The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Fiscal Policy

BILL:	CS/SB 7052
INTRODUCER:	Fiscal Policy, Banking and Insurance Committee
SUBJECT:	Insurer Accountability
DATE:	April 24, 2023
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Thomas	Knudson		**BI Submitted as Comm. Bill/Fav.**
2.	Thomas	Yeatman	FP	**Fav/CS**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 7052 contains various provisions intended to increase consumer protection and insurer accountability in this state.

Regarding insurance coverage, the bill:

- Expands current law prohibiting authorized insurers from cancelling a residential property insurance policy until 90 days after repairs are complete. Under the bill, for all other types of losses, authorized insurers are prohibited from cancelling a property insurance policy during any pending claim until the earlier of when the property has been repaired or 1 year after the insurer issues the final claim payment;
- Protects policyholders whose insurance company becomes insolvent by requiring that Citizens Property Insurance Corporation cover property with open claims that are being handled by the Florida Insurance Guaranty Association;
- Requires insurers that violate the insurance code to obtain prior approval of forms from the Office of Insurance Regulation (OIR) for 3 years after the violation;
- Clarifies that if a roof deductible is applied, the prohibition on applying any other deductible under the policy encompasses any other loss to the property caused by the same covered peril;
- Tolls the time period for filing a property insurance claim during an insured's term of deployment to a combat zone or combat support posting; and

- Clarifies legislative intent that Chapter 2022-271, Laws of Florida, passed during Special Session A in December 2022, (SB 2-A [2022] on Property Insurance) shall not be construed to impair any right under an insurance contract in effect on or before the effective date of that chapter law (December 16, 2022).

Regarding rates charged for insurance, the bill:

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

Regarding insurer claims handling, the bill:

- Requires liability insurers to follow proper claims handling practices on behalf of their insureds and that violations are subject to a 2.0 multiplier of fines;
- Requires residential property insurers to create and use claims-handling manuals that comply with the Insurance Code and comport to industry standards. The OIR may request a claims handling manual at any time and requires that each property insurer attest that their claims manuals comply with Florida law and that the insurer is able to properly implement their manual; and
- Strengthens the Unfair Insurance Trade Practices Act by:
  - Prohibiting altering or amending an adjuster's report without providing a detailed explanation as to why any change that has the effect of reducing the estimate of the loss was made. The insurer must also either create a list of changes and who made the change or retain all versions of the report;
  - Prohibiting officers and directors of impaired or insolvent insurers from receiving a bonus from that insurer or other entity under common ownership with that insurer.

Regarding regulatory oversight of insurers, the bill:

- Specifies factors the OIR may consider in determining whether the continued operation of an insurer may be deemed to be hazardous to its policyholders, creditors, or the general public; specifies actions the OIR may take in determining an insurer's financial condition and actions the OIR may order an insurer to take in an effort to improve the insurer's financial condition.
- Increases maximum administrative fines that may be levied by the OIR on insurers by 250 percent generally, and 500 percent for violations stemming from a state of emergency such as a hurricane;
- Requires insurers to more promptly respond to the Department of Financial Services (DFS) Division of Consumer Services and increases fines for noncompliance;
- Increases staffing for the DFS Division of Consumer Services by appropriating funding for 7 full-time equivalent positions;
- Increases staffing at the OIR by appropriating 18 full-time equivalent positions;

- Specifies objective criteria to be used by the OIR to prioritize necessary financial and market conduct examinations;
- Provides conditions whereby the OIR must initiate a market conduct examination after a hurricane;
- Requires property insurers to report to the OIR any temporary suspension of writing new policies;
- Specifies that insurance fraud referrals may be made to the statewide prosecutor for crimes that impact two or more judicial circuits; and
- Requires additional reporting from regulators regarding their enforcement actions.

See Section V. Fiscal Impact Statement.

The bill is effective July 1, 2023.

II. Present Situation:

Department of Financial Services

The Department of Financial Services (DFS) has broad duties, including licensure and regulation of insurance agents, agencies, and adjusters; insurance consumer assistance and protection; and holding and attempting to return unclaimed property to its rightful owner.[1] The DFS has a number of regulatory responsibilities over the Florida insurance market. The DFS regulates insurance adjusters, which includes public adjusters, independent adjusters, and company employee adjusters under Part VI, ch. 626, F.S. The DFS conducts insurance-related consumer outreach through its Division of Consumer Services. The Division of Workers' Compensation within the DFS administers ch. 440, F.S., through enforcement of coverage requirements,[2] administration of workers' compensation health care delivery system,[3] data collection,[4] and assisting injured workers, employers, insurers, and providers in fulfilling their responsibilities under ch. 440, F.S.[5] The DFS also administers insurer rehabilitation and liquidation in Florida under part I of ch. 631, F.S.

DFS Division of Consumer Services

The Division of Consumer Services (Division) provides education, information, and assistance to consumers for all products or services regulated by the DFS or the Financial Services Commission (Commission).[6] The Division's duties specifically include:

- Receiving consumer questions and complaints;

[1] *See, e.g.*, Department of Financial Services, *What is the Purpose of the Department*, https://oppaga.fl.gov/ (last accessed April 2, 2023).
[2] Section 440.107(3), F.S.
[3] Section 440.13, F.S.
[4] Sections 440.185 and 440.593, F.S.
[5] Section 440.191, F.S.
[6] DFS, *Department of Financial Services Long Range Program Plan: Fiscal Years 2023-24 through 2027-28*, 15 (Oct. 17, 2022), *available at http://floridafiscalportal.state.fl.us/Document.aspx?ID=24407&DocType=PDF* (last accessed April 2, 2023). *See also*, DFS, *Consumer Guides*, https://www.myfloridacfo.com/Division/Consumers/understandingCoverage/Guides/Default.htm (last visited April 2, 2023).

- Educating the public about insurance-related topics;
- Providing mediation to resolve disputes between a consumer and insurance company; and
- Serving as a conduit for referrals for further legal action by the DFS.[7]

Section 624.307(10)(b), F.S., permits the Division to impose an administrative penalty on a person who holds a license or certificate of authority from the DFS if that person fails to respond to the Division's request for information within 20 days. A licensed individual must produce any requested documents not subject to attorney-client or work product privilege.

Regulation of Insurance in Florida

The Office of Insurance Regulation (OIR) regulates specified insurance products, insurers and other risk bearing entities in Florida.[8] As part of their regulatory oversight, the OIR may suspend or revoke an insurer's certificate of authority under certain conditions.[9] The OIR is responsible for examining the affairs, transactions, accounts, records, and assets of each insurer that holds a certificate of authority to transact insurance business in Florida.[10] As part of the examination process, all persons being examined must make available to the OIR the accounts, records, documents, files, information, assets, and matters in their possession or control that relate to the subject of the examination.[11] The OIR is also authorized to conduct market conduct examinations to determine compliance with applicable provisions of the Insurance Code.[12]

Financial Examinations

The OIR is responsible for all activities concerning insurers and other risk-bearing entities such as licensing, solvency, rates, and policy forms. Section 624.361, F.S., requires the OIR to conduct financial examinations of insurers. The scope of the financial examination includes a review of the affairs, records, transactions, accounting procedures and financial condition of an insurer. The OIR is charged with conducting an exam once every five years, with the exception of a domestic insurers that have held a certificate of authority for less than three years, which are required to be examined on annual basis. The OIR is required to examine an insurer applying for an initial certificate of authority prior to issuing the certificate of authority.

Market Conduct Exams

The OIR is authorized to perform a market conduct examination of, among other entities, any authorized insurer.[13] The purpose of the examination is to determine the entity's compliance with

[7] Section 624.307(10)(a), F.S.
[8] Section 20.121(3)(a), F.S. The Financial Services Commission, composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture, serves as agency head of the Office of Insurance Regulation for purposes of rulemaking. Further, the Financial Services Commission appoints the commissioner of the Office of Insurance Regulation.
[9] Section 624.418, F.S.
[10] Section 624.316(1)(a), F.S.
[11] Section 624.318(2), F.S.
[12] Section 624.3161, F.S.
[13] Section 624.3161(1), F.S.

Florida law.[14] The costs of the examination are to be paid by the subject entity.[15] Section 624.3161, F.S., authorizes the OIR to subject any authorized insurer to a market conduct examination after a hurricane if the insurer:

- Is among the top 20 percent of insurers based upon a calculation of the ratio of hurricane-related property insurance claims filed to the number of property insurance policies in force;
- Is among the top 20 percent of insurers based upon a calculation of the ratio of consumer complaints made to the DFS to hurricane-related claims;
- Has made significant payments to its managing general agent since the hurricane; or
- Is identified by the OIR as necessitating a market conduct exam for any other reason.

The relevant criteria under ss. 624.3161 and s. 624.316, F.S., are to be applied to the market conduct examination. The market conduct examination, if any, must be started within 18 months after the landfall of the related hurricane. The insurer's managing general agent must be included in the market conduct examination as if it were the insurer.

If a market conduct examination reveals that the "insurer has exhibited a pattern or practice of willful violations of an unfair insurance trade practice related to claims-handling which caused harm to policyholders," the OIR may order the insurer to file its claims-handling practices and procedures with the OIR for review and inspection.[16] The practices and procedures are to be held by the OIR for 36 months and are considered public records, not trade secrets, during the 36-month period.[17] The term, "claims-handling practices and procedures," is defined as "any policies, guidelines, rules, protocols, standard operating procedures, instructions, or directives that govern or guide how and the manner in which an insured's claims for benefits under any policy will be processed."[18]

Annual Report on Insurer Compliance

The OIR is required to submit an annual report to the Speaker and Minority Leader of the House of Representatives, the President and Minority Leader of the Senate, the chairs of the legislative committees with jurisdiction over matters of insurance, and the Governor.[19] The report is to cover information from the preceding calendar year, the following:

- Names of the authorized insurers transacting insurance in this state, with abstracts of their financial statements including assets, liabilities, and net worth.
- Names of insurers whose business was closed during the year, the cause thereof, and amounts of assets and liabilities as ascertainable.
- Names of insurers against which delinquency or similar proceedings were instituted and related information.
- The receipts and estimated expenses of the OIR.
- Other pertinent information as the OIR deems to be in the public interest.
- A compilation of the laws passed by the Legislature relating to insurance.

[14] *Id.*
[15] Section 624.3161(4), F.S.
[16] Section 624.3161(6), F.S.
[17] *Id.*
[18] *Id.*
[19] Section 624.315, F.S.

- An analysis and summary report of the state of the insurance industry in Florida.

Administrative Fines

The OIR, through its ongoing oversight and examination process, determines whether insurance companies are operating in compliance with the code. The OIR is authorized to impose administrative fines in lieu of suspension or revocation if the OIR finds that one or more grounds exist for the discretionary revocation or suspension of the certificate of authority.[20] The OIR may impose an administrative fine, not to exceed $5,000, per nonwillful violation, with a limit of $20,000 for all nonwillful violations arising out of the same action. With respect to any willful violation, the OIR is authorized to assess a fine, not to exceed $40,000 per violation and $200,000 in aggregate for all willful violations arising out of the same action. Additionally, if an insurer owes restitution due to a violation, the insurer must provide the restitution and include 12 percent interest from the date of the violation or the inception of the insured's policy.

Authority for Insurers in Unsound Financial Condition

Section 627.7154, F.S., establishes a property insurer stability unit (unit) within the OIR. The purpose of the unit is to detect and prevent insurer insolvencies in the homeowners' and condominium unit owners' insurance market. Specifically, the unit is to identify significant concerns regarding insurer compliance with the insurance code. The unit must, at minimum:

- Conduct target market exams when there is reason to believe that an insurer's claims practices, rate requirements, investment activities, or financial statements suggest said insurer may be in an unsound financial condition.
- Monitor closely all risk-based capital reports, own-risked solvency assessments, reinsurance agreements, and financial statements filed by insurers.
- Have primary responsibility, coordinating with Florida Commission on Hurricane Loss Projection Methodology, to conduct annual catastrophe stress tests of all domestic insurers and insurers that are commercially domiciled in this state.
- Update required wind mitigation credits.
- Review the causes of insolvency and business practices of insurers that have been referred to the Division of Rehabilitation and Liquidation of the DFS, and make recommendations to prevent future occurrences of such insurers.
- File biannual reports on the status of the homeowners' and condominium unit owners' insurance market to the Governor, the President of the Senate, the Speaker of the House of Representatives, the Minority Leader of the Senate, the Minority Leader of the House of Representatives, and the chairs of the legislative committees with jurisdiction over matters of insurance.[21]

The section also specifies events that trigger a referral to the insurer stability unit. Expenses for the unit are to be paid from the Insurance Regulatory Trust Fund, except that, if the unit

[20] Section 624.4211, F.S.
[21] Section 627.7154(3), F.S.

recommends that a market conduct examination or targeted market examination be conducted, the reasonable cost of the examination must be paid by the person examined.[22]

National Association of Insurance Commissioners Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition

The National Association of Insurance Commissioners (NAIC) provides expertise, data, and analysis to provide guidance to insurance regulators. Founded in 1871, the organization is governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories to coordinate regulation of multistate insurers.[23] The NAIC has adopted numerous model laws on various insurance regulatory topics.[24] The NAIC has adopted Model Law MO-385, entitled, Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition.[25] The purpose of the model law is to set standards which may be used to identify insurers in such condition as to render the continuance of their business hazardous to their policyholders, creditors or the general public.[26]

The model law provides the following standards to consider to determine whether the continued operation of any insurer transacting an insurance business might be deemed to be hazardous to its policyholders, creditors or the general public:

- Adverse findings reported in financial condition and market conduct examination reports, audit reports, and actuarial opinions, reports or summaries;
- The National Association of Insurance Commissioners Insurance Regulatory Information System and its other financial analysis solvency tools and reports;
- Whether the insurer has made adequate provision for the anticipated cash flows required by its obligations and expenses;
- Whether the insurer's reinsurance program provides sufficient protection for the insurer's remaining surplus after taking into account the insurer's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer;
- Whether the insurer's operating loss in the last twelve-month period or any shorter period of time is greater than fifty percent (50%) of the insurer's remaining surplus as regards policyholders in excess of the minimum required;
- Whether the insurer's operating loss in the last twelve-month period or any shorter period of time, excluding net capital gains, is greater than twenty percent (20%) of the insurer's remaining surplus as regards policyholders in excess of the minimum required;
- Whether a reinsurer, obligor or any entity within the insurer's insurance holding company system, is insolvent, threatened with insolvency or delinquent in payment of its monetary or other obligations which in the opinion of the commissioner may affect the insurer's solvency;
- Contingent liabilities, pledges or guaranties which either individually or collectively involve a total amount which in the opinion of the commissioner may affect the solvency of the insurer;

[22] Section 627.7154(4), F.S.
[23] National Association of Insurance Commissioners, *Our Story*, https://content.naic.org/about (last accessed March 31, 2023).
[24] National Association of Insurance Commissioners, *Model Laws*, https://content.naic.org/model-laws (last accessed March 31, 2023).
[25] https://content.naic.org/sites/default/files/MO385.pdf (last accessed March 31, 2023).
[26] *Id.*

- Whether any "controlling person" of an insurer is delinquent in the transmitting to, or payment of, net premiums to the insurer;
- The age and collectibility of receivables;
- Whether the management of an insurer fails to possess and demonstrate the competence, fitness and reputation deemed necessary to serve the insurer in such position;
- Whether management of an insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished false and misleading information concerning an inquiry;
- Whether the insurer has failed to meet financial and holding company filing requirements in the absence of a reason satisfactory to the commissioner;
- Whether management of an insurer either has filed any false or misleading sworn financial statement, or has released false or misleading financial statement to lending institutions or to the general public, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the insurer;
- Whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner;
- Whether the insurer has experienced or will experience in the foreseeable future cash flow or liquidity problems;
- Whether management has established reserves that do not comply with minimum standards established by state insurance laws, regulations, statutory accounting standards, sound actuarial principles and standards of practice;
- Whether management persistently engages in material under reserving that results in adverse development;
- Whether transactions among affiliates, subsidiaries or controlling persons for which the insurer receives assets or capital gains, or both, do not provide sufficient value, liquidity or diversity to assure the insurer's ability to meet its outstanding obligations as they mature;
- The ratio of the annual premium volume to surplus or of its liabilities to surplus in relation to loss experience and/or the kinds of risks insured;
- Whether the insurer's asset portfolio when viewed in light of current economic conditions and indications of financial or operational leverage is of sufficient value, liquidity, or diversity to assure the company's ability to meet its outstanding obligations as they mature;
- Whether the excess of surplus to policyholders over and above an insurer's statutorily required surplus to policyholders has decreased by more than 50 percent in the preceding 12-month period or any shorter period of time.
- Whether residential property insurers have sufficient capital, surplus, and reinsurance to withstand significant weather events, including but not limited to hurricanes;
- The insurer's required surplus, capital, or capital stock is impaired to an extent prohibited by law;
- The insurer continues to write new business when it has not maintained the required surplus or capital;
- The insurer attempts to dissolve or liquidate without first having made provisions, satisfactory to the OIR, for liabilities arising from insurance policies issued by the insurer;
- The insurer meets one or more of the grounds for the appointment of a receiver; and
- Any other finding determined by the commissioner to be hazardous to the insurer's policyholders, creditors or general public.

Financial Services Commission Rule Chapter 69O-141, Florida Administrative Code

The Commission adopted Rule Chapter 69O-141, F.A.C., in 1991 related to the establishment of "standards and procedures for administrative supervision of insurers in unsound condition or which are engaging in methods or practices which render the continuance of business hazardous to the public or insureds."[27] These rules closely track the NAIC model regulation on this subject discussed above. The rule chapter includes the following rules:

- 69O-141.001 Purpose
- 69O-141.002 Standards Regarding Administrative Supervision
- 69O-141.003 Plan of Correction
- 69O-141.004 Period of Supervision
- 69O-141.005 Appointment of Deputy Supervisors
- 69O-141.006 Costs of Administrative Supervision
- 69O-141.020 Procedures for Withdrawal, Surrender of Certificate of Authority, or Discontinuance of Writing Insurance in this State Pursuant to Section 624.430, Florida Statutes

Unfair Insurance Claim Settlement Practices

Florida law prohibits a person from engaging in an unfair or deceptive act or practice involving the business of insurance.[28] The definition of unfair or deceptive acts or practices includes, in part, the following unfair claim settlement practices:

- Attempting to settle claims on the basis of a document that was altered without knowledge or consent of the insured;
- A material misrepresentation made to an insured for the purpose and with the intent of effecting settlement on less favorable terms than provided under the contract or policy;
- Committing or performing with such frequency as to indicate a general business practice certain acts, such as failing to adopt and implement standards for the proper investigation of claims;
- Failing to pay undisputed amounts of partial or full benefits owed under first-party property insurance policies within 90 days after an insurer received notice of a residential property insurance claim, determines the amounts of partial or full benefits, and agrees to coverage, unless payment of the undisputed benefits is prevented by "an act of God, prevented by the impossibility of performance, or due to actions by the insured or claimant that constitute fraud, lack of cooperation, or intentional misrepresentation regarding the claim for which benefits are owed."[29]

An insurer that violates these provisions is subject to a fine in an amount not greater than $5,000 for each nonwillful violation, not to exceed an aggregate amount of $20,000, and not greater than $40,000 for each willful violation arising from the same action, not to exceed an aggregate amount of $200,000.[30]

[27] Rule 69O-141.001, F.A.C.
[28] Section 626.9521(1), F.S.
[29] Section 626.9541(1)(i), F.S.
[30] Section 626.9521(2), F.S.

DFS Insurance Fraud Investigations

The Division of Investigative and Forensic Services investigates various types of insurance fraud including Personal Injury Protection fraud, workers' compensation fraud, vehicle fraud, application fraud, licensee fraud, homeowner's insurance fraud, and healthcare fraud.[31] The Division is directed by statute to investigate fraudulent insurance acts, violations of the Unfair Insurance Trade Practices Act, [32] false and fraudulent insurance claims,[33] and willful violations of the Florida Insurance Code and rules adopted pursuant to the code.[34] The Division employs sworn law enforcement officers to investigate insurance fraud.

Mitigation Discounts

Residential property insurance rate filings must account for mitigation measures undertaken by policyholders to reduce hurricane losses.[35] Specifically, the rate filings must include actuarially reasonable discounts, credits, or other rate differentials or appropriate reductions in deductibles to consumers who implement windstorm damage mitigation techniques to their properties.[36] Upon their filing by an insurer or rating organization, the OIR determines the discounts, credits, other rate differentials and appropriate reductions in deductibles that reflect the full actuarial value of such revaluation,[37] which in turn may be used in rate filings under the rating law. Windstorm mitigation measures that must be evaluated for purposes of mitigation discounts include fixtures or construction techniques that enhance roof strength, roof covering performance, roof-to-wall strength, wall-to-floor-to-foundation strength, opening protection, and window, door, and skylight strength.[38]

Citizens Property Insurance Corporation—Overview

Citizens Property Insurance Corporation (Citizens) is a state-created, not-for-profit, tax-exempt governmental entity whose public purpose is to provide property insurance coverage to those unable to find affordable coverage in the voluntary admitted market.[39] Citizens is not a private insurance company.[40] Citizens was statutorily created in 2002 when the Florida Legislature combined the state's two insurers of last resort, the Florida Residential Property and Casualty Joint Underwriting Association (RPCJUA) and the Florida Windstorm Underwriting Association (FWUA).[41] Citizens offers property insurance through three different accounts: a personal lines account, a commercial lines account, and a coastal account.

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[31] *See* https://myfloridacfo.com/Division/DIFS/ (last accessed April 2, 2023).
[32] Section 626.9541, F.S.
[33] Section 817.234, F.S.
[34] Section 624.15, F.S.
[35] Section 627.062(2)(j), F.S.
[36] Section 627.0629(1), F.S.
[37] *Id*.
[38] *Id*.
[39] The term "admitted market" means insurance companies licensed to transact insurance in Florida.
[40] Section 627.351(6)(a)1., F.S.
[41] Section 2, ch. 2002-240, Laws of Fla.

Citizens operates in accordance with the provisions in s. 627.351(6), F.S., and is governed by an eight member Board of Governors (board) that administers its Plan of Operations. The Plan of Operations is reviewed and approved by the Commission.[42] The Governor, President of the Senate, Speaker of the House of Representatives, and Chief Financial Officer each appoint two members to the board.[43] Citizens is subject to regulation by the OIR of Insurance Regulation.

Form Review

Each insurer must file with the OIR their basic insurance policy or annuity contract forms and any application form that is to be made a part of the policy or contract.[44] These forms may not be delivered or issued for delivery unless the form has been filed with the OIR.[45]

Notice of Cancellation, Nonrenewal, or Renewal of Insurance Policies

The requirements for an insurer to provide notice of cancellation, nonrenewal, or renewal premium are set forth in s. 627.4133, F.S. The specific notice depends on the type of insurance provided and the particular circumstances of the subject policy.

Insurers writing personal lines residential or commercial lines residential property insurance policies are generally subject to the following requirements:

- An insurer must give written notice of cancellation, nonrenewal, or termination at least 120 days prior to the effective date of the cancellation, nonrenewal, or termination and the notice is required to include the reason for nonrenewal, cancellation, or termination;[46] and
- An insurer must give written notice of renewal premium at least 45 days prior to the renewal premium[47] and the notice of renewal premium must specify certain information, including the dollar amount of any premium increase that is due to an approved rate increase and the total dollar amount that is due to coverage changes.[48]

Separate Roof Deductibles

An insurer issuing a personal lines residential property insurance policy may include in such policy a separate roof deductible that meets all of the following requirements:

- Allows property insurers to include in the policy a separate roof deductible of up to two percent of the Coverage A limit of the policy or 50 percent of the cost to replace the roof. The policyholder must also be offered the option to decline the roof deductible by signing a form approved by the OIR. If a roof deductible is added to the policy at renewal, the insurer must provide a notice of change in policy terms and allow the policyholder to decline the separate roof deductible.

[42] Section 627.351(6)(a)2., F.S.
[43] Section 627.351(6)(c)4.a., F.S.
[44] Section 627.410, F.S.
[45] *Id.*
[46] Section 627.4133(2)(b), F.S.
[47] Section 627.4133(2)(a), F.S.
[48] Section 627.4133(7), F.S.

- Requires that policyholders that select a roof deductible must receive an actuarially sound premium credit or discount.
- Provides that the roof deductible does not apply to:
  - A total loss to the primary structure in accordance with the valued policy law under s. 627.702, F.S., which is caused by a covered peril.
  - A loss caused by a hurricane.
  - A roof loss resulting from a tree fall or other hazard that damages the roof and punctures the roof deck.
  - A roof loss requiring the repair of less than 50 percent of the roof.
- Specifies that when a roof deductible is applied, no other deductibles under the policy may be applied.
- Specifies that a roof deductible only applies to a claim adjusted on a replacement cost basis.
- Authorizes an insurer to limit the claim payment for a roof to the actual cash value of the loss to the roof until the insurer receives reasonable proof of payment by the policyholder of the roof deductible.
- Requires a roof deductible provision to be clear and unambiguous.
- Requires the inclusion of the following disclosures:
  - On the page immediately behind the declarations page, notice that a roof deductible may result in high out-of-pocket expenses to the policyholder.
    On the policy declarations page, prominent display of the actual dollar value of the roof deductible at issuance and renewal. Allows an insurer to limit payment on a roof claim to actual cash value until the policyholder pays the roof deductible.[49]

Claim Handling – Late Payments

Florida's property insurance prompt payment statute provides for an insurer's[50] duty to acknowledge, investigate, and settle payment of a claim, if appropriate, within certain timeframes. These laws are meant to require insurance companies to make quick payments of any claims filed and deter unnecessary delays.

The insurer must acknowledge a filed claim within 14 days of its submission,[51] and begin an investigation, as is reasonably necessary, within 14 days after receiving a proof-of-loss statement.[52] Within 90 days of receiving notice of the initial, reopened, or supplemental claim, the insurer must either pay the claim in full, pay a portion of the claim, or deny the claim.[53,54] These provisions must be complied within the stated timeframes unless the failure is caused by

[49] Section 627.701(10), F.S.
[50] Section 627.70131(5), F.S., defines "insurer" as any residential property insurer.
[51] Section 627.70131(1)(a), F.S.
[52] Section 627.70131(3)(a), F.S.
[53] Section 627.70131(7)(b), F.S., defines "claim", for purposes of this subsection, as: 1. A claim under an insurance policy providing residential coverage as defined in s. 627.4025(1), F.S.,; 2. A claim for structural or contents coverage under a commercial property insurance policy if the insured structure is 10,000 square feet or less; or 3. A claim for contents coverage under a commercial tenant policy if the insured premises is 10,000 square feet or less.
[54] Section 627.70131(7)(a), F.S.

factors beyond the control of the insurer which reasonably prevent the insurer from complying with them.[55]

Except for claims subject to a hurricane deductible, any physical inspection must be conducted within 45 days after the insurer receives the proof-of-loss statement.[56] Within 7 days of assigning an adjuster, the insurer must notify the insured that a request may be made for an estimate of the amount of the loss. If a request is received, the insurer must send such estimate to the insured within the later of 7 days after the insurer received the request or 7 days after the detailed estimate is completed.[57]

A licensed adjuster assigned to investigate a claim must provide a policyholder with written notification of his or her name and state adjuster license number, and include it on any subsequent communication with the policyholder.[58] An insurer must keep a record or log of each adjuster who communicates with the policyholder and provide a list of such adjusters to the insured, the OIR or the DFS upon request.

Notice of Property Insurance Claims

Section 627.70132, F.S., requires insureds to notify an insurer of a claim or reopened claim,[59] within 1 year after the date of loss.[60] Notice of a supplemental claim[61] must be given to the insurer within 18 months of the date of loss or such claim is barred. Section 627.706(5), F.S., requires insureds to notify an insurer of a claim, supplemental claim, or reopened sinkhole claim within 2 years after the insured knew or reasonably should have known about the loss.

III. Effect of Proposed Changes:

DFS Division of Consumer Services

Section 1 amends s. 624.307, F.S., to:

- Reduce insurer response time from 20 to 14 days upon a written request for documents and information from the Division concerning a consumer complaint.
- Increase fines for non-compliance to $5,000 per violation (from $2,500 per violation) on entities and up to $1,000 per violation on a licensed individual (from a sliding scale of $250/$500/$1,000 on individuals for a 1st/2nd/3rd+ violation).
- Allow electronic responses upon a written request for documents and information from the Division concerning a consumer complaint.

[55] Section 627.70131(1)(a) and (3)(a), F.S.
[56] Section 627.70131(3)(b), F.S.
[57] Section 627.70131(3)(d), F.S.
[58] Section 627.70131(3)(b) and (c), F.S.
[59] Section 627.70132(1)(a), F.S., defines "reopened claim" as a claim that an insurer has previously closed, but that has been reopened upon an insured's request for additional costs for loss or damage previously disclosed to the insurer.
[60] Section 627.702(3), F.S., provides that the date of loss for claims resulting from specified and other weather-related events, such as hurricanes and tornadoes, is the date that the hurricane made landfall or the other weather-related event is verified by the National Oceanic and Atmospheric Administration.
[61] Section 627.70132(1)(b), F.S., defines "supplemental claim" as a claim for additional loss or damage from the same peril which the insured has previously adjusted or for which costs have been incurred while completing repairs or replacement pursuant to an open claim for which timely notice was previously provided to the insurer.

Annual and Quarterly Reports on Insurer Compliance

Section 2 amends s. 624.315, F.S., to require that the OIR quarterly issue a report of all agency actions taken against insurers. The report must identify the insurer, the violation, and the penalty. The report must be submitted to the Commission, the President of the Senate, the Speaker of the House of Representatives, and the legislative committees with jurisdiction over insurance matters. The OIR must also issue an annual report on the same matters.

Financial Examinations

Section 3 amends s. 624.316, F.S., to require the OIR to develop a risk-based selection methodology for scheduling examinations of insurers. Such methodology must include:

- Use of a risk-focused analysis to prioritize financial examinations of insurers when such reporting indicates a decline in the insurer's financial condition.
- Consideration of:
  - Level of capitalization and identification of unfavorable trends;
  - Negative trends in profitability or cash flow from operations;
  - National Association of Insurance Commissioners Insurance Regulatory Information System ratio results;
  - Risk-based capital and risk-based capital trend test results;
  - The structure and complexity of the insurer;
  - Changes in the insurer's officers or board of directors;
  - Changes in the insurer's business strategy or operations;
  - Findings and recommendations from an examination made pursuant to ss. 624.316 or s. 624.3161, F.S.;
  - Current or pending regulatory actions by the OIR or the DFS;
  - Information obtained from other regulatory agencies or independent organization ratings and reports; and
  - The impact of an insurer's insolvency on policyholders of the insurer and the public generally.
- Prioritization of property insurers for which the OIR identifies significant concerns about an insurer's solvency pursuant to s. 627.7154, F.S.
- Any other matters the OIR deems necessary to consider for the protection of the public.
- To facilitate the development of the methodology for scheduling examinations, the Commission may adopt by rule the National Association of Insurance Commissioners Financial Analysis Handbook, to the extent that the handbook is consistent with and does not negate the requirements of this section.

Market Conduct Exams

Section 4 amends s. 624.3161, F.S., to provide that any authorized insurer transacting residential property insurance business:

- May be subject to an additional market conduct examination after a hurricane if, at any time more than 90 days after the end of the hurricane, the insurer is among the top 20 percent of insurers based upon a calculation of the ratio of hurricane-related property insurance claims filed to the number of property insurance policies in force;

- Must be subject to a market conduct examination after a hurricane if, at any time more than 90 days after the end of the hurricane, the insurer:
  - Is among the top 20 percent of insurers based upon a calculation of the ratio of hurricane claim-related consumer complaints made about that insurer to the DFS to the insurer's total number of hurricane-related claims;
  - Is among the top 20 percent of insurers based upon a calculation of the ratio of hurricane claims closed without payment to the insurer's total number of hurricane claims;
  - Has made significant payments to its managing general agent since the hurricane; or
  - Is identified by the OIR as necessitating a market conduct exam for any other reason

The bill requires the OIR to create a risk-based selection methodology for scheduling and conducting market conduct examinations of insurers and other entities regulated by the OIR. Such methodology must prioritize examinations of insurers and other entities to whom any of the following conditions applies:

- An insurance regulator in another state has initiated or taken regulatory action against the insurer or entity regarding an act or omission of such insurer which, if committed in this state, would constitute a violation of the laws of this state or any rule or order of the OIR or the DFS.
- Given the insurer's market share in this state, the DFS or the OIR has received a disproportionate number of the following types of claims-handling complaints against the insurer:
  - Failure to timely communicate with respect to claims;
  - Failure to timely pay claims;
  - Untimely payments giving rise to the payment of statutory interest;
  - Failure to adjust and pay claims in accordance with the terms and conditions of the policy or contract and in compliance with state law;
  - Violations of the Unfair Insurance Trade Practices Act;
  - Failure to use licensed and duly appointed claims adjusters;
  - Failure to maintain reasonable claims records; or
  - Failure to adhere to the company's claims-handling manual.
- The results of a National Association of Insurance Commissioners Market Conduct Annual Statement indicate that the insurer is a negative outlier with regard to particular metrics.
- There is evidence that the insurer is violating or has violated the Unfair Insurance Trade Practices Act.
- The insurer otherwise meets the criteria for a market conduct examination.
- Any other conditions the OIR deems necessary for the protection of the public.

Administrative Fines

Section 5 amends s. 624.4211, F.S., to increase caps in administrative fines to:

- For violations related to a covered loss or claim arising out of a state of emergency:
  - Non-willful violations – Up to $25,000 per violation with an aggregate up to $100,000 for violations arising out of the same action.
  - Willful violations – Up to $200,000 per violation with an aggregate up to $1,000,000 for violations arising out of the same action.
- For all other violations:

- Non-willful violations – up to $12,500 and up to an aggregate $50,000 for violations arising out of the same action.
- Willful violations – up to $100,000 and up to an aggregate $500,000 for violations arising out of the same action.

Notice of Temporary Suspension of Writing New Business

Section 6 creates s. 624.4301, F.S., to require authorized insurers to give written notice to the OIR before any temporary suspension of writing new residential property insurance policies at least 20 business days before the effective date of the suspension or 5 business days before notifying its agents, whichever is earlier. The notice must specify the reason for and time period of the suspension and the proposed communication to its agents. This requirement does not apply to a temporary suspension made in response to a hurricane that may make landfall if such temporary suspension ceases within 72 hours after hurricane conditions are no longer present.

Hazardous Insurer Standards

Section 7 creates s. 624.805, F.S., to provide standards for the OIR to consider in determining whether continued operation of any insurer may be deemed to be hazardous to its policyholders, creditors, or the general public. In making such a determination, the OIR may consider, in the totality of the circumstances, any of the following:

- Adverse findings reported in financial condition or market conduct examination reports, audit reports, or actuarial opinions, reports, or summaries;
- The National Association of Insurance Commissioners Insurance Regulatory Information Systems and its other financial analysis solvency tools and reports;
- Whether the insurer has made adequate provisions for the anticipated cash flows required to cover its obligations and expenses;
- The ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection;
- Whether the insurer's operating loss in the last twelve-month period is greater than fifty percent of the insurer's remaining surplus;
- Whether the insurer's operating loss in the last twelve-month period excluding net capital gains, is greater than twenty percent of the insurer's remaining surplus;
- Whether a reinsurer, obligor, or any entity within the insurer's insurance holding company system, is insolvent, threatened with insolvency or delinquent in payment of its monetary or other obligations, and which may affect the solvency of the insurer;
- Contingent liabilities, pledges, or guaranties which in the opinion of the OIR may affect the solvency of the insurer;
- Whether any "affiliate" of an insurer is delinquent in the transmitting to, or payment of, net premiums to the insurer;
- The age and collectability of receivables;
- Whether the management of an insurer fails to possess and demonstrate the competence, fitness, and reputation deemed necessary;
- Whether management of an insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished false or misleading information to the OIR;

- Whether the insurer has failed to meet financial and holding company filing requirements in the absence of a reason satisfactory to the OIR;
- Whether management of an insurer has filed or released any false or misleading financial statement, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the insurer;
- Whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner;
- Whether the insurer has experienced or will experience in the foreseeable future cash flow or liquidity problems;
- Whether management has established reserves that do not comply with minimum standards established by state insurance laws, regulations, statutory accounting standards, sound actuarial principals and standards of practice;
- Whether management persistently engages in material under reserving that results in adverse development;
- Whether transactions among affiliates, subsidiaries, or controlling persons for which the insurer receives assets or capital gains, or both, do not provide sufficient value, liquidity, or diversity to assure the insurer's ability to meet its outstanding obligations as they mature;
- The ratio of the annual premium volume to surplus or of its liabilities to surplus in relation to loss experience and/or the kinds of risks insured;
- Whether the insurer's asset portfolio when viewed in light of current economic conditions and indications of financial or operational leverage is of sufficient value, liquidity or diversity to assure the company's ability to meet its outstanding obligations as they mature;
- Whether the excess of surplus to policyholders over and above an insurer's statutorily required surplus to policyholders has decreased by more than 50% in the preceding 12-month period;
- Whether residential property insurers have sufficient capital, surplus, and reinsurance to withstand significant weather events, including but not limited to hurricanes;
- The insurer's required surplus, capital, or capital stock is impaired to an extent prohibited by law;
- The insurer continues to write new business when it has not maintained the required surplus or capital;
- The insurer attempts to dissolve or liquidate without first having made provisions, satisfactory to the OIR, for liabilities arising from insurance policies issued by the insurer;
- Whether an insurer has incurred substantial new debt, has had to rely on frequent or substantial capital infusions, has a highly leveraged balance sheet, or relies increasingly on outside consulting sources;
- The insurer meets one or more of the grounds in s. 631.051, F.S., for the appointment of the DFS as receiver; or
- Any other finding determined by the OIR to be hazardous to the insurer's policyholders, creditors, or general public.

In making a determination of an insurer's financial condition, the OIR may:

- Disregard any credit or amount receivable resulting from transactions with a reinsurer that is insolvent, impaired, or otherwise subject to a delinquency proceeding;
- Make appropriate adjustments including disallowance to asset values attributable to investments in or transactions with parents, subsidiaries, or affiliates consistent with the

National Association of Insurance Commissioners Accounting Practices and Procedures Manual, state laws and rules;
- Refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor; and
- Increase the insurer's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the insurer will be called upon to meet the obligation undertaken within the next twelve-month period.

If the OIR determines that the continued operations of an insurer licensed to transact business in this state may be hazardous to its policyholders, creditors, or the general public, the OIR may issue an order requiring the insurer to do any of the following:
- Reduce the total amount of present and potential liability for policy benefits by procuring additional reinsurance;
- Reduce, suspend, or limit the volume of business being accepted or renewed;
- Reduce general insurance and commission expenses by specified methods or amounts;
- Increase the insurer's capital and surplus;
- Suspend or limit the declaration and payment of dividend by an insurer to its stockholders or to its policyholders;
- File reports in a form acceptable to the OIR concerning the market value of an insurer's assets;
- Limit or withdraw from certain investments or discontinue certain investment practices to the extent the OIR deems necessary;
- Document the adequacy of premium rates in relation to the risks insured;
- File, in addition to regular annual statements, interim financial reports on the a form prescribed by the commission adopted by the National Association of Insurance Commissioners or in such format as promulgated by the OIR;
- Correct corporate governance practice deficiencies, and adopt and utilize governance practices acceptable to the OIR;
- Provide a business plan to the OIR in order to continue to transact business in the state; and
- Adjust rates for any non-life insurance product written by the insurer that the OIR considers necessary to improve the financial condition of the insurer, notwithstanding any other provision of law limiting the frequency or amount of rate adjustments.

These provisions are not to be interpreted to limit the powers granted to the OIR by any laws of this state or to supersede any laws of this state. The OIR may, pursuant to law, in its discretion and without advance notice or hearing, issue an immediate final order to any insurer requiring the authorized actions.

Section 8 amends s. 624.81, F.S., relating to notice to comply with written requirements of the OIR, to repeal Commission rulemaking authority to define standards of hazardous financial condition and corrective action.

Section 9 creates s. 624.865, F.S., to provide rulemaking authority to the Commission to administer ss. 624.80-624.87, F.S. (administrative supervision of insurers). Such rules must protect the interests of insureds, claimants, insurers, and the public.

Section 10 amends s. 628.8015, F.S., to conform a cross-reference.

Insurance Fraud – Licensure

Section 11 amends s. 626.207, F.S., to revise the DFS licensure suspension statutes to specify that the 7-year disqualification period for misdemeanors applies to misdemeanors related to Insurance Code violations, in addition to the current ground that the violation is directly related to the financial services business.

Fines for Unfair Insurance Trade Practices

Section 12 amends s. 626.9521, F.S., to increase the fines for any person that violates the Unfair Insurance Trade Practices Act. Fines for each nonwillful violation may not exceed $12,500 (up from $5,000) and fines for each willful violation may not exceed $100,000 (up from $40,000). Fines may not exceed an aggregate amount of $50,000 (up from $20,000) for all nonwillful violations arising out of the same action or an aggregate amount of $500,000 (up from $200,000) for all willful violations arising out of the same action.

Fines for "twisting" and for "churning" may not exceed $12,500 (up from $5,000) for each nonwillful violation and may not exceed $187,500 (up from $75,000) for each willful violation. Fines for willfully submitting fraudulent signatures on an application or policy-related document may not exceed $12,500 (up from $5,000) for each nonwillful violation and may not exceed $187,500 (up from $75,000) for each willful violation.

Fines for a violation related to a covered loss or claim caused by an emergency for which the Governor declared a state of emergency may not exceed $25,000 for each nonwillful violation and may not exceed $200,000 for each willful violation. Such fines may not exceed an aggregate amount of $100,000 for all nonwillful violations arising out of the same action or an aggregate amount of $1,000,000 for all willful violations arising out of the same action.

Unfair Insurance Claims Settlement Practices

Section 13 amends s. 626.9541, F.S., to provide that it is an unfair claims settlement practice to, with such frequency as to indicate a general business practice, alter or amend an insurance adjuster's report without providing a detailed explanation as to why any change that has the effect of reducing the estimate of the loss was made; and either:

- Including on the report or as an addendum to the report a detailed list of all changes made to the report and the identity of the person who ordered each change; or
- Retaining all versions of the report, and including within each such version, for each change made within such version of the report, the identity of each person who made or ordered such change.

The bill provides that it is an unfair insurance trade practice for a director or an officer of an impaired insurer to receive a bonus from such insurer or from a holding company or an affiliate that shares common ownership or control with such insurer.

DFS Insurance Fraud Investigations

Section 14 amends s. 626.989, F.S., to provide that insurance fraud referrals may be made by the DFS to the statewide prosecutor for crimes that impact two or more judicial circuits.

The bill directs the Division of Investigative and Forensic Services, Bureau of Insurance Fraud, within the DFS, to submit a performance report to the President of the Senate and the Speaker of the House of Representatives by January 1 of each year. The report is to include at least:

- The total number of initial referrals received, cases opened, cases presented for prosecution, cases closed, and convictions resulting from cases presented for prosecution by the Bureau of Insurance Fraud by type of insurance fraud and circuit.
- The number of referrals received from insurers and the outcome of those referrals.
- The number of investigations undertaken by the Bureau of Insurance Fraud which were not the result of a referral from an insurer and the outcome of those referrals.
- The number of investigations that resulted in a referral to a regulatory agency and the disposition of those referrals.
- The number and reasons provided by local prosecutors or the statewide prosecutor for declining prosecution of a case presented by the Bureau of Insurance fraud.
- The total number of employees assigned to the Bureau of Insurance Fraud delineated by location of staff assigned; and the number and location of employees assigned to the Bureau of Insurance Fraud who were assigned to work other types of fraud cases.
- The average caseload and turnaround time by type of case for each investigator.
- The training provided during the year to insurance fraud investigators.

Mitigation Discounts

Section 15 amends s. 627.0629, F.S., to require insurers to provide information on their website describing the hurricane mitigation discounts available to policyholders. The bill further provides that on or before January 1, 2025, and every five years thereafter, the OIR reevaluate and update the fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm and the discounts, credits, other rate differentials, and reductions in deductibles that reflect the full actuarial value of such fixtures or construction techniques.

Insurance of Policies with Claims of Insolvent Insurers

Section 16 amends s. 627.351, F.S., to provide that the Citizens Property Insurance Corporation may not determine that a risk is ineligible for coverage with the corporation solely because such risk has unrepaired damage caused by a covered loss that is the subject of a claim that has been filed with the Florida Insurance Guaranty Association (FIGA). This requirement applies until the earlier of 36 months after the date the FIGA began servicing such claim or closes the claim.

Form Review

Section 17 amends s. 627.410, F.S., to provide that the OIR may not waive review of the insurance documents or forms of any insurer whom the OIR enters a final order determining that

such insurer violated any provision of the Insurance Code for a period of 36 months after the date of such order.

Claims Handling Manuals

Section 18 creates s. 627.4108, F.S., to require each authorized residential property insurer to create and use a claims-handling manual that provides guidelines and procedures and that complies with the Insurance Code and comports to usual and customary industry claims-handling practices. Such manual must include guidelines and procedures for:

- Initially receiving and acknowledging initial receipt of the claim and reviewing and evaluating the claim;
- Communicating with policyholders, beginning with the receipt of the claim and continuing until closure of the claim;
- Setting the claim reserve;
- Investigating the claim, including conducting inspections of the property that is the subject of the claim;
- Making preliminary estimates and estimates of the covered damages to the insured property and communicating such estimates to the policyholder;
- The payment, partial payment, or denial of the claim and communicating such claim decision to the policyholder;
- Closing claims; and
- Any aspect of the claims-handling process which the OIR determines should be included in the claims-handling manual in order to:
  - Comply with the laws of this state or rules or orders of the OIR or the DFS;
  - Ensure the claims-handling manual comports with usual and customary industry claims-handling guidelines; or
  - Protect policyholders of the insurer or the general public.

The bill provides that the OIR may request a copy of the insurer's claims-handling manuals. If requested by the OIR, the insurer must submit within 5 business days:

- A true and correct copy of each claims-handling manual requested; and
- An attestation, on a form prescribed by the Commission, that certifies:
  - That the insurer has provided a true and correct copy of each currently applicable, or otherwise specifically requested, claims-handling manual; and
  - The timeframe for which each submitted claims-handling manual was or is in effect.

Each authorized residential property insurer must annually certify and attest that:

- Each of the insurer's current claims-handling manuals complies with the requirements of this code and comports to usual and customary industry claims-handling practices; and
- The insurer maintains adequate resources available to implement the requirements of each of its claims-handling manuals at all times, including during natural disasters and catastrophic events.

The bill provides that the Commission may adopt emergency rules to implement this section.

Cancellation during Pending Claims

Section 19 amends s. 627.4133, F.S., to provide that an authorized insurer insurer may not cancel or nonrenew a residential property insurance policy:

- For a period of 90 days after the property has been repaired, if such property has been damaged as a result of a hurricane or wind loss that is the subject of the declaration of emergency and the filing of an order by the Commissioner of Insurance Regulation.
- Until the earlier of when property has been repaired or 1 year after the insurer issues the final claim payment, if such property was damaged by any covered peril, but was not damaged as a result of a hurricane or wind loss that is the subject of the declaration of emergency and the filing of an order by the Commissioner of Insurance Regulation.

A structure is deemed repaired when substantially completed and restored to the extent that it is insurable by another authorized insurer.

The bill extends the application of the provisions of this section to personal residential and commercial residential policies covering property that was damaged as the result of Hurricane Ian or Hurricane Nicole.

Administration of Claims

Section 20 amends s. 627.426, F.S., to require each liability insurer, upon receiving actual notice of an incident or a loss that could give rise to a covered liability claim, to do all of the following:

- Assign a licensed and appointed insurance adjuster to investigate the extent of the insured's probable exposure and diligently attempt to resolve any questions concerning the existence or extent of the insured's coverage.
- Evaluate the claim fairly, honestly, and with due regard for the interests of the insured based on available information; consider the extent of the claimant's recoverable damages; and consider the information in a reasonable and prudent manner.
- Request from the insured or claimant additional relevant information the insurer reasonably deems necessary to evaluate whether to settle a claim.
- Conduct all oral and written communications with the insured with the honesty and candor.
- Make reasonable efforts to explain to persons not represented by counsel matters requiring expertise beyond the level normally expected of a layperson with no training in insurance or claims-handling issues.
- Retain all written and recorded communications and create and retain a summary of all verbal communications in a reasonable manner for a period of not less than 5 years after the later of the entry of a judgment against the insured in excess of policy limits becoming final or the conclusion of the extracontractual claim, if any, including any related appeals.
- Provide the insured within 30 days of a request, all communications related to the insurer's handling of the claim which are not privileged as to the insured.
- Provide, upon request and at the insurer's expense, reasonable accommodations necessary to communicate effectively with an insured covered under the Americans with Disabilities Act.
- In handling third-party claims, communicate to an insured the identity of any other person or entity the insurer has reason to believe may be liable; the insurer's evaluation of the claim given the facts known to the insurer at that time; the likelihood and possible extent of an excess judgment; steps the insured can take to avoid exposure to an excess judgment,

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

- Initiate settlement negotiations by tendering its policy limits to the claimant in exchange for a general release of the insured if the facts available to the insurer indicate that the insured's liability is likely to exceed the policy limits.
- Give fair consideration to a settlement offer that is not unreasonable under the facts available to the insurer and settle in exchange for a general release of the insured, if possible, when reasonably prudent to do so. The insurer must provide reasonable assistance to the insured to comply with the insured's obligations to cooperate and act reasonably to attempt to satisfy any conditions of a claimant's settlement offer. If it is not possible to settle a liability claim within the available policy limits in exchange for a general release of the insured, the insurer must act reasonably to attempt to minimize the excess exposure to the insured.
- Attempt to minimize the magnitude of possible excess judgments against the insured when multiple claims arise out of a single occurrence and the combined value of all claims exceeds the total of all applicable policy limits.
- Attempt to settle the claim in exchange for a general release of all insureds against whom a claim may be presented if a loss creates the potential for a third-party claim against more than one insured. If it is not possible to settle in exchange for a general release of all insureds, the insurer, in consultation with the insureds, must attempt to enter into reasonable settlements of claims against certain insureds in exchange for a general release of such insureds to the exclusion of other insureds.
- Respond to any request for insurance information in compliance with ss. 626.9372 or 627.4137, F.S., as applicable.
- Take reasonable measures to preserve evidence, for a reasonable period of time, which is needed for the defense of the liability claim if it appears the insured's probable exposure is greater than policy limits.
- Comply with the existing provision for claim administration, as applicable; or
- Comply with the Unfair Insurance Trade Practices Act.

The bill defines "actual notice" for purposes of this section to mean the insurer's receipt of notice of an incident or a loss that could give rise to a covered claim that is communicated to the insurer or an agent of the insurer:

- By any manner permitted by the policy or other documents provided to the insured by the insurer;
- Through the claims link on the insurer's website; or
- Through the e-mail address designated by the insurer under s. 624.422, F.S.

The bill provides that, in determining whether an insurer violated these provisions, it is relevant whether the insured, claimant, or their representative was acting in good faith in furnishing information regarding the claim, in making demands of the insurer, in setting deadlines, and in attempting to settle the claim. This includes whether:

- The insured met its duty to cooperate with the insurer in the defense of the claim and in making settlements by taking reasonable actions requested by the claimant or required by the policy which are necessary to assist the insurer in settling a covered claim, including:
  - Executing affidavits regarding the facts within the insured's knowledge regarding the covered loss; and
  - Providing documents, including if reasonably necessary to settle a covered claim valued in excess of policy limits and upon the request of the claimant, a summary of the insured's assets, liabilities, obligations, other insurance policies that may provide coverage for the claim, and the name and contact information of the insured's employer when the insured is a natural person who was acting in the course and scope of employment when the incident giving rise to the claim occurred.
- The claimant and any claimant's representative:
  - Acted honestly in furnishing information regarding the claim;
  - Acted reasonably in setting deadlines; and
  - Refrained from taking actions that may be reasonably expected to prevent an insurer from accepting the settlement demand.

A violation of the subsection is a violation of the Florida Insurance Code and subject to the applicable enforcement provisions and any imposed related administrative fines imposed is subject to a 2.0 multiplier and may exceed the limits on fine amounts and aggregate fine amounts provided for under the Code. The subsection does not create a civil cause of action and does not abrogate or diminish any existing civil cause of action. Any proceedings, determinations, or enforcement actions taken by the OIR for violations of the subsection are not admissible in any civil action.

Roof Deductibles

Section 21 amends s. 627.701(10), F.S., to provide that if a roof deductible is applied, no other deductible under the policy may be applied to the loss "or to any other loss to the property caused by the same covered peril."

Notice of Property Insurance Claims

Section 22 amends s. 627.70132, F.S., to toll the time period for filing a property insurance claim during any term of deployment to a combat zone or combat support posting which materially affects the ability of a servicemember to file a claim, supplemental claim, or reopened claim.

Legislative Intent

Section 23 provides legislative intent that Chapter 2022-271, Laws of Florida, passed during Special Session A in December 2023, shall not be construed to impair any right under an insurance contract in effect on or before the effective date of that chapter law (December 16, 2022). The bill provides that to the extent that Chapter 2022-271, Laws of Florida, affects a right under an insurance contract that chapter law applies to an insurance contract issued or renewed after the effective date of that chapter law. This section is intended to clarify existing law and is remedial in nature.

Insurance Rates - Change in Law

Section 24 requires, in order to ensure that rates accurately reflect the risk, that every residential property insurer rate filing and every motor vehicle insurer rate filing made or pending with the Office of Insurance Regulation on or after July 1, 2023, must reflect the projected savings or reduction in claim frequency, claim severity, and loss adjustment expenses, including for attorney fees, payment of attorney fees to claimants, and any other reduction actuarially indicated, due to the combined effect of the applicable provisions of:

- Chapter 2021-77, L.O.F. (SB 76 – 2021);
- Chapter 2022-268, L.O.F. (SB 2-D - 2022);
- Chapter 2022-271, L.O.F. (SB 2-A - 2022); and
- Chapter 2023-15, L.O.F. (HB 837 - 2023).

In its review, the OIR must consider the projected savings or reduction in claim frequency, claim severity, and loss adjustment expenses, including for attorney fees, payment of attorney fees to claimants, and any other reduction actuarially indicated. The OIR is authorized to develop methodology and data that incorporate generally accepted actuarial techniques and standards to be used in its review. The OIR is authorized to contract with an appropriate vendor to advise in developing such methodology and data. The methodology and data are not intended to create a mandatory minimum rate decrease, but rather to ensure that the rates are not excessive, inadequate, or unfairly discriminatory and allow such insurers a reasonable rate of return

The bill appropriates $500,000 from the Insurance Regulatory Trust Fund to the OIR to implement this section.

OIR Program Funding

Section 25 authorizes 18 FTEs with associated salary rate of 1,116,500 and appropriates $1,879,129 in recurring funds and $185,086 in non-recurring funds from the Insurance Regulatory Trust Fund to the OIR to implement the bill.

DFS Program Funding

Section 25 authorizes seven FTEs with associated salary rate of 350,000 and appropriates $574,036 in recurring funds and $33,467 in non-recurring funds from the Insurance Regulatory Trust Fund to the DFS to implement the bill.

Effective Date

Section 27 provides an effective date of July 1, 2023.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill should have a positive impact on individuals and businesses whose premiums for property insurance and motor vehicle insurance will include consideration the impact of recent legislative reforms on projected losses. Property insurance customers should benefit from more frequent updates to mitigation credits and greater public awareness of their availability.

The additional reporting requirements created by the bill will have an indeterminate impact on insurers.

C. Government Sector Impact:

The bill appropriates $500,000 from the Insurance Regulatory Trust Fund to the OIR to implement section 24 of the bill relating to rate review.

The bill authorizes 18 FTES with associated salary rate of 1,116,500 and appropriates $1,879,129 in recurring funds and $185,086 in non-recurring funds from the Insurance Regulatory Trust Fund to the OIR to implement the bill.

The bill authorizes seven FTEs with associated salary rate of 350,000 and appropriates $574,036 in recurring funds and $33,467 in non-recurring funds from the Insurance Regulatory Trust Fund to the DFS to implement the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 624.307, 624.315, 624,316, 624.3161, 624.4211, 624.81, 626.207, 626.9521, 626.9541, 626.989, 627.0629, 627.351, 627.410, 627.4133, 627.426, 627.701, 627.70132, and 628.8015.

This bill creates the following sections of the Florida Statutes: 624.4301, 624.805, 624.865, and 627.4108.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Fiscal Policy Committee on April 20, 2023:
The committee substitute:

- Deletes section 7 (payments to affiliates), section 12 (motor vehicle insurance claim settlement practices), section 22 (emergency order after a natural disasters), and section 23 (title insurance rates) from the bill.
- Revises risk-based selection methodology factors for financial examinations.
- Revises market conduct examination provisions.
- Specifies factors the OIR may consider in determining whether the continued operation of an insurer may be deemed to be hazardous to its policyholders, creditors, or the general public; specifying actions the OIR may take in determining an insurer's financial condition; specifying actions the OIR may order a hazardous insurer to take; authorizing the Commission to adopt rules.
- Revises claim administration practice provisions to provide that administrative fines imposed for violations are subject to a 2.0 multiplier and may exceed the limits on fine amounts and aggregate fine amounts provided for under the Insurance Code; providing that any proceedings, determinations, or enforcement actions taken by the OIR against an insurer for violations are not admissible in any civil action.
- Applies notice of temporary suspension of writing new business provision to only residential property insurance; exempts temporary hurricane-related suspensions.
- Provides that in lieu of making a list of changes to the adjuster’s report, the company may retain all versions of the report.
- Prohibits officers and directors of insolvent insurers from receiving bonuses paid by a holding company or affiliate with common ownership.
- Revises the date by which insurers must include available discounts on their websites.
- Requires residential property insurers to create and use claims-handling manuals that comply with the Insurance Code and comport to industry standards. Eliminates annual submission requirement. The OIR may request manual at any time and requires attestation with submission.

- Revises standards for handling liability claims; specifies the section does not create a civil cause of action, nor does it abrogate or diminish an existing civil cause of action.
- Tolls the time period to file a claim for a servicemember deployed to a combat zone or combat supporting posting.
- Revises language specifying the purpose of the insurance rate change in law section.
- Provides that the OIR may develop "methodology and data" – rather than "factors" - that incorporate generally accepted actuarial techniques and standards to be used in its review of rate filings based on the passage of recent legislation.
- Authorizes 18 FTES with associated salary rate of 1,116,500 and appropriates $1,879,129 in recurring funds and $185,086 in non-recurring funds from the Insurance Regulatory Trust Fund to the OIR to implement the bill.
- Authorizes seven FTEs with associated salary rate of 350,000 and appropriates $574,036 in recurring funds and $33,467 in non-recurring funds from the Insurance Regulatory Trust Fund to the DFS to implement the bill.

B. Amendments:

None.