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:	SB 7052
INTRODUCER:	Banking and Insurance Committee
SUBJECT:	Insurer Accountability
DATE:	April 19, 2023
REVISED:	

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

I. Summary:

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

Regarding insurance coverage the proposed bill:

- Prohibits authorized and surplus lines insurers from cancelling a property insurance policy during any pending claim until after repairs are complete;
- Requires that Citizens cover property with open claims that are being handled by FIGA (Florida Insurance Guaranty Association);
- Prohibits the Office of Insurance Regulation (OIR) from waiving its review of policy forms for 3 years for any insurer that has violated the Insurance Code;
- Provides that the prohibition on applying any other deductible under the policy if a roof deductible is applied 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 active duty military service; and
- Clarifies legislative intent that Chapter 2022-271, Laws of Florida, passed during Special Session A in December 2023, (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).
- Clarifies that the provisions of do not impair rights under policies in effect before the act's effective date.

Regarding rates charged for insurance, the proposed 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 OIR to obtain an actuarial study to implement this requirement.
- Requires that property insurance mitigation discounts be updated at least every 5 years and insurers to provide consumer-friendly information on their website describing hurricane mitigation discounts available to policyholders; and
- Makes title insurance rates subject to OIR rate review.

Regarding insurer claims handling, the proposed bill:

- Requires OIR to ensure liability insurers are complying with proper claims handling practices by following specified best practices
- Creates a 60-day prompt-pay law for non-PIP motor vehicle insurance claims similar to the prompt pay law for residential property insurance claims;
- Requires insurers to annually submit their claims manuals to the OIR and attest that the manual comports to usual and customary industry claims handling practices; and
- Strengthens the Unfair Insurance Trade Practices Act by:
  - Prohibiting altering or amending an adjuster's report without including a list of changes, who made the change, and an explanation of a change that reduces coverage; and
  - Prohibiting payment of bonuses to officers and directors while an insurer is impaired or insolvent.

Regarding regulatory oversight of insurers, the bill:

- Increases maximum administrative fines 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.
- Provides additional funding for the DFS Division of Consumer Services.
  - Appropriates five positions with associated salary rate of 325,000 and the sum of $494,774 in recurring funds and $23,410 in non-recurring funds to the DFS from the Insurance Regulatory Trust Fund.
- Specifies objective criteria to be used by OIR to:
  - Prioritize necessary financial and market conduct examinations.
  - Determine when payments to affiliates are excessive.
- Provides conditions whereby the OIR must initiate a market conduct examination.
- Requires insurers to report to the OIR any temporary suspension of writing new policies.
- Applies the standard order that OIR issues to protect consumers after hurricanes to surplus lines insurers.
- Specifies that insurance fraud referrals may be made to the statewide prosecutor for crimes that impact two or more judicial circuits.
- 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;
- 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.

---

[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).
[7] Section 624.307(10)(a), F.S.

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 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 OIR as necessitating a market conduct exam for any other reason.

[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.
[14] *Id.*
[15] Section 624.3161(4), F.S.

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.
- 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

[16] Section 624.3161(6), F.S.
[17] *Id.*
[18] *Id.*
[19] Section 624.315, F.S.
[20] Section 624.4211, F.S.

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.

Financial Consideration or Payment by an Insurer to an Affiliate

All insurers with a Florida certificate of authority must file quarterly and annual reports with the OIR containing various financial data, including audited financial statements, actuarial opinions, and certain claims data.[21] Each year, insurers must file an annual statement covering the preceding calendar year on or before March 1. Quarterly statements covering each period ending on March 31, June 30, and September 30 must be filed within 45 days after each such date.[22]

The OIR must make publicly available data detailing the number of policies, amount of premium, number of cancellations, and other data for each property insurer on a statewide basis.[23] The information must be published on the OIR website within one month after each quarterly and annual filing.[24] This information is not a trade secret as defined in s. 688.002(4), F.S., or s. 812.081, F.S., and is not subject to the public records exemption for trade secrets provided in s. 119.0715, F.S.[25]

Each insurer doing business in this state which pays a fee, commission, or other financial consideration or payment to any affiliate directly or indirectly is required upon request to provide to the OIR any information the OIR deems necessary. The fee, commission, or other financial consideration or payment to any affiliate must be fair and reasonable. In determining whether the fee, commission, or other financial consideration or payment is fair and reasonable, the OIR must consider the actual cost of the service being provided.[26]

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.

[21] Section 624.424, F.S.
[22] Section 624.424(1)(a), F.S.
[23] Section 624.424(10)(b), F.S.
[24] *Id.*
[25] *Id.*
[26] Section 624.424(13), F.S

- 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.[27]

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 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.[28]

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.[29] 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."[30]

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.[31]

[27] Section 627.7154(3), F.S.
[28] Section 627.7154(4), F.S.
[29] Section 626.9521(1), F.S.
[30] Section 626.9541(1)(i), F.S.
[31] 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.[32] The Division is directed by statute to investigate fraudulent insurance acts, violations of the Unfair Insurance Trade Practices Act, [33] false and fraudulent insurance claims,[34] and willful violations of the Florida Insurance Code and rules adopted pursuant to the code.[35] 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.[36] 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.[37] 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,[38] 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.[39]

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.[40] Citizens is not a private insurance company.[41] 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).[42] Citizens offers property insurance through three different accounts: a personal lines account, a commercial lines account, and a coastal account.

[32] *See* https://myfloridacfo.com/Division/DIFS/ (last accessed April 2, 2023).
[33] Section 626.9541, F.S.
[34] Section 817.234, F.S.
[35] Section 624.15, F.S.
[36] Section 627.062(2)(j), F.S.
[37] Section 627.0629(1), F.S.
[38] *Id*.
[39] *Id*.
[40] The term "admitted market" means insurance companies licensed to transact insurance in Florida.
[41] Section 627.351(6)(a)1., F.S.
[42] 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 Financial Services Commission.[43] The Governor, President of the Senate, Speaker of the House of Representatives, and Chief Financial Officer each appoint two members to the board.[44] 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.[45] These forms may not be delivered or issued for delivery unless the form has been filed with the OIR.[46]

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;[47] and
- An insurer must give written notice of renewal premium at least 45 days prior to the renewal premium[48] 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.[49]

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.

[43] Section 627.351(6)(a)2., F.S.
[44] Section 627.351(6)(c)4.a., F.S.
[45] Section 627.410, F.S.
[46] *Id.*
[47] Section 627.4133(2)(b), F.S.
[48] Section 627.4133(2)(a), F.S.
[49] 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.[50]

Claim Handling – Late Payments

Florida's property insurance prompt payment statute provides for an insurer's[51] 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,[52] and begin an investigation, as is reasonably necessary, within 14 days after receiving a proof-of-loss statement.[53] 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.[54,55] These provisions must be complied within the stated timeframes unless the failure is caused by

[50] Section 627.701(10), F.S.
[51] Section 627.70131(5), F.S., defines "insurer" as any residential property insurer.
[52] Section 627.70131(1)(a), F.S.
[53] Section 627.70131(3)(a), F.S.
[54] 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.
[55] Section 627.70131(7)(a), F.S.

factors beyond the control of the insurer which reasonably prevent the insurer from complying with them.[56]

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.[57] 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.[58]

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.[59] 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,[60] within 1 year after the date of loss.[61] Notice of a supplemental claim[62] 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.

OIR Emergency Order After Natural Disasters

The Financial Services Commission is required to adopt by rule standardized requirements that may be applied to insurers after a hurricane or other natural disaster.[63] The rules shall address the following areas:

- Claims reporting requirements.
- Grace periods for payment of premiums and performance of other duties by insureds.
- Temporary postponement of cancellations and nonrenewals.

[56] Section 627.70131(1)(a) and (3)(a), F.S.
[57] Section 627.70131(3)(b), F.S.
[58] Section 627.70131(3)(d), F.S.
[59] Section 627.70131(3)(b) and (c), F.S.
[60] 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.
[61] 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.
[62] 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.
[63] Section 627.7019(1), F.S.

The rules must require the OIR to issue an order within 72 hours after the occurrence of a hurricane or other natural disaster specifying which standardized requirements apply, the geographic areas in which they apply, the time at which applicability commences, and the time at which applicability terminates.[64]

Title Insurance Rates

Title insurance rates are set by rule of the Financial Services Commission.[65] In adopting the rates, the commission must consider the following:[66]

- The title insurers' loss experience and prospective loss experience under closing protection letters and policy liabilities.
- A reasonable margin for underwriting profit and contingencies sufficient to allow title insurers, agents, and agencies to earn a rate of return that will attract and retain adequate capital investment in the title insurance business and maintain an efficient title insurance delivery system.
- Past expenses and prospective expenses for administration and handling of risks.
- Liability for defalcation.[67]
- Other relevant factors.

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.

Annual Report on Insurer Compliance

Section 2 amends s. 624.315, F.S., to require an annual report by the OIR inspector general to the Legislature and Cabinet regarding the agency's actions to enforce insurer compliance.

Quarterly Reports of the OIR Action against Insurers

Section 3 creates s. 624.3512, 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.

[64] Section 627.7019(2), F.S.
[65] Section 627.782(1), F.S.
[66] Section 627.782(2), F.S.
[67] The act or an instance of embezzling; a failure to meet a promise or an expectation. https://www.merriam-webster.com/dictionary/defalcation (last accessed March 31, 2023).

The report must be submitted to the Financial Services Commission, the President of the Senate, the Speaker of the House of Representatives, and the legislative committees with jurisdiction over insurance matters.

Financial Examinations

Section 4 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 currently required risk-based capital reports to prioritize financial examinations of insurers where such reporting indicates a decline in the insurer's financial condition.
- Consideration of any downgrade or threatened downgrade in the insurer's financial strength rating.
- Prioritization of property insurers for which the OIR identifies significant concerns about an insurer's solvency.
- Any other conditions the OIR deems necessary for the protection of the public.

Market Conduct Exams

Section 5 amends s. 624.3161, F.S., to require 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. Under such methodology, the OIR must initiate a market conduct examination if any of the following conditions exist:

- An insurance regulator in another state has initiated or taken regulatory action against the insurer or entity.
- Given the insurer's market share in this state, the DFS or the OIR has received a disproportionate number of claim handling complaints against the insurer.
- Results of a NAIC Market Conduct Annual Statement that indicate an insurer is a negative outlier with regard to particular metrics.
- Evidence the insurer is engaged in a pattern or practice of violations of the Unfair Insurance Trade Practices Act.
- The insurer meets the criteria in s. 624.3161(7), F.S.
- Any other conditions the OIR deems are necessary for the protection of the public.

Administrative Fines

Section 6 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.

Financial Consideration or Payment by an Insurer to an Affiliate

Section 7 amends s. 624.424, F.S., to establish criteria for the OIR to consider when evaluating a fee, commission, or other financial consideration or payment by an insurer to any affiliate is fair and reasonable. The bill requires that in all instances the insurer must provide to the OIR documentation supporting that the payment to the affiliate is fair and reasonable for the service being provided. The criteria the office must consider in evaluating such payments include:

- The actual cost of the services provided, and the cost of the service if provided by a non-affiliate.
- The relative financial condition of the insurer and the managing general agent.
- The level of holding company debt and how debt is serviced.
- The dividends paid by a managing general agent, and for what purpose.
- Whether contract terms are in the best interest of policyholders.

For each agreement with an affiliate in force on July 1, 2023, each insurer must provide to the OIR no later than October 1, 2023:

- The cost incurred by the affiliate to provide each service;
- The amount charged to the insurer for that service; and
- The dollar amount of fees forgiven, waived, or reimbursed by the affiliate for the two most recent preceding years.

Notice of Temporary Suspension of Writing New Business

Section 8 creates s. 624.4301, F.S., to require insurers to give written notice to the OIR before any temporary suspension of writing new 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.

Insurance Fraud – Licensure

Section 9 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 10 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 11 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 including on the report or as an addendum to the report a detailed list of all changes made to the report and the identity of the person who ordered each change. Any change that has the effect of reducing the estimate of the loss must include a detailed explanation why such change was made.

The bill provides that it is an unfair insurance trade practice for a director or an officer of an impaired insurer to or permit the insurer to pay a bonus to any officer or director of the insurer.

Claim Settlement Practices Relating to Motor Vehicle Insurance

Section 12 amends s. 626.9743, F.S., to create a prompt-pay law for first-party and third-party motor vehicle insurance claims, including those with a surplus lines insurer, which mirrors the law for residential property insurance claims. The bill provides that:

- Upon an insurer's receiving a communication with respect to a claim, the insurer must, within 7 calendar days, review and acknowledge receipt of such communication unless payment is made within that period of time or unless the failure to acknowledge is caused by factors beyond the control of the insurer. If the acknowledgment is not in writing, a notification indicating acknowledgement shall be made in the insurer's claim file and dated. The acknowledgment must be responsive to the communication.
- Unless otherwise provided by the policy of insurance or by law, within 7 days after an insurer receives proof-of-loss statements, the insurer must begin such investigation as is reasonably necessary unless the failure to begin such investigation is caused by factors beyond the control of the insurer.
    - If such investigation involves a physical inspection of the motor vehicle, the licensed adjuster assigned by the insurer must provide the policyholder with a printed or electronic document containing his or her name and state adjuster license number. An insurer must conduct any such physical inspection within 7 days after its receipt of the proof-of-loss statements.
    - Any subsequent communication with the policyholder regarding the claim must also include the name and license number of the adjuster communicating about the claim.

Communication of the adjuster's name and license number may be included with other information provided to the policyholder.
    - An insurer may use electronic methods to investigate the loss. An insurer may void the insurance policy if the policyholder or any other person at the direction of the policyholder commits insurance fraud.
    - The insurer must send the policyholder a copy of any detailed estimate of the amount of the loss within 7 days after the estimate is generated by an insurer's adjuster.
- An insurer shall maintain:
    - A record or log of each adjuster who communicates with the policyholder as provided in paragraphs (3)(b) and (c) and provide a list of such adjusters to the insured, the OIR, or the DFS upon request.
    - Claim records, including dates of:
        - Any claim-related communication made between the insurer and the policyholder or the policyholder's representative;
        - The insurer's receipt of the policyholder's proof of loss statement;
        - Any claim-related request for information made by the insurer to the policyholder or the policyholder's representative;
        - Any claim-related inspections of the property made by the insurer, including physical inspections and inspections made by electronic means;
        - Any detailed estimate of the amount of the loss generated by the insurer's adjuster;
        - The beginning and end of any tolling period provided for in subsection (8); and
        - The insurer's payment or denial of the claim.
- When providing a preliminary or partial estimate of damage regarding a claim, an insurer shall include with the estimate the following statement printed in at least 12-point bold, uppercase type: THIS ESTIMATE REPRESENTS OUR CURRENT EVLAUATION OF THE COVERED DAMAGES TO YOUR INSURED PROPERTY AND MAY BE REVISED AS WE CONTINUE TO EVALUATE YOUR CLAIM. IF YOU HAVE QUESTIONS, CONCERNS, OR ADDITIONAL INFORMATION REGARDING YOUR CLAIM, WE ENCOURAGE YOU TO CONTACT US.
- When providing a payment on a claim which is not the full and final payment for the claim, an insurer shall include with the payment the following statement printed in at least 12-point bold, uppercase type: WE ARE CONTINUING TO EVALUATE YOUR CLAIM INVOLVING YOUR INSURED PROPERTY AND MAY ISSUE ADDITIONAL PAYMENTS. IF YOU HAVE QUESTIONS, CONCERNS, OR ADDITIONAL INFORMATION REGARDING YOUR CLAIM, WE ENCOURAGE YOU TO CONTACT US.
- Within 60 days after an insurer receives notice of an initial, or supplemental motor vehicle claim, the insurer must pay or deny such claim or a portion of the claim unless the failure to pay is caused by factors beyond the control of the insurer. The insurer must provide a reasonable explanation in writing to the policyholder of the basis for the payment, denial, or partial denial of a claim. If the insurer's claim payment is less than specified in any insurer's detailed estimate of the amount of the loss, the insurer must provide a reasonable explanation in writing of the difference to the policyholder.
- The requirements of this section are tolled:
    - During the pendency of any mediation proceeding under s. 627.745, F.S., or any alternative dispute resolution proceeding provided for in the insurance contract.

- Upon the failure of a policyholder or a representative of the policyholder to provide material claims information requested by the insurer within 10 days after the request was received.

DFS Insurance Fraud Investigations

Section 13 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 14 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 15 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.

Form Review

Section 16 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 17 creates s. 627.4108, F.S., to require each insurer to annually submit their claims handling manuals to the OIR and attest that the manuals comply with the Insurance Code and comport to usual and customary industry claims handling practices and that the company has adequate resources to implement the manual, including during a catastrophic event.

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

Cancellation during Pending Claims

Section 18 amends s. 627.4133, F.S., to provide that an authorized insurer or surplus lines insurer may not cancel or nonrenew a personal residential or commercial residential property insurance policy covering a dwelling or residential property if such property was not damaged as a result of a hurricane or wind loss that is the subject of the declaration of emergency, then until the dwelling or residential property has been repaired, if such property was damaged by any covered peril.

The bill applies to surplus lines insurers the currently existing prohibition against cancelling or nonrenewing such policies for a period of 90 days after the dwelling or residential property has been repaired, if such property which has been damaged as a result of a hurricane or wind loss that is the subject of the declaration of emergency.

Administration of Claims

Section 19 amends s. 627.426, F.S., relating to the administration of claims, to require the OIR to ensure that each liability insurer, upon receiving actual notice of an incident or a loss that could give rise to a covered liability claim under an insurance policy:

- Assigns a duly 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.
- Based on available information, ethically evaluates every claim fairly, honestly, and with due regard for the interests of the insured; considers the extent of the claimant's recoverable damages; and considers the information in a reasonable and prudent manner.
- Requests from the insured or claimant additional relevant information the insurer reasonably deems necessary to evaluate whether to settle a claim.
- Conducts all oral and written communications with the insured with the utmost honesty and complete candor.
- Makes reasonable efforts to explain to persons not represented by counsel matters requiring expertise beyond the level normally expected of a layperson with no training in insurance or claims-handling issues.

- Retains all written communications and notes and retains a summary of all verbal communications in a reasonable manner for a period of not less than 5 years after the later of the entry of a judgment against the insured in excess of policy limits becomes final, or the conclusion of the extracontractual claim, if any, including any related appeals.
- Provides the insured, upon request, with all communications related to the insurer's handling of the claim which are not privileged as to the insured.
- Provides, 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, communicates 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; 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; and 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.
- If, after the expiration of the safe harbor periods in s. 624.155(4) or (6), F.S., as applicable, the facts available to the insurer indicate that the insured's liability is likely to exceed the policy limits, initiates settlement negotiations by tendering its policy limits to the claimant in exchange for a general release of the insured.
- Gives fair consideration to a settlement offer that is not unreasonable under the facts available to the insurer and failure to settle, if possible, when a reasonably prudent person, faced with the prospect of paying the total probable exposure of the insured, would do so. The insurer 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, the insurer must act reasonably to attempt to minimize the excess exposure to the insured.
- When multiple claims arise out of a single occurrence, the combined value of all claims exceeds the total of all applicable policy limits, and the claimants are unwilling to globally settle within the policy limits, thereafter, attempts to minimize the magnitude of possible excess judgments against the insured. The insurer is entitled to great discretion to decide how much to offer each respective claimant in its attempt to protect the insured. The insurer may, in its effort to minimize the excess liability of the insured, use its discretion to offer the full available policy limits to one or more claimants to the exclusion of other claimants and may leave the insured exposed to some liability after all the policy limits are paid. An insurer does not violate this section simply because it is unable to settle all claims in a multiple claimant case.
- When a loss creates the potential for a third-party claim against more than one insured, attempts to settle the claim on behalf of all insureds against whom a claim may be presented. If it is not possible to settle on behalf of all insureds, the insurer, in consultation with the insureds, must attempt to enter into reasonable settlements of claims against certain insureds to the exclusion of other insureds.
- Responds to any request for insurance information in compliance with s. 626.9372 or s. 627.4137, F.S., as applicable.

- Where it appears the insured's probable exposure is greater than policy limits, takes reasonable measures to preserve, for a reasonable period of time, evidence that is needed for the defense of the liability claim.
- Complies with s. 627.426, F.S., if applicable; or
- Complies with any other provision of this act.

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

Roof Deductibles

Section 20 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 21 amends s. 627.70132, F.S., to toll the time period for filing a property insurance claim during an insured's active duty military service.

OIR Emergency Order after Natural Disasters

Section 22 amends s. 627.7019, F.S., to provide that such orders apply to surplus lines insurers.

Title Insurance Rates

Section 23 amends s. 627.782, F.S., to provide that title insurers must file their rates with the OIR to ensure they are not inadequate, excessive, or unfairly discriminatory. Removes the authority for the Commission to set the rates by rule.

Legislative Intent

Section 24 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 25 requires that every residential property insurer rate filing and every motor vehicle insurer rate filing must reflect, and the OIR must consider in reviewing rates, an actuarially anticipated impact on the frequency and severity of claims and associated loss adjustment expenses due to the combined effect of revisions made by:

- 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).

Authorizes the OIR to develop presumed factor(s) to evaluate the effects of the bills. The bill appropriates $500,000 from the Insurance Regulatory Trust Fund for the OIR to obtain an actuarial study.

DFS Program Funding

Section 26 appropriates five positions with associated salary rate of 325,000 and the sum of $494,774 in recurring funds and $23,410 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. Title insurance customers should benefit from full OIR review of rates to ensure they are not excessive, inadequate, or unfairly discriminatory.

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 for the OIR to obtain an actuarial study.

The bill appropriates five positions with associated salary rate of 325,000 and the sum of $494,774 in recurring funds and $23,410 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, 624.424, 626.207, 626.9521, 626.9541, 626.9743, 626.989, 627.0629, 627.351, 627.410, 627.4133, 627.426, 627.701, 627.70132, 627.7019, and 627.782.

This bill creates the following sections of the Florida Statutes: 624.3512, 624.4301, and 627.4108.

IX. Additional Information:

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

None.

B. Amendments:

None.