1
2 An act relating to insurer accountability; creating s.
3 624.115, F.S.; specifying a requirement for the Office
4 of Insurance Regulation in referring criminal
5 violations; amending s. 624.307, F.S.; authorizing
6 electronic responses to certain requests from the
7 Division of Consumer Services of the Department of
8 Financial Services concerning consumer complaints;
9 revising the timeframe in which responses must be
10 made; revising administrative penalties; amending s.
11 624.315, F.S.; requiring the office to annually and
12 quarterly create and publish specified reports
13 relating to the enforcement of insurer compliance;
14 requiring the office to submit such reports to the
15 Financial Services Commission and the Legislature by
16 specified dates; amending s. 624.316, F.S.; revising
17 the minimum intervals in which the office must examine
18 certain insurers; revising periods that examinations
19 must cover; requiring the office to create a specified
20 methodology for scheduling examinations of insurers;
21 specifying requirements for such methodology;
22 providing construction; specifying requirements for
23 the office in proposing rules to the commission;
24 authorizing the commission to adopt rules; amending s.
25 624.3161, F.S.; revising requirements and conditions
26 for certain insurer market conduct examinations after
27 a hurricane; requiring the office to create, and the
28 commission to adopt by rule, a specified selection
29 methodology for examinations; specifying requirements



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30 for such methodology; specifying rulemaking
31 requirements; specifying requirements, procedures, and
32 conditions for the office’s review of a liability
33 insurer’s claims-handling practices and the imposition
34 of enhanced enforcement penalties; defining the term
35 “actual notice”; providing construction; amending s.
36 624.4211, F.S.; revising administrative fines the
37 office may impose in lieu of revocation or suspension;
38 creating s. 624.4301, F.S.; specifying requirements
39 for residential property insurers temporarily
40 suspending writing new policies in notifying the
41 office; providing applicability and construction;
42 authorizing the commission to adopt rules; creating s.
43 624.805, F.S.; specifying factors the office may
44 consider in determining whether the continued
45 operation of an insurer may be deemed to be hazardous
46 to its policyholders or creditors or to the general
47 public; specifying actions the office may take in
48 determining an insurer’s financial condition;
49 authorizing the office to issue an order requiring a
50 hazardous insurer to take specified actions; providing
51 construction; authorizing the office to issue
52 immediate final orders; amending s. 624.81, F.S.;
53 deleting certain rulemaking authority of the
54 commission; creating s. 624.865, F.S.; authorizing the
55 commission to adopt certain rules; amending s.
56 628.8015, F.S.; conforming provisions to changes made
57 by the act; amending s. 626.207, F.S.; revising a
58 condition for disqualification of an insurance



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59 representative applicant or licensee; amending s.
60 626.9521, F.S.; revising and specifying applicable
61 fines for unfair methods of competition and unfair or
62 deceptive acts or practices; amending s. 626.9541,
63 F.S.; adding an unfair claim settlement practice by an
64 insurer; prohibiting an officer or a director of an
65 impaired insurer from receiving a bonus from such
66 insurer or from certain holding companies or
67 affiliates; defining the term "bonus"; providing a
68 criminal penalty; amending s. 626.989, F.S.; revising
69 a reporting requirement for the department's Division
70 of Investigative and Forensic Services; revising a
71 requirement for state attorneys or other prosecuting
72 agencies having jurisdiction to inform the division
73 under certain circumstances; requiring the division to
74 submit an annual performance report to the
75 Legislature; specifying requirements for the report;
76 amending s. 627.0629, F.S.; specifying requirements
77 for residential property insurers in providing certain
78 hurricane mitigation discount information to
79 policyholders in a specified manner; specifying
80 requirements for the office in reevaluating and
81 updating certain fixtures and construction techniques;
82 deleting obsolete dates; amending s. 627.351, F.S.;
83 prohibiting Citizens Property Insurance Corporation
84 from determining that a risk is ineligible for
85 coverage solely on a specified basis; providing
86 applicability; amending s. 627.410, F.S.; prohibiting
87 the office from exempting specified insurers from form



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88 filing requirements for a specified period; providing
89 construction; creating s. 627.4108, F.S.; specifying
90 requirements for residential property insurers in
91 creating and using claims-handling manuals;
92 authorizing the office to request submission of such
93 manuals; providing requirements for such submissions;
94 requiring authorized insurers to annually submit a
95 certified attestation to the office; authorizing the
96 commission to adopt emergency rules; amending s.
97 627.4133, F.S.; revising prohibitions on insurers
98 against the cancellation or nonrenewal of property
99 insurance policies; revising applicability; providing
100 construction; defining the term “insurer”; amending s.
101 627.701, F.S.; providing that if a roof deductible is
102 applied under a personal lines residential property
103 insurance policy, no other deductible under the policy
104 may be applied to any other loss to the property
105 caused by the same covered peril; amending s.
106 627.70132, F.S.; providing for the tolling of certain
107 timeframes for filing notices of property insurance
108 claims by named insureds who are servicemembers under
109 specified circumstances; providing construction
110 relating to chapter 2022-271, Laws of Florida;
111 requiring residential property insurers and motor
112 vehicle insurer rate filings to reflect certain
113 projected savings and reductions in expenses;
114 specifying requirements for the office in reviewing
115 rate filings; authorizing the office to develop
116 certain methodology and data and contract with a

117 vendor for a certain purpose; providing applicability;
118 providing appropriations; providing an effective date.
119
120 Be It Enacted by the Legislature of the State of Florida:
121
122 Section 1. Section 624.115, Florida Statutes, is created to
123 read:
124 624.115 Referral of criminal violations.—If, during an
125 investigation or examination, the office has reason to believe
126 that any criminal law of this state has or may have been
127 violated, the office shall refer any relevant records and
128 information to the Division of Investigative and Forensic
129 Services, state or federal law enforcement, or prosecutorial
130 agencies, as applicable, and shall provide investigative
131 assistance to those agencies as required.
132 Section 2. Paragraph (b) of subsection (10) of section
133 624.307, Florida Statutes, is amended to read:
134 624.307 General powers; duties.—
135 (10)
136 (b) Any person licensed or issued a certificate of
137 authority by the department or the office shall respond, in
138 writing or electronically, to the division within 14 ~~20~~ days
139 after receipt of a written request for documents and information
140 from the division concerning a consumer complaint. The response
141 must address the issues and allegations raised in the complaint
142 and include any requested documents concerning the consumer
143 complaint not subject to attorney-client or work-product
144 privilege. The division may impose an administrative penalty for
145 failure to comply with this paragraph of up to $5,000 ~~$2,500~~ per



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146 violation upon any entity licensed by the department or the
147 office ~~and $250 for the first violation, $500 for the second~~
148 ~~violation,~~ and up to $1,000 per ~~for the third or subsequent~~
149 violation by ~~upon~~ any individual licensed by the department or
150 the office.
151 Section 3. Present subsection (4) of section 624.315,
152 Florida Statutes, is redesignated as subsection (5), and a new
153 subsection (4) is added to that section, to read:
154 624.315 Annual reports; quarterly reports ~~report~~.—
155 (4)(a) The office shall create a report detailing all
156 actions of the office to enforce insurer compliance with this
157 code and all rules and orders of the office or department during
158 the previous year. For each of the following, the report must
159 detail the insurer or other licensee or registrant against whom
160 such action was taken; whether the office found any violation of
161 law or rule by such party, and, if so, detail such violation;
162 and the resolution of such action, including any penalties
163 imposed by the office. The report must be published on the
164 website of the office and submitted to the commission, the
165 President of the Senate, the Speaker of the House of
166 Representatives, and the legislative committees with
167 jurisdiction over matters of insurance on or before January 31
168 of each year. The report must include, but need not be limited
169 to:
170 1. The revocation, denial, or suspension of any license or
171 registration issued by the office.
172 2. All actions taken pursuant to s. 624.310.
173 3. Fines imposed by the office for violations of this code.
174 4. Consent orders entered into by the office.

175 5. Examinations and investigations conducted and completed
176 by the office pursuant to ss. 624.316 and 624.3161.
177 6. Investigations conducted and completed, by line of
178 insurance, for which the office found violations of law or rule
179 but did not take enforcement action.
180 (b) Each quarter, the office shall create a report
181 detailing all actions of the office to enforce insurer
182 compliance during the previous quarter. The report must include,
183 but need not be limited to, the subjects that must be included
184 in the annual report under paragraph (a). The report must be
185 submitted to the commission, the President of the Senate, the
186 Speaker of the House of Representatives, and the legislative
187 committees with jurisdiction over matters of insurance. The
188 report is due on or before April 30, July 31, October 31, and
189 January 31, respectively, for the immediately preceding quarter.
190 The report due January 31 may be included within the annual
191 report required under paragraph (a).
192 (c) The office need not include within any report required
193 under this subsection information that would violate any
194 confidentiality provision included within any agreement, order,
195 or consent order entered into or adopted by the office.
196 Section 4. Paragraph (a) of subsection (2) of section
197 624.316, Florida Statutes, is amended, and subsections (3) and
198 (4) are added to that section, to read:
199 624.316 Examination of insurers.—
200 (2)(a) Except as provided in paragraph (f), the office may
201 examine each insurer as often as may be warranted for the
202 protection of the policyholders and in the public interest, but
203 must, at a minimum, examine:


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204 1. High-risk insurers at least once every 3 years.
205 2. Average- and low-risk insurers at least once every ~~and~~
206 ~~shall examine each domestic insurer not less frequently than~~
207 ~~once every~~ 5 years.
208

209 The examination shall cover the number of fiscal years since the
210 last examination ~~preceding 5 fiscal years~~ of the insurer, except
211 for examinations of low-risk insurers, in which case the
212 examination need only cover at least the preceding 5 fiscal
213 years, and shall be commenced within 12 months after the end of
214 the most recent fiscal year being covered by the examination.
215 The examination may cover any period of the insurer’s operations
216 since the last previous examination. The examination may include
217 examination of events subsequent to the end of the most recent
218 fiscal year and the events of any prior period that affect the
219 present financial condition of the insurer.
220 (3) The office shall create, and the commission shall adopt
221 by rule, a risk-based selection methodology for scheduling
222 examinations of insurers subject to this section. Except as
223 otherwise specified in subsection (2), this requirement does not
224 restrict the authority of the office to conduct examinations
225 under this section as often as it deems advisable. Such
226 methodology must include all of the following:
227 (a) Use of a risk-focused analysis to prioritize financial
228 examinations of insurers when such reporting indicates a decline
229 in the insurer’s financial condition.
230 (b) Consideration of:
231 1. The level of capitalization and identification of
232 unfavorable trends;

233 2. Negative trends in profitability or cash flow from
234 operations;
235 3. National Association of Insurance Commissioners
236 Insurance Regulatory Information System ratio results;
237 4. Risk-based capital and risk-based capital trend test
238 results;
239 5. The structure and complexity of the insurer;
240 6. Changes in the insurer's officers or board of directors;
241 7. Changes in the insurer's business strategy or
242 operations;
243 8. Findings and recommendations from an examination made
244 pursuant to this section or s. 624.3161;
245 9. Current or pending regulatory actions by the office or
246 the department;
247 10. Information obtained from other regulatory agencies or
248 independent organization ratings and reports; and
249 11. The impact of an insurer's insolvency on policyholders
250 of the insurer and the public generally.
251 (c) Prioritization of property insurers for which the
252 office identifies significant concerns about an insurer's
253 solvency pursuant to s. 627.7154.
254 (d) Any other matters the office deems necessary to
255 consider for the protection of the public.
256 (4) The office shall present any proposed rules
257 implementing this section to the commission no later than
258 October 1, 2023. In addition to the methodology required by this
259 section, such rule or rules must include a plan to implement the
260 examination schedule in subsection (2). To facilitate the
261 development of the methodology for scheduling examinations


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262 pursuant to this section, the commission may also adopt by rule
263 the National Association of Insurance Commissioners Financial
264 Analysis Handbook, to the extent that the handbook is consistent
265 with and does not negate the requirements of this section.
266 Section 5. Subsection (7) of section 624.3161, Florida
267 Statutes, is amended, and subsections (8) and (9) are added to
268 that section, to read:
269 624.3161 Market conduct examinations.—
270 (7) Notwithstanding subsection (1), any authorized insurer
271 transacting residential property insurance business in this
272 state:
273 (a) May be subject to an additional market conduct
274 examination after a hurricane if, at any time more than 90 days
275 after the end of the hurricane, the insurer:
276 (a) is among the top 20 percent of insurers based upon a
277 calculation of the ratio of hurricane-related property insurance
278 claims filed to the number of property insurance policies in
279 force;
280 (b) Must be subject to a market conduct examination after a
281 hurricane if, at any time more than 90 days after the end of the
282 hurricane, the insurer:
283 1. Is among the top 20 percent of insurers based upon a
284 calculation of the ratio of hurricane claim-related consumer
285 complaints made about that insurer to the department to the
286 insurer's total number of hurricane-related claims;
287 2. Is among the top 20 percent of insurers based upon a
288 calculation of the ratio of hurricane claims closed without
289 payment to the insurer's total number of hurricane claims on
290 policies providing wind or windstorm coverage;


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291 3.~~(c)~~ Has made significant payments to its managing general
292 agent since the hurricane; or
293 4.~~(d)~~ Is identified by the office as necessitating a market
294 conduct exam for any other reason.
295
296 All relevant criteria under this section and s. 624.316 shall be
297 applied to the market conduct examination under this subsection.
298 Such an examination must be initiated within 18 months after the
299 landfall of a hurricane that results in an executive order or a
300 state of emergency issued by the Governor. The requirements of
301 this subsection do not limit the authority of the office to
302 conduct at any time a market conduct examination of a property
303 insurer in the aftermath of a hurricane. This subsection does
304 not require the office to conduct multiple market conduct
305 examinations of the same insurer when multiple hurricanes make
306 landfall in this state in a single calendar year. An examination
307 of an insurer under this subsection must also include an
308 examination of its managing general agent as if it were the
309 insurer.
310 (8) The office shall create, and the commission shall adopt
311 by rule, a selection methodology for scheduling and conducting
312 market conduct examinations of insurers and other entities
313 regulated by the office. This requirement does not restrict the
314 authority of the office to conduct market conduct examinations
315 as often as it deems necessary. Such selection methodology must
316 prioritize market conduct examinations of insurers and other
317 entities regulated by the office to whom any of the following
318 conditions applies:
319 (a) An insurance regulator in another state has initiated

320 or taken regulatory action against the insurer or entity
321 regarding an act or omission of such insurer or entity which, if
322 committed in this state, would constitute a violation of the
323 laws of this state or any rule or order of the office or
324 department.
325 (b) Given the insurer's market share in this state, the
326 department or the office has received a disproportionate number
327 of the following types of claims-handling complaints against the
328 insurer:
329 1. Failure to timely communicate with respect to claims;
330 2. Failure to timely pay claims;
331 3. Untimely payments giving rise to the payment of
332 statutory interest;
333 4. Failure to adjust and pay claims in accordance with the
334 terms and conditions of the policy or contract and in compliance
335 with state law;
336 5. Violations of part IX of chapter 626, the Unfair
337 Insurance Trade Practices Act;
338 6. Failure to use licensed and duly appointed claims
339 adjusters;
340 7. Failure to maintain reasonable claims records; or
341 8. Failure to adhere to the company's claims-handling
342 manual.
343 (c) The results of a National Association of Insurance
344 Commissioners Market Conduct Annual Statement indicate that the
345 insurer is a negative outlier with regard to particular metrics.
346 (d) There is evidence that the insurer is violating or has
347 violated the Unfair Insurance Trade Practices Act.
348 (e) The insurer meets the criteria in subsection (7).



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349 (f) Any other conditions the office deems necessary for the
350 protection of the public.
351
352 The office shall present the proposed rule required by this
353 subsection to the commission no later than October 1, 2023. In
354 addition to the methodology required by this subsection, the
355 rule must provide criteria for how the office, in coordination
356 with the department, will determine what constitutes a
357 disproportionate number of claims-handling complaints described
358 in paragraph (b).
359 (9) If the office concludes through an examination pursuant
360 to this section that an insurer providing liability coverage in
361 this state exhibits a pattern or practice of violations of the
362 Florida Insurance Code during any investigation or examination
363 of the insurer, the office must review the insurer's claims-
364 handling practices to determine if the insurer should be subject
365 to the enhanced enforcement penalties of this subsection.
366 (a) A liability insurer may be subject to enhanced
367 enforcement penalties if the office reviews the insurer's
368 claims-handling practices and finds a pattern or practice of the
369 insurer failing to do the following when responding to covered
370 liability claims under an insurance policy, after receiving
371 actual notice of such claims:
372 1. Assign a licensed and appointed insurance adjuster to
373 investigate whether coverage is provided under the policy and
374 diligently attempt to resolve any questions concerning the
375 extent of the insured's coverage.
376 2. Evaluate the claim fairly, honestly, and with due regard
377 for the interests of the insured based on available information.



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378 3. Request from the insured or claimant additional relevant
379 information the insurer reasonably deems necessary to evaluate
380 whether to settle a claim.
381 4. Conduct all oral and written communications with the
382 insured with honesty and candor.
383 5. Make reasonable efforts to explain to persons not
384 represented by counsel matters requiring expertise beyond the
385 level normally expected of a layperson with no training in
386 insurance or claims-handling issues.
387 6. Retain all written and recorded communications and
388 create and retain a summary of all verbal communications in a
389 reasonable manner for a period of not less than 2 years after
390 the later of the entry of a final judgment against the insured
391 in excess of policy limits or, if an extracontractual claim is
392 made, the conclusion of that claim and any related appeals.
393 7. Within 30 days after a request, provide the insured with
394 all communications related to the insurer's handling of the
395 claim which are not privileged as to the insured.
396 8. Provide, upon request and at the insurer's expense,
397 reasonable accommodations necessary to communicate effectively
398 with an insured covered under the Americans with Disabilities
399 Act.
400 9. When handling a third-party claim, communicate each of
401 the following to the insured:
402 a. The identity of any other person or entity the insurer
403 has reason to believe may be liable.
404 b. The insurer's final and completed estimate of the claim.
405 c. The possibility of an excess judgment.
406 d. The insured's right to secure personal counsel at his or



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407 her own expense.
408 e. That the insured should cooperate with the insurer,
409 including providing information required by the insurer because
410 of a settlement opportunity or in accordance with the policy.
411 f. Any formal settlement demands or offers to settle by the
412 claimant and any offers to settle on behalf of the insured.
413 10. Respond to any request for insurance information in
414 compliance with s. 626.9372 or s. 627.4137, as applicable.
415 11. Seek to obtain a general release of each insured in
416 making any settlement offer to a third-party claimant.
417 12. Take reasonable measures to preserve any documentary,
418 photographic, and forensic evidence as needed for the defense of
419 the liability claim if it appears likely that the insured’s
420 liability exposure is greater than policy limits and the insurer
421 fails to secure a general release in favor of the insured.
422 13. Comply with subsections (1) and (2), if applicable.
423 14. Comply with the Unfair Insurance Trade Practices Act.
424 (b) As used in this subsection, the term “actual notice”
425 means the insurer’s receipt of notice of an incident or a loss
426 that could give rise to a covered claim that is communicated to
427 the insurer or an agent of the insurer:
428 1. By any manner permitted by the policy or other documents
429 provided to the insured by the insurer;
430 2. Through the claims link on the insurer’s website; or
431 3. Through the e-mail address designated by the insurer
432 under s. 624.422.
433 (c) In reviewing claims-handling practices, it is relevant
434 whether the insured, claimant, and any representative of the
435 insured or claimant were acting reasonably toward the insurer in



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436 furnishing information regarding the claim, in making demands of
437 the insurer, in setting deadlines, and in attempting to settle
438 the claim. Such matters include whether:
439 1. The insured cooperated with the insurer in the defense
440 of the claim and in making settlements by taking reasonable
441 actions requested by the claimant or required by the policy
442 which are necessary to assist the insurer in settling a covered
443 claim, including:
444 a. Executing affidavits regarding the facts within the
445 insured’s knowledge regarding the covered loss; and
446 b. Providing documents, including, if reasonably necessary
447 to settle a covered claim valued in excess of policy limits and
448 upon the request of the claimant, a summary of the insured’s
449 assets, liabilities, obligations, and other insurance policies
450 that may provide coverage for the claim and the name and contact
451 information of the insured’s employer when the insured is a
452 natural person who was acting in the course and scope of
453 employment when the incident giving rise to the claim occurred.
454 2. The claimant and any claimant’s representative:
455 a. Acted honestly in furnishing information regarding the
456 claim;
457 b. Acted reasonably in setting deadlines; and
458 c. Refrained from taking actions that may be reasonably
459 expected to prevent an insurer from accepting the settlement
460 demand, such as providing insufficient detail within the demand,
461 providing unreasonable deadlines for acceptance of the demand,
462 or including unreasonable conditions to settlement.
463 (d) In addition to authorized penalties for a liability
464 insurer that the office has determined has a pattern or practice



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465 <u>of violations of the Florida Insurance Code at the conclusion of</u>
466 <u>any investigation or examination, the office may impose enhanced</u>
467 <u>enforcement penalties for insurer claims-handling practices that</u>
468 <u>fail to meet the review standards of this subsection. Such</u>
469 <u>enhanced enforcement penalties include, but are not limited to,</u>
470 <u>administrative fines that are subject to a 2.0 multiplier and</u>
471 <u>fines that exceed the limits on fine amounts and aggregate fine</u>
472 <u>amounts provided for under this code.</u>
473 <u>(e) This subsection does not create a civil cause of</u>
474 <u>action, a civil remedy under s. 624.155, or an unfair trade</u>
475 <u>practice under s. 626.9541.</u>
476 Section 6. Section 624.4211, Florida Statutes, is amended
477 to read:
478 624.4211 Administrative fine in lieu of suspension or
479 revocation.—
480 (1) If the office finds that one or more grounds exist for
481 the discretionary revocation or suspension of a certificate of
482 authority issued under this chapter, the office may, in lieu of
483 such revocation or suspension, impose a fine upon the insurer.
484 (2)<u>(a)</u> With respect to <u>a</u> ~~any~~ nonwillful violation, such
485 fine may not exceed<u>:</u>
486 <u>1. Twenty-five thousand dollars per violation, up to an</u>
487 <u>aggregate amount of $100,000 for all nonwillful violations</u>
488 <u>arising out of the same action, related to a covered loss or</u>
489 <u>claim caused by an emergency for which the Governor declared a</u>
490 <u>state of emergency pursuant to s. 252.36.</u>
491 <u>2. Twelve thousand five hundred dollars</u> ~~$5,000~~ per
492 violation<u>, up to</u>~~. In no event shall such fine exceed~~ an
493 aggregate amount of <u>$50,000</u> ~~$20,000~~ for all <u>other</u> nonwillful



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494 violations arising out of the same action.
495 (b) If an insurer discovers a nonwillful violation, the
496 insurer shall correct the violation and, if restitution is due,
497 make restitution to all affected persons. Such restitution shall
498 include interest at 12 percent per year from either the date of
499 the violation or the date of inception of the affected person's
500 policy, at the insurer's option. The restitution may be a credit
501 against future premiums due, provided that interest accumulates
502 until the premiums are due. If the amount of restitution due to
503 any person is $50 or more and the insurer wishes to credit it
504 against future premiums, it shall notify such person that she or
505 he may receive a check instead of a credit. If the credit is on
506 a policy that is not renewed, the insurer shall pay the
507 restitution to the person to whom it is due.
508 (3)(a) With respect to a ~~any~~ knowing and willful violation
509 of a lawful order or rule of the office or commission or a
510 provision of this code, the office may impose a fine upon the
511 insurer in an amount not to exceed:
512 1. Two hundred thousand dollars for each such violation, up
513 to an aggregate amount of $1 million for all knowing and willful
514 violations arising out of the same action, related to a covered
515 loss or claim caused by an emergency for which the Governor
516 declared a state of emergency pursuant to s. 252.36.
517 2. One hundred thousand dollars ~~$40,000~~ for each such
518 violation, up to~~. In no event shall such fine exceed~~ an
519 aggregate amount of $500,000 ~~$200,000~~ for all other knowing and
520 willful violations arising out of the same action.
521 (b) In addition to such fines, the insurer shall make
522 restitution when due in accordance with subsection (2).



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523 (4) The failure of an insurer to make restitution when due
524 as required under this section constitutes a willful violation
525 of this code. However, if an insurer in good faith is uncertain
526 as to whether any restitution is due or as to the amount of such
527 restitution, it shall promptly notify the office of the
528 circumstances; and the failure to make restitution pending a
529 determination thereof shall not constitute a violation of this
530 code.
531 Section 7. Section 624.4301, Florida Statutes, is created
532 to read:
533 624.4301 Notice of temporary discontinuance of writing new
534 residential property insurance policies.—
535 (1) Any authorized insurer, before temporarily suspending
536 writing new residential property insurance policies in this
537 state, must give notice to the office of the insurer's reasons
538 for such action, the effective dates of the temporary
539 suspension, and the proposed communication to its agents. Such
540 notice must be provided on a form approved by the office and
541 adopted by the commission. The insurer shall submit such notice
542 to the office the earlier of 20 business days before the
543 effective date of the temporary suspension of writing or 5
544 business days before notifying its agents of the temporary
545 suspension of writing. The insurer must provide any other
546 information requested by the office related to the insurer's
547 temporary suspension of writing. The requirements of this
548 section do not:
549 (a) Apply to a temporary suspension of writing new business
550 made in response to:
551 1. A hurricane that may make landfall in this state if such



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552 temporary suspension ceases within 72 hours after hurricane
553 conditions are no longer present in this state; or
554 2. Any other natural emergency as defined in s. 252.34(8)
555 which impacts one or more counties and is the subject of a
556 declared state of emergency by any local, state, or federal
557 authority, if such temporary suspension applies only to the
558 affected counties and ceases within 72 hours after such natural
559 emergency is no longer present in those counties.
560 (b) Require such insurers to obtain the approval of the
561 office before temporarily suspending writing new residential
562 property insurance policies in this state.
563 (2) The commission may adopt rules to administer this
564 section.
565 Section 8. Section 624.805, Florida Statutes, is created to
566 read:
567 624.805 Hazardous insurer standards; office's evaluation
568 and enforcement authority; immediate final order.—
569 (1) In determining whether the continued operation of any
570 authorized insurer transacting business in this state may be
571 deemed to be hazardous to its policyholders or creditors or to
572 the general public, the office may consider, in the totality of
573 the circumstances of such insurer, any of the following:
574 (a) Adverse findings reported in financial condition or
575 market conduct examination reports, audit reports, or actuarial
576 opinions, reports, or summaries.
577 (b) The National Association of Insurance Commissioners
578 Insurance Regulatory Information System and its other financial
579 analysis solvency tools and reports.
580 (c) Whether the insurer has made adequate provisions,



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581 according to presently accepted actuarial standards of practice,
582 for the anticipated cash flows required to cover its contractual
583 obligations and related expenses.
584 (d) The ability of an assuming reinsurer to perform and
585 whether the insurer's reinsurance program provides sufficient
586 protection for the insurer's remaining surplus after taking into
587 account the insurer's cash flow and the lines of insurance
588 written, as well as the financial condition of the assuming
589 reinsurer.
590 (e) Whether the insurer's operating loss in the last 12-
591 month period, including, but not limited to, net capital gain or
592 loss, change in nonadmitted assets, and cash dividends paid to
593 shareholders is greater than 50 percent of the insurer's
594 remaining surplus as regards policyholders in excess of the
595 minimum required.
596 (f) Whether the insurer's operating loss in the last 12-
597 month period, excluding net capital gains, is greater than 20
598 percent of the insurer's remaining surplus as regards
599 policyholders in excess of the minimum required.
600 (g) Whether a reinsurer, an obligor, or any entity within
601 the insurer's insurance holding company system is insolvent,
602 threatened with insolvency, or delinquent in payment of its
603 monetary or other obligations, and which in the opinion of the
604 office may affect the solvency of the insurer.
605 (h) Contingent liabilities, pledges, or guaranties that
606 individually or collectively involve a total amount that in the
607 opinion of the office may affect the solvency of the insurer.
608 (i) Whether any affiliate, as defined in s. 624.10(1), of
609 the insurer is delinquent in the transmitting to, or payment of,

610 net premiums to the insurer.
611 (j) The age and collectability of receivables.
612 (k) Whether the management of the insurer, including
613 officers, directors, or any other person who directly or
614 indirectly controls the operation of the insurer, fails to
615 possess and demonstrate the competence, fitness, and reputation
616 deemed necessary to serve the insurer in such position.
617 (l) Whether management of the insurer has failed to respond
618 to inquiries relative to the condition of the insurer or has
619 furnished false or misleading information to the office
620 concerning an inquiry.
621 (m) Whether the insurer has failed to meet financial and
622 holding company filing requirements in the absence of a reason
623 satisfactory to the office.
624 (n) Whether management of the insurer has filed any false
625 or misleading sworn financial statement, has released a false or
626 misleading financial statement to lending institutions or to the
627 general public, has made a false or misleading entry, or has
628 omitted an entry of material amount in the books of the insurer.
629 (o) Whether the insurer has grown so rapidly and to such an
630 extent that it lacks adequate financial and administrative
631 capacity to meet its obligations in a timely manner.
632 (p) Whether the insurer has experienced, or will experience
633 in the foreseeable future, cash flow or liquidity problems.
634 (q) Whether management has established reserves that do not
635 comply with minimum standards established by state insurance
636 laws and regulations, statutory accounting standards, sound
637 actuarial principles, and standards of practice.
638 (r) Whether management persistently engages in material


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639 under-reserving that results in adverse development.
640 (s) Whether transactions among affiliates, subsidiaries, or
641 controlling persons for which the insurer receives assets or
642 capital gains, or both, do not provide sufficient value,
643 liquidity, or diversity to assure the insurer’s ability to meet
644 its outstanding obligations as they mature.
645 (t) The ratio of the annual premium volume to surplus or of
646 its liabilities to surplus in relation to loss experience, the
647 kinds of risks insured, or both.
648 (u) Whether the insurer’s asset portfolio, when viewed in
649 light of current economic conditions and indications of
650 financial or operational leverage, is of sufficient value,
651 liquidity, or diversity to assure the company’s ability to meet
652 its outstanding obligations as they mature.
653 (v) Whether the excess of surplus as regards policyholders
654 above the insurer’s statutorily required surplus as regards
655 policyholders has decreased by more than 50 percent in the
656 preceding 12-month period.
657 (w) As to a residential property insurer, whether it has
658 sufficient capital, surplus, and reinsurance to withstand
659 significant weather events, including, but not limited to,
660 hurricanes.
661 (x) Whether the insurer’s required surplus, capital, or
662 capital stock is impaired to an extent prohibited by law.
663 (y) Whether the insurer continues to write new business
664 when it has not maintained the required surplus or capital.
665 (z) Whether the insurer moves to dissolve or liquidate
666 without first having made provisions satisfactory to the office
667 for liabilities arising from insurance policies issued by the



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668 insurer.
669 (aa) Whether the insurer has incurred substantial new debt,
670 has had to rely on frequent or substantial capital infusions, or
671 has a highly leveraged balance sheet.
672 (bb) Whether the insurer relies increasingly on other
673 entities, including, but not limited to, affiliates, third-party
674 administrators, managing general agents, or management
675 companies.
676 (cc) Whether the insurer meets one or more of the grounds
677 in s. 631.051 for the appointment of the department as receiver.
678 (dd) Any other finding determined by the office to be
679 hazardous to the insurer's policyholders or creditors or to the
680 general public.
681 (2) For the purposes of making a determination of an
682 insurer's financial condition under the Florida Insurance Code,
683 the office may:
684 (a) Disregard any credit or amount receivable resulting
685 from transactions with a reinsurer that is insolvent, impaired,
686 or otherwise subject to a delinquency proceeding;
687 (b) Make appropriate adjustments, including disallowance to
688 asset values attributable to investments in or transactions with
689 parents, subsidiaries, or affiliates, consistent with the
690 National Association of Insurance Commissioners Accounting
691 Practices and Procedures Manual and state laws and rules;
692 (c) Refuse to recognize the stated value of accounts
693 receivable if the ability to collect receivables is highly
694 speculative in view of the age of the account or the financial
695 condition of the debtor; or
696 (d) Increase the insurer's liability, in an amount equal to



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697 any contingent liability, pledge, or guarantee not otherwise
698 included, if there is a substantial risk that the insurer will
699 be called upon to meet the obligation undertaken within the next
700 12-month period.
701 (3) If the office determines that the continued operations
702 of an insurer authorized to transact business in this state may
703 be hazardous to its policyholders or creditors or to the general
704 public, the office may issue an order requiring the insurer to
705 do any of the following:
706 (a) Reduce the total amount of present and potential
707 liability for policy benefits by procuring additional
708 reinsurance.
709 (b) Reduce, suspend, or limit the volume of business being
710 accepted or renewed.
711 (c) Reduce expenses by specified methods or amounts.
712 (d) Increase the insurer's capital and surplus.
713 (e) Suspend or limit the declaration and payment of
714 dividends by an insurer to its stockholders or to its
715 policyholders.
716 (f) File reports in a form acceptable to the office
717 concerning the market value of the insurer's assets.
718 (g) Limit or withdraw from certain investments or
719 discontinue certain investment practices to the extent the
720 office deems necessary.
721 (h) Document the adequacy of premium rates in relation to
722 the risks insured.
723 (i) File, in addition to regular annual statements, interim
724 financial reports on a form prescribed by the commission and
725 adopted by the National Association of Insurance Commissioners.

726 (j) Correct corporate governance practice deficiencies and
727 adopt and use governance practices acceptable to the office.
728 (k) Provide a business plan acceptable to the office in
729 order to continue to transact business in this state.
730 (l) Notwithstanding any other law limiting the frequency or
731 amount of rate adjustments, adjust rates for any non-life
732 insurance product written by the insurer which the office
733 considers necessary to improve the financial condition of the
734 insurer.
735 (4) This section may not be interpreted to limit the powers
736 granted to the office by any laws of this state, nor may it be
737 interpreted to supersede any laws of this state.
738 (5) The office may, pursuant to ss. 120.569 and 120.57, in
739 its discretion and without advance notice or hearing, issue an
740 immediate final order to any insurer requiring the actions
741 listed in subsection (3).
742 Section 9. Subsection (11) of section 624.81, Florida
743 Statutes, is amended to read:
744 624.81 Notice to comply with written requirements of
745 office; noncompliance.—
746 ~~(11) The commission may adopt rules to define standards of~~
747 ~~hazardous financial condition and corrective action~~
748 ~~substantially similar to that indicated in the National~~
749 ~~Association of Insurance Commissioners' 1997 "Model Regulation~~
750 ~~to Define Standards and Commissioner's Authority for Companies~~
751 ~~Deemed to be in Hazardous Financial Condition," which are~~
752 ~~necessary to implement the provisions of this part.~~
753 Section 10. Section 624.865, Florida Statutes, is created
754 to read:

755 624.865 Rulemaking.—The commission may adopt rules to
756 administer ss. 624.80-624.87. Such rules must protect the
757 interests of insureds, claimants, insurers, and the public.
758 Section 11. Paragraph (d) of subsection (2) and paragraph
759 (b) of subsection (3) of section 628.8015, Florida Statutes, are
760 amended to read:
761 628.8015 Own-risk and solvency assessment; corporate
762 governance annual disclosure.—
763 (2) OWN-RISK AND SOLVENCY ASSESSMENT.—
764 (d) *Exemption.*—
765 1. An insurer is exempt from the requirements of this
766 subsection if:
767 a. The insurer has annual direct written and unaffiliated
768 assumed premium, including international direct and assumed
769 premium, but excluding premiums reinsured with the Federal Crop
770 Insurance Corporation and the National Flood Insurance Program,
771 of less than $500 million; or
772 b. The insurer is a member of an insurance group and the
773 insurance group has annual direct written and unaffiliated
774 assumed premium, including international direct and assumed
775 premium, but excluding premiums reinsured with the Federal Crop
776 Insurance Corporation and the National Flood Insurance Program,
777 of less than $1 billion.
778 2. If an insurer is:
779 a. Exempt under sub-subparagraph 1.a., but the insurance
780 group of which the insurer is a member is not exempt under sub-
781 subparagraph 1.b., the ORSA summary report must include every
782 insurer within the insurance group. The insurer may satisfy this
783 requirement by submitting more than one ORSA summary report for

784 any combination of insurers if any combination of reports
785 includes every insurer within the insurance group.
786 b. Not exempt under sub-subparagraph 1.a., but the
787 insurance group of which it is a member is exempt under sub-
788 subparagraph 1.b., the insurer must submit to the office the
789 ORSA summary report applicable only to that insurer.
790 3. The office may require an exempt insurer to maintain a
791 risk management framework, conduct an ORSA, and file an ORSA
792 summary report:
793 a. Based on unique circumstances, including, but not
794 limited to, the type and volume of business written, ownership
795 and organizational structure, federal agency requests, and
796 international supervisor requests;
797 b. If the insurer has risk-based capital for a company
798 action level event pursuant to s. 624.4085(3), meets one or more
799 of the standards of an insurer deemed to be in hazardous
800 financial condition under s. 624.805 ~~as defined in rules adopted~~
801 ~~by the commission pursuant to s. 624.81(11)~~, or exhibits
802 qualities of an insurer in hazardous financial condition as
803 determined by the office; or
804 c. If the office determines it is in the best interest of
805 the state.
806 4. If an exempt insurer becomes disqualified for an
807 exemption because of changes in premium as reported on the most
808 recent annual statement of the insurer or annual statements of
809 the insurers within the insurance group of which the insurer is
810 a member, the insurer must comply with the requirements of this
811 section effective 1 year after the year in which the insurer
812 exceeded the premium thresholds.

813 (3) CORPORATE GOVERNANCE ANNUAL DISCLOSURE.—
814 (b) *Disclosure requirement.*—
815 1.a. An insurer, or insurer member of an insurance group,
816 of which the office is the lead state regulator, as determined
817 by the procedures in the most recent National Association of
818 Insurance Commissioners Financial Analysis Handbook, shall
819 submit a corporate governance annual disclosure to the office by
820 June 1 of each calendar year. The initial corporate governance
821 annual disclosure must be submitted by December 31, 2018.
822 b. An insurer or insurance group not required to submit a
823 corporate governance annual disclosure under sub-subparagraph a.
824 shall do so at the request of the office, but not more than once
825 per calendar year. The insurer or insurance group shall notify
826 the office of the proposed submission date within 30 days after
827 the request of the office.
828 c. Before December 31, 2018, the office may require an
829 insurer or insurance group to provide a corporate governance
830 annual disclosure:
831 (I) Based on unique circumstances, including, but not
832 limited to, the type and volume of business written, the
833 ownership and organizational structure, federal agency requests,
834 and international supervisor requests;
835 (II) If the insurer has risk-based capital for a company
836 action level event pursuant to s. 624.4085(3), meets one or more
837 of the standards of an insurer deemed to be in hazardous
838 financial condition under s. 624.805 ~~as defined in rules adopted~~
839 ~~pursuant to s. 624.81(11)~~, or exhibits qualities of an insurer
840 in hazardous financial condition as determined by the office;
841 (III) If the insurer is the member of an insurer group of



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842 which the office acts as the lead state regulator as determined
843 by the procedures in the most recent National Association of
844 Insurance Commissioners Financial Analysis Handbook; or
845 (IV) If the office determines that it is in the best
846 interest of the state.
847 2. The chief executive officer or corporate secretary of
848 the insurer or the insurance group must sign the corporate
849 governance annual disclosure attesting that, to the best of his
850 or her knowledge and belief, the insurer has implemented the
851 corporate governance practices and provided a copy of the
852 disclosure to the board of directors or the appropriate board
853 committee.
854 3.a. Depending on the structure of its system of corporate
855 governance, the insurer or insurance group may provide corporate
856 governance information at one of the following levels:
857 (I) The ultimate controlling parent level;
858 (II) An intermediate holding company level; or
859 (III) The individual legal entity level.
860 b. The insurer or insurance group may make the corporate
861 governance annual disclosure at:
862 (I) The level used to determine the risk appetite of the
863 insurer or insurance group;
864 (II) The level at which the earnings, capital, liquidity,
865 operations, and reputation of the insurer are collectively
866 overseen and the supervision of those factors is coordinated and
867 exercised; or
868 (III) The level at which legal liability for failure of
869 general corporate governance duties would be placed.
870



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871 An insurer or insurance group must indicate the level of
872 reporting used and explain any subsequent changes in the
873 reporting level.
874 4. The review of the corporate governance annual disclosure
875 and any additional requests for information shall be made
876 through the lead state as determined by the procedures in the
877 most recent National Association of Insurance Commissioners
878 Financial Analysis Handbook.
879 5. An insurer or insurance group may comply with this
880 paragraph by cross-referencing other existing relevant and
881 applicable documents, including, but not limited to, the ORSA
882 summary report, Holding Company Form B or F filings, Securities
883 and Exchange Commission proxy statements, or foreign regulatory
884 reporting requirements, if the documents contain information
885 substantially similar to the information described in paragraph
886 (c). The insurer or insurance group shall clearly identify and
887 reference the specific location of the relevant and applicable
888 information within the corporate governance annual disclosure
889 and attach the referenced document if it has not already been
890 filed with, or made available to, the office.
891 6. Each year following the initial filing of the corporate
892 governance annual disclosure, the insurer or insurance group
893 shall file an amended version of the previously filed corporate
894 governance annual disclosure indicating changes that have been
895 made. If changes have not been made in the previously filed
896 disclosure, the insurer or insurance group should so indicate.
897 Section 12. Paragraph (c) of subsection (3) of section
898 626.207, Florida Statutes, is amended to read:
899 626.207 Disqualification of applicants and licensees;



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900 penalties against licensees; rulemaking authority.—
901 (3) An applicant who has been found guilty of or has
902 pleaded guilty or nolo contendere to a crime not included in
903 subsection (2), regardless of adjudication, is subject to:
904 (c) A 7-year disqualifying period for all misdemeanors
905 directly related to the financial services business or any
906 misdemeanor directly related to any violation of the Florida
907 Insurance Code.
908 Section 13. Subsections (2) and (3) of section 626.9521,
909 Florida Statutes, are amended to read:
910 626.9521 Unfair methods of competition and unfair or
911 deceptive acts or practices prohibited; penalties.—
912 (2) Except as provided in subsection (3), any person who
913 violates any provision of this part is subject to a fine in an
914 amount not greater than $12,500 ~~$5,000~~ for each nonwillful
915 violation and not greater than $100,000 ~~$40,000~~ for each willful
916 violation. Fines under this subsection imposed against an
917 insurer may not exceed an aggregate amount of $50,000 ~~$20,000~~
918 for all nonwillful violations arising out of the same action or
919 an aggregate amount of $500,000 ~~$200,000~~ for all willful
920 violations arising out of the same action. The fines may be
921 imposed in addition to any other applicable penalty.
922 (3)(a) If a person violates s. 626.9541(1)(l), the offense
923 known as “twisting,” or violates s. 626.9541(1)(aa), the offense
924 known as “churning,” the person commits a misdemeanor of the
925 first degree, punishable as provided in s. 775.082, and an
926 administrative fine not greater than $12,500 ~~$5,000~~ shall be
927 imposed for each nonwillful violation or an administrative fine
928 not greater than $187,500 ~~$75,000~~ shall be imposed for each

929 willful violation. To impose an administrative fine for a
930 willful violation under this paragraph, the practice of
931 "churning" or "twisting" must involve fraudulent conduct.
932 (b) If a person violates s. 626.9541(1)(ee) by willfully
933 submitting fraudulent signatures on an application or policy-
934 related document, the person commits a felony of the third
935 degree, punishable as provided in s. 775.082, and an
936 administrative fine ~~not greater than $5,000 shall be imposed for~~
937 ~~each nonwillful violation or an administrative fine~~ not greater
938 than $187,500 ~~$75,000~~ shall be imposed for each ~~willful~~
939 violation.
940 (c) If a person violates any provision of this part and
941 such violation is related to a covered loss or covered claim
942 caused by an emergency for which the Governor declared a state
943 of emergency pursuant to s. 252.36, such person is subject to a
944 fine in an amount not greater than $25,000 for each nonwillful
945 violation and not greater than $200,000 for each willful
946 violation. Fines imposed under this paragraph against an insurer
947 may not exceed an aggregate amount of $100,000 for all
948 nonwillful violations arising out of the same action or an
949 aggregate amount of $1 million for all willful violations
950 arising out of the same action.
951 (d) Administrative fines under paragraphs (a) and (b) ~~this~~
952 ~~subsection~~ may not exceed an aggregate amount of $125,000
953 ~~$50,000~~ for all nonwillful violations arising out of the same
954 action or an aggregate amount of $625,000 ~~$250,000~~ for all
955 willful violations arising out of the same action.
956 Section 14. Paragraphs (i) and (w) of subsection (1) of
957 section 626.9541, Florida Statutes, are amended to read:

958 626.9541 Unfair methods of competition and unfair or
959 deceptive acts or practices defined.—
960 (1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE
961 ACTS.—The following are defined as unfair methods of competition
962 and unfair or deceptive acts or practices:
963 (i) *Unfair claim settlement practices.*—
964 1. Attempting to settle claims on the basis of an
965 application, when serving as a binder or intended to become a
966 part of the policy, or any other material document which was
967 altered without notice to, or knowledge or consent of, the
968 insured;
969 2. A material misrepresentation made to an insured or any
970 other person having an interest in the proceeds payable under
971 such contract or policy, for the purpose and with the intent of
972 effecting settlement of such claims, loss, or damage under such
973 contract or policy on less favorable terms than those provided
974 in, and contemplated by, such contract or policy;
975 3. Committing or performing with such frequency as to
976 indicate a general business practice any of the following:
977 a. Failing to adopt and implement standards for the proper
978 investigation of claims;
979 b. Misrepresenting pertinent facts or insurance policy
980 provisions relating to coverages at issue;
981 c. Failing to acknowledge and act promptly upon
982 communications with respect to claims;
983 d. Denying claims without conducting reasonable
984 investigations based upon available information;
985 e. Failing to affirm or deny full or partial coverage of
986 claims, and, as to partial coverage, the dollar amount or extent


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987 of coverage, or failing to provide a written statement that the
988 claim is being investigated, upon the written request of the
989 insured within 30 days after proof-of-loss statements have been
990 completed;
991 f. Failing to promptly provide a reasonable explanation in
992 writing to the insured of the basis in the insurance policy, in
993 relation to the facts or applicable law, for denial of a claim
994 or for the offer of a compromise settlement;
995 g. Failing to promptly notify the insured of any additional
996 information necessary for the processing of a claim;
997 h. Failing to clearly explain the nature of the requested
998 information and the reasons why such information is necessary;
999 ~~or~~
1000 i. Failing to pay personal injury protection insurance
1001 claims within the time periods required by s. 627.736(4)(b). The
1002 office may order the insurer to pay restitution to a
1003 policyholder, medical provider, or other claimant, including
1004 interest at a rate consistent with the amount set forth in s.
1005 55.03(1), for the time period within which an insurer fails to
1006 pay claims as required by law. Restitution is in addition to any
1007 other penalties allowed by law, including, but not limited to,
1008 the suspension of the insurer's certificate of authority; or
1009 j. Altering or amending an insurance adjuster's report
1010 without:
1011 (I) Providing a detailed explanation as to why any change
1012 that has the effect of reducing the estimate of the loss was
1013 made; and
1014 (II) Including on the report or as an addendum to the
1015 report a detailed list of all changes made to the report and the



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1016 identity of the person who ordered each change; or
1017 (III) Retaining all versions of the report, and including
1018 within each such version, for each change made within such
1019 version of the report, the identity of each person who made or
1020 ordered such change; or
1021 4. Failing to pay undisputed amounts of partial or full
1022 benefits owed under first-party property insurance policies
1023 within 60 days after an insurer receives notice of a residential
1024 property insurance claim, determines the amounts of partial or
1025 full benefits, and agrees to coverage, unless payment of the
1026 undisputed benefits is prevented by factors beyond the control
1027 of the insurer as defined in s. 627.70131(5).
1028 (w) *Soliciting or accepting new or renewal insurance risks*
1029 *by insolvent or impaired insurer or receipt of certain bonuses*
1030 *by an officer or director of an insolvent insurer prohibited;*
1031 *penalty.*—
1032 1. Whether or not delinquency proceedings as to the insurer
1033 have been or are to be initiated, but while such insolvency or
1034 impairment exists, no director or officer of an insurer, except
1035 with the written permission of the office, shall authorize or
1036 permit the insurer to solicit or accept new or renewal insurance
1037 risks in this state after such director or officer knew, or
1038 reasonably should have known, that the insurer was insolvent or
1039 impaired.
1040 2. Regardless of whether delinquency proceedings as to the
1041 insurer have been or are to be initiated, but while such
1042 insolvency or impairment exists, a director or an officer of an
1043 impaired insurer may not receive a bonus from such insurer, nor
1044 may such director or officer receive a bonus from a holding

1045 company or an affiliate that shares common ownership or control
1046 with such insurer.
1047 3. As used in this paragraph, the term:
1048 a. “Bonus” means a payment, in addition to an officer’s or
1049 a director’s usual compensation, which is in addition to any
1050 amounts contracted for or otherwise legally due.
1051 b. “Impaired” includes impairment of capital or surplus, as
1052 defined in s. 631.011(12) and (13).
1053 4.~~2.~~ Any such director or officer, upon conviction of a
1054 violation of this paragraph, commits ~~is guilty of~~ a felony of
1055 the third degree, punishable as provided in s. 775.082, s.
1056 775.083, or s. 775.084.
1057 Section 15. Subsection (6) of section 626.989, Florida
1058 Statutes, is amended, and subsection (10) is added to that
1059 section, to read:
1060 626.989 Investigation by department or Division of
1061 Investigative and Forensic Services; compliance; immunity;
1062 confidential information; reports to division; division
1063 investigator’s power of arrest.—
1064 (6)(a) Any person, other than an insurer, agent, or other
1065 person licensed under the code, or an employee thereof, having
1066 knowledge or who believes that a fraudulent insurance act or any
1067 other act or practice which, upon conviction, constitutes a
1068 felony or a misdemeanor under the code, or under s. 817.234, is
1069 being or has been committed may send to the Division of
1070 Investigative and Forensic Services a report or information
1071 pertinent to such knowledge or belief and such additional
1072 information relative thereto as the department may request. Any
1073 professional practitioner licensed or regulated by the



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1074 Department of Business and Professional Regulation, except as
1075 otherwise provided by law, any medical review committee as
1076 defined in s. 766.101, any private medical review committee, and
1077 any insurer, agent, or other person licensed under the code, or
1078 an employee thereof, having knowledge or who believes that a
1079 fraudulent insurance act or any other act or practice which,
1080 upon conviction, constitutes a felony or a misdemeanor under the
1081 code, or under s. 817.234, is being or has been committed shall
1082 send to the Division of Investigative and Forensic Services a
1083 report or information pertinent to such knowledge or belief and
1084 such additional information relative thereto as the department
1085 may require.
1086 (b) The Division of Investigative and Forensic Services
1087 shall review such information or reports and select such
1088 information or reports as, in its judgment, may require further
1089 investigation. It shall then cause an independent examination of
1090 the facts surrounding such information or report to be made to
1091 determine the extent, if any, to which a fraudulent insurance
1092 act or any other act or practice which, upon conviction,
1093 constitutes a felony or a misdemeanor under the code, or under
1094 s. 817.234, is being committed.
1095 (c) The Division of Investigative and Forensic Services
1096 shall report any alleged violations of law which its
1097 investigations disclose to the appropriate licensing agency and
1098 state attorney or other prosecuting agency having jurisdiction,
1099 including, but not limited to, the statewide prosecutor for
1100 crimes that impact two or more judicial circuits in this state,
1101 with respect to any such violation, as provided in s. 624.310.
1102 ~~If prosecution by the state attorney or other prosecuting agency~~


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~~having jurisdiction with respect to such violation is not begun within 60 days of the division's report,~~ The state attorney or other prosecuting agency having jurisdiction with respect to such violation shall inform the division of any ~~the~~ reasons why prosecution of such violation was:

1. Not begun within 60 days after the division's report; or

2. Declined ~~for the lack of prosecution~~.

(10) The Division of Investigative and Forensic Services Bureau of Insurance Fraud shall prepare and submit a performance report to the President of the Senate and the Speaker of the House of Representatives by September 1 of each year. The annual report must include, but need not be limited to:

(a) 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.

(b) The number of referrals received from insurers, the office, and the Division of Consumer Services of the department, and the outcome of those referrals.

(c) 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.

(d) The number of investigations that resulted in a referral to a regulatory agency and the disposition of those referrals.

(e) The number of cases presented by the Bureau of Insurance Fraud which local prosecutors or the statewide prosecutor declined to prosecute and the reasons provided for

1132 declining prosecution.
1133 (f) A summary of the annual report required under s.
1134 626.9896.
1135 (g) The total number of employees assigned to the Bureau of
1136 Insurance Fraud, delineated by location of staff assigned, and
1137 the number and location of employees assigned to the Bureau of
1138 Insurance Fraud who were assigned to work other types of fraud
1139 cases.
1140 (h) The average caseload and turnaround time by type of
1141 case for each investigator.
1142 (i) The training provided during the year to insurance
1143 fraud investigators.
1144 Section 16. Subsections (1), (3), and (4) of section
1145 627.0629, Florida Statutes, are amended to read:
1146 627.0629 Residential property insurance; rate filings.—
1147 (1) It is the intent of the Legislature that insurers
1148 provide savings to consumers who install or implement windstorm
1149 damage mitigation techniques, alterations, or solutions to their
1150 properties to prevent windstorm losses. A rate filing for
1151 residential property insurance must include actuarially
1152 reasonable discounts, credits, or other rate differentials, or
1153 appropriate reductions in deductibles, for properties on which
1154 fixtures or construction techniques demonstrated to reduce the
1155 amount of loss in a windstorm have been installed or
1156 implemented. The fixtures or construction techniques must
1157 include, but are not limited to, fixtures or construction
1158 techniques that enhance roof strength, roof covering
1159 performance, roof-to-wall strength, wall-to-floor-to-foundation
1160 strength, opening protection, and window, door, and skylight



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strength. Credits, discounts, or other rate differentials, or appropriate reductions in deductibles, for fixtures and construction techniques that meet the minimum requirements of the Florida Building Code must be included in the rate filing. The office shall determine the discounts, credits, other rate differentials, and appropriate reductions in deductibles that reflect the full actuarial value of such revaluation, which may be used by insurers in rate filings. Effective October 1, 2023, each insurer subject to the requirements of this section must provide information on the insurer’s website describing the hurricane mitigation discounts available to policyholders. Such information must be accessible on, or through a hyperlink located on, the home page of the insurer’s website or the primary page of the insurer’s website for property insurance policyholders or applicants for such coverage in this state. On or before January 1, 2025, and every 5 years thereafter, the office shall reevaluate and update the fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm and the discounts, credits, other rate differentials, and appropriate reductions in deductibles that reflect the full actuarial value of such fixtures or construction techniques. The office shall adopt rules and forms necessitated by such reevaluation.

(3) A rate filing ~~made on or after July 1, 1995,~~ for mobile home owner insurance must include appropriate discounts, credits, or other rate differentials for mobile homes constructed to comply with American Society of Civil Engineers Standard ANSI/ASCE 7-88, adopted by the United States Department of Housing and Urban Development on July 13, 1994, and that also

1190 comply with all applicable tie-down requirements provided by
1191 state law.
1192 (4) The Legislature finds that separate consideration and
1193 notice of hurricane insurance premiums will assist consumers by
1194 providing greater assurance that hurricane premiums are lawful
1195 and by providing more complete information regarding the
1196 components of property insurance premiums. ~~Effective January 1,~~
1197 ~~1997,~~ A rate filing for residential property insurance shall be
1198 separated into two components, rates for hurricane coverage and
1199 rates for all other coverages. A premium notice reflecting a
1200 rate implemented on the basis of such a filing shall separately
1201 indicate the premium for hurricane coverage and the premium for
1202 all other coverages.
1203 Section 17. Paragraph (ll) is added to subsection (6) of
1204 section 627.351, Florida Statutes, to read:
1205 627.351 Insurance risk apportionment plans.—
1206 (6) CITIZENS PROPERTY INSURANCE CORPORATION.—
1207 <u>(ll) The corporation may not determine that a risk is</u>
1208 <u>ineligible for coverage with the corporation solely because such</u>
1209 <u>risk has unrepaired damage caused by a covered loss that is the</u>
1210 <u>subject of a claim that has been filed with the Florida</u>
1211 <u>Insurance Guaranty Association. This paragraph applies to a risk</u>
1212 <u>until the earlier of 24 months after the date the Florida</u>
1213 <u>Insurance Guaranty Association began servicing such claim or the</u>
1214 <u>Florida Insurance Guaranty Association closes the claim.</u>
1215 Section 18. Subsection (4) of section 627.410, Florida
1216 Statutes, is amended to read:
1217 627.410 Filing, approval of forms.—
1218 (4) The office may, by order, exempt from the requirements

1219 of this section for so long as it deems proper any insurance
1220 document or form or type thereof as specified in such order, to
1221 which, in its opinion, this section may not practicably be
1222 applied, or the filing and approval of which are, in its
1223 opinion, not desirable or necessary for the protection of the
1224 public. The office may not exempt from the requirements of this
1225 section the insurance documents or forms of any insurer, against
1226 whom the office enters a final order determining that such
1227 insurer violated any provision of this code, for a period of 36
1228 months after the date of such order, and may not be deemed
1229 approved under subsection (2).
1230 Section 19. Section 627.4108, Florida Statutes, is created
1231 to read:
1232 627.4108 Claims-handling manuals; submission; attestation.—
1233 (1) Each authorized residential property insurer conducting
1234 business in this state must create and use a claims-handling
1235 manual that provides guidelines and procedures and that complies
1236 with the requirements of this code and, at a minimum, comports
1237 to usual and customary industry claims-handling practices. Such
1238 manual must include guidelines and procedures for:
1239 (a) Initially receiving and acknowledging initial receipt
1240 of the claim and reviewing and evaluating the claim;
1241 (b) Communicating with policyholders, beginning with the
1242 receipt of the claim and continuing until closure of the claim;
1243 (c) Setting the claim reserve;
1244 (d) Investigating the claim, including conducting
1245 inspections of the property that is the subject of the claim;
1246 (e) Making preliminary estimates and estimates of the
1247 covered damages to the insured property and communicating such

1248 estimates to the policyholder;
1249 (f) The payment, partial payment, or denial of the claim
1250 and communicating such claim decision to the policyholder;
1251 (g) Closing claims; and
1252 (h) Any aspect of the claims-handling process which the
1253 office determines should be included in the claims-handling
1254 manual in order to:
1255 1. Comply with the laws of this state or rules or orders of
1256 the office or department;
1257 2. Ensure that the claims-handling manual, at a minimum,
1258 comports with usual and customary industry claims-handling
1259 guidelines; or
1260 3. Protect policyholders of the insurer or the general
1261 public.
1262 (2) At any time, the office may request that a residential
1263 property insurer submit a physical or electronic copy of the
1264 insurer's currently applicable, or otherwise specifically
1265 requested, claims-handling manuals. Upon receiving such a
1266 request, a residential property insurer must submit to the
1267 office within 5 business days:
1268 (a) A true and correct copy of each claims-handling manual
1269 requested; and
1270 (b) An attestation, on a form prescribed by the commission,
1271 that certifies:
1272 1. That the insurer has provided a true and correct copy of
1273 each currently applicable, or otherwise specifically requested,
1274 claims-handling manual; and
1275 2. The timeframe for which each submitted claims-handling
1276 manual was or is in effect.


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1277 (3)(a) Annually, each authorized residential property
1278 insurer must certify and attest, on a form prescribed by the
1279 commission, that:
1280 1. Each of the insurer's current claims-handling manuals
1281 complies with the requirements of this code and comports to, at
1282 a minimum, usual and customary industry claims-handling
1283 practices; and
1284 2. The insurer maintains adequate resources available to
1285 implement the requirements of each of its claims-handling
1286 manuals at all times, including during natural disasters and
1287 catastrophic events.
1288 (b) Such attestation must be submitted to the office:
1289 1. On or before August 1, 2023; and
1290 2. Annually thereafter, on or before May 1 of each calendar
1291 year.
1292 (4) The commission is authorized, and all conditions are
1293 deemed met, to adopt emergency rules under s. 120.54(4), for the
1294 purpose of implementing this section. Notwithstanding any other
1295 law, emergency rules adopted under this section are effective
1296 for 6 months after adoption and may be renewed during the
1297 pendency of procedures to adopt permanent rules addressing the
1298 subject of the emergency rules.
1299 Section 20. Paragraph (d) of subsection (2) of section
1300 627.4133, Florida Statutes, is amended to read:
1301 627.4133 Notice of cancellation, nonrenewal, or renewal
1302 premium.—
1303 (2) With respect to any personal lines or commercial
1304 residential property insurance policy, including, but not
1305 limited to, any homeowner, mobile home owner, farmowner,



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1306 condominium association, condominium unit owner, apartment
1307 building, or other policy covering a residential structure or
1308 its contents:
1309 (d)1. ~~Upon a declaration of an emergency pursuant to s.~~
1310 ~~252.36 and the filing of an order by the Commissioner of~~
1311 ~~Insurance Regulation,~~ An authorized insurer may not cancel or
1312 nonrenew a personal residential or commercial residential
1313 property insurance policy covering a dwelling or residential
1314 property located in this state:
1315 a. For a period of 90 days after the dwelling or
1316 residential property has been repaired, if such property ~~which~~
1317 has been damaged as a result of a hurricane or wind loss that is
1318 the subject of the declaration of emergency pursuant to s.
1319 252.36 and the filing of an order by the Commissioner of
1320 Insurance Regulation ~~for a period of 90 days after the dwelling~~
1321 ~~or residential property has been repaired~~. ~~A structure is deemed~~
1322 ~~to be repaired when substantially completed and restored to the~~
1323 ~~extent that it is insurable by another authorized insurer that~~
1324 ~~is writing policies in this state.~~
1325 b. Until the earlier of when the dwelling or residential
1326 property has been repaired or 1 year after the insurer issues
1327 the final claim payment, if such property was damaged by any
1328 covered peril and sub-subparagraph a. does not apply.
1329 2. However, an insurer or agent may cancel or nonrenew such
1330 a policy prior to the repair of the dwelling or residential
1331 property:
1332 a. Upon 10 days' notice for nonpayment of premium; or
1333 b. Upon 45 days' notice:
1334 (I) For a material misstatement or fraud related to the



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1335 claim;
1336 (II) If the insurer determines that the insured has
1337 unreasonably caused a delay in the repair of the dwelling; or
1338 (III) If the insurer has paid policy limits.
1339 3. If the insurer elects to nonrenew a policy covering a
1340 property that has been damaged, the insurer shall provide at
1341 least 90 days' notice to the insured that the insurer intends to
1342 nonrenew the policy 90 days after the dwelling or residential
1343 property has been repaired. Nothing in this paragraph shall
1344 prevent the insurer from canceling or nonrenewing the policy 90
1345 days after the repairs are complete for the same reasons the
1346 insurer would otherwise have canceled or nonrenewed the policy
1347 but for the limitations of subparagraph 1. The Financial
1348 Services Commission may adopt rules, and the Commissioner of
1349 Insurance Regulation may issue orders, necessary to implement
1350 this paragraph.
1351 4. This paragraph shall also apply to personal residential
1352 and commercial residential policies covering property that was
1353 damaged as the result of Hurricane Ian or Hurricane Nicole
1354 ~~Tropical Storm Bonnie, Hurricane Charley, Hurricane Frances,~~
1355 ~~Hurricane Ivan, or Hurricane Jeanne~~.
1356 5. For purposes of this paragraph:
1357 a. A structure is deemed to be repaired when substantially
1358 completed and restored to the extent that it is insurable by
1359 another authorized insurer writing policies in this state.
1360 b. The term "insurer" means an authorized insurer.
1361 Section 21. Paragraph (a) of subsection (10) of section
1362 627.701, Florida Statutes, is amended to read:
1363 627.701 Liability of insureds; coinsurance; deductibles.—



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1364 (10)(a) Notwithstanding any other provision of law, an
1365 insurer issuing a personal lines residential property insurance
1366 policy may include in such policy a separate roof deductible
1367 that meets all of the following requirements:
1368 1. The insurer has complied with the offer requirements
1369 under subsection (7) regarding a deductible applicable to losses
1370 from perils other than a hurricane.
1371 2. The roof deductible may not exceed the lesser of 2
1372 percent of the Coverage A limit of the policy or 50 percent of
1373 the cost to replace the roof.
1374 3. The premium that a policyholder is charged for the
1375 policy includes an actuarially sound credit or premium discount
1376 for the roof deductible.
1377 4. The roof deductible applies only to a claim adjusted on
1378 a replacement cost basis.
1379 5. The roof deductible does not apply to any of the
1380 following events:
1381 a. A total loss to a primary structure in accordance with
1382 the valued policy law under s. 627.702 which is caused by a
1383 covered peril.
1384 b. A roof loss resulting from a hurricane as defined in s.
1385 627.4025(2)(c).
1386 c. A roof loss resulting from a tree fall or other hazard
1387 that damages the roof and punctures the roof deck.
1388 d. A roof loss requiring the repair of less than 50 percent
1389 of the roof.
1390
1391 If a roof deductible is applied, no other deductible under the
1392 policy may be applied to the loss or to any other loss to the



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1393 property caused by the same covered peril.
1394 Section 22. Subsection (2) of section 627.70132, Florida
1395 Statutes, is amended to read:
1396 627.70132 Notice of property insurance claim.—
1397 (2) A claim or reopened claim, but not a supplemental
1398 claim, under an insurance policy that provides property
1399 insurance, as defined in s. 624.604, including a property
1400 insurance policy issued by an eligible surplus lines insurer,
1401 for loss or damage caused by any peril is barred unless notice
1402 of the claim was given to the insurer in accordance with the
1403 terms of the policy within 1 year after the date of loss. A
1404 supplemental claim is barred unless notice of the supplemental
1405 claim was given to the insurer in accordance with the terms of
1406 the policy within 18 months after the date of loss. The time
1407 limitations of this subsection are tolled during any term of
1408 deployment to a combat zone or combat support posting which
1409 materially affects the ability of a named insured who is a
1410 servicemember as defined in s. 250.01 to file a claim,
1411 supplemental claim, or reopened claim.
1412 Section 23. Chapter 2022-271, Laws of Florida, shall not be
1413 construed to impair any right under an insurance contract in
1414 effect on or before the effective date of that chapter law. To
1415 the extent that chapter 2022-271, Laws of Florida, affects a
1416 right under an insurance contract, that chapter law applies to
1417 an insurance contract issued or renewed after the applicable
1418 effective date provided by the chapter law. This section is
1419 intended to clarify existing law and is remedial in nature.
1420 Section 24. (1) Every residential property insurer and
1421 every motor vehicle insurer rate filing made or pending with the



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1422 Office of Insurance Regulation on or after July 1, 2023, must
1423 reflect the projected savings or reduction in claim frequency,
1424 claim severity, and loss adjustment expenses, including for
1425 attorney fees, payment of attorney fees to claimants, and any
1426 other reduction actuarially indicated, due to the combined
1427 effect of the applicable provisions of chapters 2021-77, 2022-
1428 268, 2022-271, and 2023-15, Laws of Florida, in order to ensure
1429 that rates for such insurance accurately reflect the risk of
1430 providing such insurance.
1431 (2) The Office of Insurance Regulation must consider in its
1432 review of such rate filings the projected savings or reduction
1433 in claim frequency, claim severity, and loss adjustment
1434 expenses, including for attorney fees, payment of attorney fees
1435 to claimants, and any other reduction actuarially indicated, due
1436 to the combined effect of the applicable provisions of chapters
1437 2021-77, 2022-268, 2022-271, and 2023-15, Laws of Florida. The
1438 office may develop methodology and data that incorporate
1439 generally accepted actuarial techniques and standards to be used
1440 in its review of rate filings governed by this section. The
1441 office may contract with an appropriate vendor to advise the
1442 office in developing such methodology and data to consider. Such
1443 methodology and data are not intended to create a mandatory
1444 minimum rate decrease for all residential property insurers and
1445 motor vehicle insurers, respectively, but rather to ensure that
1446 the rates for such coverage meet the requirements of s. 627.062,
1447 Florida Statutes, and thus are not excessive, inadequate, or
1448 unfairly discriminatory and allow such insurers a reasonable
1449 rate of return.
1450 (3) This section does not apply to rate filings made


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1451 pursuant to s. 627.062(2)(k), Florida Statutes.
1452 (4) For the 2023-2024 fiscal year, the sum of $500,000 in
1453 nonrecurring funds is appropriated from the Insurance Regulatory
1454 Trust Fund in the Department of Financial Services to the Office
1455 of Insurance Regulation to implement this section.
1456 Section 25. For the 2023-2024 fiscal year, 18 full-time
1457 equivalent positions with associated salary rate of 1,116,500
1458 are authorized and the sum of $1,879,129 in recurring funds and
1459 $185,086 in nonrecurring funds is appropriated from the
1460 Insurance Regulatory Trust Fund to the Office of Insurance
1461 Regulation to implement this act.
1462 Section 26. For the 2023-2024 fiscal year, seven full-time
1463 equivalent positions with associated salary rate of 350,000 are
1464 authorized and the sum of $574,036 in recurring funds and
1465 $33,467 in nonrecurring funds is appropriated from the Insurance
1466 Regulatory Trust Fund to the Department of Financial Services to
1467 implement this act.
1468 Section 27. This act shall take effect July 1, 2023.



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