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Proposed Committee Substitute by the Committee on Banking and Insurance

A bill to be entitled

An act relating to property insurance; amending s. 215.47, F.S.; authorizing the State Board of Administration to invest in certain revenue bonds under certain circumstances; amending s. 215.555, F.S.; revising the dates of an insurer's contract year for purposes of calculating the insurer's retention; requiring the State Board of Administration to offer an additional amount of reimbursement coverage to certain insurers that purchased coverage during a certain calendar year; requiring an insurer that purchases certain coverage to retain an amount equal to a percentage of the insurer's surplus on a certain date; providing that an insurer's retention will apply along with a mandatory coverage after an optional coverage is exhausted; revising an expiration date on the requirement for the State Board of Administration to offer certain optional coverage to insurers; revising the dates on which the State Board of Administration is required to publish a statement of the estimated borrowing capacity of the Hurricane Catastrophe Fund; authorizing the State Board of Administration to reimburse insurers based on a formula related to the claims-paying capacity of the Hurricane Catastrophe Fund; requiring the formula to determine an actuarially indicated premium to include specified cash build-up factors; authorizing insurers


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to purchase temporary increased coverage limit for certain future hurricane seasons; providing that a cash build-up factor does not apply to temporary increased coverage limit premiums; deleting authority for the State Board of Administration to increase the claims-paying capacity of the Hurricane Catastrophe Fund; amending s. 627.062, F.S.; revising the date by which certain filings for a rate increase must be made by a file and use filing; exempting certain rate filings from determination by the Office of Insurance Regulation that the rate in the rate filing is excessive or unfairly discriminatory; requiring the Office of Insurance Regulation to annually publish an inflation trend factor; exempting the inflation trend factor from the rulemaking requirements of chapter 120, Florida Statutes; authorizing an insurer that satisfies certain criteria to annually adjust rates based on the inflation trend factor; requiring the Office of Insurance Regulation to approve or disapprove the adoption of an inflation trend factor by an insurer within a certain period of time; amending s. 627.0621, F.S.; deleting a limitation on the application of the attorney-client privilege and work product doctrine in challenges to actions by the Office of Insurance Regulation relating to rate filings; amending s. 627.0629, F.S.; authorizing an insurer to include in its rates the actual cost of certain reinsurance; amending s. 627.351, F.S.; revising the date after which a seller of certain

residential property must disclose the structure's windstorm mitigation rating to the prospective purchaser of the property; requiring Citizen's Property Insurance Corporation to implement rate increases until the implementation of actuarially sound rates; requiring the corporation to transfer a portion of the funds received from the rate increase into the General Revenue Fund; revising the dates after which the State Board of Administration is required to reduce the boundaries of high-risk areas eligible for wind-only coverages under certain circumstances; amending s. 627.3512, F.S.; authorizing insurers to recoup assessments within a certain period; requiring insurers to file a final accounting report with the Office of Insurance Regulation which documents the assessment recouped; requiring the officer of the insurer who signs the report to acknowledge certain statements; prohibiting insurers that do not file the report from including the uncollected assessment amount in any subsequent rate filing; amending s. 627.712, F.S.; revising the properties for which an insurer must make policies available which exclude windstorm coverage; amending s. 631.57, F.S.; deleting provisions requiring certain insurers to submit certain information; amending s. 631.64, F.S.; authorizing insurers to recoup certain assessments; requiring the recoupment to begin within a certain period; limiting the recoupment factor; authorizing insurers to carry forward certain

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assessments that have not been recouped; requiring insurers to file a final accounting report with the Office of Insurance Regulation which documents the assessment recouped; requiring the officer of the insurer who signs the report to acknowledge certain statements; providing that all excess recoupment be sent to the Florida Insurance Guaranty Association; requiring that the insurer document the accounting of the over-recoupment in the final accounting report; authorizing the commission to adopt rules; repealing s. 627.0621, F.S., relating to a requirement for the Office of Insurance Regulation to publish certain rate filing information on the Internet; providing for the appropriation of certain transferred funds to the Insurance Regulatory Trust Fund for purposes of the My Safe Florida Home Program; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (20) is added to section 215.47, Florida Statutes, to read:

215.47 Investments; authorized securities; loan of securities.—Subject to the limitations and conditions of the State Constitution or of the trust agreement relating to a trust fund, moneys available for investments under ss. 215.44-215.53 may be invested as follows:

(20) The State Board of Administration may, consistent with sound investment policy, invest in revenue bonds issued pursuant

to s. 215.555(6).

Section 2. Paragraph (e) of subsection (2), subsection (4), paragraph (b) of subsection (5), and subsection (17) of section 215.555, Florida Statutes, are amended to read:

215.555 Florida Hurricane Catastrophe Fund.—

(2) DEFINITIONS.—As used in this section:

(e) "Retention" means the amount of losses below which an insurer is not entitled to reimbursement from the fund. An insurer's retention shall be calculated as follows:

1. The board shall calculate and report to each insurer the retention multiples for that year. For the contract year beginning June 1, 2005, the retention multiple shall be equal to $4.5 billion divided by the total estimated reimbursement premium for the contract year; for subsequent years, the retention multiple shall be equal to $4.5 billion, adjusted based upon the reported exposure from the prior contract year to reflect the percentage growth in exposure to the fund for covered policies since 2004, divided by the total estimated reimbursement premium for the contract year. Total reimbursement premium for purposes of the calculation under this subparagraph shall be estimated using the assumption that all insurers have selected the 90-percent coverage level. In 2010, the contract year begins June 1 and ends December 31, 2010. In 2011 and thereafter, the contract year begins January 1 and ends December 31.

2. The retention multiple as determined under subparagraph 1. shall be adjusted to reflect the coverage level elected by the insurer. For insurers electing the 90-percent coverage level, the adjusted retention multiple is 100 percent of the

amount determined under subparagraph 1. For insurers electing the 75-percent coverage level, the retention multiple is 120 percent of the amount determined under subparagraph 1. For insurers electing the 45-percent coverage level, the adjusted retention multiple is 200 percent of the amount determined under subparagraph 1.

3. An insurer shall determine its provisional retention by multiplying its provisional reimbursement premium by the applicable adjusted retention multiple and shall determine its actual retention by multiplying its actual reimbursement premium by the applicable adjusted retention multiple.

4. For insurers who experience multiple covered events causing loss during the contract year, beginning June 1, 2005, each insurer's full retention shall be applied to each of the covered events causing the two largest losses for that insurer. For each other covered event resulting in losses, the insurer's retention shall be reduced to one-third of the full retention. The reimbursement contract shall provide for the reimbursement of losses for each covered event based on the full retention with adjustments made to reflect the reduced retentions on or after January 1 of the contract year provided the insurer reports its losses as specified in the reimbursement contract.

(4) REIMBURSEMENT CONTRACTS.—

(a) The board shall enter into a contract with each insurer writing covered policies in this state to provide to the insurer the reimbursement described in paragraphs (b) and (d), in exchange for the reimbursement premium paid into the fund under subsection (5). As a condition of doing business in this state, each such insurer shall enter into such a contract.


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(b)1. The contract shall contain a promise by the board to reimburse the insurer for 45 percent, 75 percent, or 90 percent of its losses from each covered event in excess of the insurer's retention, plus 5 percent of the reimbursed losses to cover loss adjustment expenses.

2. The insurer must elect one of the percentage coverage levels specified in this paragraph and may, upon renewal of a reimbursement contract, elect a lower percentage coverage level if no revenue bonds issued under subsection (6) after a covered event are outstanding, or elect a higher percentage coverage level, regardless of whether or not revenue bonds are outstanding. All members of an insurer group must elect the same percentage coverage level. Any joint underwriting association, risk apportionment plan, or other entity created under s. 627.351 must elect the 90-percent coverage level.

3. The contract shall provide that reimbursement amounts shall not be reduced by reinsurance paid or payable to the insurer from other sources.

4. Notwithstanding any other provision contained in this section, the board shall make available to insurers that purchased coverage provided by this subparagraph in 2008 ~~2007~~, insurers qualifying as limited apportionment companies under s. 627.351(6)(c), and insurers that have been approved to participate in the Insurance Capital Build-Up Incentive Program pursuant to s. 215.5595 a contract or contract addendum that provides an additional amount of reimbursement coverage of up to $10 million. The premium to be charged for this additional reimbursement coverage shall be 50 percent of the additional reimbursement coverage provided, which shall include one prepaid

reinstatement. The minimum retention level that an eligible participating insurer must retain associated with this additional coverage layer is 30 percent of the insurer's surplus as of December 31, 2008 ~~December 31, 2007~~. This coverage shall be in addition to all other coverage that may be provided under this section. The coverage provided by the fund under this subparagraph shall be in addition to the claims-paying capacity as defined in subparagraph (c)1., but only with respect to those insurers that select the additional coverage option and meet the requirements of this subparagraph. The claims-paying capacity with respect to all other participating insurers and limited apportionment companies that do not select the additional coverage option shall be limited to their reimbursement premium's proportionate share of the actual claims-paying capacity otherwise defined in subparagraph (c)1. and as provided for under the terms of the reimbursement contract. Coverage provided in the reimbursement contract shall increase for insurers selecting this option, and the premium shall be treated as the premium for the mandatory coverage. The optional coverage retention as specified shall be accessed before the mandatory coverage under the reimbursement contract, but once the limit of coverage selected under this option is exhausted, the insurer's retention under the mandatory coverage will apply. This coverage will apply and be paid concurrently with mandatory coverage ~~not be affected by the additional premiums paid by participating insurers exercising the additional coverage option allowed in this subparagraph~~. This subparagraph expires on January 1, 2012 ~~May 31, 2009~~.

(c)1. The contract shall also provide that the obligation

of the board with respect to all contracts covering a particular contract year shall not exceed the actual claims-paying capacity of the fund up to a limit of $15 billion for that contract year adjusted based upon the reported exposure from the prior contract year to reflect the percentage growth in exposure to the fund for covered policies since 2003, provided the dollar growth in the limit may not increase in any year by an amount greater than the dollar growth of the balance of the fund as of December 31, less any premiums or interest attributable to optional coverage, as defined by rule which occurred over the prior calendar year.

2. In July ~~May before the start of the upcoming contract year~~ and ~~in~~ October of ~~during~~ the contract year, the board shall publish in the Florida Administrative Weekly a statement of the fund's estimated borrowing capacity and the projected balance of the fund as of December 31. After the end of each calendar year, the board shall notify insurers of the estimated borrowing capacity and the balance of the fund as of December 31 to provide insurers with data necessary to assist them in determining their retention and projected payout from the fund for loss reimbursement purposes. In conjunction with the development of the premium formula, as provided for in subsection (5), the board shall publish factors or multiples that assist insurers in determining their retention and projected payout for the next contract year. For all regulatory and reinsurance purposes, an insurer may calculate its projected payout from the fund as its share of the total fund premium for the current contract year multiplied by the sum of the projected balance of the fund as of December 31 and the estimated

borrowing capacity for that contract year as reported under this subparagraph.

(d)1. For purposes of determining potential liability and to aid in the sound administration of the fund, the contract shall require each insurer to report such insurer's losses from each covered event on an interim basis, as directed by the board. The contract shall require the insurer to report to the board no later than December 31 of each year, and quarterly thereafter, its reimbursable losses from covered events for the year. The contract shall require the board to determine and pay, as soon as practicable after receiving these reports of reimbursable losses, the initial amount of reimbursement due and adjustments to this amount based on later loss information. The adjustments to reimbursement amounts shall require the board to pay, or the insurer to return, amounts reflecting the most recent calculation of losses.

2. In determining reimbursements pursuant to this subsection, the contract shall provide that the board shall pay to each insurer such insurer's projected payout, which is the amount of reimbursement it is owed, up to an amount equal to the insurer's share of the actual premium paid for that contract year, multiplied by the actual claims-paying capacity available for that contract year.

3. The board may reimburse insurers for amounts up to the published factors or multiples for determining each participating insurer's retention and projected payout derived as a result of the development of the premium formula in those situations in which the total reimbursement of losses to such insurers would not exceed the estimated claims-paying capacity

of the fund. Otherwise, such factors or multiples shall be reduced uniformly among all insurers to reflect the estimated claims-paying capacity.

(e)1. Except as provided in subparagraphs 2. and 3., the contract shall provide that if an insurer demonstrates to the board that it is likely to qualify for reimbursement under the contract, and demonstrates to the board that the immediate receipt of moneys from the board is likely to prevent the insurer from becoming insolvent, the board shall advance the insurer, at market interest rates, the amounts necessary to maintain the solvency of the insurer, up to 50 percent of the board's estimate of the reimbursement due the insurer. The insurer's reimbursement shall be reduced by an amount equal to the amount of the advance and interest thereon.

2. With respect only to an entity created under s. 627.351, the contract shall also provide that the board may, upon application by such entity, advance to such entity, at market interest rates, up to 90 percent of the lesser of:

a. The board's estimate of the amount of reimbursement due to such entity; or

b. The entity's share of the actual reimbursement premium paid for that contract year, multiplied by the currently available liquid assets of the fund. In order for the entity to qualify for an advance under this subparagraph, the entity must demonstrate to the board that the advance is essential to allow the entity to pay claims for a covered event and the board must determine that the fund's assets are sufficient and are sufficiently liquid to allow the board to make an advance to the entity and still fulfill the board's reimbursement obligations

to other insurers. The entity's final reimbursement for any contract year in which an advance has been made under this subparagraph must be reduced by an amount equal to the amount of the advance and any interest on such advance. In order to determine what amounts, if any, are due the entity, the board may require the entity to report its exposure and its losses at any time to determine retention levels and reimbursements payable.

3. The contract shall also provide specifically and solely with respect to any limited apportionment company under s. 627.351(2)(b)3. that the board may, upon application by such company, advance to such company the amount of the estimated reimbursement payable to such company as calculated pursuant to paragraph (d), at market interest rates, if the board determines that the fund's assets are sufficient and are sufficiently liquid to permit the board to make an advance to such company and at the same time fulfill its reimbursement obligations to the insurers that are participants in the fund. Such company's final reimbursement for any contract year in which an advance pursuant to this subparagraph has been made shall be reduced by an amount equal to the amount of the advance and interest thereon. In order to determine what amounts, if any, are due to such company, the board may require such company to report its exposure and its losses at such times as may be required to determine retention levels and loss reimbursements payable.

(f) In order to ensure that insurers have properly reported the insured values on which the reimbursement premium is based and to ensure that insurers have properly reported the losses for which reimbursements have been made, the board shall

inspect, examine, and verify the records of each insurer's covered policies at such times as the board deems appropriate and according to standards established by rule for the specific purpose of validating the accuracy of exposures and losses required to be reported under the terms and conditions of the reimbursement contract. The costs of the examinations shall be borne by the board. However, in order to remove any incentive for an insurer to delay preparations for an examination, the board shall be reimbursed by the insurer for any examination expenses incurred in addition to the usual and customary costs of the examination, which additional expenses were incurred as a result of an insurer's failure, despite proper notice, to be prepared for the examination or as a result of an insurer's failure to provide requested information while the examination is in progress. If the board finds any insurer's records or other necessary information to be inadequate or inadequately posted, recorded, or maintained, the board may employ experts to reconstruct, rewrite, record, post, or maintain such records or information, at the expense of the insurer being examined, if such insurer has failed to maintain, complete, or correct such records or deficiencies after the board has given the insurer notice and a reasonable opportunity to do so. Any information contained in an examination report, which information is described in s. 215.557, is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution, as provided in s. 215.557. Nothing in this paragraph expands the exemption in s. 215.557.

(g) The contract shall provide that in the event of the insolvency of an insurer, the fund shall pay directly to the

Florida Insurance Guaranty Association for the benefit of Florida policyholders of the insurer the net amount of all reimbursement moneys owed to the insurer. As used in this paragraph, the term "net amount of all reimbursement moneys" means that amount which remains after reimbursement for:

1. Preliminary or duplicate payments owed to private reinsurers or other inuring reinsurance payments to private reinsurers that satisfy statutory or contractual obligations of the insolvent insurer attributable to covered events to such reinsurers; or

2. Funds owed to a bank or other financial institution to cover obligations of the insolvent insurer under a credit agreement that assists the insolvent insurer in paying claims attributable to covered events.

The private reinsurers, banks, or other financial institutions shall be reimbursed or otherwise paid prior to payment to the Florida Insurance Guaranty Association, notwithstanding any law to the contrary. The guaranty association shall pay all claims up to the maximum amount permitted by chapter 631; thereafter, any remaining moneys shall be paid pro rata to claims not fully satisfied. This paragraph does not apply to a joint underwriting association, risk apportionment plan, or other entity created under s. 627.351.

(5) REIMBURSEMENT PREMIUMS.—

(b) The State Board of Administration shall select an independent consultant to develop a formula for determining the actuarially indicated premium to be paid to the fund. The formula shall specify, for each zip code or other limited

geographical area, the amount of premium to be paid by an insurer for each $1,000 of insured value under covered policies in that zip code or other area. In establishing premiums, the board shall consider the coverage elected under paragraph (4)(b) and any factors that tend to enhance the actuarial sophistication of ratemaking for the fund, including deductibles, type of construction, type of coverage provided, relative concentration of risks, and other such factors deemed by the board to be appropriate. The formula must provide for a cash build-up factor. For the 2009-2010 contract year, the factor is 5 percent. For the contract year beginning June 1, 2010, and ending December 31, 2010, the factor is 10 percent. For the 2011 contract year, the factor is 15 percent. For the 2012 contract year, the factor is 20 percent. For the 2013 contract year and thereafter, the factor is 25 percent. The formula may provide for a procedure to determine the premiums to be paid by new insurers that begin writing covered policies after the beginning of a contract year, taking into consideration when the insurer starts writing covered policies, the potential exposure of the insurer, the potential exposure of the fund, the administrative costs to the insurer and to the fund, and any other factors deemed appropriate by the board. The formula must be approved by unanimous vote of the board. The board may, at any time, revise the formula pursuant to the procedure provided in this paragraph.

(17) TEMPORARY INCREASE IN COVERAGE LIMIT OPTIONS.—

(a) *Findings and intent.*—

1. The Legislature finds that:

a. Because of temporary disruptions in the market for

catastrophic reinsurance, many property insurers were unable to procure sufficient amounts of reinsurance for the 2006 hurricane season or were able to procure such reinsurance only by incurring substantially higher costs than in prior years.

b. The reinsurance market problems were responsible, at least in part, for substantial premium increases to many consumers and increases in the number of policies issued by Citizens Property Insurance Corporation.

c. It is likely that the reinsurance market disruptions will not significantly abate prior to the 2007 hurricane season.

2. It is the intent of the Legislature to create options for insurers to purchase a temporary increased coverage limit above the statutorily determined limit in subparagraph (4)(c)1., applicable for the 2007, 2008, ~~and~~ 2009<u>, 2010, 2011, 2012, and 2013</u> hurricane seasons, to address market disruptions and enable insurers, at their option, to procure additional coverage from the Florida Hurricane Catastrophe Fund.

(b) *Applicability of other provisions of this section.*—All provisions of this section and the rules adopted under this section apply to the coverage created by this subsection unless specifically superseded by provisions in this subsection.

(c) *Optional coverage.*—For the contract year commencing June 1, 2007, and ending May 31, 2008, the contract year commencing June 1, 2008, and ending May 31, 2009, ~~and~~ the contract year commencing June 1, 2009, and ending May 31, 2010, <u>the contract year commencing June 1, 2010, and ending December 31, 2010, the contract year commencing January 1, 2011, and ending December 31, 2011, the contract year commencing January 1, 2012, and ending December 31, 2012, and the contract year</u>

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commencing January 1, 2013, and ending December 31, 2013, the board shall offer, for each of such years, the optional coverage as provided in this subsection.

(d) *Additional definitions.*—As used in this subsection, the term:

1. "FHCF" means Florida Hurricane Catastrophe Fund.

2. "FHCF reimbursement premium" means the premium paid by an insurer for its coverage as a mandatory participant in the FHCF, but does not include additional premiums for optional coverages.

3. "Payout multiple" means the number or multiple created by dividing the statutorily defined claims-paying capacity as determined in subparagraph (4)(c)1. by the aggregate reimbursement premiums paid by all insurers estimated or projected as of calendar year-end.

4. "TICL" means the temporary increase in coverage limit.

5. "TICL options" means the temporary increase in coverage options created under this subsection.

6. "TICL insurer" means an insurer that has opted to obtain coverage under the TICL options addendum in addition to the coverage provided to the insurer under its FHCF reimbursement contract.

7. "TICL reimbursement premium" means the premium charged by the fund for coverage provided under the TICL option.

8. "TICL coverage multiple" means the coverage multiple when multiplied by an insurer's reimbursement premium that defines the temporary increase in coverage limit.

9. "TICL coverage" means the coverage for an insurer's losses above the insurer's statutorily determined claims-paying


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capacity based on the claims-paying limit in subparagraph (4)(c)1., which an insurer selects as its temporary increase in coverage from the fund under the TICL options selected. A TICL insurer's increased coverage limit options shall be calculated as follows:

a. The board shall calculate and report to each TICL insurer the TICL coverage multiples based on 12 options for increasing the insurer's FHCF coverage limit. Each TICL coverage multiple shall be calculated by dividing $1 billion, $2 billion, $3 billion, $4 billion, $5 billion, $6 billion, $7 billion, $8 billion, $9 billion, $10 billion, $11 billion, or $12 billion by the total estimated aggregate FHCF reimbursement premiums for the 2007-2008 contract year, and the 2008-2009 contract year~~, and the 2009-2010 contract year~~.

b. For the 2009-2010 contract year, the board shall calculate and report to each TICL insurer the TICL coverage multiples based on 10 options for increasing the insurer's FHCF coverage limit. Each TICL coverage multiple shall be calculated by dividing $1 billion, $2 billion, $3 billion, $4 billion, $5 billion, $6 billion, $7 billion, $8 billion, $9 billion, and $10 billion by the total estimated aggregate FHCF reimbursement premiums for the 2009-2010 contract year.

c. For the contract year beginning June 1, 2010, and ending December 31, 2010, the board shall calculate and report to each TICL insurer the TICL coverage multiples based on eight options for increasing the insurer's FHCF coverage limit. Each TICL coverage multiple shall be calculated by dividing $1 billion, $2 billion, $3 billion, $4 billion, $5 billion, $6 billion, $7 billion, and $8 billion by the total estimated aggregate FHCF

reimbursement premiums for the contract year.

d. For the 2011 contract year, the board shall calculate and report to each TICL insurer the TICL coverage multiples based on six options for increasing the insurer's FHCF coverage limit. Each TICL coverage multiple shall be calculated by dividing $1 billion, $2 billion, $3 billion, $4 billion, $5 billion, and $6 billion by the total estimated aggregate FHCF reimbursement premiums for the 2011 contract year.

e. For the 2012 contract year, the board shall calculate and report to each TICL insurer the TICL coverage multiples based on four options for increasing the insurer's FHCF coverage limit. Each TICL coverage multiple shall be calculated by dividing $1 billion, $2 billion, $3 billion, and $4 billion by the total estimated aggregate FHCF reimbursement premiums for the 2012 contract year.

f. For the 2013 contract year, the board shall calculate and report to each TICL insurer the TICL coverage multiples based on two options for increasing the insurer's FHCF coverage limit. Each TICL coverage multiple shall be calculated by dividing $1 billion and $2 billion by the total estimated aggregate FHCF reimbursement premiums for the 2013 contract year.

g.~~b.~~ The TICL insurer's increased coverage shall be the FHCF reimbursement premium multiplied by the TICL coverage multiple. In order to determine an insurer's total limit of coverage, an insurer shall add its TICL coverage multiple to its payout multiple. The total shall represent a number that, when multiplied by an insurer's FHCF reimbursement premium for a given reimbursement contract year, defines an insurer's total

limit of FHCF reimbursement coverage for that reimbursement contract year.

10. "TICL options addendum" means an addendum to the reimbursement contract reflecting the obligations of the fund and insurers selecting an option to increase an insurer's FHCF coverage limit.

(e) *TICL options addendum.*—

1. The TICL options addendum shall provide for reimbursement of TICL insurers for covered events occurring between June 1, 2007, and May 31, 2008, ~~and~~ between June 1, 2008, and May 31, 2009, ~~or~~ between June 1, 2009, and May 31, 2010, between June 1, 2010, and December 31, 2010, between January 1, 2011, and December 31, 2011, between January 1, 2012, and December 31, 2012, or between January 1, 2013, and December 31, 2013, in exchange for the TICL reimbursement premium paid into the fund under paragraph (f). Any insurer writing covered policies has the option of selecting an increased limit of coverage under the TICL options addendum and shall select such coverage at the time that it executes the FHCF reimbursement contract.

2. The TICL addendum shall contain a promise by the board to reimburse the TICL insurer for 45 percent, 75 percent, or 90 percent of its losses from each covered event in excess of the insurer's retention, plus 5 percent of the reimbursed losses to cover loss adjustment expenses. The percentage shall be the same as the coverage level selected by the insurer under paragraph (4)(b).

3. The TICL addendum shall provide that reimbursement amounts shall not be reduced by reinsurance paid or payable to


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the insurer from other sources.

4. The priorities, schedule, and method of reimbursements under the TICL addendum shall be the same as provided under subsection (4).

(f) *TICL reimbursement premiums.*—Each TICL insurer shall pay to the fund, in the manner and at the time provided in the reimbursement contract for payment of reimbursement premiums, a TICL reimbursement premium determined as specified in subsection (5), except that a cash build-up factor does not apply to the TICL reimbursement premiums. However, the TICL reimbursement premium shall be increased in contract year 2009-2010 by a factor of two, in the contract year beginning June 1, 2010, and ending December 31, 2010, by a factor of three, in the 2011 contract year by a factor of four, in the 2012 contract year by a factor of five, and in the 2013 contract year by a factor of six.

(g) *Effect on claims-paying capacity of the fund.*—For the contract terms commencing June 1, 2007, June 1, 2008, and June 1, 2009, the program created by this subsection shall increase the claims-paying capacity of the fund as provided in subparagraph (4)(c)1. by an amount not to exceed $12 billion and shall depend on the TICL coverage options selected and the number of insurers that select the TICL optional coverage. The additional capacity shall apply only to the additional coverage provided under the TICL options and shall not otherwise affect any insurer's reimbursement from the fund if the insurer chooses not to select the temporary option to increase its limit of coverage under the FHCF.

~~(h) *Increasing the claims-paying capacity of the fund.*—For~~

~~the contract years commencing June 1, 2007, June 1, 2008, and June 1, 2009, the board may increase the claims-paying capacity of the fund as provided in paragraph (g) by an amount not to exceed $4 billion in four $1 billion options and shall depend on the TICL coverage options selected and the number of insurers that select the TICL optional coverage. Each insurer's TICL premium shall be calculated based upon the additional limit of increased coverage that the insurer selects. Such limit is determined by multiplying the TICL multiple associated with one of the four options times the insurer's FHCF reimbursement premium. The reimbursement premium associated with the additional coverage provided in this paragraph shall be determined as specified in subsection (5).~~

Section 3. Subsections (2) and (5) of section 627.062, Florida Statutes, is amended to read:

627.062 Rate standards.—

(2) As to all such classes of insurance:

(a) Insurers or rating organizations shall establish and use rates, rating schedules, or rating manuals to allow the insurer a reasonable rate of return on such classes of insurance written in this state. A copy of rates, rating schedules, rating manuals, premium credits or discount schedules, and surcharge schedules, and changes thereto, shall be filed with the office under one of the following procedures except as provided in subparagraph 3.:

1. If the filing is made at least 90 days before the proposed effective date and the filing is not implemented during the office's review of the filing and any proceeding and judicial review, then such filing shall be considered a "file

and use" filing. In such case, the office shall finalize its review by issuance of a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing. The notice of intent to approve and the notice of intent to disapprove constitute agency action for purposes of the Administrative Procedure Act. Requests for supporting information, requests for mathematical or mechanical corrections, or notification to the insurer by the office of its preliminary findings shall not toll the 90-day period during any such proceedings and subsequent judicial review. The rate shall be deemed approved if the office does not issue a notice of intent to approve or a notice of intent to disapprove within 90 days after receipt of the filing.

2. If the filing is not made in accordance with the provisions of subparagraph 1., such filing shall be made as soon as practicable, but no later than 30 days after the effective date, and shall be considered a "use and file" filing. An insurer making a "use and file" filing is potentially subject to an order by the office to return to policyholders portions of rates found to be excessive, as provided in paragraph (h).

3. For all property insurance filings made or submitted before December 31, 2010 ~~after January 25, 2007, but before December 31, 2009~~, an insurer seeking a rate that is greater than the rate most recently approved by the office shall make a "file and use" filing. For purposes of this subparagraph, motor vehicle collision and comprehensive coverages are not considered to be property coverages.

(b) Upon receiving a rate filing, the office shall review the rate filing to determine if a rate is excessive, inadequate,

or unfairly discriminatory, except as provided in paragraph (k) or paragraph (l). In making that determination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, consider the following factors:

1. Past and prospective loss experience within and without this state.

2. Past and prospective expenses.

3. The degree of competition among insurers for the risk insured.

4. Investment income reasonably expected by the insurer, consistent with the insurer's investment practices, from investable premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves. The commission may adopt rules using reasonable techniques of actuarial science and economics to specify the manner in which insurers shall calculate investment income attributable to such classes of insurance written in this state and the manner in which such investment income shall be used to calculate insurance rates. Such manner shall contemplate allowances for an underwriting profit factor and full consideration of investment income which produce a reasonable rate of return; however, investment income from invested surplus may not be considered.

5. The reasonableness of the judgment reflected in the filing.

6. Dividends, savings, or unabsorbed premium deposits allowed or returned to Florida policyholders, members, or subscribers.

7. The adequacy of loss reserves.


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8. The cost of reinsurance. The office shall not disapprove a rate as excessive solely due to the insurer having obtained catastrophic reinsurance to cover the insurer's estimated 250-year probable maximum loss or any lower level of loss.

9. Trend factors, including trends in actual losses per insured unit for the insurer making the filing.

10. Conflagration and catastrophe hazards, if applicable.

11. Projected hurricane losses, if applicable, which must be estimated using a model or method found to be acceptable or reliable by the Florida Commission on Hurricane Loss Projection Methodology, and as further provided in s. 627.0628.

12. A reasonable margin for underwriting profit and contingencies.

13. The cost of medical services, if applicable.

14. Other relevant factors which impact upon the frequency or severity of claims or upon expenses.

(c) In the case of fire insurance rates, consideration shall be given to the availability of water supplies and the experience of the fire insurance business during a period of not less than the most recent 5-year period for which such experience is available.

(d) If conflagration or catastrophe hazards are given consideration by an insurer in its rates or rating plan, including surcharges and discounts, the insurer shall establish a reserve for that portion of the premium allocated to such hazard and shall maintain the premium in a catastrophe reserve. Any removal of such premiums from the reserve for purposes other than paying claims associated with a catastrophe or purchasing reinsurance for catastrophes shall be subject to approval of the

office. Any ceding commission received by an insurer purchasing reinsurance for catastrophes shall be placed in the catastrophe reserve.

(e) After consideration of the rate factors provided in paragraphs (b), (c), and (d), a rate may be found by the office to be excessive, inadequate, or unfairly discriminatory based upon the following standards:

1. Rates shall be deemed excessive if they are likely to produce a profit from Florida business that is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.

2. Rates shall be deemed excessive if, among other things, the rate structure established by a stock insurance company provides for replenishment of surpluses from premiums, when the replenishment is attributable to investment losses.

3. Rates shall be deemed inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply.

4. A rating plan, including discounts, credits, or surcharges, shall be deemed unfairly discriminatory if it fails to clearly and equitably reflect consideration of the policyholder’s participation in a risk management program adopted pursuant to s. 627.0625.

5. A rate shall be deemed inadequate as to the premium charged to a risk or group of risks if discounts or credits are allowed which exceed a reasonable reflection of expense savings and reasonably expected loss experience from the risk or group of risks.


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6. A rate shall be deemed unfairly discriminatory as to a risk or group of risks if the application of premium discounts, credits, or surcharges among such risks does not bear a reasonable relationship to the expected loss and expense experience among the various risks.

(f) In reviewing a rate filing, the office may require the insurer to provide at the insurer's expense all information necessary to evaluate the condition of the company and the reasonableness of the filing according to the criteria enumerated in this section.

(g) The office may at any time review a rate, rating schedule, rating manual, or rate change; the pertinent records of the insurer; and market conditions. If the office finds on a preliminary basis that a rate may be excessive, inadequate, or unfairly discriminatory, the office shall initiate proceedings to disapprove the rate and shall so notify the insurer. However, the office may not disapprove as excessive any rate for which it has given final approval or which has been deemed approved for a period of 1 year after the effective date of the filing unless the office finds that a material misrepresentation or material error was made by the insurer or was contained in the filing. Upon being so notified, the insurer or rating organization shall, within 60 days, file with the office all information which, in the belief of the insurer or organization, proves the reasonableness, adequacy, and fairness of the rate or rate change. The office shall issue a notice of intent to approve or a notice of intent to disapprove pursuant to the procedures of paragraph (a) within 90 days after receipt of the insurer's initial response. In such instances and in any administrative

proceeding relating to the legality of the rate, the insurer or rating organization shall carry the burden of proof by a preponderance of the evidence to show that the rate is not excessive, inadequate, or unfairly discriminatory. After the office notifies an insurer that a rate may be excessive, inadequate, or unfairly discriminatory, unless the office withdraws the notification, the insurer shall not alter the rate except to conform with the office's notice until the earlier of 120 days after the date the notification was provided or 180 days after the date of the implementation of the rate. The office may, subject to chapter 120, disapprove without the 60-day notification any rate increase filed by an insurer within the prohibited time period or during the time that the legality of the increased rate is being contested.

(h) In the event the office finds that a rate or rate change is excessive, inadequate, or unfairly discriminatory, the office shall issue an order of disapproval specifying that a new rate or rate schedule which responds to the findings of the office be filed by the insurer. The office shall further order, for any "use and file" filing made in accordance with subparagraph (a)2., that premiums charged each policyholder constituting the portion of the rate above that which was actuarially justified be returned to such policyholder in the form of a credit or refund. If the office finds that an insurer's rate or rate change is inadequate, the new rate or rate schedule filed with the office in response to such a finding shall be applicable only to new or renewal business of the insurer written on or after the effective date of the responsive filing.

(i) Except as otherwise specifically provided in this chapter, the office shall not prohibit any insurer, including any residual market plan or joint underwriting association, from paying acquisition costs based on the full amount of premium, as defined in s. 627.403, applicable to any policy, or prohibit any such insurer from including the full amount of acquisition costs in a rate filing.

(j) With respect to residential property insurance rate filings, the rate filing must account for mitigation measures undertaken by policyholders to reduce hurricane losses.

(k) Notwithstanding any other provision of this section:

1. A rate filing for residential property insurance relating to rate changes, rating factors, territories, classification, discounts, credits, or similar matters with respect to any policy form, including endorsements issued with the form, is exempt from a determination by the office that the rate is excessive or unfairly discriminatory under s. 627.062 if:

a. All changes specified in the filing do not result in an increase from the insurer's rates then in effect of more than the rate increase authorized by s. 627.0629(5), plus the actual additional cost paid due to the application of s. 215.555(17)(f), plus the actual additional cost paid due to the application by the Florida Hurricane Catastrophe Fund of a cash buildup factor pursuant to s. 215.555(5)(b); and

b. All changes specified in the filing do not result in an overall premium increase of more than 10 percent statewide, and 12 percent for an individual policyholder, for reasons related solely to the rate change.


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2. An insurer that submits a filing pursuant to this paragraph shall include a copy of the reinsurance contract, proof of the billing or payment for the contract, and the calculations upon which the rate change is based.

3. A rate filing is not exempt under subparagraph 1. if the filing exceeds the overall premium increases authorized under subparagraph 1. in any 12-month period. An insurer must proceed under other provisions of this section or other provisions of law if the insurer seeks to exceed the premium or rate limitations of subparagraph 1.

4. This paragraph does not limit the authority of the office to disapprove a rate as inadequate or to disapprove a filing for the use of unfairly discriminatory rating factors pursuant to s. 626.9541. An insurer that elects to implement a rate change under this paragraph must file its rate filing with the office at least 40 days before the effective date of the rate change. The office shall have 30 days after the date that the rate filing is submitted to review the filing and determine if the rate is inadequate or uses unfairly discriminatory rating factors. Absent a finding by the office within the 30-day period that the rate is inadequate or that the insurer has used unfairly discriminatory rating factors, the filing is deemed approved. If the office finds during the 30-day period that the filing will result in inadequate premiums or otherwise endanger the insurer’s solvency, the rate increase shall proceed pending additional action by the office to ensure the adequacy of the rate.

5. This paragraph does not apply to rate filings for any insurance other than residential property insurance.

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(l) Beginning January 2010, the office shall publish an annual informational memorandum to establish an inflation trend factor for residential property insurance representing an estimate of cost increases based on industry-wide data available from the Insurance Services Office or other public source. Such factor is exempt from the rulemaking requirement of chapter 120 and an insurer is not required to adopt the factor. An insurer making an annual filing to adopt the factor shall adjust its rates based solely upon the inflation trend factor to increase statewide rates in an amount equal to the inflation trend factor or 5 percent, whichever is less. Any rate increase implemented pursuant to this paragraph may not exceed 8 percent for any policyholder. An insurer is eligible to adopt the inflation trend factor if it has not implemented a rate increase within the 6 months preceding the inflation trend factor filing. An insurer adopting the inflation trend factor is not eligible to make another inflation trend factor filing to increase rates for the same program for 12 months after the inflation trend factor filing is implemented. The information required for the inflation trend factor filing shall be limited to rates and rating examples and an explanation demonstrating the insurer's eligibility to adopt the inflation trend factor. The office must approve or disapprove the adoption of the inflation trend factor based on the criteria in this subsection within 30 days of receipt of a complete filing. This paragraph applies only to residential property insurance.

The provisions of this subsection do ~~shall~~ not apply to workers' compensation and employer's liability insurance and to motor

vehicle insurance.

(5) With respect to a rate filing involving coverage of the type for which the insurer is required to pay a reimbursement premium to the Florida Hurricane Catastrophe Fund, the insurer may fully recoup in its property insurance premiums any reimbursement premiums paid to the Florida Hurricane Catastrophe Fund, together with reasonable costs of other reinsurance, but except as otherwise provided in this section, may not recoup reinsurance costs that duplicate coverage provided by the Florida Hurricane Catastrophe Fund. An insurer may not recoup more than 1 year of reimbursement premium at a time. Any under-recoupment from the prior year may be added to the following year's reimbursement premium and any over-recoupment shall be subtracted from the following year's reimbursement premium.

Section 4. Section 627.0621, Florida Statutes, is amended to read:

627.0621 Transparency in rate regulation.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Rate filing" means any original or amended rate residential property insurance filing.

(b) "Recommendation" means any proposed, preliminary, or final recommendation from an office actuary reviewing a rate filing with respect to the issue of approval or disapproval of the rate filing or with respect to rate indications that the office would consider acceptable.

(2) WEBSITE FOR PUBLIC ACCESS TO RATE FILING INFORMATION.—With respect to any rate filing made on or after July 1, 2008, the office shall provide the following information on a publicly accessible Internet website:


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(a) The overall rate change requested by the insurer.

(b) All assumptions made by the office's actuaries.

(c) A statement describing any assumptions or methods that deviate from the actuarial standards of practice of the Casualty Actuarial Society or the American Academy of Actuaries, including an explanation of the nature, rationale, and effect of the deviation.

(d) All recommendations made by any office actuary who reviewed the rate filing.

(e) Certification by the office's actuary that, based on the actuary's knowledge, his or her recommendations are consistent with accepted actuarial principles.

(f) The overall rate change approved by the office.

~~(3) ATTORNEY-CLIENT PRIVILEGE; WORK PRODUCT.—It is the intent of the Legislature that the principles of the public records and open meetings laws apply to the assertion of attorney-client privilege and work product confidentiality by the office in connection with a challenge to its actions on a rate filing. Therefore, in any administrative or judicial proceeding relating to a rate filing, attorney-client privilege and work product exemptions from disclosure do not apply to communications with office attorneys or records prepared by or at the direction of an office attorney, except when the conditions of paragraphs (a) and (b) have been met:~~

~~(a) The communication or record reflects a mental impression, conclusion, litigation strategy, or legal theory of the attorney or office that was prepared exclusively for civil or criminal litigation or adversarial administrative proceedings.~~


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~~(b) The communication occurred or the record was prepared after the initiation of an action in a court of competent jurisdiction, after the issuance of a notice of intent to deny a rate filing, or after the filing of a request for a proceeding under ss. 120.569 and 120.57.~~

Section 5. Subsection (5) of section 627.0629, Florida Statutes, is amended to read:

627.0629 Residential property insurance; rate filings.—

(5) In order to provide an appropriate transition period, an insurer may, in its sole discretion, implement an approved rate filing for residential property insurance over a period of years. An insurer electing to phase in its rate filing must provide an informational notice to the office setting out its schedule for implementation of the phased-in rate filing. An insurer may include in its rate the actual cost of reinsurance that duplicates available coverage of the Temporary Increase in Coverage Limits, TICL, from the Florida Hurricane Catastrophe Fund. The insurer may include the cost of reinsurance in its rate even if the insurer does not purchase the TICL layer. However, this cost for reinsurance may not include any expense or profit load or result in a total annual base rate increase in excess of 10 percent.

Section 6. Paragraphs (a), (m), and (x) of subsection (6) of section 627.351, Florida Statutes, are amended to read:

627.351 Insurance risk apportionment plans.—

(6) CITIZENS PROPERTY INSURANCE CORPORATION.—

(a)1. It is the public purpose of this subsection to ensure the existence of an orderly market for property insurance for Floridians and Florida businesses. The Legislature finds that


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private insurers are unwilling or unable to provide affordable property insurance coverage in this state to the extent sought and needed. The absence of affordable property insurance threatens the public health, safety, and welfare and likewise threatens the economic health of the state. The state therefore has a compelling public interest and a public purpose to assist in assuring that property in the state is insured and that it is insured at affordable rates so as to facilitate the remediation, reconstruction, and replacement of damaged or destroyed property in order to reduce or avoid the negative effects otherwise resulting to the public health, safety, and welfare, to the economy of the state, and to the revenues of the state and local governments which are needed to provide for the public welfare. It is necessary, therefore, to provide affordable property insurance to applicants who are in good faith entitled to procure insurance through the voluntary market but are unable to do so. The Legislature intends by this subsection that affordable property insurance be provided and that it continue to be provided, as long as necessary, through Citizens Property Insurance Corporation, a government entity that is an integral part of the state, and that is not a private insurance company. To that end, Citizens Property Insurance Corporation shall strive to increase the availability of affordable property insurance in this state, while achieving efficiencies and economies, and while providing service to policyholders, applicants, and agents which is no less than the quality generally provided in the voluntary market, for the achievement of the foregoing public purposes. Because it is essential for this government entity to have the maximum financial resources

to pay claims following a catastrophic hurricane, it is the intent of the Legislature that Citizens Property Insurance Corporation continue to be an integral part of the state and that the income of the corporation be exempt from federal income taxation and that interest on the debt obligations issued by the corporation be exempt from federal income taxation.

2. The Residential Property and Casualty Joint Underwriting Association originally created by this statute shall be known, as of July 1, 2002, as the Citizens Property Insurance Corporation. The corporation shall provide insurance for residential and commercial property, for applicants who are in good faith entitled, but are unable, to procure insurance through the voluntary market. The corporation shall operate pursuant to a plan of operation approved by order of the Financial Services Commission. The plan is subject to continuous review by the commission. The commission may, by order, withdraw approval of all or part of a plan if the commission determines that conditions have changed since approval was granted and that the purposes of the plan require changes in the plan. The corporation shall continue to operate pursuant to the plan of operation approved by the Office of Insurance Regulation until October 1, 2006. For the purposes of this subsection, residential coverage includes both personal lines residential coverage, which consists of the type of coverage provided by homeowner’s, mobile home owner’s, dwelling, tenant’s, condominium unit owner’s, and similar policies, and commercial lines residential coverage, which consists of the type of coverage provided by condominium association, apartment building, and similar policies.


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3. Effective January 1, 2009, a personal lines residential structure that has a dwelling replacement cost of $2 million or more, or a single condominium unit that has a combined dwelling and content replacement cost of $2 million or more is not eligible for coverage by the corporation. Such dwellings insured by the corporation on December 31, 2008, may continue to be covered by the corporation until the end of the policy term. However, such dwellings that are insured by the corporation and become ineligible for coverage due to the provisions of this subparagraph may reapply and obtain coverage if the property owner provides the corporation with a sworn affidavit from one or more insurance agents, on a form provided by the corporation, stating that the agents have made their best efforts to obtain coverage and that the property has been rejected for coverage by at least one authorized insurer and at least three surplus lines insurers. If such conditions are met, the dwelling may be insured by the corporation for up to 3 years, after which time the dwelling is ineligible for coverage. The office shall approve the method used by the corporation for valuing the dwelling replacement cost for the purposes of this subparagraph. If a policyholder is insured by the corporation prior to being determined to be ineligible pursuant to this subparagraph and such policyholder files a lawsuit challenging the determination, the policyholder may remain insured by the corporation until the conclusion of the litigation.

4. It is the intent of the Legislature that policyholders, applicants, and agents of the corporation receive service and treatment of the highest possible level but never less than that generally provided in the voluntary market. It also is intended

that the corporation be held to service standards no less than those applied to insurers in the voluntary market by the office with respect to responsiveness, timeliness, customer courtesy, and overall dealings with policyholders, applicants, or agents of the corporation.

5. Effective January 1, 2009, a personal lines residential structure that is located in the "wind-borne debris region," as defined in s. 1609.2, International Building Code (2006), and that has an insured value on the structure of $750,000 or more is not eligible for coverage by the corporation unless the structure has opening protections as required under the Florida Building Code for a newly constructed residential structure in that area. A residential structure shall be deemed to comply with the requirements of this subparagraph if it has shutters or opening protections on all openings and if such opening protections complied with the Florida Building Code at the time they were installed. Effective January 1, 2012 ~~January 1, 2010~~, for personal lines residential property insured by the corporation that is located in the wind-borne debris region and has an insured value on the structure of $500,000 or more, a prospective purchaser of any such residential property must be provided by the seller a written disclosure that contains the structure's windstorm mitigation rating based on the uniform home grading scale adopted under s. 215.55865. Such rating shall be provided to the purchaser at or before the time the purchaser executes a contract for sale and purchase.

(m)1. Rates for coverage provided by the corporation shall be actuarially sound and subject to the requirements of s. 627.062, except as otherwise provided in this paragraph. The


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corporation shall file its recommended rates with the office at least annually. The corporation shall provide any additional information regarding the rates which the office requires. The office shall consider the recommendations of the board and issue a final order establishing the rates for the corporation within 45 days after the recommended rates are filed. The corporation may not pursue an administrative challenge or judicial review of the final order of the office.

2. In addition to the rates otherwise determined pursuant to this paragraph, the corporation shall impose and collect an amount equal to the premium tax provided for in s. 624.509 to augment the financial resources of the corporation.

3. After the public hurricane loss-projection model under s. 627.06281 has been found to be accurate and reliable by the Florida Commission on Hurricane Loss Projection Methodology, that model shall serve as the minimum benchmark for determining the windstorm portion of the corporation's rates. This subparagraph does not require or allow the corporation to adopt rates lower than the rates otherwise required or allowed by this paragraph.

4. The rate filings for the corporation which were approved by the office and which took effect January 1, 2007, are rescinded, except for those rates that were lowered. As soon as possible, the corporation shall begin using the lower rates that were in effect on December 31, 2006, and shall provide refunds to policyholders who have paid higher rates as a result of that rate filing. The rates in effect on December 31, 2006, shall remain in effect for the 2007 and 2008 calendar years except for any rate change that results in a lower rate. The next rate

change that may increase rates shall take effect pursuant to a new rate filing recommended by the corporation and established by the office, subject to the requirements of this paragraph.

5. Beginning on July 15, 2009, and each year thereafter, the corporation must make a recommended actuarially sound rate filing for each personal and commercial line of business it writes, to be effective no earlier than January 1, 2010.

6. Notwithstanding the board's recommended rates and the office's final order regarding the corporation's filed rates under subparagraph 1., the corporation shall implement a rate increase each year which does not exceed 10 percent for any single policy issued by the corporation, adjusted for exposure change. The corporation may also implement an increase to reflect the effect on the corporation of the cash buildup factor pursuant to s. 215.555(5)(b).

7. The corporation's implementation of rates as prescribed in subparagraph 6. shall cease upon the corporation's implementation of actuarially sound rates.

8. Beginning January 1, 2010, and each year thereafter, the corporation shall transfer 10 percent of the funds received from the rate increase prescribed by subparagraph 6. to the General Revenue Fund. The corporation's transfer of such funds shall cease upon the corporation's implementation of actuarially sound rates.

(x) It is the intent of the Legislature that the amendments to this subsection enacted in 2002 should, over time, reduce the probable maximum windstorm losses in the residual markets and should reduce the potential assessments to be levied on property insurers and policyholders statewide. In furtherance of this


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intent:

1. The board shall, on or before February 1 of each year, provide a report to the President of the Senate and the Speaker of the House of Representatives showing the reduction or increase in the 100-year probable maximum loss attributable to wind-only coverages and the quota share program under this subsection combined, as compared to the benchmark 100-year probable maximum loss of the Florida Windstorm Underwriting Association. For purposes of this paragraph, the benchmark 100-year probable maximum loss of the Florida Windstorm Underwriting Association shall be the calculation dated February 2001 and based on November 30, 2000, exposures. In order to ensure comparability of data, the board shall use the same methods for calculating its probable maximum loss as were used to calculate the benchmark probable maximum loss.

2. Beginning February 1, 2013 ~~February 1, 2010~~, if the report under subparagraph 1. for any year indicates that the 100-year probable maximum loss attributable to wind-only coverages and the quota share program combined does not reflect a reduction of at least 25 percent from the benchmark, the board shall reduce the boundaries of the high-risk area eligible for wind-only coverages under this subsection in a manner calculated to reduce such probable maximum loss to an amount at least 25 percent below the benchmark.

3. Beginning February 1, 2018 ~~February 1, 2015~~, if the report under subparagraph 1. for any year indicates that the 100-year probable maximum loss attributable to wind-only coverages and the quota share program combined does not reflect a reduction of at least 50 percent from the benchmark, the

boundaries of the high-risk area eligible for wind-only coverages under this subsection shall be reduced by the elimination of any area that is not seaward of a line 1,000 feet inland from the Intracoastal Waterway.

Section 7. Section 627.3512, Florida Statutes, is amended to read:

627.3512 Recoupment of residual market deficit assessments.—

(1) An insurer or insurer group may recoup any assessments that have been paid during or after 1995 by the insurer or insurer group to defray deficits of an insurance risk apportionment plan or assigned risk plan under ss. 627.311 and 627.351, net of any earnings returned to the insurer or insurer group by the association or plan for any year after 1993. The insurer or insurer group shall begin the recoupment process within 180 days after the date of the assessment as indicated on the invoice received by the insurer or insurer group. An insurer that fails to begin the recoupment process within 180 days after the date of the assessment may not recoup the amount assessed. ~~A limited apportionment company as defined in s. 627.351(6)(c) may recoup any regular assessment that has been levied by, or paid to, Citizens Property Insurance Corporation.~~

(2) The recoupment shall be made by applying a separate recoupment ~~assessment~~ factor on policies of the same line or type as were considered by the residual markets in determining the assessment liability of the insurer or insurer group. An insurer or insurer group shall calculate a separate assessment factor for personal lines and commercial lines. ~~The separate assessment factor shall provide for full recoupment of the~~


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~~assessments over a period of 1 year, unless the insurer or insurer group, at its option, elects to recoup the assessments over a longer period. The assessment factor expires upon collection of the full amount allowed to be recouped.~~ Amounts recouped under this section are not subject to premium taxes, fees, or commissions.

(3)~~(2)~~ The recoupment ~~assessment~~ factor may ~~must~~ not be more than 3 percentage points above the ratio of the deficit assessment to the Florida direct written premium for policies for the lines or types of business as to which the assessment was calculated~~, as written in the year the deficit assessment was paid~~. If an insurer or insurer group fails to collect the full amount of the deficit assessment within a 1-year period, the insurer or insurer group may ~~must~~ carry forward the amount of the deficit and adjust the deficit assessment to be recouped in the ~~a~~ subsequent year ~~by that amount~~. The insurer or insurer group shall adjust the recoupment factor to be applied for the subsequent year. The insurer or insurer group may not apply any recoupment factor in a manner that is unfairly discriminatory among its policyholders within the same lines, types, or sublines of business.

(4)~~(3)~~ The insurer or insurer group shall file with the office a statement setting forth the amount of the assessment factor and an explanation of how the factor will be applied, at least 15 days prior to the factor being applied to any policies. The statement shall include documentation of the assessment paid by the insurer or insurer group and the arithmetic calculations supporting the assessment factor. The office shall complete its review within 30 ~~15~~ days after receipt of the filing and shall


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limit its review to verification of the arithmetic calculations. The insurer or insurer group may use the assessment factor at any time after the expiration of the 30-day ~~15-day~~ period unless the office has notified the insurer or insurer group in writing that the arithmetic calculations are incorrect.

(5) If an insurer or insurer group over-recoups any assessment it has, it shall forward all excess recoupment to the corporation to be held in a separate account to offset future assessments.

(6) A final accounting report documenting the assessment recouped shall be submitted to the office within 60 days after the recoupment period ends. The chief executive officer or chief financial officer must certify under oath and subject to the penalty of perjury, on a form approved by the commission, that he or she has reviewed the report; that the information in the report is true and accurate; and that, based on his or her knowledge:

(a) The report does not contain any untrue statement of a material fact or omit a material fact necessary in order to make the statements not misleading, in light of the circumstances under which the statements were made;

(b) The effective dates of the recoupment period are correct;

(c) The recoupment factor used is correct;

(d) The direct written premium and associated recoupment amounts received each month for the entire recoupment period are correct; and

(e) All excess recoupment moneys have been paid to the corporation.

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(7) Any insurer or insurer group that does not elect to use this process to recoup an assessment amount that it has paid is prohibited from including this uncollected assessment amount as any component in any subsequent rate filing required by s. 627.062 or s. 627.0651.

(8) ~~(4)~~ The commission may adopt rules to implement this section.

Section 8. Subsections (1) and (2) of section 627.712, Florida Statutes, are amended to read:

627.712 Residential windstorm coverage required; availability of exclusions for windstorm or contents.—

(1) An insurer issuing a residential property insurance policy must provide windstorm coverage. Except as provided in paragraph (2)(c), this section does not apply with respect to risks that are eligible for wind-only coverage from Citizens Property Insurance Corporation under s. 627.351(6), and with respect to risks that are not eligible for coverage from Citizens Property Insurance Corporation under s. 627.351(6)(a)3. or s. 627.351(6)(a)5. A risk ineligible for Citizens coverage under s. 627.351(6)(a)3. or s. 627.351(6)(a)5. is exempt from the requirements of this section only if the risk is located within the boundaries of the high-risk account of the corporation.

(2) A property insurer must make available, at the option of the policyholder, an exclusion of windstorm coverage.

(a) The coverage may be excluded only if:

1. When the policyholder is a natural person, the policyholder personally writes and provides to the insurer the following statement in his or her own handwriting and signs his

or her name, which must also be signed by every other named insured on the policy, and dated: "I do not want the insurance on my (home/mobile home/condominium unit) to pay for damage from windstorms. I will pay those costs. My insurance will not."

2. When the policyholder is other than a natural person, the policyholder provides to the insurer on the policyholder's letterhead the following statement that must be signed by the policyholder's authorized representative and dated: "...(Name of entity)... does not want the insurance on its ...(type of structure)... to pay for damage from windstorms. ...(Name of entity)... will be responsible for these costs. ...(Name of entity's)... insurance will not."

(b) If the structure insured by the policy is subject to a mortgage or lien, the policyholder must provide the insurer with a written statement from the mortgageholder or lienholder indicating that the mortgageholder or lienholder approves the policyholder electing to exclude windstorm coverage or hurricane coverage from his or her or its property insurance policy.

(c) ~~If the residential structure is eligible for wind-only coverage from Citizens Property Insurance Corporation,~~ An insurer nonrenewing a policy and issuing a replacement policy, or issuing a new policy, that does not provide wind coverage shall provide a notice to the mortgageholder or lienholder indicating the policyholder has elected coverage that does not cover wind.

Section 9. Subsection (3) of section 631.57, Florida Statutes, is amended to read:

631.57 Powers and duties of the association.—

(3)(a) To the extent necessary to secure the funds for the


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respective accounts for the payment of covered claims, to pay the reasonable costs to administer the same, and to the extent necessary to secure the funds for the account specified in s. 631.55(2)(c) or to retire indebtedness, including, without limitation, the principal, redemption premium, if any, and interest on, and related costs of issuance of, bonds issued under s. 631.695 and the funding of any reserves and other payments required under the bond resolution or trust indenture pursuant to which such bonds have been issued, the office, upon certification of the board of directors, shall levy assessments in the proportion that each insurer's net direct written premiums in this state in the classes protected by the account bears to the total of said net direct written premiums received in this state by all such insurers for the preceding calendar year for the kinds of insurance included within such account. Assessments shall be remitted to and administered by the board of directors in the manner specified by the approved plan. Each insurer so assessed shall have at least 30 days' written notice as to the date the assessment is due and payable. Every assessment shall be made as a uniform percentage applicable to the net direct written premiums of each insurer in the kinds of insurance included within the account in which the assessment is made. The assessments levied against any insurer shall not exceed in any one year more than 2 percent of that insurer's net direct written premiums in this state for the kinds of insurance included within such account during the calendar year next preceding the date of such assessments.

(b) If sufficient funds from such assessments, together with funds previously raised, are not available in any one year

in the respective account to make all the payments or reimbursements then owing to insurers, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available.

(c) Assessments shall be included as an appropriate factor in the making of rates.

(d) No state funds of any kind shall be allocated or paid to said association or any of its accounts.

(e)1.a. In addition to assessments otherwise authorized in paragraph (a) and to the extent necessary to secure the funds for the account specified in s. 631.55(2)(c) for the direct payment of covered claims of insurers rendered insolvent by the effects of a hurricane and to pay the reasonable costs to administer such claims, or to retire indebtedness, including, without limitation, the principal, redemption premium, if any, and interest on, and related costs of issuance of, bonds issued under s. 631.695 and the funding of any reserves and other payments required under the bond resolution or trust indenture pursuant to which such bonds have been issued, the office, upon certification of the board of directors, shall levy emergency assessments upon insurers holding a certificate of authority. The emergency assessments payable under this paragraph by any insurer shall not exceed in any single year more than 2 percent of that insurer’s direct written premiums, net of refunds, in this state during the preceding calendar year for the kinds of insurance within the account specified in s. 631.55(2)(c).

b. Any emergency assessments authorized under this paragraph shall be levied by the office upon insurers referred to in sub-subparagraph a., upon certification as to the need for

such assessments by the board of directors. In the event the board of directors participates in the issuance of bonds in accordance with s. 631.695, emergency assessments shall be levied in each year that bonds issued under s. 631.695 and secured by such emergency assessments are outstanding, in such amounts up to such 2-percent limit as required in order to provide for the full and timely payment of the principal of, redemption premium, if any, and interest on, and related costs of issuance of, such bonds. The emergency assessments provided for in this paragraph are assigned and pledged to the municipality, county, or legal entity issuing bonds under s. 631.695 for the benefit of the holders of such bonds, in order to enable such municipality, county, or legal entity to provide for the payment of the principal of, redemption premium, if any, and interest on such bonds, the cost of issuance of such bonds, and the funding of any reserves and other payments required under the bond resolution or trust indenture pursuant to which such bonds have been issued, without the necessity of any further action by the association, the office, or any other party. To the extent bonds are issued under s. 631.695 and the association determines to secure such bonds by a pledge of revenues received from the emergency assessments, such bonds, upon such pledge of revenues, shall be secured by and payable from the proceeds of such emergency assessments, and the proceeds of emergency assessments levied under this paragraph shall be remitted directly to and administered by the trustee or custodian appointed for such bonds.

c. Emergency assessments under this paragraph may be payable in a single payment or, at the option of the


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association, may be payable in 12 monthly installments with the first installment being due and payable at the end of the month after an emergency assessment is levied and subsequent installments being due not later than the end of each succeeding month.

d. If emergency assessments are imposed, the report required by s. 631.695(7) shall include an analysis of the revenues generated from the emergency assessments imposed under this paragraph.

e. If emergency assessments are imposed, the references in sub-subparagraph (1)(a)3.b. and s. 631.695(2) and (7) to assessments levied under paragraph (a) shall include emergency assessments imposed under this paragraph.

~~2. In order to ensure that insurers paying emergency assessments levied under this paragraph continue to charge rates that are neither inadequate nor excessive, within 90 days after being notified of such assessments, each insurer that is to be assessed pursuant to this paragraph shall submit a rate filing for coverage included within the account specified in s. 631.55(2)(c) and for which rates are required to be filed under s. 627.062. If the filing reflects a rate change that, as a percentage, is equal to the difference between the rate of such assessment and the rate of the previous year's assessment under this paragraph, the filing shall consist of a certification so stating and shall be deemed approved when made. Any rate change of a different percentage shall be subject to the standards and procedures of s. 627.062.~~

2.~~3.~~ In the event the board of directors participates in the issuance of bonds in accordance with s. 631.695, an annual

assessment under this paragraph shall continue while the bonds issued with respect to which the assessment was imposed are outstanding, including any bonds the proceeds of which were used to refund bonds issued pursuant to s. 631.695, unless adequate provision has been made for the payment of the bonds in the documents authorizing the issuance of such bonds.

3.~~4.~~ Emergency assessments under this paragraph are not premium and are not subject to the premium tax, to any fees, or to any commissions. An insurer is liable for all emergency assessments that the insurer collects and shall treat the failure of an insured to pay an emergency assessment as a failure to pay the premium. An insurer is not liable for uncollectible emergency assessments.

Section 10. Section 631.64, Florida Statutes, is amended to read:

631.64 Recognition of assessments in rates.—

(1) The rates and premiums charged for insurance policies to which this part applies may include amounts sufficient to recoup a sum equal to the amounts paid to the association by the member insurer less any amounts returned to the member insurer by the association, and such rates shall not be deemed excessive because they contain an amount reasonably calculated to recoup assessments paid by the member insurer. The member insurer shall begin the recoupment process within 180 days after the date of the assessment as indicated on the invoice received by the member insurer. A member insurer that fails to begin the recoupment process within 180 days after the date of the assessment may not recoup the amount assessed.

(2) The recoupment factor may not be more than 2 percentage

points above the ratio of the deficit assessment to the Florida direct written premium for policies for the lines or types of business as to which the assessment was calculated. If a member insurer fails to collect the full amount of the deficit assessment within a 1-year period, the member insurer may carry forward the amount of the deficit assessment to be recouped in the next subsequent year. The member insurer shall adjust the recoupment factor to be applied for the next subsequent year. The member insurer may not apply any recoupment factor in a manner that is unfairly discriminatory among its policyholders within the same lines, types, or sublines of business.

(3) A final accounting report documenting the assessment recouped shall be submitted to the office within 60 days after the recoupment period ends. The chief executive officer or chief financial officer must certify under oath and subject to the penalty of perjury, on a form approved by the commission, that he or she has reviewed the report; that the information in the report is true and accurate; and that, based on his or her knowledge:

(a) The report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements not misleading, in light of the circumstances under which the statements were made;

(b) The effective dates of the recoupment period are correct; and

(c) The direct written premium and associated recoupment amounts received each month for the entire recoupment period are correct.

(4) If a member insurer over-recoups any assessment it has


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paid, it shall forward all excess recoupment to the association. An accounting of the over-recoupment shall be documented in the final accounting report.

(5) Any member insurer that does not elect to use this process to recoup an assessment amount that it has paid is prohibited from including this uncollected assessment amount as any component in any subsequent rate filing required by s. 627.062 or s. 627.0651.

(6) The commission may adopt rules to implement this section.

Section 11. Upon receipt of funds transferred to the General Revenue fund pursuant to s. 627.351(6)(m)8., Florida Statutes, the funds transferred are appropriated on a nonrecurring basis from the General Revenue Fund to the Insurance Regulatory Trust Fund in the Department of Financial Services for purposes of the My Safe Florida Home Program specified in s. 215.5586, Florida Statutes. The My Safe Florida Home Program shall use the funds solely for the provision of mitigation grants pursuant to s. 215.5586(2), Florida Statutes, for single family homes insured by the corporation. The department shall establish a separate account within the trust fund for accounting purposes.

Section 12. This act shall take effect July 1, 2009.