
576 receivable if the ability to collect receivables is highly
577 speculative in view of the age of the account or the financial
578 condition of the debtor; or
579 (d) Increase the insurer's liability, in an amount equal to
580 any contingent liability, pledge, or guarantee not otherwise
581 included, if there is a substantial risk that the insurer will
582 be called upon to meet the obligation undertaken within the next
583 12-month period.
584 (3) If the office determines that the continued operations
585 of an insurer authorized to transact business in this state may
586 be hazardous to its policyholders or creditors or to the general
587 public, the office may issue an order requiring the insurer to
588 do any of the following:
589 (a) Reduce the total amount of present and potential
590 liability for policy benefits by procuring additional
591 reinsurance.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592 (b) Reduce, suspend, or limit the volume of business being
593 accepted or renewed.
594 (c) Reduce expenses by specified methods or amounts.
595 (d) Increase the insurer's capital and surplus.
596 (e) Suspend or limit the declaration and payment of
597 dividends by an insurer to its stockholders or to its
598 policyholders.
599 (f) File reports in a form acceptable to the office
600 concerning the market value of the insurer's assets.
601 (g) Limit or withdraw from certain investments or
602 discontinue certain investment practices to the extent the
603 office deems necessary.
604 (h) Document the adequacy of premium rates in relation to
605 the risks insured.
606 (i) File, in addition to regular annual statements, interim
607 financial reports on a form prescribed by the commission and
608 adopted by the National Association of Insurance Commissioners.
609 (j) Correct corporate governance practice deficiencies and
610 adopt and use governance practices acceptable to the office.
611 (k) Provide a business plan acceptable to the office in
612 order to continue to transact business in this state.
613 (l) Notwithstanding any other law limiting the frequency or
614 amount of rate adjustments, adjust rates for any non-life
615 insurance product written by the insurer which the office
616 considers necessary to improve the financial condition of the
617 insurer.
618 (4) This section may not be interpreted to limit the powers
619 granted to the office by any laws of this state, nor may it be
620 interpreted to supersede any laws of this state.

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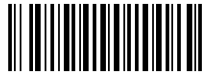
621 (5) The office may, pursuant to ss. 120.569 and 120.57, in
622 its discretion and without advance notice or hearing, issue an
623 immediate final order to any insurer requiring the actions
624 listed in subsection (3).
625 Section 9. Subsection (11) of section 624.81, Florida
626 Statutes, is amended to read:
627 624.81 Notice to comply with written requirements of
628 office; noncompliance.—
629 ~~(11) The commission may adopt rules to define standards of~~
630 ~~hazardous financial condition and corrective action~~
631 ~~substantially similar to that indicated in the National~~
632 ~~Association of Insurance Commissioners' 1997 "Model Regulation~~
633 ~~to Define Standards and Commissioner's Authority for Companies~~
634 ~~Deemed to be in Hazardous Financial Condition," which are~~
635 ~~necessary to implement the provisions of this part.~~
636 Section 10. Section 624.865, Florida Statutes, is created
637 to read:
638 624.865 Rulemaking.—The commission may adopt rules to
639 administer ss. 624.80-624.87. Such rules must protect the
640 interests of insureds, claimants, insurers, and the public.
641 Section 11. Paragraph (d) of subsection (2) and paragraph
642 (b) of subsection (3) of section 628.8015, Florida Statutes, are
643 amended to read:
644 628.8015 Own-risk and solvency assessment; corporate
645 governance annual disclosure.—
646 (2) OWN-RISK AND SOLVENCY ASSESSMENT.—
647 (d) *Exemption.*—
648 1. An insurer is exempt from the requirements of this
649 subsection if: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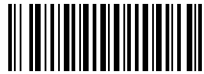
650 a. The insurer has annual direct written and unaffiliated
651 assumed premium, including international direct and assumed
652 premium, but excluding premiums reinsured with the Federal Crop
653 Insurance Corporation and the National Flood Insurance Program,
654 of less than $500 million; or
655 b. The insurer is a member of an insurance group and the
656 insurance group has annual direct written and unaffiliated
657 assumed premium, including international direct and assumed
658 premium, but excluding premiums reinsured with the Federal Crop
659 Insurance Corporation and the National Flood Insurance Program,
660 of less than $1 billion.
661 2. If an insurer is:
662 a. Exempt under sub-subparagraph 1.a., but the insurance
663 group of which the insurer is a member is not exempt under sub-
664 subparagraph 1.b., the ORSA summary report must include every
665 insurer within the insurance group. The insurer may satisfy this
666 requirement by submitting more than one ORSA summary report for
667 any combination of insurers if any combination of reports
668 includes every insurer within the insurance group.
669 b. Not exempt under sub-subparagraph 1.a., but the
670 insurance group of which it is a member is exempt under sub-
671 subparagraph 1.b., the insurer must submit to the office the
672 ORSA summary report applicable only to that insurer.
673 3. The office may require an exempt insurer to maintain a
674 risk management framework, conduct an ORSA, and file an ORSA
675 summary report:
676 a. Based on unique circumstances, including, but not
677 limited to, the type and volume of business written, ownership
678 and organizational structure, federal agency requests, and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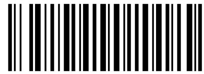
679 international supervisor requests;
680 b. If the insurer has risk-based capital for a company
681 action level event pursuant to s. 624.4085(3), meets one or more
682 of the standards of an insurer deemed to be in hazardous
683 financial condition under s. 624.805 ~~as defined in rules adopted~~
684 ~~by the commission pursuant to s. 624.81(11)~~, or exhibits
685 qualities of an insurer in hazardous financial condition as
686 determined by the office; or
687 c. If the office determines it is in the best interest of
688 the state.
689 4. If an exempt insurer becomes disqualified for an
690 exemption because of changes in premium as reported on the most
691 recent annual statement of the insurer or annual statements of
692 the insurers within the insurance group of which the insurer is
693 a member, the insurer must comply with the requirements of this
694 section effective 1 year after the year in which the insurer
695 exceeded the premium thresholds.
696 (3) CORPORATE GOVERNANCE ANNUAL DISCLOSURE.—
697 (b) *Disclosure requirement.*—
698 1.a. An insurer, or insurer member of an insurance group,
699 of which the office is the lead state regulator, as determined
700 by the procedures in the most recent National Association of
701 Insurance Commissioners Financial Analysis Handbook, shall
702 submit a corporate governance annual disclosure to the office by
703 June 1 of each calendar year. The initial corporate governance
704 annual disclosure must be submitted by December 31, 2018.
705 b. An insurer or insurance group not required to submit a
706 corporate governance annual disclosure under sub-subparagraph a.
707 shall do so at the request of the office, but not more than once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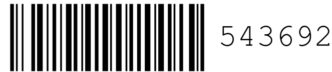
708 per calendar year. The insurer or insurance group shall notify
709 the office of the proposed submission date within 30 days after
710 the request of the office.
711 c. Before December 31, 2018, the office may require an
712 insurer or insurance group to provide a corporate governance
713 annual disclosure:
714 (I) Based on unique circumstances, including, but not
715 limited to, the type and volume of business written, the
716 ownership and organizational structure, federal agency requests,
717 and international supervisor requests;
718 (II) If the insurer has risk-based capital for a company
719 action level event pursuant to s. 624.4085(3), meets one or more
720 of the standards of an insurer deemed to be in hazardous
721 financial condition under s. 624.805 ~~as defined in rules adopted~~
722 ~~pursuant to s. 624.81(11)~~, or exhibits qualities of an insurer
723 in hazardous financial condition as determined by the office;
724 (III) If the insurer is the member of an insurer group of
725 which the office acts as the lead state regulator as determined
726 by the procedures in the most recent National Association of
727 Insurance Commissioners Financial Analysis Handbook; or
728 (IV) If the office determines that it is in the best
729 interest of the state.
730 2. The chief executive officer or corporate secretary of
731 the insurer or the insurance group must sign the corporate
732 governance annual disclosure attesting that, to the best of his
733 or her knowledge and belief, the insurer has implemented the
734 corporate governance practices and provided a copy of the
735 disclosure to the board of directors or the appropriate board
736 committee.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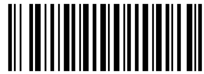
737 3.a. Depending on the structure of its system of corporate
738 governance, the insurer or insurance group may provide corporate
739 governance information at one of the following levels:
740 (I) The ultimate controlling parent level;
741 (II) An intermediate holding company level; or
742 (III) The individual legal entity level.
743 b. The insurer or insurance group may make the corporate
744 governance annual disclosure at:
745 (I) The level used to determine the risk appetite of the
746 insurer or insurance group;
747 (II) The level at which the earnings, capital, liquidity,
748 operations, and reputation of the insurer are collectively
749 overseen and the supervision of those factors is coordinated and
750 exercised; or
751 (III) The level at which legal liability for failure of
752 general corporate governance duties would be placed.
753
754 An insurer or insurance group must indicate the level of
755 reporting used and explain any subsequent changes in the
756 reporting level.
757 4. The review of the corporate governance annual disclosure
758 and any additional requests for information shall be made
759 through the lead state as determined by the procedures in the
760 most recent National Association of Insurance Commissioners
761 Financial Analysis Handbook.
762 5. An insurer or insurance group may comply with this
763 paragraph by cross-referencing other existing relevant and
764 applicable documents, including, but not limited to, the ORSA
765 summary report, Holding Company Form B or F filings, Securities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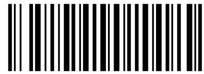
766 and Exchange Commission proxy statements, or foreign regulatory
767 reporting requirements, if the documents contain information
768 substantially similar to the information described in paragraph
769 (c). The insurer or insurance group shall clearly identify and
770 reference the specific location of the relevant and applicable
771 information within the corporate governance annual disclosure
772 and attach the referenced document if it has not already been
773 filed with, or made available to, the office.
774 6. Each year following the initial filing of the corporate
775 governance annual disclosure, the insurer or insurance group
776 shall file an amended version of the previously filed corporate
777 governance annual disclosure indicating changes that have been
778 made. If changes have not been made in the previously filed
779 disclosure, the insurer or insurance group should so indicate.
780 Section 12. Paragraph (c) of subsection (3) of section
781 626.207, Florida Statutes, is amended to read:
782 626.207 Disqualification of applicants and licensees;
783 penalties against licensees; rulemaking authority.—
784 (3) An applicant who has been found guilty of or has
785 pleaded guilty or nolo contendere to a crime not included in
786 subsection (2), regardless of adjudication, is subject to:
787 (c) A 7-year disqualifying period for all misdemeanors
788 directly related to the financial services business or any
789 misdemeanor directly related to any violation of the Florida
790 Insurance Code.
791 Section 13. Subsections (2) and (3) of section 626.9521,
792 Florida Statutes, are amended to read:
793 626.9521 Unfair methods of competition and unfair or
794 deceptive acts or practices prohibited; penalties.—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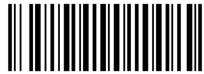
795 (2) Except as provided in subsection (3), any person who
796 violates any provision of this part is subject to a fine in an
797 amount not greater than $12,500 ~~$5,000~~ for each nonwillful
798 violation and not greater than $100,000 ~~$40,000~~ for each willful
799 violation. Fines under this subsection imposed against an
800 insurer may not exceed an aggregate amount of $50,000 ~~$20,000~~
801 for all nonwillful violations arising out of the same action or
802 an aggregate amount of $500,000 ~~$200,000~~ for all willful
803 violations arising out of the same action. The fines may be
804 imposed in addition to any other applicable penalty.
805 (3)(a) If a person violates s. 626.9541(1)(l), the offense
806 known as "twisting," or violates s. 626.9541(1)(aa), the offense
807 known as "churning," the person commits a misdemeanor of the
808 first degree, punishable as provided in s. 775.082, and an
809 administrative fine not greater than $12,500 ~~$5,000~~ shall be
810 imposed for each nonwillful violation or an administrative fine
811 not greater than $187,500 ~~$75,000~~ shall be imposed for each
812 willful violation. To impose an administrative fine for a
813 willful violation under this paragraph, the practice of
814 "churning" or "twisting" must involve fraudulent conduct.
815 (b) If a person violates s. 626.9541(1)(ee) by willfully
816 submitting fraudulent signatures on an application or policy-
817 related document, the person commits a felony of the third
818 degree, punishable as provided in s. 775.082, and an
819 administrative fine ~~not greater than $5,000 shall be imposed for~~
820 ~~each nonwillful violation or an administrative fine~~ not greater
821 than $187,500 ~~$75,000~~ shall be imposed for each ~~willful~~
822 violation.
823 (c) If a person violates any provision of this part and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824 such violation is related to a covered loss or covered claim
825 caused by an emergency for which the Governor declared a state
826 of emergency pursuant to s. 252.36, such person is subject to a
827 fine in an amount not greater than $25,000 for each nonwillful
828 violation and not greater than $200,000 for each willful
829 violation. Fines imposed under this paragraph against an insurer
830 may not exceed an aggregate amount of $100,000 for all
831 nonwillful violations arising out of the same action or an
832 aggregate amount of $1 million for all willful violations
833 arising out of the same action.
834 (d) Administrative fines under paragraphs (a) and (b) ~~this~~
835 ~~subsection~~ may not exceed an aggregate amount of $125,000
836 ~~$50,000~~ for all nonwillful violations arising out of the same
837 action or an aggregate amount of $625,000 ~~$250,000~~ for all
838 willful violations arising out of the same action.
839 Section 14. Paragraphs (i) and (w) of subsection (1) of
840 section 626.9541, Florida Statutes, are amended to read:
841 626.9541 Unfair methods of competition and unfair or
842 deceptive acts or practices defined.—
843 (1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE
844 ACTS.—The following are defined as unfair methods of competition
845 and unfair or deceptive acts or practices:
846 (i) *Unfair claim settlement practices.*—
847 1. Attempting to settle claims on the basis of an
848 application, when serving as a binder or intended to become a
849 part of the policy, or any other material document which was
850 altered without notice to, or knowledge or consent of, the
851 insured;
852 2. A material misrepresentation made to an insured or any

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853 other person having an interest in the proceeds payable under
854 such contract or policy, for the purpose and with the intent of
855 effecting settlement of such claims, loss, or damage under such
856 contract or policy on less favorable terms than those provided
857 in, and contemplated by, such contract or policy;
858 3. Committing or performing with such frequency as to
859 indicate a general business practice any of the following:
860 a. Failing to adopt and implement standards for the proper
861 investigation of claims;
862 b. Misrepresenting pertinent facts or insurance policy
863 provisions relating to coverages at issue;
864 c. Failing to acknowledge and act promptly upon
865 communications with respect to claims;
866 d. Denying claims without conducting reasonable
867 investigations based upon available information;
868 e. Failing to affirm or deny full or partial coverage of
869 claims, and, as to partial coverage, the dollar amount or extent
870 of coverage, or failing to provide a written statement that the
871 claim is being investigated, upon the written request of the
872 insured within 30 days after proof-of-loss statements have been
873 completed;
874 f. Failing to promptly provide a reasonable explanation in
875 writing to the insured of the basis in the insurance policy, in
876 relation to the facts or applicable law, for denial of a claim
877 or for the offer of a compromise settlement;
878 g. Failing to promptly notify the insured of any additional
879 information necessary for the processing of a claim;
880 h. Failing to clearly explain the nature of the requested
881 information and the reasons why such information is necessary;

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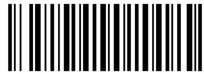
882 ~~or~~
883 i. Failing to pay personal injury protection insurance
884 claims within the time periods required by s. 627.736(4)(b). The
885 office may order the insurer to pay restitution to a
886 policyholder, medical provider, or other claimant, including
887 interest at a rate consistent with the amount set forth in s.
888 55.03(1), for the time period within which an insurer fails to
889 pay claims as required by law. Restitution is in addition to any
890 other penalties allowed by law, including, but not limited to,
891 the suspension of the insurer’s certificate of authority; or
892 j. Altering or amending an insurance adjuster’s report
893 without:
894 (I) Providing a detailed explanation as to why any change
895 that has the effect of reducing the estimate of the loss was
896 made; and
897 (II) Including on the report or as an addendum to the
898 report a detailed list of all changes made to the report and the
899 identity of the person who ordered each change; or
900 (III) Retaining all versions of the report, and including
901 within each such version, for each change made within such
902 version of the report, the identity of each person who made or
903 ordered such change; or
904 4. Failing to pay undisputed amounts of partial or full
905 benefits owed under first-party property insurance policies
906 within 60 days after an insurer receives notice of a residential
907 property insurance claim, determines the amounts of partial or
908 full benefits, and agrees to coverage, unless payment of the
909 undisputed benefits is prevented by factors beyond the control
910 of the insurer as defined in s. 627.70131(5).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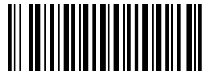
911 (w) *Soliciting or accepting new or renewal insurance risks*
912 *by insolvent or impaired insurer or receipt of certain bonuses*
913 *by an officer or director of an insolvent insurer prohibited;*
914 *penalty.*—
915 1. Whether or not delinquency proceedings as to the insurer
916 have been or are to be initiated, but while such insolvency or
917 impairment exists, no director or officer of an insurer, except
918 with the written permission of the office, shall authorize or
919 permit the insurer to solicit or accept new or renewal insurance
920 risks in this state after such director or officer knew, or
921 reasonably should have known, that the insurer was insolvent or
922 impaired.
923 2. Regardless of whether delinquency proceedings as to the
924 insurer have been or are to be initiated, but while such
925 insolvency or impairment exists, a director or an officer of an
926 impaired insurer may not receive a bonus from such insurer, nor
927 may such director or officer receive a bonus from a holding
928 company or an affiliate that shares common ownership or control
929 with such insurer.
930 3. As used in this paragraph, the term:
931 a. "Bonus" means a payment, in addition to an officer's or
932 a director's usual compensation, which is in addition to any
933 amounts contracted for or otherwise legally due.
934 b. "Impaired" includes impairment of capital or surplus, as
935 defined in s. 631.011(12) and (13).
936 4.~~2.~~ Any such director or officer, upon conviction of a
937 violation of this paragraph, commits ~~is guilty of~~ a felony of
938 the third degree, punishable as provided in s. 775.082, s.
939 775.083, or s. 775.084.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940 Section 15. Subsection (6) of section 626.989, Florida
941 Statutes, is amended, and subsection (10) is added to that
942 section, to read:
943 626.989 Investigation by department or Division of
944 Investigative and Forensic Services; compliance; immunity;
945 confidential information; reports to division; division
946 investigator's power of arrest.—
947 (6)(a) Any person, other than an insurer, agent, or other
948 person licensed under the code, or an employee thereof, having
949 knowledge or who believes that a fraudulent insurance act or any
950 other act or practice which, upon conviction, constitutes a
951 felony or a misdemeanor under the code, or under s. 817.234, is
952 being or has been committed may send to the Division of
953 Investigative and Forensic Services a report or information
954 pertinent to such knowledge or belief and such additional
955 information relative thereto as the department may request. Any
956 professional practitioner licensed or regulated by the
957 Department of Business and Professional Regulation, except as
958 otherwise provided by law, any medical review committee as
959 defined in s. 766.101, any private medical review committee, and
960 any insurer, agent, or other person licensed under the code, or
961 an employee thereof, having knowledge or who believes that a
962 fraudulent insurance act or any other act or practice which,
963 upon conviction, constitutes a felony or a misdemeanor under the
964 code, or under s. 817.234, is being or has been committed shall
965 send to the Division of Investigative and Forensic Services a
966 report or information pertinent to such knowledge or belief and
967 such additional information relative thereto as the department
968 may require.

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969 (b) The Division of Investigative and Forensic Services
970 shall review such information or reports and select such
971 information or reports as, in its judgment, may require further
972 investigation. It shall then cause an independent examination of
973 the facts surrounding such information or report to be made to
974 determine the extent, if any, to which a fraudulent insurance
975 act or any other act or practice which, upon conviction,
976 constitutes a felony or a misdemeanor under the code, or under
977 s. 817.234, is being committed.
978 (c) The Division of Investigative and Forensic Services
979 shall report any alleged violations of law which its
980 investigations disclose to the appropriate licensing agency and
981 state attorney or other prosecuting agency having jurisdiction,
982 including, but not limited to, the statewide prosecutor for
983 crimes that impact two or more judicial circuits in this state,
984 with respect to any such violation, as provided in s. 624.310.
985 If prosecution by the state attorney or other prosecuting agency
986 having jurisdiction with respect to such violation is not begun
987 within 60 days of the division's report, The state attorney or
988 other prosecuting agency having jurisdiction with respect to
989 such violation shall inform the division of any the reasons why
990 prosecution of such violation was:
991 1. Not begun within 60 days after the division's report; or
992 2. Declined for the lack of prosecution.
993 (10) The Division of Investigative and Forensic Services
994 Bureau of Insurance Fraud shall prepare and submit a performance
995 report to the President of the Senate and the Speaker of the
996 House of Representatives by September 1 of each year. The annual
997 report must include, but need not be limited to:

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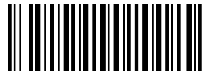
998 (a) The total number of initial referrals received, cases
999 opened, cases presented for prosecution, cases closed, and
1000 convictions resulting from cases presented for prosecution by
1001 the Bureau of Insurance Fraud, by type of insurance fraud and
1002 circuit.
1003 (b) The number of referrals received from insurers, the
1004 office, and the Division of Consumer Services of the department,
1005 and the outcome of those referrals.
1006 (c) The number of investigations undertaken by the Bureau
1007 of Insurance Fraud which were not the result of a referral from
1008 an insurer and the outcome of those referrals.
1009 (d) The number of investigations that resulted in a
1010 referral to a regulatory agency and the disposition of those
1011 referrals.
1012 (e) The number of cases presented by the Bureau of
1013 Insurance Fraud which local prosecutors or the statewide
1014 prosecutor declined to prosecute and the reasons provided for
1015 declining prosecution.
1016 (f) A summary of the annual report required under s.
1017 626.9896.
1018 (g) The total number of employees assigned to the Bureau of
1019 Insurance Fraud, delineated by location of staff assigned, and
1020 the number and location of employees assigned to the Bureau of
1021 Insurance Fraud who were assigned to work other types of fraud
1022 cases.
1023 (h) The average caseload and turnaround time by type of
1024 case for each investigator.
1025 (i) The training provided during the year to insurance
1026 fraud investigators.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1027 Section 16. Subsections (1), (3), and (4) of section
1028 627.0629, Florida Statutes, are amended to read:
1029 627.0629 Residential property insurance; rate filings.—
1030 (1) It is the intent of the Legislature that insurers
1031 provide savings to consumers who install or implement windstorm
1032 damage mitigation techniques, alterations, or solutions to their
1033 properties to prevent windstorm losses. A rate filing for
1034 residential property insurance must include actuarially
1035 reasonable discounts, credits, or other rate differentials, or
1036 appropriate reductions in deductibles, for properties on which
1037 fixtures or construction techniques demonstrated to reduce the
1038 amount of loss in a windstorm have been installed or
1039 implemented. The fixtures or construction techniques must
1040 include, but are not limited to, fixtures or construction
1041 techniques that enhance roof strength, roof covering
1042 performance, roof-to-wall strength, wall-to-floor-to-foundation
1043 strength, opening protection, and window, door, and skylight
1044 strength. Credits, discounts, or other rate differentials, or
1045 appropriate reductions in deductibles, for fixtures and
1046 construction techniques that meet the minimum requirements of
1047 the Florida Building Code must be included in the rate filing.
1048 The office shall determine the discounts, credits, other rate
1049 differentials, and appropriate reductions in deductibles that
1050 reflect the full actuarial value of such revaluation, which may
1051 be used by insurers in rate filings. Effective October 1, 2023,
1052 each insurer subject to the requirements of this section must
1053 provide information on the insurer’s website describing the
1054 hurricane mitigation discounts available to policyholders. Such
1055 information must be accessible on, or through a hyperlink

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1056 located on, the home page of the insurer’s website or the
1057 primary page of the insurer’s website for property insurance
1058 policyholders or applicants for such coverage in this state. On
1059 or before January 1, 2025, and every 5 years thereafter, the
1060 office shall reevaluate and update the fixtures or construction
1061 techniques demonstrated to reduce the amount of loss in a
1062 windstorm and the discounts, credits, other rate differentials,
1063 and appropriate reductions in deductibles that reflect the full
1064 actuarial value of such fixtures or construction techniques. The
1065 office shall adopt rules and forms necessitated by such
1066 reevaluation.
1067 (3) A rate filing ~~made on or after July 1, 1995,~~ for mobile
1068 home owner insurance must include appropriate discounts,
1069 credits, or other rate differentials for mobile homes
1070 constructed to comply with American Society of Civil Engineers
1071 Standard ANSI/ASCE 7-88, adopted by the United States Department
1072 of Housing and Urban Development on July 13, 1994, and that also
1073 comply with all applicable tie-down requirements provided by
1074 state law.
1075 (4) The Legislature finds that separate consideration and
1076 notice of hurricane insurance premiums will assist consumers by
1077 providing greater assurance that hurricane premiums are lawful
1078 and by providing more complete information regarding the
1079 components of property insurance premiums. ~~Effective January 1,~~
1080 ~~1997,~~ A rate filing for residential property insurance shall be
1081 separated into two components, rates for hurricane coverage and
1082 rates for all other coverages. A premium notice reflecting a
1083 rate implemented on the basis of such a filing shall separately
1084 indicate the premium for hurricane coverage and the premium for

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1085 all other coverages.
1086 Section 17. Paragraph (ll) is added to subsection (6) of
1087 section 627.351, Florida Statutes, to read:
1088 627.351 Insurance risk apportionment plans.—
1089 (6) CITIZENS PROPERTY INSURANCE CORPORATION.—
1090 (ll) The corporation may not determine that a risk is
1091 ineligible for coverage with the corporation solely because such
1092 risk has unrepaired damage caused by a covered loss that is the
1093 subject of a claim that has been filed with the Florida
1094 Insurance Guaranty Association. This paragraph applies to a risk
1095 until the earlier of 24 months after the date the Florida
1096 Insurance Guaranty Association began servicing such claim or the
1097 Florida Insurance Guaranty Association closes the claim.
1098 Section 18. Subsection (4) of section 627.410, Florida
1099 Statutes, is amended to read:
1100 627.410 Filing, approval of forms.—
1101 (4) The office may, by order, exempt from the requirements
1102 of this section for so long as it deems proper any insurance
1103 document or form or type thereof as specified in such order, to
1104 which, in its opinion, this section may not practicably be
1105 applied, or the filing and approval of which are, in its
1106 opinion, not desirable or necessary for the protection of the
1107 public. The office may not exempt from the requirements of this
1108 section the insurance documents or forms of any insurer, against
1109 whom the office enters a final order determining that such
1110 insurer violated any provision of this code, for a period of 36
1111 months after the date of such order, and may not be deemed
1112 approved under subsection (2).
1113 Section 19. Section 627.4108, Florida Statutes, is created

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1114 to read:
1115 627.4108 Claims-handling manuals; submission; attestation.—
1116 (1) Each authorized residential property insurer conducting
1117 business in this state must create and use a claims-handling
1118 manual that provides guidelines and procedures and that complies
1119 with the requirements of this code and, at a minimum, comports
1120 to usual and customary industry claims-handling practices. Such
1121 manual must include guidelines and procedures for:
1122 (a) Initially receiving and acknowledging initial receipt
1123 of the claim and reviewing and evaluating the claim;
1124 (b) Communicating with policyholders, beginning with the
1125 receipt of the claim and continuing until closure of the claim;
1126 (c) Setting the claim reserve;
1127 (d) Investigating the claim, including conducting
1128 inspections of the property that is the subject of the claim;
1129 (e) Making preliminary estimates and estimates of the
1130 covered damages to the insured property and communicating such
1131 estimates to the policyholder;
1132 (f) The payment, partial payment, or denial of the claim
1133 and communicating such claim decision to the policyholder;
1134 (g) Closing claims; and
1135 (h) Any aspect of the claims-handling process which the
1136 office determines should be included in the claims-handling
1137 manual in order to:
1138 1. Comply with the laws of this state or rules or orders of
1139 the office or department;
1140 2. Ensure that the claims-handling manual, at a minimum,
1141 comports with usual and customary industry claims-handling
1142 guidelines; or

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1143 3. Protect policyholders of the insurer or the general
1144 public.
1145 (2) At any time, the office may request that a residential
1146 property insurer submit a physical or electronic copy of the
1147 insurer's currently applicable, or otherwise specifically
1148 requested, claims-handling manuals. Upon receiving such a
1149 request, a residential property insurer must submit to the
1150 office within 5 business days:
1151 (a) A true and correct copy of each claims-handling manual
1152 requested; and
1153 (b) An attestation, on a form prescribed by the commission,
1154 that certifies:
1155 1. That the insurer has provided a true and correct copy of
1156 each currently applicable, or otherwise specifically requested,
1157 claims-handling manual; and
1158 2. The timeframe for which each submitted claims-handling
1159 manual was or is in effect.
1160 (3)(a) Annually, each authorized residential property
1161 insurer must certify and attest, on a form prescribed by the
1162 commission, that:
1163 1. Each of the insurer's current claims-handling manuals
1164 complies with the requirements of this code and comports to, at
1165 a minimum, usual and customary industry claims-handling
1166 practices; and
1167 2. The insurer maintains adequate resources available to
1168 implement the requirements of each of its claims-handling
1169 manuals at all times, including during natural disasters and
1170 catastrophic events.
1171 (b) Such attestation must be submitted to the office:

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1172 1. On or before August 1, 2023; and
1173 2. Annually thereafter, on or before May 1 of each calendar
1174 year.
1175 (4) The commission is authorized, and all conditions are
1176 deemed met, to adopt emergency rules under s. 120.54(4), for the
1177 purpose of implementing this section. Notwithstanding any other
1178 law, emergency rules adopted under this section are effective
1179 for 6 months after adoption and may be renewed during the
1180 pendency of procedures to adopt permanent rules addressing the
1181 subject of the emergency rules.
1182 Section 20. Paragraph (d) of subsection (2) of section
1183 627.4133, Florida Statutes, is amended to read:
1184 627.4133 Notice of cancellation, nonrenewal, or renewal
1185 premium.—
1186 (2) With respect to any personal lines or commercial
1187 residential property insurance policy, including, but not
1188 limited to, any homeowner, mobile home owner, farmowner,
1189 condominium association, condominium unit owner, apartment
1190 building, or other policy covering a residential structure or
1191 its contents:
1192 (d)1. ~~Upon a declaration of an emergency pursuant to s.~~
1193 ~~252.36 and the filing of an order by the Commissioner of~~
1194 ~~Insurance Regulation,~~ An authorized insurer may not cancel or
1195 nonrenew a personal residential or commercial residential
1196 property insurance policy covering a dwelling or residential
1197 property located in this state:
1198 a. For a period of 90 days after the dwelling or
1199 residential property has been repaired, if such property ~~which~~
1200 has been damaged as a result of a hurricane or wind loss that is

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1201 the subject of the declaration of emergency pursuant to s.
1202 252.36 and the filing of an order by the Commissioner of
1203 Insurance Regulation ~~for a period of 90 days after the dwelling~~
1204 ~~or residential property has been repaired~~. ~~A structure is deemed~~
1205 ~~to be repaired when substantially completed and restored to the~~
1206 ~~extent that it is insurable by another authorized insurer that~~
1207 ~~is writing policies in this state.~~
1208 b. Until the earlier of when the dwelling or residential
1209 property has been repaired or 1 year after the insurer issues
1210 the final claim payment, if such property was damaged by any
1211 covered peril and sub-subparagraph a. does not apply.
1212 2. However, an insurer or agent may cancel or nonrenew such
1213 a policy prior to the repair of the dwelling or residential
1214 property:
1215 a. Upon 10 days’ notice for nonpayment of premium; or
1216 b. Upon 45 days’ notice:
1217 (I) For a material misstatement or fraud related to the
1218 claim;
1219 (II) If the insurer determines that the insured has
1220 unreasonably caused a delay in the repair of the dwelling; or
1221 (III) If the insurer has paid policy limits.
1222 3. If the insurer elects to nonrenew a policy covering a
1223 property that has been damaged, the insurer shall provide at
1224 least 90 days’ notice to the insured that the insurer intends to
1225 nonrenew the policy 90 days after the dwelling or residential
1226 property has been repaired. Nothing in this paragraph shall
1227 prevent the insurer from canceling or nonrenewing the policy 90
1228 days after the repairs are complete for the same reasons the
1229 insurer would otherwise have canceled or nonrenewed the policy

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1230 but for the limitations of subparagraph 1. The Financial
1231 Services Commission may adopt rules, and the Commissioner of
1232 Insurance Regulation may issue orders, necessary to implement
1233 this paragraph.
1234 4. This paragraph shall also apply to personal residential
1235 and commercial residential policies covering property that was
1236 damaged as the result of Hurricane Ian or Hurricane Nicole
1237 ~~Tropical Storm Bonnie, Hurricane Charley, Hurricane Frances,~~
1238 ~~Hurricane Ivan, or Hurricane Jeanne~~.
1239 5. For purposes of this paragraph:
1240 a. A structure is deemed to be repaired when substantially
1241 completed and restored to the extent that it is insurable by
1242 another authorized insurer writing policies in this state.
1243 b. The term “insurer” means an authorized insurer.
1244 Section 21. Paragraph (a) of subsection (10) of section
1245 627.701, Florida Statutes, is amended to read:
1246 627.701 Liability of insureds; coinsurance; deductibles.—
1247 (10)(a) Notwithstanding any other provision of law, an
1248 insurer issuing a personal lines residential property insurance
1249 policy may include in such policy a separate roof deductible
1250 that meets all of the following requirements:
1251 1. The insurer has complied with the offer requirements
1252 under subsection (7) regarding a deductible applicable to losses
1253 from perils other than a hurricane.
1254 2. The roof deductible may not exceed the lesser of 2
1255 percent of the Coverage A limit of the policy or 50 percent of
1256 the cost to replace the roof.
1257 3. The premium that a policyholder is charged for the
1258 policy includes an actuarially sound credit or premium discount

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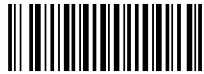
1259 for the roof deductible.
1260 4. The roof deductible applies only to a claim adjusted on
1261 a replacement cost basis.
1262 5. The roof deductible does not apply to any of the
1263 following events:
1264 a. A total loss to a primary structure in accordance with
1265 the valued policy law under s. 627.702 which is caused by a
1266 covered peril.
1267 b. A roof loss resulting from a hurricane as defined in s.
1268 627.4025(2)(c).
1269 c. A roof loss resulting from a tree fall or other hazard
1270 that damages the roof and punctures the roof deck.
1271 d. A roof loss requiring the repair of less than 50 percent
1272 of the roof.
1273
1274 If a roof deductible is applied, no other deductible under the
1275 policy may be applied to the loss or to any other loss to the
1276 property caused by the same covered peril.
1277 Section 22. Subsection (2) of section 627.70132, Florida
1278 Statutes, is amended to read:
1279 627.70132 Notice of property insurance claim.—
1280 (2) A claim or reopened claim, but not a supplemental
1281 claim, under an insurance policy that provides property
1282 insurance, as defined in s. 624.604, including a property
1283 insurance policy issued by an eligible surplus lines insurer,
1284 for loss or damage caused by any peril is barred unless notice
1285 of the claim was given to the insurer in accordance with the
1286 terms of the policy within 1 year after the date of loss. A
1287 supplemental claim is barred unless notice of the supplemental

 543692

1288 claim was given to the insurer in accordance with the terms of
1289 the policy within 18 months after the date of loss. The time
1290 limitations of this subsection are tolled during any term of
1291 deployment to a combat zone or combat support posting which
1292 materially affects the ability of a named insured who is a
1293 servicemember as defined in s. 250.01 to file a claim,
1294 supplemental claim, or reopened claim.
1295 Section 23. Chapter 2022-271, Laws of Florida, shall not be
1296 construed to impair any right under an insurance contract in
1297 effect on or before the effective date of that chapter law. To
1298 the extent that chapter 2022-271, Laws of Florida, affects a
1299 right under an insurance contract, that chapter law applies to
1300 an insurance contract issued or renewed after the applicable
1301 effective date provided by the chapter law. This section is
1302 intended to clarify existing law and is remedial in nature.
1303 Section 24. (1) Every residential property insurer and
1304 every motor vehicle insurer rate filing made or pending with the
1305 Office of Insurance Regulation on or after July 1, 2023, must
1306 reflect the projected savings or reduction in claim frequency,
1307 claim severity, and loss adjustment expenses, including for
1308 attorney fees, payment of attorney fees to claimants, and any
1309 other reduction actuarially indicated, due to the combined
1310 effect of the applicable provisions of chapters 2021-77, 2022-
1311 268, 2022-271, and 2023-15, Laws of Florida, in order to ensure
1312 that rates for such insurance accurately reflect the risk of
1313 providing such insurance.
1314 (2) The Office of Insurance Regulation must consider in its
1315 review of such rate filings the projected savings or reduction
1316 in claim frequency, claim severity, and loss adjustment

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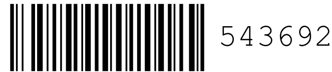
1317 expenses, including for attorney fees, payment of attorney fees
1318 to claimants, and any other reduction actuarially indicated, due
1319 to the combined effect of the applicable provisions of chapters
1320 2021-77, 2022-268, 2022-271, and 2023-15, Laws of Florida. The
1321 office may develop methodology and data that incorporate
1322 generally accepted actuarial techniques and standards to be used
1323 in its review of rate filings governed by this section. The
1324 office may contract with an appropriate vendor to advise the
1325 office in developing such methodology and data to consider. Such
1326 methodology and data are not intended to create a mandatory
1327 minimum rate decrease for all residential property insurers and
1328 motor vehicle insurers, respectively, but rather to ensure that
1329 the rates for such coverage meet the requirements of s. 627.062,
1330 Florida Statutes, and thus are not excessive, inadequate, or
1331 unfairly discriminatory and allow such insurers a reasonable
1332 rate of return.
1333 (3) This section does not apply to rate filings made
1334 pursuant to s. 627.062(2)(k), Florida Statutes.
1335 (4) For the 2023-2024 fiscal year, the sum of $500,000 in
1336 nonrecurring funds is appropriated from the Insurance Regulatory
1337 Trust Fund in the Department of Financial Services to the Office
1338 of Insurance Regulation to implement this section.
1339 Section 25. For the 2023-2024 fiscal year, 18 full-time
1340 equivalent positions with associated salary rate of 1,116,500
1341 are authorized and the sum of $1,879,129 in recurring funds and
1342 $185,086 in nonrecurring funds is appropriated from the
1343 Insurance Regulatory Trust Fund to the Office of Insurance
1344 Regulation to implement this act.
1345 Section 26. For the 2023-2024 fiscal year, seven full-time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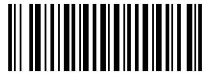
1346 equivalent positions with associated salary rate of 350,000 are
1347 authorized and the sum of $574,036 in recurring funds and
1348 $33,467 in nonrecurring funds is appropriated from the Insurance
1349 Regulatory Trust Fund to the Department of Financial Services to
1350 implement this act.
1351 Section 27. This act shall take effect July 1, 2023.
1352
1353 ================= T I T L E A M E N D M E N T ================
1354 And the title is amended as follows:
1355 Delete everything before the enacting clause
1356 and insert:
1357 A bill to be entitled
1358 An act relating to insurer accountability; creating s.
1359 624.115, F.S.; specifying a requirement for the Office
1360 of Insurance Regulation in referring criminal
1361 violations; amending s. 624.307, F.S.; authorizing
1362 electronic responses to certain requests from the
1363 Division of Consumer Services of the Department of
1364 Financial Services concerning consumer complaints;
1365 revising the timeframe in which responses must be
1366 made; revising administrative penalties; amending s.
1367 624.315, F.S.; requiring the office to annually and
1368 quarterly create and publish specified reports
1369 relating to the enforcement of insurer compliance;
1370 requiring the office to submit such reports to the
1371 Financial Services Commission and the Legislature by
1372 specified dates; amending s. 624.316, F.S.; revising
1373 the minimum intervals in which the office must examine
1374 certain insurers; revising periods that examinations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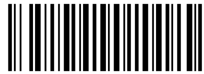
1375 must cover; requiring the office to create a specified
1376 methodology for scheduling examinations of insurers;
1377 specifying requirements for such methodology;
1378 providing construction; specifying requirements for
1379 the office in proposing rules to the commission;
1380 authorizing the commission to adopt rules; amending s.
1381 624.3161, F.S.; revising requirements and conditions
1382 for certain insurer market conduct examinations after
1383 a hurricane; requiring the office to create, and the
1384 commission to adopt by rule, a specified selection
1385 methodology for examinations; specifying requirements
1386 for such methodology; specifying rulemaking
1387 requirements; specifying requirements, procedures, and
1388 conditions for the office's review of a liability
1389 insurer's claims-handling practices and the imposition
1390 of enhanced enforcement penalties; defining the term
1391 "actual notice"; providing construction; amending s.
1392 624.4211, F.S.; revising administrative fines the
1393 office may impose in lieu of revocation or suspension;
1394 creating s. 624.4301, F.S.; specifying requirements
1395 for residential property insurers temporarily
1396 suspending writing new policies in notifying the
1397 office; providing applicability and construction;
1398 authorizing the commission to adopt rules; creating s.
1399 624.805, F.S.; specifying factors the office may
1400 consider in determining whether the continued
1401 operation of an insurer may be deemed to be hazardous
1402 to its policyholders or creditors or to the general
1403 public; specifying actions the office may take in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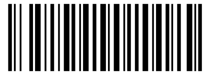
1404 determining an insurer's financial condition;
1405 authorizing the office to issue an order requiring a
1406 hazardous insurer to take specified actions; providing
1407 construction; authorizing the office to issue
1408 immediate final orders; amending s. 624.81, F.S.;
1409 deleting certain rulemaking authority of the
1410 commission; creating s. 624.865, F.S.; authorizing the
1411 commission to adopt certain rules; amending s.
1412 628.8015, F.S.; conforming provisions to changes made
1413 by the act; amending s. 626.207, F.S.; revising a
1414 condition for disqualification of an insurance
1415 representative applicant or licensee; amending s.
1416 626.9521, F.S.; revising and specifying applicable
1417 fines for unfair methods of competition and unfair or
1418 deceptive acts or practices; amending s. 626.9541,
1419 F.S.; adding an unfair claim settlement practice by an
1420 insurer; prohibiting an officer or a director of an
1421 impaired insurer from receiving a bonus from such
1422 insurer or from certain holding companies or
1423 affiliates; defining the term "bonus"; providing a
1424 criminal penalty; amending s. 626.989, F.S.; revising
1425 a reporting requirement for the department's Division
1426 of Investigative and Forensic Services; revising a
1427 requirement for state attorneys or other prosecuting
1428 agencies having jurisdiction to inform the division
1429 under certain circumstances; requiring the division to
1430 submit an annual performance report to the
1431 Legislature; specifying requirements for the report;
1432 amending s. 627.0629, F.S.; specifying requirements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1433 for residential property insurers in providing certain
1434 hurricane mitigation discount information to
1435 policyholders in a specified manner; specifying
1436 requirements for the office in reevaluating and
1437 updating certain fixtures and construction techniques;
1438 deleting obsolete dates; amending s. 627.351, F.S.;
1439 prohibiting Citizens Property Insurance Corporation
1440 from determining that a risk is ineligible for
1441 coverage solely on a specified basis; providing
1442 applicability; amending s. 627.410, F.S.; prohibiting
1443 the office from exempting specified insurers from form
1444 filing requirements for a specified period; providing
1445 construction; creating s. 627.4108, F.S.; specifying
1446 requirements for residential property insurers in
1447 creating and using claims-handling manuals;
1448 authorizing the office to request submission of such
1449 manuals; providing requirements for such submissions;
1450 requiring authorized insurers to annually submit a
1451 certified attestation to the office; authorizing the
1452 commission to adopt emergency rules; amending s.
1453 627.4133, F.S.; revising prohibitions on insurers
1454 against the cancellation or nonrenewal of property
1455 insurance policies; revising applicability; providing
1456 construction; defining the term “insurer”; amending s.
1457 627.701, F.S.; providing that if a roof deductible is
1458 applied under a personal lines residential property
1459 insurance policy, no other deductible under the policy
1460 may be applied to any other loss to the property
1461 caused by the same covered peril; amending s.

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1462 627.70132, F.S.; providing for the tolling of certain
1463 timeframes for filing notices of property insurance
1464 claims by named insureds who are servicemembers under
1465 specified circumstances; providing construction
1466 relating to chapter 2022-271, Laws of Florida;
1467 requiring residential property insurers and motor
1468 vehicle insurer rate filings to reflect certain
1469 projected savings and reductions in expenses;
1470 specifying requirements for the office in reviewing
1471 rate filings; authorizing the office to develop
1472 certain methodology and data and contract with a
1473 vendor for a certain purpose; providing applicability;
1474 providing appropriations; providing an effective date.