Tab 1	**SB 258** by **Bean (CO-INTRODUCERS) Benacquisto**; (Identical to H 00879) Genetic Information Used for Insurance Purposes

Tab 2	**SB 264** by **Gruters**; (Compare to CS/H 00537) Florida Workers' Compensation Joint Underwriting Association

124924	A	S	RCS	BI, Gruters	Delete L.25 - 28:	03/11 06:29 PM

Tab 3	**CS/SB 302** by **HP, Brandes**; (Compare to H 00411) Nonemergency Medical Transportation Services

~~817360~~	A	S	WD	BI, Brandes	btw L.63 - 64:	03/11 06:29 PM
~~529474~~	A	S	WD	BI, Rouson	Delete L.68 - 77:	03/11 06:29 PM

Tab 4	**SB 524** by **Diaz (CO-INTRODUCERS) Farmer**; (Similar to H 01113) Health Insurance Savings Programs

441564	D	S	RCS	BI, Diaz	Delete everything after	03/11 06:29 PM
893134	AA	S	RCS	BI, Diaz	Delete L.79:	03/11 06:29 PM

Tab 5	**SB 538** by **Brandes**; (Similar to CS/H 00387) Nonadmitted Insurance Market Reform

207744	A	S	RCS	BI, Brandes	Delete L.84 - 106.	03/11 06:29 PM

Tab 6	**SB 714** by **Brandes**; (Similar to CS/H 00301) Insurance

917258	A	S	RCS	BI, Brandes	btw L.29 - 30:	03/11 06:29 PM
474272	A	S	RCS	BI, Perry	btw L.29 - 30:	03/11 06:29 PM
738068	A	S	RS	BI, Brandes	Delete L.30 - 38:	03/11 06:29 PM
548022	SA	S	RCS	BI, Brandes	Delete L.30 - 38:	03/11 06:29 PM
~~437860~~	A	S	WD	BI, Brandes	Delete L.39 - 48:	03/11 06:29 PM
~~545368~~	A	S	WD	BI, Brandes	Delete L.115 - 117:	03/11 06:29 PM

Tab 7	**SB 754** by **Stewart**; (Identical to H 00323) Motor Vehicle Insurance Coverage for Windshield Glass

Tab 8	**SB 1070** by **Lee**; (Similar to H 01033) Continuing Care Contracts

436274	D	S	RCS	BI, Lee	Delete everything after	03/11 06:29 PM
242422	AA	S	RCS	BI, Perry	Delete L.187 - 188:	03/11 06:29 PM
564702	AA	S	RCS	BI, Lee	Delete L.1293:	03/11 06:29 PM
738088	AA	S	RCS	BI, Perry	btw L.1682 - 1683:	03/11 06:29 PM

Tab 9	**SB 1184** by **Baxley**; (Similar to H 00837) Payments to Surviving Successors

176592	D	S	RCS	BI, Baxley	Delete everything after	03/11 06:29 PM

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

BANKING AND INSURANCE
Senator Broxson, Chair
Senator Rouson, Vice Chair

MEETING DATE: Monday, March 11, 2019
TIME: 4:00—6:00 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Broxson, Chair; Senator Rouson, Vice Chair; Senators Brandes, Gruters, Lee, Perry, Taddeo, and Thurston

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 258** Bean (Identical H 879)	Genetic Information Used for Insurance Purposes; Prohibiting life insurers and long-term care insurers, except under certain circumstances, from canceling, limiting, or denying coverage, or establishing differentials in premium rates, based on genetic information; prohibiting such insurers from taking certain actions relating to genetic information for any insurance purpose, etc. BI 03/11/2019 Favorable HP RC	Favorable Yeas 5 Nays 3
2	**SB 264** Gruters (Compare CS/H 537)	Florida Workers' Compensation Joint Underwriting Association; Providing that certain dividends or premium refunds must be retained by the association's joint underwriting plan of insurers for future use, etc. BI 03/11/2019 Fav/CS FT AP	Fav/CS Yeas 7 Nays 0
3	**CS/SB 302** Health Policy / Brandes (Compare H 411)	Nonemergency Medical Transportation Services; Authorizing Medicaid nonemergency transportation services to be provided to a Medicaid recipient by certain transportation network companies or transportation brokers, subject to compliance with certain requirements; requiring the Agency for Health Care Administration to update certain regulations, policies, or other guidance by a specified date; authorizing a licensed basic life support or licensed advanced life support ambulance service to provide nonemergency Medicaid transportation in permitted ambulances in any county at the request of a certain eligible plan, etc. HP 02/11/2019 Not Considered HP 02/19/2019 Fav/CS BI 03/11/2019 Favorable RC	Favorable Yeas 8 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 524** Diaz (Similar H 1113)	Health Insurance Savings Programs; Designating the "Patient Savings Act"; authorizing health insurers and health maintenance organizations to implement shared savings incentive programs; providing that a direct written premium must be reduced by the dollar amount of certain incentives, for the purpose of certain taxes; requiring the Office of Insurance Regulation to review insurers' filings of their program descriptions, etc. BI 03/11/2019 Fav/CS GO AP	Fav/CS Yeas 7 Nays 0
5	**SB 538** Brandes (Similar CS/H 387)	Nonadmitted Insurance Market Reform; Deleting a limitation on per-policy fees charged by surplus lines agents for exporting certified policies; requiring that such fees be itemized separately for the customer before purchase and enumerated in the policy; deleting a requirement for surplus lines agents to quarterly file a certain affidavit with the Florida Surplus Lines Service Office, etc. BI 03/11/2019 Fav/CS FT AP	Fav/CS Yeas 8 Nays 0
6	**SB 714** Brandes (Similar CS/H 301)	Insurance; Citing this act as "Omnibus Prime"; revising circumstances under which a person may not bring a civil action against an insurer; providing that provisions relating to unfair methods of competition and unfair or deceptive insurance acts or practices do not prohibit insurers or agents from offering or giving to insureds certain free or discounted services or offerings relating to loss control or loss mitigation, etc. BI 03/11/2019 Fav/CS JU RC	Fav/CS Yeas 8 Nays 0
7	**SB 754** Stewart (Identical H 323)	Motor Vehicle Insurance Coverage for Windshield Glass; Prohibiting motor vehicle repair shops or their employees from offering anything of value to a customer in exchange for making an insurance claim for motor vehicle glass replacement or repair, including offers made through certain persons, etc. BI 03/11/2019 Favorable CM RC	Favorable Yeas 8 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
8	**SB 1070** Lee (Similar H 1033)	Continuing Care Contracts; Adding certain Florida Insurance Code provisions to the Office of Insurance Regulation's authority to regulate providers of continuing care and continuing care at-home; revising requirements for certain persons relating to provider acquisitions; specifying requirements for the office if a regulatory action level event occurs; specifying requirements for certain management company contracts; prohibiting certain actions by certain persons of an impaired or insolvent continuing care facility, etc. BI 03/11/2019 Fav/CS CF AP	Fav/CS Yeas 7 Nays 0
9	**SB 1184** Baxley (Similar H 837)	Payments to Surviving Successors; Authorizing a financial institution to pay to the surviving successor of a decedent depositor, without any court proceeding, order, or judgment authorizing the payment and not earlier than a specified time, the funds in the decedent's qualified accounts if the sum does not exceed a specified amount; requiring the surviving successor to provide a certified copy of the decedent's death certificate and a specified affidavit to the financial institution, etc. BI 03/11/2019 Fav/CS JU RC	Fav/CS Yeas 7 Nays 0

Other Related Meeting Documents

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	SB 258
INTRODUCER:	Senators Bean and Benacquisto
SUBJECT:	Genetic Information Used for Insurance Purposes
DATE:	March 8, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Knudson	BI	**Favorable**
2.			HP	
3.			RC	

I. Summary:

SB 258 prohibits life insurers, life insurers offering disability income insurance, and long-term care insurers from using genetic information, in the absence of a diagnosis related to such information:

- To cancel, limit, or deny coverage;
- To establish differentials in premium rates; or
- For underwriting purposes.

Florida currently applies these prohibitions to health insurers.

The bill also amends the existing prohibition against health insurers soliciting genetic test results in any manner for any insurance purpose. Under the bill the prohibition only applies in the absence of a diagnosis of a condition related to the genetic information. The bill applies the revised prohibition to life insurers and long-term care insurers.

The provisions of the bill will apply to policies issued or renewed by life insurers and long-term care insurers on or after January 1, 2020.

II. Present Situation:

Use of Genetic Information for Insurance Purposes – Florida Requirements

Insurance policies for life, disability income, and long-term care[1] are exempt from s. 627.4301, F.S., which provides standards for the use of genetic information by health insurers. Health

[1] Section 627.4301(2)(c), F.S. Other types of insurance that are wholly exempt from the statute are accident-only policies, hospital indemnity or fixed indemnity policies, dental policies, and vision policies.

insurers[2] may not, in the absence of a diagnosis of a condition related to genetic information, use such information to cancel, limit, or deny coverage, or establish differentials in premium rates. Health insurers are also prohibited from requiring or soliciting genetic information, using genetic test results, or considering a person's decisions or actions relating to genetic testing in any manner for any insurance purpose.

Section 627.4031, F.S., defines "genetic information" to mean information derived from genetic testing to determine the presence or absence of variations or mutations, including carrier status, in an individual's genetic material or genes that are:

- Scientifically or medically believed to cause a disease disorder, or syndrome, or are associated with a statistically increased risk of developing a disease; or
- Associated with a statistically increased risk of developing a disease, disorder, or syndrome, which is producing or showing no symptoms at the time of testing.

Genetic testing, for purposes of s. 627.4031, F.S., does not include routine physical examinations or chemical, blood, or urine analysis, unless specifically conducted to obtain genetic information, or questions regarding family history.

Federal Laws on the Use of Genetic Information for Insurance Purposes

Federal law generally prohibits health insurers from soliciting genetic information and using such information for underwriting purposes. Federal law does not apply these prohibitions to life insurance, disability insurance, or long-term care insurance.

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 (GINA) amended a number of existing federal laws to prohibit health insurers from using genetic information for underwriting purposes.[3] The act does not apply to life insurance, long-term care insurance or disability insurance.

Title I of GINA provides protections against discrimination by health insurers on the basis of genetic information.[4] GINA prohibits health insurers and health plan administrators from using genetic information to make rating or coverage decisions.[5] These decisions include eligibility for coverage and setting premium or contribution amounts.

[2] Section 627.4301(1)(b), F.S., defines health insurer to mean, "an authorized insurer offering health insurance as defined in s. 624.603, F.S., a self-insured plan as defined in s. 624.031, F.S., a multiple-employer welfare arrangement as defined in s. 624.437, F.S., a prepaid limited health service organization as defined in s. 636.003, F.S., a health maintenance organization as defined in s. 641.19, F.S., a prepaid health clinic as defined in s. 641.402, F.S., a fraternal benefit society as defined in s. 632.601, F.S., or any health care arrangement whereby risk is assumed."
[3] Pub. L. No. 110-233, s. 122 Stat. 881-921 (2008). https://www.gpo.gov/fdsys/pkg/PLAW-110publ233/pdf/PLAW-110publ233.pdf (last accessed March 7, 2019).
[4] 110th Congress, *Summary: H.R.493 Public Law* (May 21, 2008) (last accessed February 1, 2018).
[5] *See* 29 USC 1182; 42 USC 300gg-1; and 42 USC 300gg-53.

GINA generally prohibits health insurers and health plan administrators from requesting or requiring genetic information of an individual or the individual's family members,[6] nor may such information be requested, required or purchased for underwriting purposes.[7] Underwriting purposes include rules for eligibility, determining coverage or benefits, cost-sharing mechanisms, calculating premiums or contribution amounts, rebates, payments in kind, pre-existing condition exclusions, and other activities related to the creation, renewal, or replacement of health insurance or health benefits. Underwriting purposes does not include determining medical appropriateness where an individual seeks a health benefit under a plan, coverage, or policy.[8] Genetic information may be used by an insurer to make a determination regarding the payment of benefits, for example, as the basis of a diagnosis that then would lead to benefits being provided under the insurance policy.

The protections in GINA apply to the individual and group health markets, including employer sponsored plans under the Employee Retirement Income Security Act of 1974 (ERISA).[9] GINA generally expanded many of the genetic information protections in the Health Insurance Portability and Accountability Act of 1996[10] (HIPAA) and applied them to the individual, group and Medicare supplemental marketplaces.[11] The protections enacted in GINA do not apply to Medicare or Medicaid because both programs bar the use of genetic information as a condition of eligibility.[12] GINA also prohibits employment discrimination on the basis of genetic information.[13]

States may provide stronger protections than GINA, which provides a baseline level of protection against prohibited discrimination on the basis of genetic information.

Health Insurance Portability and Accountability Act of 1996

HIPAA establishes national standards to ensure the privacy and nondisclosure of personal health information. The rule applies to "covered entities" which means a health plan, health care clearinghouse, other health care providers, and their business associates.[14] HIPAA provides standards for the use and disclosure of protected health information and generally prohibits covered entities and their business associates from disclosing protected health information, except as otherwise permitted or required.[15] Covered entities generally may not sell protected

---

[6] Department of Health and Human Services, *"GINA" The Genetic Information Nondiscrimination Act of 2008: Information for Researchers and Health Care Professionals*, (April 6, 2009). https://www.genome.gov/pages/policyethics/geneticdiscrimination/ginainfodoc.pdf (last accessed March 7, 2019).
[7] *See* 29 USC 1182(d); 42 USC 300gg-4(d); and 42 USC 300gg-53(e).
[8] *See* 45 CFR 164.502(a)(5)(i)(4)(B).
[9] Perry W. Payne, Jr. et al, *Health Insurance and the Genetic Information Nondiscrimination Act of 2008: Implications for Public Health Policy and Practice*, Public Health Rep., Vol. 124 (March-April 2009), 328, 331.
[10] Codified 42 USC 300gg, 29 USC 1181 et seq., and 42 USC 1320d et seq.
[11] *See* Payne at pg. 329.
[12] National Institutes of Health, *The Genetic Information Nondiscrimination Act (GINA)*.
[13] *See* 29 CFR 1635(a), which prohibits the use of genetic information in employment decision making; restricts employers and other entities from requesting, requiring, or purchasing genetic information; requires that genetic information be maintained as a confidential medical record, and places strict limits on disclosure of genetic information; and provides remedies for individuals whose genetic information is acquired, used, or disclosed in violation of GINA.
[14] See 45 CFR 160.103.
[15] See 45 CFR 164.502(a).

health information.[16] HIPPA, as modified by GINA, also prohibits health plans from using or disclosing protected health information that is genetic information for underwriting purposes.[17]

Patient Protection and Affordable Care Act of 2010

The Patient Protection and Affordable Care Act of 2010 (ACA) requires all individual and group health plans to enroll applicants regardless of their health status, age, gender, or other factors that might predict the use of health services.[18] These guaranteed issue and guaranteed renewability requirements apply to genetic testing.

Use of Genetic Information for Insurance Purposes – Requirements in Other States

Federal law under GINA applies to all states and provides a baseline level of protection that states may exceed. The NIH has identified 105 state statutes addressing health insurance nondiscrimination across 48 states and the District of Columbia.[19] Fewer states address genetic testing regarding other lines of insurance such as life insurance, disability insurance, and long-term care insurance.[20]

Examples of such statutes include Oregon, which requires informed consent to conduct testing, prohibits the use of genetic information for underwriting or ratemaking for any policy for hospital and medical expense, and prohibits using the genetic information of a blood relative for underwriting purposes regarding any insurance policy.[21] Informed consent when an insurer requests genetic testing for life or disability insurance is required in California, New Jersey, and New York.[22] Massachusetts prohibits unfair discrimination because of the basis of genetic information or a genetic test and prohibits requiring an applicant or existing policyholder to undergo genetic testing.[23] Arizona prohibits the use of genetic information for underwriting or rating disability insurance in the absence of a diagnosis, and life and disability insurance policies may not use genetic information for underwriting or ratemaking unless supported by the applicant's medical condition, medical history, and either claims experience or actuarial projections.[24]

[16] See 45 CFR 164.502(a)(5)(ii)(A).
[17] See 45 CFR 164.502(a)(5)(i).
[18] See 42 USC 300gg-1 and 42 USC 300gg-2.
[19] National Institutes of Health, *Genome Statute and Legislation Database Search*. https://www.genome.gov/policyethics/legdatabase/pubsearch.cfm (database search for "state statute," "health insurance nondiscrimination" performed by Committee on Banking and Insurance professional staff on March 7, 2019).
[20] *See id*. (database search for "state statute," "other lines of insurance nondiscrimination" performed by Committee on Banking and Insurance professional staff on March 7, 2019).
[21] Section 746.135, O.R.S.
[22] *See* Cal. Ins. Code s. 10146 et seq.; s. 17B:30-12, N.J.S.; and ISC s. 2615, N.Y.C.L.
[23] Chapter 175 sections 108I and 120E, M.G.L.
[24] Section 20-448, A.R.S.

Genetic Testing

Genetic testing includes a number of medical tests that identify and examine chromosomes, genes, or proteins for the purpose of obtaining genetic information.[25] Genetic testing is often used for medical or genealogical purposes.

Medical Genetic Testing

Genetic testing can be done to diagnose a genetic disorder, to predict the possibility of future illness, and predict a patient's response to therapy.[26] More than 2,000 genetic tests are currently available and more tests are constantly being developed.[27] The National Institutes of Health[28] (NIH) have identified the following available types of medical genetic testing:[29]

- *Diagnostic testing* identifies or rules out a specific genetic or chromosomal condition, and is often used to confirm a diagnosis when a particular condition is suspected based on the individual's symptoms. For example, a person experiencing abnormal muscle weakness may undergo diagnostic testing that screens for various muscular dystrophies.
- *Predictive and presymptomatic testing* is used to detect gene mutations associated with disorders that appear after birth, often later in life. This testing is often used by people who are asymptomatic, but have a family member with a genetic disorder. Predictive testing can identify mutations that will result in genetic disorder, or that increase a person's risk of developing disorders with a genetic basis, such as cancer.
- *Carrier testing* identifies people who carry one copy of a gene mutation that, when present in two copies, causes a genetic disorder. This test is often used by parents to determine their risk of having a child with a genetic disorder.
- *Preimplantation testing* is used to detect genetic changes in embryos developed by assisted reproductive techniques such as in-vitro fertilization. Small numbers of cells are taken from the embryos and tested for genetic changes prior to implantation of a fertilized egg.
- *Prenatal testing* detects changes in a baby's genes or chromosomes before birth. Such testing is often offered if there is an increased risk the baby will have a genetic or chromosomal disorder.
- *Newborn screening* is performed shortly after birth to identify genetic disorders that can be treated early in life. Florida screens for 31 disorders recommended by the United States Department of Health and Human Services Recommended Uniform Screening Panel and 22 secondary disorders, unless a parent objects in writing.[30]

---

[25] National Institutes of Health, *Genetic Testing*, pg. 3 (January 30, 2018). Available for download at https://ghr.nlm.nih.gov/primer/testing/uses (last accessed January 31, 2018).
[26] Francis S. Collins, *A Brief Primer on Genetic Testing* (January 24, 2003). https://www.genome.gov/10506784/a-brief-primer-on-genetic-testing/ (last accessed March 7, 2019).
[27] *See* Ohio State University Wexner Medical Center, *Facts About Testing*. https://wexnermedical.osu.edu/genetics/facts-about-testing (last accessed March 7, 2019).
[28] The National Institutes of Health is the medical research agency of the United States federal government. The NIH is part of the United States Department of Health and Human Services. The NIH is made of 27 different Institutes and Centers, each having a specific research agenda.
[29] *See* National Institutes of Health, *Genetic Testing*, at pgs. 5-6.
[30] Florida Department of Health, *Newborn Screening*. http://www.floridahealth.gov/programs-and-services/childrens-health/newborn-screening/index.html (last accessed March 7, 2019).

Genetic testing is often used for research purposes. For example, genetic testing may be used to discover genes or increase understanding of genes that are newly discovered or not well understood.[31] Testing results as part of a research study are usually not available to patients or healthcare providers.[32]

The Human Genome Project, which in April 2003 successfully sequenced and mapped all of the genes of humans, and a variety of other genetic testing has led to multiple medical advances. For example, genetic testing identified that the reason the drug Plavix, which is commonly used to prevent blood clots in patients at risk for heart attacks and strokes, does not work for approximately 30 percent of the United States population because variations in the CYP2C19 gene account for the lack of a response.[33] Thus genetic testing can identify persons for whom the drug will not be effective.

The American Medical Association supports broad protections against genetic discrimination because it believes genetic testing and genetic information is essential to advancements in medical knowledge and care.[34] Accordingly, the organization supports comprehensive federal protection against genetic discrimination because "patients remain at-risk of discrimination in a broad array of areas such as life, long-term care, and disability insurance as well as housing, education, public accommodations, mortgage lending, and elections."

Methods of genetic testing used for medical purposes include:

- Molecular genetic tests (Gene tests) that study single genes or short lengths of DNA to identify variations or mutations that lead to a genetic disorder.
- Chromosomal genetic tests that analyze whole chromosomes or long lengths of DNA to see if there are large genetic changes, such as an extra copy of a chromosome, that cause a genetic condition.
- Biochemical genetic tests study the amount or activity level of proteins; abnormalities in either can indicate changes to the DNA that result in a genetic disorder.

Genetic Ancestry Testing

Genetic ancestry testing, also called genetic genealogy, is used to identify relationships between families and identify patterns of genetic variation that are often shared among people of particular backgrounds.[35] According to the National Institutes of Health (NIH), genetic ancestry testing results may differ between providers because they compare genetic information to different databases. The tests can yield unexpected results because human populations migrate and mix with other nearby groups. Scientists can use large numbers of genetic ancestry test

[31] *See* fn. 27, Ohio State University Wexner Medical Center.
[32] National Institutes of Health, *Genetic Testing*, at pg. 24.
[33] Francis S. Collins, Perspectives on the Human Genome Project, pg. 50 (June 7, 2010).https://www.genome.gov/pages/newsroom/webcasts/2010sciencereportersworkshop/collins_nhgrisciencewriters060710.pdf (last accessed March 7, 2019).
[34] American Medical Association, *Genetic Discrimination – Appendix II. AMA Legislative Principles on Genetic Discrimination and Surreptitious Testing*, (March 2013) https://www.ama-assn.org/sites/default/files/media-browser/public/genetic-discrimination-policy-paper.pdf (last accessed March 7, 2019).
[35] National Institutes of Health, *Genetic Testing*, at pg. 25.

results to explore the history of populations. Three common types of genetic ancestry testing include:[36]

- Single nucleotide polymorphism testing evaluate large numbers of variations across a person's entire genome. The results are compared with those of others who have taken the tests to provide an estimate of a person's ethnic background.
- Mitochondrial DNA testing identifies genetic variations in mitochondrial DNA, which provides information about the direct female ancestral lines.
- Y chromosome testing, performed exclusively on males, is often used to investigate whether two families with the same surname are related.

Direct to Consumer Genetic Testing

Traditionally, genetic testing was available only through healthcare providers.[37] Direct-to-consumer genetic testing provides access to genetic testing outside the healthcare context. Generally, the consumer purchases a genetic testing kit from a vendor who mails the kit to the consumer. The consumer collects a DNA sample and mails it back to the vendor. The vendor uses a laboratory to conduct the test. The consumer is then notified of the test results.

Direct-to-consumer genetic testing has primarily been used for genealogical purposes, but increasing numbers of products now provide medical information. For example, the vendor 23andME offers, with FDA approval, genetic testing that examines the consumer's risks for certain diseases including Parkinson's disease, celiac disease, and late-onset Alzheimer's disease.[38]

Direct to consumer genetic testing is increasing in popularity, with one company reporting having sold approximately 1.5 million genetic testing kits from November 24, 2017, through November 27, 2017.[39] The increased proliferation of such testing is accompanied by increased concerns about the privacy of such information. The privacy protections of HIPAA usually do not apply to direct-to-consumer genetic testing because the vendors selling such tests are often not "covered entities" and thus not subject to HIPAA. The Federal Trade Commission recently warned consumers to consider the privacy implications of genetic testing kits.[40]

Life Insurance, Disability Insurance, and Long-Term Care Insurance

Life insurance is the insurance of human lives.[41] Life insurance can be purchased in the following forms:[42]

---

[36] National Institutes of Health, *Genetic Testing*, at pg. 26.
[37] National Institutes of Health, *Genetic Testing*, at pg. 11.
[38] 23andMe, *Find Out What Your DNA Says About Your Health, Traits and Ancestry* https://www.23andme.com/dna-health-ancestry/ (last accessed Feb. 4, 2018).
[39] Megan Molteni, *Ancestry's Genetic Testing Kits Are Heading For Your Stocking This Year*, Wired, Dec. 1, 2017, https://www.wired.com/story/ancestrys-genetic-testing-kits-are-heading-for-your-stocking-this-year/ (last accessed March 7, 2019).
[40] Federal Trade Commission, *DNA Test Kits: Consider the Privacy Implications*, (Dec. 12, 2017).https://www.consumer.ftc.gov/blog/2017/12/dna-test-kits-consider-privacy-implications (last accessed March 7, 2019).
[41] Section 624.602, F.S.
[42] National Association of Insurance Commissioners, *Life Insurance – Considerations for All Life Situations*, http://www.insureuonline.org/insureu_type_life.htm (last accessed March 7, 2019).

- Term life insurance provides coverage for a set term of years and pays a death benefit if the insured dies during the term.[43]
- Permanent life insurance remains in place if the insured pays premiums and pays a death benefit. Such policies have an actual cash value component that increases over time and from which the policyowner may borrow. There are four types of permanent life insurance:
  - Whole life insurance offers a fixed premium, guaranteed annual cash value growth and a guaranteed death benefit. It does not provide investment flexibility and the policy coverage, once established, may not be changed.
  - Universal life insurance allows the policyholder to determine the amount and timing of premium payments within certain limits. The coverage level may be adjusted. It guarantees certain levels of annual cash value growth but not investment flexibility.
  - Variable life insurance allows allocation of investment funds, but does not guarantee minimum cash value because of fluctuations in the value of investments.
  - Variable universal life insurance combines variable and universal life insurance.

Life insurance also encompasses annuities and disability policies.[44] An annuity is a contract between a customer and an insurer wherein the customer makes a lump-sum payment or a series of payments to an insurer that in return agrees to make periodic payments to the annuitant at a future date, either for the annuitant's life or a specified period. Disability insurance pays a weekly or monthly income for a set period if the insured becomes disabled and cannot continue working or obtain work.

Life insurance underwriters seek to identify and classify the risk represented by a proposed insured and then classify those risks into pools of similar mortality or morbidity risk.[45] Insureds within the same risk classification pay the same premiums, which must be adequate to ensure solvency, pay claims, and provide the insurer (with investment income) a reasonable rate of return.

Disability insurance compensates the insured for a portion of income lost because of a disabling injury or illness.[46] There are two types of disability insurance: short-term and long-term. A short-term policy typically replaces a portion of lost income from 3 to 6 months following the disability. Long-term policies generally begin 6 months after the disability and can last a set number of years or until retirement age. Disability insurance is sometimes offered by life insurers.

Insurance policy forms must be filed and approved by the OIR.[47] The Unfair Insurance Trade Practices Act prohibits "knowingly making or permitting unfair discrimination between individuals of the same actuarially supportable class and expectation of life, in the rates charged

[43] National Association of Insurance Commissioners, *Life Insurance FAQs*, http://www.insureuonline.org/consumer_life_faqs.htm (last accessed March 7, 2019).
[44] Section 624.602, F.S.
[45] American Council of Life Insurers, *Life Insurer Issues*. (On file with the Senate Committee on Banking and Insurance).
[46] *See* National Association of Insurance Commissioners, *A Worker's Most Valuable Asset: Protecting Your Financial Future with Disability Insurance* http://www.naic.org/documents/consumer_alert_protecting_financial_future_disability_insurance.htm (last accessed March 7, 2019).
[47] Section 624.410, F.S.

for a life insurance or annuity contract, in the dividends or other benefits payable thereon, or in any other term or condition of such contract."[48] Similarly, the act prohibits knowingly making or permitting unfair discrimination between individuals of the same actuarially supportable class, as determined at the time of initial issuance of the coverage, and essentially the same hazard, in the amount of premium, policy fees, or rates charged for a policy or contract of disability insurance, in benefits payable, in the terms or conditions of the contract, or in any other manner.[49]

Long-term care (LTC) insurance covers the costs of nursing homes, assisted living, home health care, and other long-term care services. A long-term care insurance policy provides coverage for medically necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, rehabilitative, maintenance or personal care services provided in a setting other than an acute care unit of a hospital.[50] Long-term care insurance usually pays fixed-dollar amounts or the actual costs of care, often subject to a maximum daily benefit amount.[51]

The long-term insurance market provides an example of the negative effects of insurers not accurately projecting their underwriting risk. Long-term care insurers made incorrect assumptions when selling the coverage, particularly in the 1980s and 1990s.[52] The LTC insurers overestimated the number of people that would cancel their coverage or allow it to lapse, underestimated the life span of insureds and the time span of the treatment they would receive, and overestimated earnings on LTC premiums which were negatively affected by dropping interest rates.[53] As a result, long-term care insurance premiums have been rising, often substantially, for the past decade.[54]

In response to substantial LTC premium increases, Florida law prohibits LTC rate increases that would result in a premium in excess of that charged on a newly issued policy, except to reflect benefit differences.[55] If the insurer is not writing new LTC policies, the rate cannot exceed the new business rate of insurers representing 80 percent of the carriers in the marketplace. In January 2017, the OIR issued consent orders allowing two of the state's largest LTC insurers, Metropolitan Life Insurance Company and Unum Life Insurance Company of America, to substantially raise LTC monthly premiums, phased in over 3 years.[56] Many insurers that write

[48] Section 626.9541(1)(g)1., F.S.
[49] Section 626.9541(1)(g)2., F.S.
[50] Section 627.9404(1), F.S.
[51] Florida Department of Financial Services, Long-Term Care: A Guide for Consumers, pg. 5. https://www.myfloridacfo.com/division/consumers/UnderstandingCoverage/Guides/documents/LTCGuide.pdf (last accessed March 7, 2019).
[52] *See* Leslie Scism, *Millions Bought Insurance to Cover Retirement Health Costs. Now They Face an Awful Choice,* Wall Street Journal, January 17, 2018. https://www.wsj.com/articles/millions-bought-insurance-to-cover-retirement-health-costs-now-they-face-an-awful-choice-1516206708 (last accessed March 7, 2019).
[53] *See* Office of Insurance Regulation, *Long-Term Care Public Rate Hearings*. (The Internet page references a rate filing decision made by the OIR on Jan. 12, 2017, related to LTC products for two insurers). https://www.floir.com/Sections/LandH/LongTermCareHearing.aspx (last accessed March 7, 2019); See Scism at fn. 35
[54] *See* Scism at fn. 35; See Office of Insurance Regulation at fn. 36. https://www.floir.com/Sections/LandH/LongTermCareHearing.aspx (last accessed March 7, 2019).
[55] Section 627.9407(7)(c), F.S.
[56] *See* Office of Insurance Regulation, *Consent Order In the Matter of: Metropolitan Life Insurance Company*, Case No. 200646-16-CO (Jan. 12, 2017) https://www.floir.com/siteDocuments/MetLife200646-16-CO.pdf (last accessed March 7, 2019); Office of Insurance Regulation, *Consent Order In The Matter of Unum Life Insurance Company of America*, Case No.

LTC insurance have taken substantial losses. Recently, General Electric announced a $6.2 billion charge against earnings and a $15 billion shortfall in insurance reserves related to long-term care insurance obligations.[57]

The American Council of Life Insurers has expressed concerns that the proliferation of genetic testing could increase adverse selection and impact the availability and affordability of products over time.[58] Studies addressing whether genetic testing leads to adverse selection have reached varying conclusions. Studies of women tested for the BRCA1 gene mutation (linked to breast cancer risk)[59] and adults tested for Alzheimer's risk[60] found little evidence of adverse selection in the life insurance market. However, the study regarding Alzheimer's risk found evidence of adverse selection for long-term care insurance, as 17 percent of those who tested positive subsequently changed their LTC policy in the year after testing positive of Alzheimer's risk, in comparison with 2 percent of those who tested negative and 4 percent of those who did not receive test results.[61]

III. Effect of Proposed Changes:

Section 1 amends s. 627.4301, F.S., to prohibit life insurers, including life insurers providing disability insurance, and long-term care insurers from canceling, limiting, or denying coverage or establishing differentials in premium rates, based on genetic information, if there is no diagnosis of a condition related to the genetic information. Such insurer also may not use such genetic information for underwriting purposes.

The bill amends the existing prohibition against health insurers soliciting genetic test results in any manner for any insurance purpose. Under the bill the prohibition only applies in the absence of a diagnosis of a condition related to the genetic information. The bill applies the revised prohibition to life insurers and long-term care insurers.

For purposes of s. 627.4301, F.S., the bill defines the following terms:

- "Life insurer" has the same meaning as in s. 624.602, F.S., and includes an insurer issuing life insurance contracts that grant additional benefits if the insured is disabled. Section 624.602, F.S., defines a life insurer as an insurer engaged in the business of issuing

200879-16-CO (Jan. 12, 2017) https://www.floir.com/siteDocuments/Unum200879-16-CO.pdf (last accessed March 7, 2019).

[57] Sonali Basak, Katherine Chiglinsky, et al, *GE's Surprise $15 Billion Shortfall Was 14 Years in the Making*, Chicago Tribune, January 25, 2018. http://www.chicagotribune.com/business/ct-biz-ge-general-electric-accounting-20180125-story.html (last accessed March 7, 2019); Steve Lohr and Chad Bray, *At G.E., $6.2 Billion Charge for Finance Unit Hurts C.E.O.'s Turnaround Push*, New York Times, Jan. 16, 2018. https://www.nytimes.com/2018/01/16/business/dealbook/general-electric-ge-capital.html (last accessed March 7, 2019).

[58] Gina Kolata, *New Gene Tests Pose a Threat to Insurers*, New York Times (May 12, 2017) https://www.nytimes.com/2017/05/12/health/new-gene-tests-pose-a-threat-to-insurers.html (last accessed March 7, 2019).

[59] Cathleen D. Zick, et. al., *Genetic Testing, Adverse Selection, and the Demand for Life Insurance*, pgs. 29-39 American Journal of Medical Genetics (July 2000) (Abstract provided by NIH at https://www.ncbi.nlm.nih.gov/pubmed/10861679 (last accessed March 7, 2019)).

[60] Cathleen D. Zick, *Genetic Testing For Alzheimer's Disease And Its Impact on Insurance Purchasing Behavior*, pgs. 483-490, Health Affairs vol. 23, no. 2 (March/April 2005) https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.24.2.483 (last accessed March 7, 2019).

[61] *See* Zick fn. 60 at pgs. 487-488.

life insurance contracts, including contracts of combined life and health and accident insurance.

- "Long-term care insurer" means an insurer that issues long-term care insurance policies as described in s. 627.9404, F.S.

Section 2 applies the act to policies entered into or renewed after January 1, 2020.

Section 3 provides an effective date of July 1, 2019.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill may lead to more individuals undergoing genetic testing, which in the aggregate will lead to advancements in medicine and, regarding the individual, can be useful in identifying and treating disease and disability.

The bill, to the extent it encourages adverse selection of life, disability, or long-term care insurance, could result in the improper classification of risks for such policies, leading to inadequate rates and, eventually, higher premiums. Such insurers use of genetic information in underwriting, risk classification, and ratemaking could result in

individuals either not being able to procure such coverages because the insurer is unwilling to offer the coverage, or offers it at a rate that is unaffordable to the consumer.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 627.4301 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Bean

4-00114-19 2019258__

A bill to be entitled

An act relating to genetic information used for insurance purposes; amending s. 627.4301, F.S.; defining terms; prohibiting life insurers and long-term care insurers, except under certain circumstances, from canceling, limiting, or denying coverage, or establishing differentials in premium rates, based on genetic information; prohibiting such insurers from taking certain actions relating to genetic information for any insurance purpose; revising a prohibition on the use of genetic test results by health insurers; revising and providing applicability; providing an effective date.

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

Section 1. Section 627.4301, Florida Statutes, is amended to read:

627.4301 Genetic information for insurance purposes.—

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

(a) "Genetic information" means information derived from genetic testing to determine the presence or absence of variations or mutations, including carrier status, in an individual's genetic material or genes that are scientifically or medically believed to cause a disease, disorder, or syndrome, or are associated with a statistically increased risk of developing a disease, disorder, or syndrome, which is asymptomatic at the time of testing. Such testing does not include routine physical examinations or chemical, blood, or

4-00114-19 2019258__

urine analysis, unless conducted purposefully to obtain genetic information, or questions regarding family history.

(b) "Health insurer" means an authorized insurer offering health insurance as defined in s. 624.603, a self-insured plan as defined in s. 624.031, a multiple-employer welfare arrangement as defined in s. 624.437, a prepaid limited health service organization as defined in s. 636.003, a health maintenance organization as defined in s. 641.19, a prepaid health clinic as defined in s. 641.402, a fraternal benefit society as defined in s. 632.601, or any health care arrangement whereby risk is assumed.

(c) "Life insurer" has the same meaning as in s. 624.602 and includes an insurer issuing life insurance contracts that grant additional benefits in the event of the insured's disability.

(d) "Long-term care insurer" means an insurer that issues long-term care insurance policies as described in s. 627.9404.

(2) USE OF GENETIC INFORMATION.—

(a) In the absence of a diagnosis of a condition related to genetic information, no health insurer, life insurer, or long-term care insurer authorized to transact insurance in this state may cancel, limit, or deny coverage, or establish differentials in premium rates, based on such information.

(b) Health insurers, life insurers, and long-term care insurers may not require or solicit genetic information, use genetic test results in the absence of a diagnosis of a condition related to genetic information, or consider a person's decisions or actions relating to genetic testing in any manner for any insurance purpose.

(c) This section does not apply to the underwriting or issuance of an ~~a life insurance policy, disability income policy, long-term care policy,~~ accident-only policy, hospital indemnity or fixed indemnity policy, dental policy, or vision policy or any other actions of an insurer directly related to an ~~a life insurance policy, disability income policy, long-term care policy,~~ accident-only policy, hospital indemnity or fixed indemnity policy, dental policy, or vision policy.

Section 2. This act applies to policies entered into or renewed on or after January 1, 2020.

Section 3. This act shall take effect July 1, 2019.

The Florida Senate

Committee Agenda Request

To: Senator Doug Broxson, Chair
Committee on Banking and Insurance

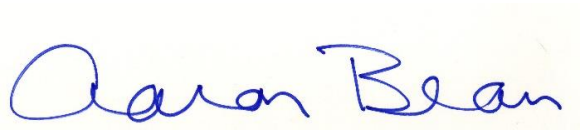
Subject: Committee Agenda Request

Date: January 24, 2019

I respectfully request that **Senate Bill # 258**, relating to Genetic Information Used for Insurance Purposes, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.



Senator Aaron Bean
Florida Senate, District 4

File signed original with committee office

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

03/11/2019
Meeting Date

SB 258
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Paul Sanford

Job Title _____

Address 106 South Monroe Street
Street

Phone 850-222-7200

Tallahassee FL 32301
City *State* *Zip*

Email _____

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing American Council of Life Insurers and Florida Insurance Council

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3-11-19
Meeting Date

258
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic SB 258

Name Patricia Born

Job Title Professor

Address 415 Saint Francis #401
Street

Tallahassee FL 32301
City *State* *Zip*

Phone (850) 591-0901

Email pborn@fsu.edu

Speaking: ☐ For ☐ Against ☒ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Am Council of Life Insurers

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/19
Meeting Date

SB0258
Bill Number (if applicable)

Topic Genetic Information Used for Insurance

Amendment Barcode (if applicable)

Name ~~Nicolette Springer~~ Trish Neely

Job Title Legislative Analyst

Address
Street

Phone 407 484 3656

Orlando FL 32832
City *State* *Zip*

Email nicolette@LWVFL.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing League of Women Voters of Florida

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/19
Meeting Date

258
Bill Number (if applicable)

Topic Genetic Information Used For Insurance

Amendment Barcode (if applicable)

Name Tom Joos

Job Title

Address 108 E. Jefferson St. (*Street*)

Phone 321-438-0766

Tallahassee (*City*) FL (*State*) 32301 (*Zip*)

Email Thomas.Joos@Moffitt.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Moffitt Cancer Center

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

March 11, 2019
Meeting Date

SB 258
Bill Number (if applicable)

Topic Genetic Information Used for Insurance Purposes
Amendment Barcode (if applicable)

Name Meredith Stanfield

Job Title Director of Legislative & Cabinet Affairs

Address PL 11, The Capitol
Street
Tallahassee FL 32399
City *State* *Zip*

Phone (850) 413-2890

Email meredith.stanfield@myfloridacfo.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Department of Financial Services

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

03/11/2019
Meeting Date

Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic SB 258

Name Dr Robert Gleeson, M.D.

Job Title ACLI consultant

Address 101 Constitution Ave NW #700 Phone 414 331 7462
Street

Washington DC 20001 Email drbobgleeson@msn.com
City *State* *Zip*

Speaking: ☐ For ☒ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing ACLI

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	CS/SB 264
INTRODUCER:	Banking and Insurance Committee and Senator Gruters
SUBJECT:	Florida Workers' Compensation Joint Underwriting Association
DATE:	March 12, 2019 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson/Knudson	Knudson	BI	**Fav/CS**
2.			FT	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

SB 264 exempts the Florida Workers' Compensation Joint Underwriting Association (JUA) from reporting and remittance of unclaimed property (e.g., dividends or premiums due employers) to the Department of Financial Services (DFS).

Within 12 months after the failed initial delivery of the dividend or premium refund the JUA must:

- Conduct a diligent search to locate the former insured.
- Notify the insurance agency on the policy of the premium dividend or refund.
- If the unclaimed dividend or premium refund is valued at $250 or more, make at least one active notification attempt to directly contact a former insured after completing the diligent search.

The JUA must publish and maintain on its website a list of the names of former insureds who have unclaimed dividends or premium refunds and the amount owed.

A former insured may claim the dividend or premium refund from the JUA at any time.

The JUA is a statutorily-created nonprofit, self-funding entity that is the insurer of last resort for employers in Florida who are unable to secure coverage in the voluntary market. The Florida Disposition of Unclaimed Property Act serves the interest of missing owners of property while the people of the state derive a financial benefit from the unclaimed and abandoned property

until the property is claimed, if ever. Currently, the Florida Disposition of Unclaimed Property Act requires holders, such as businesses and governmental entities, of unclaimed property to remit such proceeds to the DFS. The DFS deposits such proceeds into the Department of Education School Trust Fund, except for a $15 million balance that is retained in the Unclaimed Property Trust Fund for the prompt payment of verified claims to owners or heirs of owners.

II. Present Situation:

Florida's Disposition of Unclaimed Property Act

Unclaimed property constitutes any funds or other property, tangible or intangible, that have remained unclaimed by the owner for a certain specified number of years.[1] Common types of unclaimed property are dormant savings or checking accounts, unclaimed insurance proceeds, stocks, bonds, dividends, uncashed checks, refunds, credit balances, and contents of abandoned safe deposit boxes at financial institutions.[2] The Division of Unclaimed Property, within the Department of Financial Services (DFS), administers Florida's Disposition of Unclaimed Property Act.[3] The DFS is responsible for receiving property from holders, safeguarding this property, locating the rightful owners, and returning property to them.

Owners have the right to claim their property at any time. Financial institutions, insurance companies, governmental entities, and other holders of unclaimed property must report and submit unclaimed property to the DFS before May 1 of each year for the preceding calendar year. Holders of inactive accounts (presumed unclaimed property) are required to use due diligence to locate apparent owners.[4] Once the prescribed period for holding unclaimed property has expired, a holder is required to file a report with DFS by May 1 for all property valued at $50 or more and presumed unclaimed for the preceding calendar year.[5] The report generally must contain the name and social security number or federal employer identification number, if known, and the last known address of the apparent owner.[6] The report, which includes account information, is uploaded to the DFS unclaimed property website, and the unclaimed property is available to be claimed.[7]

The reporting provisions of s. 717.117, F.S., do not apply to the following circumstances:

- Unclaimed patronage refunds as provided for by contract or through bylaw provisions of entities organized under ch. 425, F.S., or that are exempt from ad valorem taxation pursuant to s. 196.2002, F.S.
- Intangible property held, issued, or owing by a business association subject to the jurisdiction of the United States Surface Transportation Board or its successor federal agency if the apparent owner of such intangible property is a business association. The holder of such

[1] See s. 717.117, F.S.
[2] See Department of Financial Services, FLTreasureHunt.Gov General Questions. https://www.fltreasurehunt.gov/UP-Web/sitePages/FAQs.jsp (last accessed March 6, 2019).
[3] Chapter 717, F.S.
[4] Section 717.117(4), F.S.
[5] Section 717.117(3), F.S.
[6] Section 717.117(1), F.S.
[7] DFS Unclaimed property website available at https://www.fltreasurehunt.gov/ (last viewed Feb. 28, 2019).

property does not have any obligation to report, to pay, or to deliver such property to the DFS.

- Credit balances, overpayments, refunds, or outstanding checks owed by a health care provider to a managed care payor with whom the health care provider has a managed care contract, if the credit balances, overpayments, refunds, or outstanding checks become due and owing pursuant to the managed care contract.[8]

Current law places an obligation on the state, DFS, to notify owners of unclaimed property accounts valued at over $250, in a cost-effective manner, including through attempts to contact the owner directly.[9] The DFS indicates that the means used to find lost property owners include social security numbers, direct mailing, motor vehicle records, state payroll records, newspaper advertisements, and the state website.

Five years is the dormancy period for most types of property, and it is the default dormancy period for any property types for which a dormancy period is not provided in statute.[10] The dormancy period for all property types of any governmental entity, or subdivision thereof, is one year, as is the case with property held by any government entity or subdivision thereof, or statutorily-created entity such as the JUA or Citizens Insurance (created by legislature, governed by the Cabinet or by a board appointed by elected officials).[11]

All funds from unclaimed property, including proceeds from the sale of safe deposit items and securities, are deposited into the Abandoned Property Trust Fund. The trust fund entirely finances program operations and pays owner claims. The department retains a balance, not to exceed $15 million, in the trust fund to enable prompt claim payments. The remaining unclaimed funds are transferred into the State School Fund to support public education. The State School Fund will receive an estimated $129.4 million in unclaimed property during the 2018-2019 fiscal year.[12]

Florida Workers' Compensation Joint Underwriting Association

The Legislature created the Workers' Compensation Joint Underwriting Association[13] (JUA) as a nonprofit, self-funding entity that is the insurer of last resort for employers in Florida who are unable to secure coverage in the voluntary market.[14] The board of the JUA is composed of a nine-member board of governors appointed by the Financial Services Commission.[15]

---

[8] Section 624.4621, F.S., relating to the regulation of group self-insurance funds, provides another exception. The section provides that any dividend or premium refund that cannot be paid to the applicable member or policyholder or former member or policyholder of the group self-insurer because the former member or policyholder cannot be reasonably located becomes the property of the group self-insurer.

[9] Section 717.118(1), F.S.

[10] Section 717.102, F.S.

[11] Section 717.113, F.S., provides that all intangible property held for the owner by any court, government or governmental subdivision or agency, public corporation, or public authority that has not been claimed by the owner for more than 1 year after it became payable or distributable is presumed unclaimed.

[12] See Section V., Fiscal Impact Statement C. Public Sector Impact in this analysis.

[13] The JUA was created in 1993 and was the successor of the Florida Workers' Insurance Plan. Ch. 93-415, L.O.F.

[14] According to the JUA, it has applied for federal tax exemption, status as of July 1, 2007, and the requested ruling is pending. Correspondence on file with Senate Banking and Insurance Committee.

[15] Section 627.311(5)(b), F.S.

The JUA establishes three tiers of employers, grouped according to their loss experience, for purposes of establishing rates. Tier One employers have good loss experience, Tier Two employers have loss experience inferior to those in Tier One, and Tier Three employers have loss experience that do not qualify them for Tier One or Tier Two.[16] For 2019, the JUA will charge rates based on premiums in the voluntary market, adjusted upward by 5 percent for Tier One employers, 20 percent for Tier Two employers, and 42 percent for Tier Three employers.[17]

Prior to the workers' compensation reforms in 2003, the JUA experienced a significant increase in the number of policies due to availability and affordability issues in the private market. The 2003 reforms revised the JUA to address affordability and availability for small employers and charitable and nonprofit organizations by creating a new subplan for such employers, limiting premiums to no more than 125 percent of the rate in the voluntary market, and authorizing assessments against employers if the subplan experienced a deficit.[18] According to the JUA no assessments have been levied on employers.

Policyholders of the JUA sometimes receive dividends and premium refunds, which are provided 7 years after the policy year. If the insured cannot be found, the JUA must remit the property to DFS once it has been unclaimed for more than 1 year after it became payable or distributable pursuant to s. 717.113, F.S.

Financial Condition of the FWCJUA

For calendar year 2017, the JUA recognized a surplus of $87,937,954. As of September 30, 2018, the JUA recognized a $91,938,906, surplus. This information is delineated below by subplan and tier, as follows:

Subplan/Tier	Effective Date of Subplan/Tier	September 30, 2018 Total Surplus or Deficit	2017 Total Surplus or (Deficit)
Subplans P, A, and C	January 1, 1994	$39,883,694	$39,171,914
Subplan D	July 1, 2003	($118,309)	($118,309)[19]
Tier 1	July 1, 2004	$6,849,573	$5,961,950
Tier 2	July 1, 2004	$15,038,034	$12,962,723
Tier 3	July 1, 2004	$30,285,914	$29,959,676
Net Surplus or Deficit		$91,938,906	$87,937,954

III. Effect of Proposed Changes:

Section 1 amends s. 627.311, F.S., to provide that any dividend or premium refund issued by the Florida Workers' Compensation Joint Underwriting Association that cannot be paid to a former

[16] Section 627.311(5)(c)22., F.S.
[17] See Office of Insurance Regulation, Letter from Sandra Starnes, Office of Insurance Regulation Director Property & Casualty Product Review, to Michael K. Clearly, Florida Workers' Compensation Joint Underwriting Association Operations Manager, regarding OIR File Number FWC 18-12920 (Dec. 19, 2018). https://www.fwcjua.com/Home/DisplayDocument?intDocId=5353 (last accessed March 6, 2019).
[18] See s. 35, Ch. 2003-412, L.O.F.
[19] The JUA estimates that total state funds needed to fund the Subplan D deficit through the contingency reserve are approximately $4.2 million, which is $3.7 million less than the $7.9 million already appropriated and received from the Florida Legislature, and thus, no additional cash needs are anticipated. See correspondence from WCJUA to the OIR, dated July 13, 2018, on file with Senate Committee on Banking and Insurance.

insured because the former insured cannot be reasonably located would be retained by the WCJUA for future use.

Within 12 months after the failed initial delivery of the dividend or premium refund the JUA must:

- Conduct a diligent search to locate the former insured using a reasonable and prudent method to locate the owner. Examples of a diligent search include searching a nationwide database using a taxpayer identification number or social security number, cross indexing with other records related to the owner, mailing to the last known address unless known to be inaccurate, or engaging a licensed agency or company capable of performing the forgoing actions.
- Notify the insurance agency on the policy of the premium dividend or refund. Such notice does not constitute notice to the owner or make the agency responsible for the unclaimed property.
- If the unclaimed dividend or premium refund is valued at $250 or more, make at least one active notification attempt to directly contact a former insured after completing the diligent search. An active notification attempt does not include publication in a newspaper, on television, on the Internet, or through other promotional efforts and items.

The JUA must publish and maintain on its website a list of the names of former insureds who have unclaimed dividends or premium refunds and the amount owed.

A former insured may claim the dividend or premium refund from the JUA at any time.

Section 2 provides this act takes effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The retention by the JUA of unclaimed property will reduce the likelihood of an assessment of policyholders of the JUA or in the private market in the event the JUA runs a deficit. To date, the JUA has never had to assess policyholders.

C. Government Sector Impact:

The bill will cause an indeterminate reduction in State School Trust Fund monies available to fund education. The DFS estimates an average annual reduction in money remitted to the Bureau of Unclaimed Property during the next three fiscal years of $321,000. The Bureau of Unclaimed Property within DFS provided the following information regarding unclaimed property remitted by the JUA:[20]

Report Year	Total Accounts	Total Value	Claimed Accounts[21]	Value of Claimed Accounts
2013	0	$0	0	$0
2014	17	$31,654.16	3	$16,407.37
2015	99	$228,649.46	29	$94,442.44
2016	43	$170,218.34	16	$96,516.19
2017	415	$565,353.39	0	$0

The State School Trust Fund is funded through transfers of money from the Bureau of Unclaimed Property within the DFS. The Office of Economic and Demographic Research estimated that the trust fund will receive $129.4 million of its $131.4 million in total funds from the Bureau of Unclaimed Property in fiscal year 2018-2019.[22] The Legislature appropriated from the trust fund $32.8 million to the Florida Education Finance Program and $86.2 million for class size reduction.[23]

VI. Technical Deficiencies:

None.

---

[20] See Department of Financial Services, *Department of Financial Services (DFS) 2019 Legislative Bill Analysis for SB 264*, pg. 1, (Jan. 28, 2019).
[21] The 2017 accounts were received on January 23, 2019. The DFS chart is dated January 28, 2019. See Department of Financial Services, *Department of Financial Services (DFS) 2019 Legislative Bill Analysis for SB 264*, (Jan. 28, 2019).
[22] Office of Economic and Demographic Research, State School Trust Fund Financial Outlook Statement (March 1, 2019); http://edr.state.fl.us/Content/revenues/outlook-statements/state-school-tf/190301_SSTFoutl.pdf (last accessed March 6, 2019).
[23] *See id*.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 627.311 of the Florida Statutes.

IX. Additional Information:

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

CS by Banking and Insurance Committee on March 11, 2019:

- Requires the JUA to conduct a diligent search to locate the former insured; notify the insurance agency on the policy of the premium dividend or refund; and if the unclaimed dividend or premium refund is valued at $250 or more, make at least one active notification attempt to directly contact a former insured.
- Requires the JUA to publish and maintain on its website a list of the names of former insureds who have unclaimed dividends or premium refunds and the amount owed.
- Provides that a former insured may claim the dividend or premium refund from the JUA at any time.

B. Amendments:

None.

124924

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/11/2019	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Gruters) recommended the following:

Senate Amendment (with title amendment)

Delete lines 25 - 28
and insert:
3. Any dividend or premium refund not paid to a former insured of the plan because the insured cannot be located must be retained by the plan as surplus, subject to the following conditions:
a. Within 12 months after the failed initial delivery of the dividend or premium refund, the plan shall:

124924

(I) Conduct a diligent search to locate the former insured. As used in this sub-subparagraph, the term "diligent search" means the use of a reasonable and prudent method under particular circumstances to locate a former insured to whom a dividend or premium refund is owed. Such method includes searching a nationwide database by using the taxpayer identification number or social security number, if known; cross-indexing with other records related to the former insured; mailing to the last known address unless the last known address is known to be inaccurate; or engaging a licensed agency or company capable of conducting such search and providing an updated address.

(II) Notify the insurance agency on the policy of such dividend or premium refund. Notification to the insurance agency does not constitute notification to the former insured and does not make the insurance agency responsible for the dividend or premium refund.

(III) For an unclaimed dividend or premium refund valued at $250 or more, make at least one active notification attempt after completing the diligent search. As used in this sub-sub-subparagraph, the term "active notification attempt" means an attempt to directly contact a former insured to notify him or her of an unclaimed dividend or premium refund. The term does not include other means of notification which do not involve an attempt to directly contact the former insured, such as publication of the name of the former insured in a newspaper, on television, on the Internet, or through other promotional efforts and items.

b. The plan shall publish and maintain on the plan's

124924

website a list of the names of the former insureds who have unclaimed dividend or premium refunds and the amount of the dividend or premium refunds owed.

c. Notwithstanding s. 95.11, a former insured with satisfactory proof may claim any such dividend or premium refund from the plan at any time.

Section 2. This act shall take effect July 1, 2019.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete line 6

and insert:

underwriting plan of insurers as surplus, subject to specified diligent search and notification requirements and subject to certain claims by former insureds; defining the terms "diligent search" and "active notification attempt";

By Senator Gruters

23-00407-19 2019264__

A bill to be entitled

An act relating to the Florida Workers' Compensation Joint Underwriting Association; amending s. 627.311, F.S.; providing that certain dividends or premium refunds must be retained by the association's joint underwriting plan of insurers for future use; providing an effective date.

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

Section 1. Paragraph (h) of subsection (5) of section 627.311, Florida Statutes, is amended to read:

627.311 Joint underwriters and joint reinsurers; public records and public meetings exemptions.—

(5)

(h) 1. Any premium or assessments collected by the plan in excess of the amount necessary to fund projected ultimate incurred losses and expenses of the plan and not paid to insureds of the plan in conjunction with loss prevention or dividend programs must ~~shall~~ be retained by the plan for future use.

2. Any state funds received by the plan in excess of the amount necessary to fund deficits in subplan D or any tier must ~~shall~~ be returned to the state.

3. Any dividend or premium refund that cannot be paid to a former insured of the plan because the former insured cannot be reasonably located must be retained by the plan for future use.

Section 2. This act shall take effect upon becoming a law.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Commerce and Tourism, *Chair*
Finance and Tax, *Vice Chair*
Appropriations Subcommittee on Criminal and Civil Justice
Banking and Insurance

JOINT COMMITTEE:
Joint Committee on Public Counsel Oversight

SENATOR JOE GRUTERS
23rd District

February 4th, 2019

The Honorable Doug Broxson, Chair
Banking and Insurance Committee
320 Knott Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Chair Broxson:

I am writing to request that Senate Bill 264, Florida Workers' Compensation Joint Underwriting Association, be placed on the agenda of the next Banking and Insurance Committee meeting.

Should you have any questions regarding this bill, please do not hesitate to reach out to me. Thank you for your time and consideration.

Warm regards,

Joe Gruters

cc: James Knudson, Staff Director
Sheri Green, Committee Administrative Assistant

REPLY TO:
❒ 381 Interstate Boulevard, Sarasota, Florida 34240 (941) 378-6309
❒ 324 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5023

Senate's Website: *www.flsenate.gov*

BILL GALVANO
President of the Senate

DAVID SIMMONS
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

3-11-2019
Meeting Date

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

SB264
Bill Number (if applicable)

Topic Florida Workers' Compensation Joint Underwriting Association
Amendment Barcode (if applicable)

Name Robert Hawken

Job Title

Address 150 S. Monroe St. Suite 300
Street

Tallahassee FL 32301
City *State* *Zip*

Phone hawk@leathfl.com

Email 850-509-5900

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Workers' Compensation Joint Underwriting Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting

THE FLORIDA SENATE

APPEARANCE RECORD

3-11-2019
Meeting Date

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

264
Bill Number (if applicable)

124924
Amendment Barcode (if applicable)

Topic _____

Name Robert Hawken

Job Title _____

Address 150 S. Monroe St. Suite 300
Street
Tall. FL 32301
City *State* *Zip*

Phone 850 509-5900

Email hawk@leathfl.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Workers' Compensation Joint Underwriting Assn.

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	CS/SB 302
INTRODUCER:	Health Policy Committee and Senator Brandes
SUBJECT:	Nonemergency Medical Transportation Services
DATE:	March 8, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Williams	Brown	HP	**Fav/CS**
2.	Billmeier	Knudson	BI	**Favorable**
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 302 authorizes a transportation network company under contract with a Medicaid managed care plan, a transportation broker under contract with a Medicaid managed care plan, a transportation broker under direct contract with the Agency for Health Care Administration (AHCA), or a transportation network company that receives referrals from a transportation broker contracting with Medicaid managed care plans or the AHCA to provide Medicaid nonemergency transportation services to a Medicaid recipient, subject to compliance with state and federal Medicaid requirements.

The bill directs the AHCA to update any regulations, policies, and other guidance, including the Non-Emergency Transportation Services Coverage Policy handbook, as necessary, to reflect this authorization by October 1, 2019.

The bill provides that requirements for transportation network companies (TNCs) and TNC drivers may not exceed those requirements for TNCs imposed under s. 627.748, F.S., except as necessary to conform to federal Medicaid transportation requirements administered by the AHCA.

The bill stipulates that its provisions may not be construed to expand or limit the existing transportation benefit provided to Medicaid recipients or to require a Medicaid managed care plan to contract with a transportation network company or a transportation broker.

CS/SB 302 amends s. 401.25, F.S., to authorize a Medicaid managed care plan that administers nonemergency Medicaid transportation benefits, a plan's subcontracted transportation broker, or a transportation broker that administers the nonemergency Medicaid transportation benefit under contract with the AHCA, to engage a licensed basic life support or a licensed advanced life support ambulance for the provision of nonemergency Medicaid transportation in permitted ambulances in any county without first obtaining a Certificate of Public Convenience and Necessity.

The bill has no fiscal impact on state or local governments.

The effective date of the bill is July 1, 2019.

II. Present Situation:

Non-Emergency Medical Transportation (NEMT) Services

Non-emergency medical transportation (NEMT) includes transportation services offered to health care consumers who face barriers getting to their medical appointments. Those barriers can include not having a valid driver's license, not having a working vehicle in the household, being unable to travel or wait for services alone, or having a physical, cognitive, mental, or developmental limitation.

NEMT services are usually intended for medical appointments or other forms of non-emergent care. NEMT is widely known to serve Medicaid beneficiaries. Transportation services were established by the federal government as required Medicaid benefits when the Medicaid program was established at the national level in 1966.[1]

Florida Medicaid Program

The Florida Medicaid program is a partnership between the federal and state governments. Each state operates its own Medicaid program under a state plan approved by the federal Centers for Medicare & Medicaid Services (CMS). The state plan outlines Medicaid eligibility standards, policies, and reimbursement methodologies.

Florida Medicaid is administered by the Agency for Health Care Administration (AHCA) and financed with federal and state funds. Just under four million Floridians are currently enrolled in Medicaid, and the program's estimated expenditures for the 2019-2020 state fiscal year are $28.2 billion.[2]

Eligibility for Florida Medicaid is based on several factors, including age, household or individual income, and assets. State Medicaid payment guidelines are provided in s. 409.903,

[1] *See* What is Non-Emergency Medical Transportation, Patient Access?: available at https://patientengagementhit.com/news/what-is-non-emergency-medical-transportation-patient-access (last visited March 3, 2019).
[2] *See* Social Security Estimating Conference, Medicaid Caseloads and Expenditures, November 19, 2018, and December 10, 2018, Executive Summary available at http://edr.state.fl.us/Content/conferences/medicaid/execsummary.pdf (last visited March 3, 2019).

F.S., (Mandatory Payments for Eligible Persons) and s. 409.904, F.S., (Optional Payments for Eligible Persons). Minimum coverage thresholds are established in federal law for certain population groups, such as children or pregnant women.

Services are not eligible for federal matching funds under Medicaid unless they are authorized by the federal government. Section 409.905, F.S., specifies mandatory Medicaid services, which are required by the federal government, while s. 409.906, F.S., specifies optional services that the state has chosen to cover in its Medicaid program. Among the mandatory services included in s. 409.905, F.S., are Medicaid transportation services. Subsection (12) of this section reads:

> The agency shall ensure that appropriate transportation services are available for a Medicaid recipient in need of transport to a qualified Medicaid provider for medically necessary and Medicaid-compensable services, provided a client's ability to choose a specific transportation provider shall be limited to those options resulting from policies established by the agency to meet the fiscal limitations of the General Appropriations Act. The agency may pay for transportation and other related travel expenses as necessary only if these services are not otherwise available.

Under the coverage policies (also known as handbooks) separately adopted in rule by the AHCA, both emergency transportation services[3] and non-emergency transportation (NET) services[4] are covered when they meet specified criteria. Each of the handbooks consistently addresses: introductory details relating to service description, legal authority, definitions; recipient and provider eligibility; coverage information; exclusions; required documentation; authorization requirements; and reimbursement guidance.

As part of the implementation of Statewide Medicaid Managed Care (SMMC) in 2011, the Florida Medicaid program incorporated into managed care contracts the provision of NET services. As specified in s. 409.973, F.S., "transportation to access covered services" is one of the benefits managed care plans are required to provide under SMMC.

Approximately 80 percent of the enrollees in Florida Medicaid have their NET services provided as part of their managed care service coverage. The remainder of the Medicaid enrollees receive NET services that are paid for by the AHCA on a fee-for-service basis.

The AHCA has a federal waiver that allows for selective contracting with transportation brokers to provide NET services to Medicaid recipients not enrolled in managed care plans. To provide this benefit to such recipients, the AHCA has contracted with two transportation brokers.[5]

---

[3] *See* Rule 59G-4.015, F.A.C.; Medicaid Emergency Transportation Services Coverage Policy (October 2016), available at https://www.flrules.org/Gateway/reference.asp?No=Ref-07441 (last visited March 3, 2019).
[4] Rule 59G-4.330, F.A.C.; Medicaid NET Coverage Policy available at http://www.fdhc.state.fl.us/medicaid/review/Specific/59G-4.330_NET_Coverage_Policy_Adoption.pdf (last visited March 3, 2019).
[5] Agency for Health Care Administration, *Senate Bill 302 Analysis* (January 23, 2019)(on file with the Senate Committee on Banking and Insurance).

The AHCA published a notice in the Florida Administrative Register (FAR) for a rule change for Rule 59G-4.330 specific to NET services, on June 6, 2018, with a workshop held on June 22, 2018, and a deadline for submission of any comments on June 25, 2018. The proposed amendment would update the policy to specify that transportation network companies are eligible to render Medicaid non-emergency transportation services. To date, no follow-up information has appeared in the FAR.[6]

Transportation Brokers

Currently, the AHCA and managed care plans participating in the SMMC program contract directly with transportation brokers to coordinate and reimburse for NET services. A transportation broker is a company that subcontracts with NET providers throughout the state to schedule, monitor, and pay for transportation services. The Medicaid transportation brokers ensure that drivers have completed background screening and drug screening requirements and that they meet all other state and federal Medicaid requirements related to transportation services. They also ensure that vehicles meet all requirements and that each recipient receives the appropriate mode of transportation.[7]

Nonemergency Medical Transportation Services

Section 316.87, F.S., created in 2016, is specific to nonemergency medical transportation services. The provision prohibits a county that has licensed or issued a permit to a provider of nonemergency medical transportation services from requiring the provider to use a vehicle larger than needed to transport the number of passengers or that is inconsistent with the medical condition of the individuals receiving the service. This section is not applicable to procurement, contracting, or provision of paratransit services, directly or indirectly, by a county or an authority, pursuant to the Americans with Disabilities Act of 1990, as amended.

Transportation Network Companies

Transportation network companies (TNCs) are regulated under s. 627.748, F.S. Transportation network companies use smartphone technology to connect individuals who want to ride with private drivers for a fee.

In addition to definitions of relevant terms, s. 627.748, F.S., contains provisions regarding exclusions, a requirement for agent designation, fare transparency, identification requirements for vehicles and drivers, electronic receipts, insurance requirements specific to the company and drivers, including related disclosures and exclusions, limitations on TNCs, zero tolerance for driver drug or alcohol use, specific driver requirements, prohibited driver and company conduct, nondiscrimination and accessibility requirements, recordkeeping, and a prohibition on local preemption.

[6] *See* https://www.flrules.org/gateway/RuleNo.asp?id=59G-4.330 (last visited March 3, 2019).
[7] Agency for Health Care Administration, *Senate Bill 302 Analysis* (January 23, 2019)(on file with the Senate Committee on Banking and Insurance).

Emergency Medical Services (EMS) and Certificates of Public Convenience and Necessity (COPCN)

Chapter 401, F.S., relates to medical telecommunications and transportation. Part III of ch. 401, F.S., consisting of ss. 401.2101-401.465, F.S., is specific to medical transportation services and provides for the regulation of emergency medical services by the Department of Health (DOH), including the licensure of EMS service entities, the certification of the staff employed by those services, and the permitting of vehicles used by the staff in those services—whether for Basic Life Support (BLS), Advanced Life Support (ALS), and Air Ambulance Services (AAS). As indicated on the DOH website, at present, the department is responsible for the licensure and oversight of over 60,000 Emergency Medical technicians and paramedics, 270+ advanced and basic life support agencies, and over 4,500 EMS vehicles.[8]

In addition to the state requirements for licensure of EMS services, the statute provides that county governments also have a responsibility in the licensure of EMS service entities. Section 401.25, F.S., relating to licensure as a BLS or an ALS EMS service, includes, among other standards, the requirement for the issuance of a Certificate of Public Convenience and Necessity by the county in which the service will operate. Section 401.25(2)(d), F.S., requires the department to issue a license to any applicant which has obtained a certificate of public convenience and necessity from each county in which the applicant will operate.

Section 401.25(6), F.S., authorizes counties to adopt ordinances that provide reasonable standards for certificates of public convenience and necessity for basic or advanced life support services and air ambulance services, and, in so doing, to consider state guidelines, recommendations of the local or regional trauma agency created under ch. 395, F.S., and the recommendations of municipalities within its jurisdiction.

Similar to s. 401.25, F.S., specific to ALS and BLS EMS entities, s. 401.251, F.S., is specific to those entities seeking to provide air ambulance services. Among the licensure requirements, paragraph (4)(b) stipulates that an air ambulance service that uses rotary-winged aircraft in conjunction with another emergency medical service must meet the provisions of s. 401.251, F.S., and must separate basic life support and advanced life support requirements unique to air ambulance operations as is required by rules of the department. Section 401.251, F.S., also subjects the air ambulance service to the provisions of s. 401.25, F.S., relating to a certificate of public convenience and necessity. However, an air ambulance service may operate in any county under the terms of mutual aid agreements.

In addition to the applicable statutory provisions, the DOH has adopted and enforces rules under chapter 64J-1, Florida Administrative Code (F.A.C.), specific to EMS regulation. Rule 64J-1.001, F.A.C., defines a "certificate of public convenience and necessity" as "a written statement or document, issued by the governing board of a county, granting permission for an applicant or licensee to provide services authorized by a license issued under chapter 401, part III, F.S., for the benefit of the population of that county or the benefit of the population of some geographic area of that county. No COPCN from one county may interfere with the prerogatives asserted by another county regarding COPCN."

[8] *See* http://www.floridahealth.gov/licensing-and-regulation/ems-system/index.html (last visited March 4, 2019).

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 316.87, F.S., relating to nonemergency transportation services. A new subsection (2) is added to this section of statute to authorize a transportation network company under contract with a Medicaid managed care plan, a transportation broker under contract with a Medicaid managed care plan, a transportation broker under direct contract with the AHCA, or a transportation network company that receives referrals from a transportation broker contracting with Medicaid managed care plans or the AHCA to provide Medicaid nonemergency transportation services to a Medicaid recipient, subject to compliance with state and federal Medicaid requirements.

The bill directs the AHCA to update any regulations, policies, and other guidance, including the Non-Emergency Transportation Services Coverage Policy handbook, as necessary to reflect this authorization by October 1, 2019.

The bill stipulates that requirements for transportation network companies and transportation network company drivers may not exceed requirements for transportation network companies imposed under s. 627.748, F.S., except as necessary to conform to federal Medicaid transportation requirements administered by the AHCA. The AHCA indicates that the only additional requirement that it would impose beyond what is specified in s. 627.748, F.S., would be to require that TNC drivers undergo FDLE Level I background screening requirements, as this is required for Medicaid providers per s. 409.907, F.S.

The bill stipulates that its provisions may not be construed to expand or limit the existing transportation benefit provided to Medicaid recipients or to require a Medicaid managed care plan to contract with a transportation network company or a transportation broker.

The AHCA indicates that it is not aware of any other state Medicaid programs that reimburse NET services provided by TNCs.[9]

Section 2 of the bill adds subsection (8) to s. 401.25, F.S., relating to Department of Health Emergency Medical Services licensure of basic life support providers and advanced life support providers. The bill authorizes a Medicaid managed care plan that administers nonemergency Medicaid transportation benefits, a plan's subcontracted transportation broker, or a transportation broker that administers the nonemergency Medicaid transportation benefit under contract with the AHCA, to engage a licensed basic life support or a licensed advanced life support ambulance service for the provision of nonemergency Medicaid transportation in permitted ambulances in any county without first obtaining a certificate of public convenience and necessity.

Section 3 of the bill provides for a July 1, 2019, effective date.

[9] Agency for Health Care Administration, *Senate Bill 302 Analysis* (January 23, 2019)(on file with the Senate Committee on Banking and Insurance).

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Affected transportation providers may benefit financially from potential flexibility provided for Medicaid managed care plans to contract with such providers. Individuals in need of Medicaid nonemergency transportation services may benefit from having additional options. TNCs would have the opportunity to compete with existing transportation providers such as taxis to provide services to Medicaid recipients.

C. Government Sector Impact:

The bill does not appear to have a fiscal impact on state or local governments.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The Agency for Health Care Administration might have difficulty meeting the time constraints of the requirement on lines 50-53 of the bill to update its existing regulations, policies, and other

guidance, including the nonemergency transportation services policy handbook, by October 1, 2019.[10]

VIII. Statutes Affected:

This bill substantially amends sections 316.87 and 401.25 of the Florida Statutes.

IX. Additional Information:

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

CS by Health Policy on February 19, 2019:
The CS:

- Adds to the list of those entities that may provide nonemergency transportation services a transportation network company that receives referrals from a transportation broker contracting with Medicaid managed care plans or the Agency for Health Care Administration (AHCA);
- Directs the AHCA to update any regulations, policies, and other guidance necessary, not just the Non-emergency Transportation Services Coverage Policy as was required by the underlying bill; and
- Amends s. 401.25, F.S., relating to Department of Health Emergency Medical Services licensure of basic life support providers and advanced life support providers and creates a new subsection (8) of that section to authorize a Medicaid managed care plan that administers nonemergency Medicaid transportation benefits, a plan's subcontracted transportation broker, or a transportation broker that administers the nonemergency Medicaid transportation benefit under contract with the AHCA, to engage a licensed basic life support or a licensed advanced life support ambulance for the provision of nonemergency Medicaid transportation in permitted ambulances in any county without first obtaining a Certificate of Public Convenience and Necessity, as would otherwise be required under paragraph (2)(d) of that section.

B. Amendments:

None.

[10] Agency for Health Care Administration, *Senate Bill 302 Analysis* (January 23, 2019)(on file with the Senate Committee on Banking and Insurance).

817360

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
03/11/2019	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Brandes) recommended the following:

Senate Amendment (with title amendment)

Between lines 63 and 64

insert:

(3) A transportation network company under contract with a public transit provider, as defined in s. 341.031(1), may provide nonemergency transportation services to individual users. Requirements for transportation network companies and transportation network company drivers under this subsection may not exceed those imposed under s. 627.748.

817360

11
12 ================ T I T L E A M E N D M E N T ================
13 And the title is amended as follows:
14 Delete line 16
15 and insert:
16 agency; providing construction; authorizing a
17 transportation network company under contract with a
18 public transit provider to provide nonemergency
19 transportation services to individual users; providing
20 that the requirements for transportation network
21 companies and transportation network company drivers
22 may not exceed specified requirements; amending s.
23 401.25,

529474

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
03/11/2019	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Rouson) recommended the following:

Senate Amendment (with title amendment)

Delete lines 68 - 77

and insert:

(8)(a) A managed care plan that administers the nonemergency Medicaid transportation benefit or the plan's subcontracted transportation broker, or a transportation broker administering the nonemergency Medicaid transportation benefit for the Agency for Health Care Administration, shall attempt to secure in each county nonemergency ambulance transportation

529474

services with the ambulance provider or providers that have obtained a certificate of public convenience and necessity in the county.

(b) If a managed care plan, its subcontracted transportation broker, or a transportation broker is unable to secure nonemergency ambulance transportation services in a county after a good faith attempt, the managed care plan, its subcontracted transportation broker, or the transportation broker may request an ambulance provider that is licensed as a basic life support service or an advanced life support service in accordance with this section and that uses vehicles permitted in accordance with s. 401.26. Such an ambulance provider may provide nonemergency Medicaid transportation services in the county and is exempt from paragraph (2)(d). For purposes of this paragraph, a managed care plan, its subcontracted transportation broker, or a transportation broker has in good faith attempted to secure a nonemergency transportation trip with an ambulance provider in a county when the following have occurred:

1. The managed care plan, its subcontracted transportation broker, or the transportation broker has contacted all providers that operate within the county which are licensed as a basic life support service or an advanced life support service in accordance with this section and use vehicles permitted in accordance with s. 401.26, regarding the need for a nonemergency ambulance Medicaid transportation trip in the county and the applicable timeframe for the trip requested;

2. In making the contact pursuant to subparagraph 1., the managed care plan, its subcontracted transportation broker, or the transportation broker offered to schedule a nonemergency

529474

ambulance Medicaid transportation trip at the established Medicaid rate and in accordance with such other terms required by the Agency for Health Care Administration; and

3. The managed care plan, its subcontracted transportation broker, or the transportation broker allowed a reasonable time period after delivery of the offer, given the circumstances of the transportation need and the urgency of the request, for the ambulance provider to accept and schedule the trip or decline the trip. An ambulance provider that fails to respond to a request within a reasonable period of time is deemed to have declined the trip request.

(c) A managed care plan, its subcontracted transportation broker, or a transportation broker shall retain for at least 5 years records that document all good faith attempts to secure a nonemergency transportation trip with an ambulance provider pursuant to this subsection and any instances of securing nonemergency transportation services with an ambulance provider that does not possess a certificate of public convenience and necessity in the county where the service was provided.

================ T I T L E A M E N D M E N T ================

And the title is amended as follows:

Delete lines 17 - 21

and insert:

F.S.; requiring certain managed care plans or their subcontracted transportation brokers or certain transportation brokers to attempt to secure in each county nonemergency ambulance transportation services with the ambulance provider or providers that have

obtained a certificate of public convenience and necessity in the county; authorizing the managed care plan, its subcontracted transportation broker, or the transportation broker to request an ambulance provider licensed as a basic life support service or an advanced life support service under certain circumstances; authorizing the ambulance provider to provide nonemergency Medicaid transportation services in that county; exempting the ambulance provider from certain certificate of public convenience and necessity requirements; specifying the circumstances under which a managed care plan, its subcontracted transportation broker, or a transportation broker has in good faith attempted to secure a nonemergency transportation trip with an ambulance provider; requiring a managed care plan, its subcontracted transportation broker, or a transportation broker to retain certain records for a specified minimum period; providing an effective date.

By the Committee on Health Policy; and Senator Brandes

588-02478-19 2019302c1

A bill to be entitled

An act relating to nonemergency medical transportation services; amending s. 316.87, F.S.; authorizing Medicaid nonemergency transportation services to be provided to a Medicaid recipient by certain transportation network companies or transportation brokers, subject to compliance with certain requirements; requiring the Agency for Health Care Administration to update certain regulations, policies, or other guidance by a specified date; providing that the requirements for transportation network companies and transportation network company drivers may not exceed specified requirements, except as necessary to conform to federal Medicaid transportation requirements administered by the agency; providing construction; amending s. 401.25, F.S.; authorizing a licensed basic life support or licensed advanced life support ambulance service to provide nonemergency Medicaid transportation in permitted ambulances in any county at the request of a certain eligible plan; providing an effective date.

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

Section 1. Section 316.87, Florida Statutes, is amended to read:

316.87 Nonemergency medical transportation services.—

(1) To ensure the availability of nonemergency medical transportation services throughout the state, a provider

588-02478-19 2019302c1

licensed by the county or operating under a permit issued by the county may not be required to use a vehicle that is larger than needed to transport the number of persons being transported or that is inconsistent with the medical condition of the individuals receiving the nonemergency medical transportation services. This subsection ~~section~~ does not apply to the procurement, contracting, or provision of paratransit transportation services, directly or indirectly, by a county or an authority, pursuant to the Americans with Disabilities Act of 1990, as amended.

(2)(a) Subject to compliance with any applicable state and federal Medicaid requirements, a transportation network company under contract with a Medicaid managed care plan, a transportation broker under contract with a Medicaid managed care plan, a transportation broker under direct contract with the Agency for Health Care Administration, or a transportation network company that receives referrals from a transportation broker contracting with Medicaid managed care plans or the Agency for Health Care Administration may provide Medicaid nonemergency transportation services to a Medicaid recipient. The Agency for Health Care Administration shall update any regulations, policies, or other guidance, including the Non-Emergency Transportation Services Coverage Policy, as necessary to reflect this authorization by October 1, 2019. Requirements for transportation network companies and transportation network company drivers may not exceed those imposed under s. 627.748, except as necessary to conform to federal Medicaid transportation requirements administered by the Agency for Health Care Administration.

(b) This subsection may not be construed to expand or limit the existing transportation benefit provided to Medicaid recipients or to require a Medicaid managed care plan to contract with a transportation network company or a transportation broker.

Section 2. Subsection (8) is added to section 401.25, Florida Statutes, to read:

401.25 Licensure as a basic life support or an advanced life support service.—

(8) At the request of an eligible plan as defined in s. 409.962 which administers the nonemergency Medicaid transportation benefit, the plan's subcontracted transportation broker, or a transportation broker that administers the nonemergency Medicaid transportation benefit for the Agency for Health Care Administration, a licensed basic life support or licensed advanced life support ambulance service may provide nonemergency Medicaid transportation in permitted ambulances in any county without obtaining a certificate of public convenience and necessity as required in paragraph (2)(d).

Section 3. This act shall take effect July 1, 2019.

2019 AGENCY LEGISLATIVE BILL ANALYSIS

AGENCY: Agency for Health Care Administration

BILL INFORMATION	
BILL NUMBER:	SB 302
BILL TITLE:	Nonemergency Medical Transportation
BILL SPONSOR:	Senator Brandes
EFFECTIVE DATE:	July 1, 2019

COMMITTEES OF REFERENCE
1) N/A
2)
3)
4)

CURRENT COMMITTEE
N/A

SIMILAR BILLS	
BILL NUMBER:	HB 411

PREVIOUS LEGISLATION	
BILL NUMBER:	N/A
SPONSOR:	
YEAR:	
LAST ACTION:	

IDENTICAL BILLS	
BILL NUMBER:	N/A
SPONSOR:	

Is this bill part of an agency package?
Y ___ N __x__

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	January 23, 2019
LEAD AGENCY ANALYST:	Matt Brackett, Division of Medicaid and Brittney Moulton, Division of Medicaid
ADDITIONAL ANALYST(S):	Christina Vracar, Division of Medicaid
LEGAL ANALYST:	
FISCAL ANALYST:	

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

Senate Bill (SB) 302 amends section 316.87, Florida Statutes (F.S.) to allow transportation network companies (TNCs) to deliver transportation services to Florida Medicaid recipients. In addition, SB 302 amends the statute to permit the Agency for Health Care Administration (Agency) and health plans participating in the Statewide Medicaid Managed Care (SMMC) program to either contract directly with TNCs or with transportation brokers who contract with TNCs. The language does not require either the Agency or health plans to allow TNCs to provide transportation services to Medicaid recipients. The bill further specifies that the Agency cannot impose stricter requirements on TNCs than what is stated in section 627.748, F.S. except when necessary to comply with federal Medicaid transportation regulations, which the Agency may need to do, particularly for background screenings. Currently, the screening requirements specified in section 627.748, F.S. do not align with Medicaid background screening requirements contained in section 409.907, F.S., which requires all Medicaid providers undergo a Florida Department of Law Enforcement (FDLE) Level I background screening (in accordance with Chapter 435, F.S.).

SB 302 also directs the Agency to update the Medicaid Non-Emergency Transportation Services Coverage Policy by October 1, 2019 to reflect the changes specified in the bill.

The bill has an effective date of July 1, 2019.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

The Agency for Health Care Administration (Agency) is the single state agency responsible for the administration of the Florida Medicaid program, authorized under Title XIX of the Social Security Act (SSA). This authority includes establishing and maintaining a Medicaid state plan, approved by the Centers for Medicare and Medicaid Services. A Medicaid state plan is an agreement between a state and the federal government describing how that state administers its Medicaid program. It establishes groups of individuals covered under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements.

The state Medicaid program may request a formal waiver of the requirements codified in the SSA. Federal waivers give state flexibility not afforded through the Medicaid state plan. Florida has several waivers authorized that facilitate implementation of certain statutory requirements.

In Florida, the majority of Medicaid recipients receive their services through a managed care plan contracted on a regional basis with the Agency under the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has three components: the integrated Managed Medical Assistance (MMA) component, Long-term Care (LTC) component and Dental component. Florida's SMMC program benefits are authorized through federal waivers and are specifically required by the Florida Legislature in sections 409.973 and 409.98, F.S. The SMMC benefits are a robust health care package covering medical, behavioral health, long-term care, and dental services.

Medicaid covers transportation services for medical emergencies and to all Medicaid services through the MMA and LTC programs.

The Agency has a federal waiver that allows for selective contracting with transportation brokers to provide non-emergency transportation (NET) services to recipients in the fee-for-service (FFS) delivery system. To provide this benefit to the FFS population, the Agency has contracted with two transportation brokers.

Non-Emergency Transportation Services

As a benefit specified in the state plan, Florida Medicaid provides NET services to eligible recipients of all ages for the purpose of accessing Medicaid-covered services. Depending on the recipient's individual needs, NET services can range from city buses to air ambulances equipped for advanced life support. The services transport recipients to and from appointments, hospitals, and other medically necessary services. NET services are also available to transport recipients to receive services outside of their region or state.

Vehicles utilized for NET services vary greatly. Recipients who are either wheelchair bound or bedridden require special vans, while those who require medical management or assistance need air or ground ambulances. Recipients who do not need special assistance may use public transportation or taxis. Florida Medicaid allows for the following vehicle types under the NET benefit:

- Public transportation
- Taxis and private vehicles
- Multi-load passenger vans
- Wheelchair and stretcher vans
- Ground ambulances
- Air ambulances
- Commercial airlines

Aside from reimbursing for recipients' transportation, the NET benefit also covers transporting an escort (e.g., parent, guardian, or authorized representative) and lodging expenses for trips out-of-state or region. NET is applicable to any Medicaid covered service, and the number of trips is not restricted.

Florida Medicaid requires that vehicles and drivers must meet certain requirements to be eligible to transport Medicaid recipients. These include completing background screening requirements, maintaining clean interiors, ensuring regular engine maintenance, and having adequate storage space and seating. Drivers must complete a Florida Department of Law Enforcement Level I background screening, but do not need to undergo a Level II background screening like other Medicaid providers. This is due to their classification as a non-traditional provider under the federal Health Insurance Portability and Accountability Act. The Agency has authority to require background screenings under Title 42 Code of Federal Regulations section 455.434 and section 409.907, F.S.

Transportation Brokers

Currently, the Agency and health plans participating in the SMMC program contract directly with transportation brokers to coordinate and reimburse for NET services. A transportation broker is a company that subcontracts with NET providers throughout the state to schedule, monitor, and pay for transportation services. The Medicaid transportation brokers ensure that drivers have completed background screening and drug screening requirements and that they meet all other state and federal Medicaid requirements related to transportation services. They also ensure that vehicles meet all requirements and that each recipient receives the appropriate mode of transportation.

Transportation Network Companies

Based on a system of independent contractors, Transportation Network Companies (TNCs) such as Uber and Lyft function by using a digital platform to connect riders with transportation in their respective areas. Utilizing a smartphone application, riders can schedule, select, and track the location of their drivers while awaiting pick up. The drivers have the ability to select which transportation requests to fulfill based on their schedule and proximity to location. Because they function independently, TNC drivers can set their own hours and schedules. In addition, rates for TNCs tend to fluctuate depending on peak demand times.

Effective July 1, 2017, TNCs operating in Florida had to conform to section 627.748, F.S. Under this law, drivers wanting to contract with TNCs must pass a local and national criminal background check that includes a search of Multi-State/Multi-Jurisdiction Criminal Records Locator or similar commercial nationwide database, a search of the United States Department of Justice National Sex Offender Public website, a driving history report, and meet specific insurance liability requirements. These requirements are not identical to the Level I background check requirements defined in section 435.03, F.S. In addition, TNCs have the option of subcontracting with third parties to complete the required screenings.

Aside from insurance and background requirements, TNCs do not have to follow uniform vehicle inspection standards, as this is not specified in statute. However, nationwide TNCs have similar requirements including passing an all-points inspection, having four doors, and being free from dents and interior damage. Additionally, these TNCs also have customer ratings standards that drivers must meet in order to remain contracted.

The Agency is not aware of any other state Medicaid programs that reimburse NET services provided by TNCs.

2. EFFECT OF THE BILL:

Senate Bill (SB) 302 amends section 316.87, F.S. by adding language that allows for transportation network companies (TNCs) as defined in section 627.748, F.S. to provide non-emergency transportation (NET) services to Florida Medicaid recipients. If passed, TNCs may contract directly with health plans participating in the Statewide Medicaid Managed Care program or through transportation brokers that are either contracted with the Agency or the health plans. The bill does not mandate that the Agency or health plans use TNCs for non-emergency transportation services.

The bill requires the Agency to update its Medicaid NET coverage policy by October 1, 2019 to reflect this change. Updating the Medicaid coverage policies is part of the Agency's routine business practices and poses an insignificant operational impact. Updates to the coverage policy will be subject to the administrative procedures act requirements, outlined in Chapter 120, F.S., which may take up to nine months. This may mean that the rule may not be finalized and adopted by October 1, 2019.

The bill specifies that the Agency may not impose stricter requirements on TNCs beyond what is specified in section 627.748, F.S. unless it is necessary to comply with federal and state regulations. The only additional requirement that the Agency would implement beyond what is specified in s. 627.748, F.S., would be to require that drivers undergo FDLE Level I background screening requirements, as this is required for Medicaid providers per s. 409.907, F.S.

The changes in this bill do not pose a fiscal impact to the Agency.

SB 302 takes effect on July 1, 2019.

3. DOES THE BILL DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES? Y _X__ N ___

If yes, explain:	Existing rules will need to be amended to comply with the bill.
Is the change consistent with the agency's core mission?	Y _X__ N ___
Rule(s) impacted (provide references to F.A.C., etc.):	59G-4.330 – Nonemergency Transportation Services Coverage Policy

4. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?

Proponents and summary of position:	Transportation Network Companies and Transportation Brokers

Opponents and summary of position:	Unknown

5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL? Y ___ N _X__

If yes, provide a description:	
Date Due:	
Bill Section Number(s):	

6. ARE THERE ANY GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC.? REQURIED BY THIS BILL? Y ___ N _X__

Board:	N/A
Board Purpose:	N/A
Who Appointments:	N/A
Appointee Term:	N/A
Changes:	N/A
Bill Section Number(s):	N/A

FISCAL ANALYSIS

1. DOES THE BILL HAVE A FISCAL IMPACT TO LOCAL GOVERNMENT? Y __ N __X__

Revenues:	Unknown
Expenditures:	Unknown
Does the legislation increase local taxes or fees? If yes, explain.	No
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	N/A

2. DOES THE BILL HAVE A FISCAL IMPACT TO STATE GOVERNMENT? Y ___ N _X__

Revenues:	Unknown
Expenditures:	Unknown
Does the legislation contain a State Government appropriation?	No
If yes, was this appropriated last year?	N/A

3. **DOES THE BILL HAVE A THE FISCAL IMPACT TO THE PRIVATE SECTOR?** Y _X_ N ___

Revenues:	Unknown
Expenditures:	Unknown
Other:	Transportation Network Companies would have the opportunity to compete with existing transportation providers such as taxis to provide services to Medicaid recipients.

4. **DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES?** Y ___ N _X_

If yes, explain impact.	N/A
Bill Section Number:	N/A

TECHNOLOGY IMPACT

1. **DOES THE BILL IMPACT THE AGENCY'S TECHNOLOGY SYSTEMS (I.E. IT SUPPORT, LICENSING SOFTWARE, DATA STORAGE, ETC.)?** Y _X_ N ___

If yes, describe the anticipated impact to the agency including any fiscal impact.	Routine operational procedures and business functions to update Florida Medicaid to include transportation network companies and transportation brokers as provider types to enroll in Florida Medicaid.

FEDERAL IMPACT

1. **DOES THE BILL HAVE A FEDERAL IMPACT (I.E. FEDERAL COMPLIANCE, FEDERAL FUNDING, FEDERAL AGENCY INVOLVEMENT, ETC.)?** Y ___ N _X_

If yes, describe the anticipated impact including any fiscal impact.	N/A

ADDITIONAL COMMENTS

N/A

LEGAL – GENERAL COUNSEL'S OFFICE REVIEW

The Florida Senate

Committee Agenda Request

To: Senator Doug Broxson
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: February 25, 2019

I respectfully request that **Senate Bill #302**, relating to **Nonemergency Medical Transportation Services**, be placed on the:

- ☒ committee agenda at your earliest possible convenience.
- ☐ next committee agenda.

Senator Jeff Brandes
Florida Senate, District 24

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/2019
Meeting Date

CS/SB 302
Bill Number (if applicable)

Topic Medicaid

Amendment Barcode (if applicable)

Name Cari Roth

Job Title Lobbyist for FL. Ambulance Association, Manatee, Lee & Charlotte Counties

Address 215 S. Monroe St Suite 815
Street

Phone 850/999-4100

Tlk FL 32303
City *State* *Zip*

Email croth@deanmead.com

Speaking: ☐ For ☒ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3.11.19
Meeting Date

302
Bill Number (if applicable)

Topic Non Emergency Medical Transport

Amendment Barcode (if applicable)

Name Sarah Suskey

Job Title

Address 204 S. Monroe St
Street

Phone 850.222.8100

TLH FL 32301
City *State* *Zip*

Email sbs@cardenaspartners.com

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing TechNet

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/2019
Meeting Date

302
Bill Number (if applicable)

Topic Non-Emergency Medical Transport Svcs

Amendment Barcode (if applicable)

Name Christian R. Camara -- Institute for Justice

Job Title Legislative Fellow

Address 901 N Glebe Road, Suite 900
Street

Phone 305.721.1600

Arlington VA 22203
City *State* *Zip*

Email Christian@ChamberConsultantsFL.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Institute for Justice

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/19
Meeting Date

302
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Medical transportation

Name Ron Watson

Job Title Lobbyist

Address 3738 Mundan Way
Street
Tallahassee FL 32309
City *State* *Zip*

Phone 850 567 1202

Email Watson.Strategies@Comcast.net

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Renal Coalition

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3-11-19
Meeting Date

302
Bill Number (if applicable)

Topic Non-Emergency Transportation

Amendment Barcode (if applicable)

Name Audrey Brown

Job Title ~~Florida Assoc. of Health Plans~~ President/CEO

Address 200 W. College Ave.
Street

Phone

Tallahassee FL 32301
City *State* *Zip*

Email

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FL Assoc. of Health Plans

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/2019
Meeting Date

302
Bill Number (if applicable)

Topic Non Emergency Medical Transport

Amendment Barcode (if applicable)

Name Jorge Chamizo

Job Title Attorney

Address 108 South Monroe Street
Street
Tallahassee, FL 32301
City *State* *Zip*

Phone (850) 681-0024

Email jorge@flapartners.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Uber Technologies

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3-11-19
Meeting Date

302
Bill Number (if applicable)

529474
Amendment Barcode (if applicable)

Topic NEMT

Name Audrey Brown

Job Title President + CEO

Address 206 W College Ave.
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850-386-2904

Email

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FL Association of Health Plans

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	CS/SB 524
INTRODUCER:	Banking and Insurance Committee and Senators Diaz and Farmer
SUBJECT:	Health Insurance Savings Programs
DATE:	March 12, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.			GO	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

I. CS/SB 524 creates the Patient Savings Act, which allows health insurers and health maintenance organizations (HMOs) to create a shared savings incentive program that may provide financial incentives to insureds with individual policies or contracts when they obtain shoppable health care services offered by their health insurer or HMO through their shared savings list. The shoppable health care services are lower-cost, high-quality non-emergency services for which a shared savings incentive is available for insureds under the program. The insurer's shared savings incentive list may include shoppable health care services within and outside of Florida. The program is voluntary for insurers, HMOs, policyholders, and subscribers. Health insurers offering a shared savings incentive program must submit an annual report to the Office of Insurance Regulation regarding the performance of the program.

The bill does not have a fiscal impact on the Office of Insurance Regulation.

II. Present Situation:

Health care spending in the United States is expected to grow an average of 5.5 percent annually from 2018-2027, reaching nearly $6.0 trillion by 2027.[1] Consumers are becoming responsible for a growing proportion of this spending, as demonstrated in the increased use of high deductible

[1] Office of the Actuary, Centers for Medicare & Medicaid Services (CMS), National Health Expenditure Projections 2018-2027, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf (last viewed March 2, 2019).

health plans, and other forms of cost sharing. Since 2012, the percentage of workers covered by a plan with a deductible of $1,000 or greater has grown from 34 to 51 percent.[2]

Price transparency and quality transparency enable consumers to obtain more value out of the health care system. Greater awareness and access by consumers to pricing information before obtaining health care services may result in lower overall payments for health care services and higher quality providers. A recent study concluded that the use of private price transparency platforms was associated with lower claims payments for common medical services. [3] According to a 2017 survey, 98 percent of health plans around the country indicated that they have cost calculator tools, but only 2 percent of policyholders or subscribers use them.[4] Financial incentives may encourage consumer to access price information. Incentives may include reductions in premiums, cash payments, or lower out-of-pocket costs for their members if they select low-price, high quality providers.

Regulation of Health Insurance

The Office of Insurance Regulation is responsible for the regulation of insurers and other risk-bearing entities.[5] Rates and forms of individual and small group policies and contracts are subject to prior approval. The Insurance Code does not address a shared savings program.

Section 627.6385, F.S., requires health insurers writing individual policies to make available on their website a method for policyholders to estimate their copayments, deductibles, and other cost-sharing responsibilities for health care services and procedures.[6] Insurers are required to provide a hyperlink to health information, including service bundles and quality of care information, developed by the Agency for Health Care Administration. Likewise, the federal Patient Protection and Affordable Care Act[7] requires insurance policies and contracts to provide price and coverage information to enrollees, including cost sharing and payments with respect to out-of-network coverage.[8]

State Group Insurance Program

On January 1, 2019, the Division of State Group Insurance of the Department of Management Services instituted a voluntary shared savings program to reward policyholders, subscribers, or their dependents for making informed and cost-effective decisions about health care spending, thereby reducing healthcare costs.[9] The program allows participants to earn rewards by receiving rewardable healthcare services through two state vendors. Rewards are credited to a select pretax

[2] North Carolina Medical Journal, 79. 1.34.
[3] JAMA. 2014:312(16):1670-1676.
[4] Catalyst for Payment Reform Survey available at http://www.catalyzepaymentreform.org/wp-content/uploads/2017/04/National-Scorecard.png (last viewed March 2, 2019).
[5] Section 20.121, F.S. The Financial Services Commission, composed of the Governor, Attorney General, Commissioner of Agriculture, and the Chief Financial Officer, are the agency head for purposes of rulemaking.
[6] The Agency for Healthcare Administration, available at http://www.floridahealthfinder.gov/index.html (last viewed March 2, 2019).
[7] Patient Protection and Affordable Care Act, Public Law 111–148, was enacted on March 23, 2010; and amended by the Health Care and Education Reconciliation Act, Public Law 111–152, was enacted on March 30, 2010.
[8] 45 CFR Part 147 and Section 2715A Public Health Service Act.
[9] Ch. 2017-70, L.O.F.

savings or spending account of the participant, and funds can be used to pay for eligible medical, dental, and vision expenses. Rewards are earned after the participant shops for a rewardable healthcare service on the website, receives the service, and the claim has been paid.[10]

III. Effect of Proposed Changes:

Section 1 creates s. 627.6387, F.S., the "Patient Saving Act." This section establishes the shared savings incentive program, which is a voluntary incentive program a health insurer may establish to provide incentives when the insured who has an individual policy, contract, or certificate of insurance obtains a shoppable health care service from a health insurer's shared savings list. An insured may not be required to participate in a shared savings incentive program. For purposes this section, the terms, "health care provider," health insurer," "shared savings incentive," "shared "savings incentive program," and "shoppable health care service" are defined.

A "health care provider" means a hospital, a facility licensed under ch. 395; F.S., an entity licensed under ch. 400, F.S,; a health care practitioner as defined in s. 456.001, F.S.; a blood bank, plasma center, industrial clinic, and renal dialysis facility; or a professional association, partnership, corporation, joint venture, or other association for professional activity by health care providers. The term includes entities and professionals outside of this state with an active, unencumbered license for an equivalent facility or practitioner type issued by another state, the District of Columbia, or a possession or territory of the United States.

A "health insurer" is an authorized insurer offering health insurance as defined in s. 624.603, F.S., or a health maintenance organization as defined in s. 641.19, F.S. The term does not include the state group health insurance program.

A "shared savings incentive," is a voluntary and optional financial incentive that a health insurer may provide to an insured for choosing certain shoppable health care services under a shared savings incentive program and may include, but is not limited to, the incentives described in s. 626.9541(4)(a), F,S., which relate to participation in a wellness or health improvement program. The term, "shared savings incentive program," means a voluntary and optional incentive program established by a health insurer pursuant to this section.

- A "shoppable health care service" is a lower-cost, high quality nonemergency health care service for which a shared savings incentive is available for insureds under a health insurer's shared savings incentive program. Shoppable health care services may be provided within or outside of this state and include, but are not limited to: Clinical laboratory services.
- Infusion therapy.
- Inpatient and outpatient surgical procedures.
- Obstetrical and gynecological services.
- Inpatient and outpatient nonsurgical diagnostic tests and procedures.
- Physical and occupational therapy services.
- Radiology and imaging services.
- Prescription drugs.
- Services provided through telehealth.

[10] MyBenefits, Shared Savings Program, available at https://www.mybenefits.myflorida.com/health/shared_savings_program (last viewed March 2, 2019).

A health insurer that offers a shared savings incentive program must:

- Establish the program as a component part of the policy, contract, or certificate of insurance provided by the health insurer.
- File a description of the program with the OIR on a form prescribed by the commission. The OIR must determine if the program complies with the statutory requirements.
- Notify each insured about the program annually, and at the time of renewal, and notify an applicant for insurance of the availability of the program at the time of enrollment.
- Publish on a webpage easily accessible to insureds and to applicants for insurance coverage a list of shoppable health care services and health care providers and the shared savings incentive amount applicable for each service.
- Notify insureds and the OIR 30 days before program termination.

A shared saving incentive:

- May not be less than 25 percent of the savings generated by the insured's participation in any shared savings incentive offered by the health insurer. The baseline for the savings calculation is the average in-network amount paid for that service in the most recent 12-month period or some other methodology established by the health insurer and approved by the OIR.
- Must be credited or deposited quarterly to an insured's account as a return or reduction in premium, or credited to the insured flexible spending account, health savings account, or health reimbursement account, such that the amount does not does not constitute income for the insured.

A health insurer offering a shared savings program must submit an annual report to the OIR after the end of each plan year. At a minimum, the report must include the following information:

- Number of insureds who participated in the program and the number of instances of participation.
- The total cost of services provided as a part of the program.
- The total value of the incentive payments made to insureds participating in the program and the values distributed as premium reductions, credits to flexible spending, health savings, or health reimbursement accounts.
- An inventory of the shoppable health care services offered by the health insurer.

A shared savings incentive offered by a health insurer:

- Is not an administrative expense for rate development or rate filing purposes.
- Does not constitute an unfair method of competition or an unfair or deceptive act or practice under s. 626.9541, F.S., and is presumed to be appropriate unless credible data clearly demonstrates otherwise.

A shared savings incentive amount provided as a return or reduction in premium reduces the health insurer's direct written premium by the shared savings incentive dollar amount for purposes of ss. 624.509 and 624.5091, F.S. (insurance premium tax and retaliatory tax).

The commission may adopt rules necessary to implement and enforce this section.

Section 2 provides the bill takes effect January 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

The bill would allow insurers to reduce their direct written premiums by the dollar amount of the shared savings incentives provided to insureds for purposes of the insurance premium tax and the retaliatory tax. The fiscal impact is indeterminate.

B. Private Sector Impact:

The implementation of a shared savings incentive program may encourage insureds to obtain high quality health care services at lower prices.

C. Government Sector Impact:

See Tax/Fee Issues.

VI. Technical Deficiencies:

It is unclear whether the shared savings incentives provided to an insured could exceed the annual limits on contributions to pretax savings or spending accounts, such as the health savings account, or the amount of premiums paid by the insured during a plan year.

The term, "health insurer," is defined to mean insurance as defined in s. 624.603, F.S., which includes major medical health insurance, as well as excepted benefit, limited benefit, indemnity benefit, and supplemental benefit policies. Generally, pretax savings or spending accounts, such as the health savings account, provide tax advantages to offset health care costs. To be eligible

for a health savings accounts, an individual is required to be covered under a high deductible health plan, which provides major medical coverage.[11]

VII. Related Issues:

The bill applies to individual policies or contracts only because the bill amends Part VI of ch. 627, F.S. Section 627.601(2), F.S., provides that nothing in this part applies to or affects any group or blanket policy.

VIII. Statutes Affected:

This bill creates section 627.6387 of the Florida Statutes.

IX. Additional Information:

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

CS by Banking and Insurance on March 11, 2019:
The CS:

- Revises definitions.
- Revises and clarifies requirements of the shared savings program.
- Provides technical changes.
- Requires health insurers to submit an annual report to the Office of Insurance Regulation.

B. Amendments:

None.

[11] Internal Revenue Service, Health Savings Accounts and Other Tax-Favored Health Plans, (May4, 2019) https://www.irs.gov/pub/irs-pdf/p969.pdf (last visited Mar. 12, 2019).

441564

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/11/2019	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Diaz) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 627.6387, Florida Statutes, is created to read:

627.6387 Shared savings incentive program.—

(1) This section may be cited as the "Patient Savings Act."

(2) As used in this section, the term:

(a) "Health care provider" means a hospital, a facility

441564

licensed under chapter 395; an entity licensed under chapter 400; a health care practitioner as defined in s. 456.001; a blood bank, plasma center, industrial clinic, and renal dialysis facility; or a professional association, partnership, corporation, joint venture, or other association for professional activity by health care providers. The term includes entities and professionals outside of this state with an active, unencumbered license for an equivalent facility or practitioner type issued by another state, the District of Columbia, or a possession or territory of the United States.

(b) "Health insurer" means an authorized insurer offering health insurance as defined in s. 624.603 or a health maintenance organization as defined in s. 641.19. The term does not include the state group health insurance program provided under s. 110.123.

(c) "Shared savings incentive" means a voluntary and optional financial incentive that a health insurer may provide to an insured for choosing certain shoppable health care services under a shared savings incentive program and may include, but is not limited to, the incentives described in s. 626.9541(4)(a).

(d) "Shared savings incentive program" means a voluntary and optional incentive program established by a health insurer pursuant to this section.

(e) "Shoppable health care service" means a lower-cost, high-quality nonemergency health care service for which a shared savings incentive is available for insureds under a health insurer's shared savings incentive program. Shoppable health care services may be provided within or outside of this state

441564

and include, but are not limited to:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Services provided through telehealth.

(3) A health insurer may offer a shared savings incentive program to provide incentives to an insured when the insured obtains a shoppable health care service from the health insurer's shared savings list. An insured may not be required to participate in a shared savings incentive program. A health insurer that offers a shared savings incentive program must:

(a) Establish the program as a component part of the policy, contract, or certificate of insurance provided by the health insurer and notify the insureds and the office at least 30 days before program termination.

(b) File a description of the program on a form prescribed by commission rule. The office must review the filing and determine whether the shared savings incentive program complies with this section.

(c) Notify an insured annually and at the time of renewal, and an applicant for insurance at the time of enrollment, of the availability of the shared savings incentive program and the procedure to participate in the program.

(d) Publish on a webpage easily accessible to insureds and to applicants for insurance a list of shoppable health care services and health care providers and the shared savings incentive amount applicable for each service. A shared savings incentive may not be less than 25 percent of the savings generated by the insured's participation in any shared savings incentive offered by the health insurer. The baseline for the savings calculation is the average in-network amount paid for that service in the most recent 12-month period or some other methodology established by the health insurer and approved by the Commissioner of Insurance Regulation.

(e) At least quarterly, credit or deposit the shared savings incentive amount to the insured's account as a return or reduction in premium, or credit the shared savings incentive amount to the insured's flexible spending account, health savings account, or health reimbursement account, such that the amount does not constitute income to the insured.

(f) Submit an annual report to the office within 90 business days after the close of each plan year. At a minimum, the report must include the following information:

1. The number of insureds who participated in the program during the plan year and the number of instances of participation.

2. The total cost of services provided as a part of the program.

3. The total value of the shared savings incentive payments made to insureds participating in the program and the values distributed as premium reductions, credits to flexible spending accounts, credits to health savings accounts, or credits to

441564

health reimbursement accounts.

4. An inventory of the shoppable health care services offered by the health insurer.

(4)(a) A shared savings incentive offered by a health insurer in accordance with this section:

1. Is not an administrative expense for rate development or rate filing purposes.

2. Does not constitute an unfair method of competition or an unfair or deceptive act or practice under s. 626.9541 and is presumed to be appropriate unless credible data clearly demonstrates otherwise.

(b) A shared saving incentive amount provided as a return or reduction in premium reduces the health insurer's direct written premium by the shared saving incentive dollar amount for the purposes of the taxes in ss. 624.509 and 624.5091.

(5) The commission may adopt rules necessary to implement and enforce this section.

Section 2. This act shall take effect January 1, 2020.

================ T I T L E A M E N D M E N T ================

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to health insurance savings programs; creating s. 627.6387, F.S.; providing a short title; defining terms; authorizing health insurers, which include health maintenance organizations, to offer shared savings incentive programs to insureds;

441564

providing that insureds are not required to participate in such programs; specifying requirements for health insurers offering such programs; requiring the Office of Insurance Regulation to review filed descriptions of programs and make a certain determination; providing notification and account credit or deposit requirements for insurers; specifying the minimum shared savings incentive and the basis for calculating savings; specifying requirements for annual reports submitted by insurers to the office; providing construction; providing that certain shared saving incentive amounts reduce an insurer’s direct written premium for purposes of the insurance premium tax and the retaliatory tax; authorizing the Financial Services Commission to adopt rules; providing an effective date.

893134

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/11/2019	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Diaz) recommended the following:

Senate Amendment to Amendment (441564)

Delete line 79
and insert:
the office.

By Senator Diaz

36-00918-19 2019524__

A bill to be entitled

An act relating to health insurance savings programs; creating 627.6387, F.S.; providing a short title; providing definitions; authorizing health insurers and health maintenance organizations to implement shared savings incentive programs; providing procedures and requirements for such programs; providing construction; providing that a direct written premium must be reduced by the dollar amount of certain incentives, for the purpose of certain taxes; providing website requirements; providing notification requirements; requiring the Office of Insurance Regulation to review insurers' filings of their program descriptions; limiting the amount of annual savings incentives; authorizing the office to make rules; providing an effective date.

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

Section 1. Section 627.6387, Florida Statutes, is created to read:

627.6387 Shared savings incentive program.—

(1) This section may be cited as the "Patient Savings Act."

(2) As used in this section, the term:

(a) "Contracted amount" means the amount agreed to be paid by the health insurer pursuant to a policy, contract, or certificate of insurance to a health care provider for shoppable health care services covered by the policy, contract, or certificate of insurance.

36-00918-19 2019524__

(b) "Health care provider" means a hospital, an ambulatory surgical center, and any other medical facility licensed under chapter 395; a home health agency licensed under chapter 400; a physician licensed under chapter 458; a physician assistant licensed under chapter 458 or chapter 459; an osteopathic physician licensed under chapter 459; a chiropractic physician licensed under chapter 460; a podiatric physician licensed under chapter 461; a naturopath licensed under chapter 462; a nurse licensed under part I of chapter 464; a dentist licensed under chapter 466; a midwife licensed under chapter 467; an occupational therapist licensed under chapter 468; radiological personnel certified under chapter 468; clinical laboratory personnel licensed under chapter 483; a physical therapist and a physical therapist assistant licensed under chapter 486; a blood bank, plasma center, industrial clinic, and renal dialysis facility; or a professional association, partnership, corporation, joint venture, or other association for professional activity by health care providers.

(c) "Health insurer" means an authorized insurer offering health insurance as defined in s. 624.603 or a health maintenance organization as defined in s. 641.19. The term does not include the state group health insurance program provided under s. 110.123.

(d) "Shared savings incentive" means a voluntary and optional cash incentive that a health insurer may provide to an insured for choosing certain shoppable health care services under a shared savings incentive program and may include, but is not limited to, the incentives described in s. 626.9541(4)(a).

(e) "Shared savings incentive program" means a voluntary

and optional incentive program established by a health insurer pursuant to this section.

(f) "Shoppable health care services" means a nonemergency health care service for which an insured may receive a shared savings incentive under a health insurer's shared savings incentive program. Shoppable health care services include:

1. Clinical laboratory services.

2. Infusion therapy.

3. Inpatient and outpatient surgical procedures.

4. Obstetrical and gynecological services.

5. Inpatient and outpatient nonsurgical diagnostic tests and procedures.

6. Physical and occupational therapy services.

7. Radiology and imaging services.

8. Prescription drugs.

9. Telehealth services.

(3) Notwithstanding any other provision of law, a health insurer may implement a shared savings incentive program to provide incentives to an insured when the insured obtains a shoppable health care service from the health insurer's shared savings list. The insurer's shared savings incentive list may include shoppable health care services in and out of this state.

(a) An insured is not required to participate in a health insurer's shared savings incentive program.

(b) A health insurer is not required to establish a shared savings incentive program. A health insurer may terminate a shared savings incentive program with a 30 days' notice to the office before termination.

(c) If an insured elects to receive a shoppable health care

service from the health insurer's shared savings incentive list, the health insurer shall deposit into, or shall credit, the insured's account with the shared savings incentive amount.

(d) A shared savings incentive made by a health insurer in accordance with this section is not an administrative expense for rate development or rate filing purposes.

(e) A shared savings incentive provided to the insured under this section is deemed a return of premium or a reduction in premium based on expected claims experience and does not constitute income to the insured.

(f) A health insurer's direct written premium must be reduced by the dollar amount of the shared savings incentives provided to the insured under this section for the purposes of the premium tax in s. 624.509 and the retaliatory tax in s. 624.5091.

(4) If a health insurer establishes a shared savings incentive program, the shared savings incentive program must be a component part of the policy, contract, or certificate of insurance provided by the health insurer. Annually and at the time of enrollment or renewal, a health insurer must notify each insured of the shared savings incentive program.

(5) If a health insurer establishes a shared savings incentive program, the health insurer must:

(a) Provide on its website a method for an insured to request and obtain information on the contracted amount for shoppable health care services from a health care provider and indicate whether a shared savings incentive applies to a particular shoppable health care service.

(b) Notify insureds and applicants for insurance of the

availability of the shared savings incentive program and the procedure to participate in the program at the time of enrollment. Thereafter, annually and at the time of renewal, the health insurer must notify each insured of the shared savings incentive program.

(6) A health insurer must file a description of the shared savings incentive program on a form prescribed by the office. The office must review the filing to determine if the shared savings incentive program complies with this section.

(7) A shared savings incentive provided under this section is presumed to be appropriate unless credible data clearly demonstrates otherwise; however, shared savings incentives provided to an insured each year may not exceed 30 percent of the insured's annual paid premium.

(8) The office may adopt rules necessary to implement and enforce this section.

Section 2. This act shall take effect January 1, 2020.

The Florida Senate

Committee Agenda Request

To: Senator Doug Broxson, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: February 19, 2019

I respectfully request that **Senate Bill # 524**, relating to Health Insurance Savings Programs, be placed on the:

☐ Committee agenda at your earliest possible convenience.

☒ Next committee agenda.

Senator Manny Diaz, Jr.
Florida Senate, District 36

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

S 524

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/5/14
Meeting Date

SB524
Bill Number (if applicable)

Topic Health Insurance Savings Programs

Amendment Barcode (if applicable)

Name Matthew Choy

Job Title Director

Address 136 S. Bronough St
Street

Tallahassee, FL 32301
City *State* *Zip*

Phone 561-386-3451

Email mchoy@FLChamber.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Chamber of Commerce

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	CS/SB 538
INTRODUCER:	Banking and Insurance Committee and Senator Brandes
SUBJECT:	Nonadmitted Insurance Market Reform
DATE:	March 12, 2019 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Billmeier	Knudson	BI	**Fav/CS**
2.			FT	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 538 makes various changes to laws related to surplus lines insurance. Surplus lines insurance is insurance for which there is no market available through standard insurance carriers in the admitted market (insurance companies licensed to transact insurance in Florida). Surplus lines insurance may cover exotic risks or it may cover day-to-day risks that fall outside the underwriting guidelines of the standard market.

The bill repeals the $35 limit on the policy fee that surplus lines agents may charge when they sell a surplus lines policy. The law will continue to require that the fee be reasonable. The bill requires the fee to be itemized separately for the customer before purchase of the policy and enumerated in the policy.

The bill repeals the requirement that a surplus lines agent file a quarterly affidavit with the Florida Surplus Lines Service Office.

The bill extends the exemption from the diligent effort requirement for surplus lines agents exporting flood coverage to an eligible surplus lines insurer from July 1, 2019, until July 1, 2025.

II. Present Situation:

Surplus Lines Insurance Agents

Surplus lines insurance refers to a category of insurance for which there is no market available through standard insurance carriers in the admitted market (insurance companies licensed to transact insurance in Florida). Surplus lines insurance may cover exotic risks or it may cover day-to-day risks that fall outside the underwriting guidelines of the standard market.[1] Surplus lines insurance is sold by surplus lines insurance agents. Coverage cannot be placed in the surplus lines market unless, among other things "the full amount of insurance required must not be procurable, after a diligent effort has been made by the producing agent to do so, from among the insurers authorized to transact and actually writing that kind and class of insurance in this state."[2]

Surplus lines agents must verify that a diligent effort has been made by requiring a properly documented statement of diligent effort from the retail or producing agent.[3] The surplus lines agent's reliance must be reasonable under the particular circumstances surrounding the export of that particular risk.[4] "Diligent effort" means seeking and being denied coverage from at least three authorized insurers in the admitted market unless the cost to replace the property insured is $1 million or more. In that case, diligent effort is seeking and being denied coverage from at least one authorized insurer in the admitted market.[5]

Surplus lines agents are required to report and file with the Florida Surplus Lines Service Office[6] (FSLSO) specified information on each surplus lines insurance policy within 30 days of the effective date of the transaction, must transmit service fees to the FSLSO each month, and must transmit assessment and tax payments to the FSLSO quarterly.[7] When requested by the Department of Financial Services or the FSLSO, surplus lines agents are also required to submit a copy of any policy and certain other information.[8] Surplus lines agents are required to maintain each surplus lines contract, including applications and all certificates, and other detailed information about each surplus lines policy, in their agency office for a period of 5 years.[9] Florida law requires a surplus lines agent to file a quarterly affidavit with the FSLSO to document all surplus lines insurance transacted in the quarter.[10] The affidavit also documents the efforts the agent made to place coverage with authorized insurers and the results of the efforts.[11] To account for the administrative costs surplus lines agents incur to comply with reporting

---

[1] *See* https://www.fslso.com/About (last visited March 5, 2019).
[2] s. 626.916(1)(a), F.S.
[3] A sample "Statement of Diligent Effort" can be found here: https://www.fslso.com/BusinessForms/DiligentEffort (last visited March 7, 2019).
[4] *See* s. 626.961(1)(a), F.S.
[5] *See* s. 626.914(4), F.S.
[6] The Florida Surplus Lines Service Office was created by the Legislature as a surplus lines self-regulating organization to permit better access by consumers to approved unauthorized insurers. The FSLSO collects information from agents about surplus lines transactions in Florida and collects premium taxes for payment to the state.
[7] *See* s. 626.921(2), F.S.
[8] *See* s. 626.923, F.S.
[9] *See* s. 626.930, F.S.
[10] *See* s. 626.931, F.S.
[11] *See* s. 626.931, F.S.

requirements, the agent may charge a reasonable per-policy fee, not to exceed $35, for each policy exported.[12] This fee has not been adjusted since it was raised from $25 to $35 in 2001.[13]

Flood Insurance

The National Flood Insurance Program (NFIP)

The NFIP was created by the passage of the National Flood Insurance Act of 1968.[14] The NFIP is administered by the Federal Emergency Management Agency (FEMA) and provides property owners located in flood-prone areas the ability to purchase flood insurance protection from the federal government.

Private Market Flood Insurance in Florida

In 2014, the Legislature created s. 627.715, F.S., governing the sale of personal lines residential flood insurance.[15] "Flood" is defined as a general and temporary condition of partial or complete inundation of two or more acres of normally dry land area or of two or more properties from:

- Overflow of inland or tidal waters;
- Unusual and rapid accumulation or runoff of surface waters from any source;
- Mudflow; or
- Collapse or subsidence of land along the shore of a lake or similar body of water as a result of erosion or undermining caused by waves or currents of water exceeding anticipated cyclical levels that result in a flood as defined above.[16]

Flood insurance is a separate line of insurance from homeowner's property insurance and is not included in such a policy.[17] In the case of flood damage occurring during the course of a hurricane, the windstorm portion of the homeowner's property insurance policy does not cover the flood damage.[18] If the homeowner does not separately purchase flood insurance through the National Flood Insurance Program or an admitted Florida flood insurer, such losses will be uninsured.

A surplus lines agent may export a contract or endorsement providing flood coverage to an eligible surplus lines insurer without making a diligent effort to seek such coverage from three or more authorized insurers. This exemption from the diligent effort requirement expires July 1, 2019, or on the date on which the Commissioner of Insurance Regulation determines that there is an adequate admitted market to provide flood coverage, whichever date occurs first.

[12] *See* s. 626.916(4), F.S.
[13] *See* ch. 2001-213, L.O.F.
[14] http://www.fema.gov/media-library/assets/documents/7277?id=2216 (Last accessed January 29, 2019).
[15] Ch. 2014-80, Laws of Fla.
[16] s. 627.715(1)(b), F.S.
[17] Part X, ch. 627, F.S.
[18] Flood insurance covers rising water that sits or flows on the ground and damages property by inundation and flow. Windstorm insurance covers water falling or driven by wind that damages property by infiltration of the structure from above or laterally while carried by the wind. In short, flood insurance covers damage related to rising water and windstorm insurance covers damage related to airborne water.

The Office of Insurance Regulation reports there are 29 admitted insurance companies currently writing private flood insurance in the state.[19]

III. Effect of Proposed Changes:

Section 1 repeals the $35 limit on the policy fee contained in s. 626.916, F.S., that surplus lines agents may charge when they sell a surplus lines policy. The bill requires the fee to be itemized separately for the customer before purchase of the policy and enumerated in the policy.

Section 2 repeals the requirement in s. 626.931, F.S., that a surplus lines agent file a quarterly affidavit with the FSLSO stating that all surplus lines insurance transacted by the agent during the calendar quarter has been submitted to the FSLSO. The affidavit requirement pre-dates the FSLSO. Now, the FSLSO requires agents to electronically file each policy transaction with the FSLSO. The FSLSO believes the affidavit is no longer necessary because FSLSO staff audits agents to verify the accuracy of submitted information with original source documents.[20] Agents will still be subject to discipline by the Department of Financial Services if they fail to file required information with the FSLSO.

Sections 3, 4, and 5 make technical changes to conform to the repeal of the affidavit requirement.

Section 6 amends s. 627.715, F.S., to extend the exemption from the diligent effort requirement for surplus lines agents exporting flood coverage to an eligible surplus lines insurer from July 1, 2019, until July 1, 2025.

Section 7 provides an effective date of July 1, 2019.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

[19] Presentation by OIR "Flood Facts & Florida's Flood Insurance Market" January 2019. (On file with the Banking and Insurance Committee).
[20] Email from Gary Pullen, Executive Director of the FSLSO dated March 2, 2015 (on file with the Committee on Banking and Insurance).

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Surplus lines agents will be able to charge a per-policy exceeding $35, so long as the fee is reasonable.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 626.916, 626.931, 626.932, 626.935, 629.401, and 627.715.

IX. Additional Information:

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

CS by Banking and Insurance on March 11, 2019:
The CS removes provisions changing the surplus lines tax.

B. Amendments:

None.

207744

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/11/2019	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Brandes) recommended the following:

Senate Amendment (with title amendment)

Delete lines 84 - 106.

Delete lines 168 - 169

and insert:

Section 7. This act shall take effect July 1, 2019.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

207744

Delete lines 12 - 14
and insert:
changes made by the act; amending ss. 626.935 and 629.401,

Delete line 22
and insert:
an effective date.

By Senator Brandes

24-00535A-19 2019538__

A bill to be entitled

An act relating to nonadmitted insurance market reform; amending s. 626.916, F.S.; deleting a limitation on per-policy fees charged by surplus lines agents for exporting certified policies; requiring that such fees be itemized separately for the customer before purchase and enumerated in the policy; amending s. 626.931, F.S.; deleting a requirement for surplus lines agents to quarterly file a certain affidavit with the Florida Surplus Lines Service Office; amending s. 626.932, F.S.; conforming a provision to changes made by the act; revising the determination of the surplus lines tax on certain policies as of a specified date; amending ss. 626.935 and 629.401, F.S.; conforming provisions to changes made by the act; amending s. 627.715, F.S.; extending the expiration date of a provision authorizing surplus lines agents to export contracts or endorsements providing flood coverage to eligible surplus lines insurers without making a certain diligent effort to seek coverage from authorized insurers; providing effective dates.

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

Section 1. Subsection (4) of section 626.916, Florida Statutes, is amended to read:

626.916 Eligibility for export.—

(4) A reasonable per-policy fee~~, not to exceed $35,~~ may be

24-00535A-19 2019538__

charged by the filing surplus lines agent for each policy certified for export. The fee must be itemized separately for the customer before purchase and enumerated in the policy.

Section 2. Section 626.931, Florida Statutes, is amended to read:

626.931 ~~Agent affidavit and~~ Insurer reporting requirements.—

~~(1) Each surplus lines agent that has transacted business during a calendar quarter shall on or before the 45th day following the calendar quarter file with the Florida Surplus Lines Service Office an affidavit, on forms as prescribed and furnished by the Florida Surplus Lines Service Office, stating that all surplus lines insurance transacted by him or her during such calendar quarter has been submitted to the Florida Surplus Lines Service Office as required.~~

~~(2) The affidavit of the surplus lines agent shall include efforts made to place coverages with authorized insurers and the results thereof.~~

(1)~~(3)~~ Each foreign insurer accepting premiums shall, on or before the end of the month following each calendar quarter, file with the Florida Surplus Lines Service Office a verified report of all surplus lines insurance transacted by such insurer for insurance risks located in this state during such calendar quarter.

(2)~~(4)~~ Each alien insurer accepting premiums shall, on or before June 30 of each year, file with the Florida Surplus Lines Service Office a verified report of all surplus lines insurance transacted by such insurer for insurance risks located in this state during the preceding calendar year.

(3)~~(5)~~ The department may waive the filing requirements described in subsections (1) ~~(3)~~ and (2) ~~(4)~~.

(4)~~(6)~~ Each insurer's report and supporting information shall be in a computer-readable format as determined by the Florida Surplus Lines Service Office or shall be submitted on forms prescribed by the Florida Surplus Lines Service Office and shall show for each applicable agent:

(a) A listing of all policies, certificates, cover notes, or other forms of confirmation of insurance coverage or any substitutions thereof or endorsements thereto and the identifying number; and

(b) Any additional information required by the department or Florida Surplus Lines Service Office.

Section 3. Paragraph (a) of subsection (2) of section 626.932, Florida Statutes, is amended to read:

626.932 Surplus lines tax.—

(2)(a) The surplus lines agent shall make payable to the department the tax related to each calendar quarter's business as reported to the Florida Surplus Lines Service Office~~,~~ and remit the tax to the Florida Surplus Lines Service Office at the same time as the remittance required under s. 626.9325 ~~provided for the filing of the quarterly affidavit, under s. 626.931~~. The Florida Surplus Lines Service Office shall forward to the department the taxes and any interest collected pursuant to paragraph (b)~~,~~ within 10 days of receipt.

Section 4. Effective January 1, 2020, subsection (3) of section 626.932, Florida Statutes, is amended, and subsection (1) of that section is republished, to read:

626.932 Surplus lines tax.—

(1) The premiums charged for surplus lines coverages are subject to a premium receipts tax of 5 percent of all gross premiums charged for such insurance. The surplus lines agent shall collect from the insured the amount of the tax at the time of the delivery of the cover note, certificate of insurance, policy, or other initial confirmation of insurance, in addition to the full amount of the gross premium charged by the insurer for the insurance. The surplus lines agent is prohibited from absorbing such tax or, as an inducement for insurance or for any other reason, rebating all or any part of such tax or of his or her commission.

(3) If a surplus lines policy covers risks or exposures only partially in this state and the state is the home state as defined in the federal Nonadmitted and Reinsurance Reform Act of 2010 (NRRA), the tax payable must ~~shall~~ be computed on the gross premium. The surplus lines policy must be taxed in accordance with subsection (1) unless the policyholder elects to be taxed at the ~~tax must not exceed the tax~~ rate where the risk or exposure is located.

Section 5. Paragraph (d) of subsection (1) of section 626.935, Florida Statutes, is amended, and present paragraphs (e) through (i) of subsection (1) of that section are redesignated as paragraphs (d) through (h), respectively, to read:

626.935 Suspension, revocation, or refusal of surplus lines agent's license.—

(1) The department shall deny an application for, suspend, revoke, or refuse to renew the appointment of a surplus lines agent and all other licenses and appointments held by the

licensee under this code, on any of the following grounds:

~~(d) Failure to make and file his or her affidavit or reports when due as required by s. 626.931.~~

Section 6. Paragraph (a) of subsection (1) of section 629.401, Florida Statutes, is amended to read:

629.401 Insurance exchange.—

(1) There may be created one or more insurance exchanges, with one or more offices each, subject to such rules as are adopted by the commission. For the purposes of this section, the term "exchange" applies to any such insurance exchange proposed or created under this section. The purposes of the exchange are:

(a) To provide a facility for the underwriting of:

1. Reinsurance of all kinds of insurance.

2. Direct insurance of all kinds on risks located entirely outside the United States.

3. Surplus lines insurance for risks located in this state eligible for export under s. 626.916 or s. 626.917 and placed through a licensed Florida surplus lines agent subject to compliance with ~~the provisions of~~ ss. 626.921, 626.922, 626.923, 626.924, 626.929, 626.9295, and 626.930~~, and 626.931~~. With respect to compliance with s. 626.924, the required legend may refer to any coverage provided for by a security fund established under paragraph (3)(d).

4. Surplus lines insurance in any other state subject to the applicable surplus lines laws of such other state for risks located entirely outside of this state.

Section 7. Subsection (4) of section 627.715, Florida Statutes, is amended to read:

627.715 Flood insurance.—An authorized insurer may issue an

insurance policy, contract, or endorsement providing personal lines residential coverage for the peril of flood or excess coverage for the peril of flood on any structure or the contents of personal property contained therein, subject to this section. This section does not apply to commercial lines residential or commercial lines nonresidential coverage for the peril of flood. An insurer may issue flood insurance policies, contracts, endorsements, or excess coverage on a standard, preferred, customized, flexible, or supplemental basis.

(4) A surplus lines agent may export a contract or endorsement providing flood coverage to an eligible surplus lines insurer without making a diligent effort to seek such coverage from three or more authorized insurers under s. 626.916(1)(a). This subsection expires July 1, 2025 ~~2019~~, or on the date on which the Commissioner of Insurance Regulation determines in writing that there is an adequate admitted market to provide coverage for the peril of flood consistent with this section, whichever date occurs first. If there are fewer than three admitted insurers on the date this subsection expires, the number of declinations necessary to meet the diligent-effort requirement shall be no fewer than the number of authorized insurers providing flood coverage.

Section 8. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2019.

Florida's Private Flood Statewide Data as of September 1, 2018

- Personal Residential Private Flood
  - Policies in Force: 44,252
  - Number of Insurers Writing: 29
  - Number of Insurers that Received Certification: 15

- Excess Personal Residential Private Flood
  - Policies in Force: 6,186
  - Number of Insurers Writing: 6

- Surplus Lines
  - Personal Residential Policies in Force: 18,492
  - Personal Excess Policies in Force: 5,938
  - Commercial Policies in Force 5,560
  - Commercial Excess Policies in Force: 1,356
  - Number of Insurers Writing: 47

OIR Summit

Billmeier, Michael

From: Pullen, Gary <GPullen@fslso.com>
Sent: Monday, March 2, 2015 1:25 PM
To: BILLMEIER.MICHAEL
Subject: RE:

Michael:
Good to hear from you. The repeal of the affidavit requirement in 626.931 is language advanced and supported by our Office. This affidavit requirement, which pre-dates our Office, is no longer necessary since our Office requires that each policy transaction be filed with us electronically and we audit agents on a tri-annual basis to verify accuracy of submitted data with original source documents. Let me know if there are additional questions. Thanks! Gary

---

From: BILLMEIER.MICHAEL [mailto:BILLMEIER.MICHAEL@flsenate.gov]
Sent: Monday, March 02, 2015 1:12 PM
To: Pullen, Gary
Subject:

Hi Gary:

Hope this finds you well. I will likely be handling FSLSO issues if they arise this session. I've seen some proposed language repealing the affidavit requirement in 626.931, F.S., that might have come from your office. Are you working that issue or any others that you can tell me about?

Please call me if you have any issues or see anything that comes up during the session that we should know about.

- Michael

Michael Billmeier, Chief Attorney
Florida Senate Committee on Banking and Insurance
850-487-5370

The Florida Senate

Committee Agenda Request

To: Senator Doug Broxson
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: February 8, 2019

I respectfully request that **Senate Bill #538**, relating to **Non-admitted Insurance Market Reform**, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Jeff Brandes
Florida Senate, District 24

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/19
Meeting Date

SB 538
Bill Number (if applicable)

Topic SB 538

Amendment Barcode (if applicable)

Name Erin O'Leary

Job Title Vice President

Address 208 N. Laura Street #600
Street

Phone 904-910-4705

Jacksonville FL 32202
City *State* *Zip*

Email ekoleary@shellyins.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Shelly, Middlebrooks & O'Leary Inc

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11
Meeting Date

538
Bill Number (if applicable)

Topic NONADMITTED INSURANCE MARKET REFORM

Amendment Barcode (if applicable)

Name DONOVAN BROWN

Job Title

Address 113 E COLLEGE AVE
Street

Phone 850.815.6010

TLH
City

FL
State

32301
Zip

Email donovan@suskeyconsulting.com

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing WHOLESALE & SPECIALTY INSURANCE ASSOCIATION

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3.11.19
Meeting Date

538
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic nonadmitted market reform

Name Ashley Kalifeh

Job Title lobbyist/attorney

Address 101 E College Ave #302
Street

Phone 222-9075

Tallahassee FL 32303
City *State* *Zip*

Email akalifeh@capstoneatty

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Surplus Lines Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	CS/SB 714
INTRODUCER:	Banking and Insurance Committee and Senator Brandes
SUBJECT:	Insurance
DATE:	March 13, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Matiyow	Knudson	BI	**Fav/CS**
2.			JU	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 714 makes changes to a number of insurance related issues. The bill:

- Allows the Office of Insurance Regulation (OIR) to establish a uniform loss adjustment expense percentage to be used in calculating the amount the Florida Hurricane Catastrophe Fund (FHCF) reimburses insurers for their loss adjustment expenses related to claims paid by the FHCF. The reimbursement amount may not exceed 15 percent of losses reimbursed by the FHCF.
- Prohibits a pre-suit notice for a bad faith action under s. 624.155, F.S., from being filed during the first 60 days of the appraisal process outlined in the insurance contract.
- Deletes a provision allowing the Department of Financial Services (DFS) to return a pre-suit notice for a bad faith action under s. 624.155, F.S., if the notice lacks specific, required information.
- Provides that workers compensation insurance applicants and their agents are no longer required to have their sworn statements notarized as currently required by OIR rule.
- Allows an insurer to offer and give insureds goods or services of any value for the purposes of loss control or loss mitigation related to covered risks. Currently it is an unfair insurance trade practice to provide items or services to an insured valued at more than $100 per year.
- Allows a property, casualty, or surety insurer to offer multiple policy discounts based on the fact that another policy has been purchased from another insurer under a joint marketing arrangement or an insurer that issued the policy pursuant to the Citizens clearinghouse program.

- Requires a life insurer to provide a notice of lapse to the agent servicing a life insurance policy 21 days prior to the effective date of the lapse unless the insurer provides an online method for the agent to identify lapsing policies, the insurer has no record of the agent servicing the policy, or the agent is employed by the insurer or its affiliate.
- Allows the insurer to issue the required right to mediation notice at the time the insurer applies coverage and determines payment or at the time a claim is filed.

The effective date of the bill is July 1, 2019.

II. Present Situation:

The Florida Hurricane Catastrophe Fund (FHCF)

The FHCF is a tax-exempt[1] fund created in 1993[2] after Hurricane Andrew[3] as a form of mandatory reinsurance for residential property insurers. The FHCF is administered by the State Board of Administration (SBA)[4] and is a tax-exempt source of reimbursement to property insurers for a selected percentage (45, 75, or 90 percent)[5] of hurricane losses above the insurer's retention (deductible). The FHCF provides insurers an additional source of reinsurance that is less expensive than what is available in the private market, enabling insurers to generally write more residential property insurance in the state than would otherwise be written. Because of the low cost of coverage from the FHCF, the fund acts to lower residential property insurance premiums for consumers.

FHCF Mandatory Coverage

All insurers admitted to do business in this state writing residential property insurance that includes wind coverage must buy reimbursement coverage (reinsurance) on their residential property exposure through the FHCF. The FHCF is authorized by statute to sell $17 billion of mandatory layer coverage.[6] Each insurer that purchases coverage may receive up to its proportional share of the $17 billion mandatory layer of coverage based upon the insurer's share of the actual premium paid for the contract year, multiplied by the claims paying capacity of the fund. Each insurer may select a reimbursement contract wherein the FHCF promises to reimburse the insurer for 45 percent, 75 percent, or 90 percent of covered losses, plus 5 percent[7] of loss adjustment expenses.[8]

FHCF Premiums

The FHCF must charge insurers the actuarially indicated premium[9] for the coverage provided, based on hurricane loss projection models found acceptable by the Florida Commission on

[1] s. 215.555(1)(f), F.S.
[2] ch. 93-409, L.O.F.
[3] https://www.nhc.noaa.gov/1992andrew.html (last viewed March 11, 2019).
[4] https://www.sbafla.com/fsb/ (last viewed March 11, 2019).
[5] s. 215.555(2)(e), F.S.
[6] s. 215.555(4)(c)1., F.S.
[7] s. 215.555(4)(b), F.S.
[8] Loss adjustment expenses are costs incurred by insurers when investigating, adjusting and processing a claim.
[9] s. 215.555(2)(a), F.S.

Hurricane Loss Projection Methodology.[10] The actuarially indicated premium is an amount that is adequate to pay current and future obligations and expenses of the fund. In practice, each insurer pays the FHCF annual reimbursement premiums that are proportionate to each insurer's share of the FHCF's risk exposure. The cost of FHCF coverage is generally lower than the cost of private reinsurance because the fund is a tax-exempt non-profit corporation and does not charge a risk load as it relates to overhead and operating expenses incurred by other private insurers.[11]

FHCF Bonding and Assessment Authority

When the moneys in the FHCF are or will be insufficient to cover losses, the law[12] authorizes the FHCF to issue revenue bonds funded by emergency assessments on all lines of insurance except medical malpractice and workers compensation.[13] Emergency assessments may be levied up to 6 percent of premium for losses attributable to any one contract year, and up to 10 percent of premium for aggregate losses from multiple years. The FHCF's broad-based assessment authority is one of the reasons the FHCF was able to obtain an exemption from federal taxation from the Internal Revenue Service as an integral part of state government.[14]

Workers Compensation Insurance Sworn Statements

Employers who file applications for workers compensation insurance coverage are required to file in a form prescribed by the Financial Services Commission. The Financial Services Commission is allowed to adopt rules regarding the submission of such applications. The rules are to provide that an application must include information on the employer, the type of business, past and prospective payroll, estimated revenue, previous workers' compensation experience, employee classification, employee names, and any other information necessary to enable a carrier to accurately underwrite the applicant. Submission of an application that contains false, misleading, or incomplete information provided with the purpose of avoiding or reducing the amount of premiums for workers' compensation coverage is a felony of the second degree.[15] The application must contain a sworn statement by the employer attesting to the accuracy of the information submitted. The application must also contain a sworn statement by the agent

[10] https://www.sbafla.com/method/ (last viewed March 11, 2019).
[11] https://www.sbafla.com/fhcf/Portals/FHCF/Content/Reports/Annual/20170606_FHCF_2016_AnnualReport_A.pdf?ver=2017-07-06-085215-943 (last viewed March 11, 2019).
[12] s. 215.555(6), F.S.
[13] s. 215.555(6)(b), F.S.
[14] The U.S. Internal Revenue Service has, by a Private Letter Ruling, authorized the FHCF to issue tax-exempt bonds. The initial ruling was granted on March 27, 1998, for 5 years until June 30, 2003. On May 28, 2008, the Internal Revenue Service issued a private letter ruling holding that the prior exemption, which was to expire on June 30, 2008, could continue to be relied upon on a permanent basis (on file with the Committee on Banking and Insurance).
[15] Such a felony is punishable as provided in s. 775.082, s. 775.083, or s. 775.084, F.S.

attesting that the agent explained to the employer or officer the classification codes that are used for premium calculations.

Rule 69O-189.003, F.A.C., promulgated by the Financial Services Commission requires the sworn statements by an applicant and agent that are required to be submitted with the application to the OIR must be notarized.

Civil Remedies Against Insurers

Insurance and Insurer Obligations

Insurance is a contract, commonly referred to as a "policy," under which, for stipulated consideration called a "premium," one party, the insurer, undertakes to compensate the other, the insured, for loss on a specified subject from specified perils. Florida residents often obtain property insurance and liability insurance. Property insurance protects individuals from the loss of or damage to property and, in some instances, personal liability pertaining to the property. One of the common lines of insurance in this category is homeowner's insurance. Automobile liability insurance[16] covers suits against the insured for damages such as injury or death to another driver or passenger, as well as property damage. It is insurance for those damages for which the driver can be held liable due to the operation of the automobile.

A liability insurer generally owes two major contractual duties to its insured in exchange for premium payments—the duty to indemnify and the duty to defend.[17] The duty to indemnify refers to the insurer's obligation to issue payment to the insured or a beneficiary on a valid claim.[18] The duty to defend refers to the insurer's duty to provide a defense for the insured in court against a third party with respect to a claim within the scope of the insurance contract.[19]

Statutory and Common Law Bad Faith

Common Law Bad Faith - "Third Party Claims"

As early as 1938, Florida courts recognized an additional duty that does not arise directly from the contract, the common law duty of good faith on the part of an insurer to the insured in negotiating settlements with third-party claimants.[20] Under a liability policy, the insured's role is essentially limited to selecting the type and desired level of coverage and paying the corresponding premium.[21] As part of the contract, the insured surrenders to the insurer all control over the negotiations and decision making as to third-party claims.[22] The insured's role is relegated to the obligation to cooperate with the insurer's efforts to adjust the loss.[23] The insurer

[16] In Florida, every owner or operator of an automobile is required to maintain liability insurance to cover a minimum of $10,000 in coverage for damage to another's property in a crash. Additionally, every owner or registrant of an automobile is required to maintain personal injury protection, which covers medical expenses related to a car accident regardless of fault up to $10,000. Sections 324.022 and 627.733, F.S.
[17] 16 Williston on Contracts s. 49:105 (4th ed.).
[18] *Id.*
[19] *Id.*
[20] *Auto. Mut. Indemnity Co. v. Shaw*, 184 So. 852 (Fla. 1938).
[21] Rutledge R. Liles, *Florida Insurance Bad Faith Law: Protecting Businesses and You*, 85 Fla. Bar. J. No. 3, p. 8 (March 2011).
[22] *Id.*
[23] *Id.*

makes all the decisions with regard to third-party claims handling and thereby has the power to settle and foreclose an insured's exposure to liability, or to refuse to settle and leave the insured exposed to liability in excess of the policy limits.[24] As a result, "the relationship between the parties arising from the bodily injury liability provisions of the policy is fiduciary in nature, much akin to that of attorney and client," because the insurer owes a duty to refrain from acting solely on the basis of its own interests in the settlement of third-party claims.[25] Accordingly, and because of this relationship, the insurer owes a duty to the insured to "exercise the utmost good faith and reasonable discretion in evaluating the claim" and negotiating for a settlement within the policy limits.[26] When the insurer fails to act in the best interests of the insured in settling a third-party claim, an injured insured is entitled to hold the insurer accountable for its "bad faith"[27] if a third party obtains a judgment against the insured in excess of his or her insurance coverage.[28] A third-party claim can be brought by the insured, having been held liable for judgment in excess of policy limits by the third-party claimant,[29] or it can be brought by the third party directly or through an assignment of the insured's rights.[30]

Statutory Bad Faith -- First- and Third-Party Claims

In 1982 the Legislature enacted s. 624.155, F.S., which provides that *any person* may bring a claim for "bad faith" against an insurer for "not attempting in good faith to settle claims when, under all the circumstances, it could and should have done so, had it acted fairly and honestly toward its insured with due regard for her or his interests,"[31] the same as the common law standard.[32] Section 624.155, F.S., codifies third-party claims for "bad faith," but does not preempt the common law remedy.[33]

Additionally, s. 624.155, F.S., recognizes a claim for bad faith against an insurer not only in the instance of settlement negotiations with a third party, but also for an insured seeking payment from his or her own insurance company. Although Florida courts recognized a bad faith cause of action in the context of liability policies at common law, they did not impose the same obligation in the context of first-party insurance contracts, when the injured party was also the insured under the insurance policy.[34] At common law, first-party insurance policies were enforced solely through traditional contract remedies.[35]

In a first-party action under s. 624.155, F.S., there is never a fiduciary relationship between the parties, but an arm's length contractual one based on the insurance contract. A first-party claim against the insurer does not accrue until the conclusion of the underlying litigation for

[24] *State Farm v. Laforet*, 658 So.2d 55, 58 (Fla. 1995).
[25] *Baxter v. Royal Indem. Co*., 285 So.2d 652, 655 (Fla. 1st DCA 1973), *cert. discharged*, 317 So.2d 725 (Fla. 1975).
[26] *Id*.
[27] Liles, *supra* note 6.
[28] *Opperman v. Nationwide Mut. Fire Ins. Co.*, 515 So.2d 263, 265 (Fla. 5th DCA 1987).
[29] *See Powell v. Prudential Prop. and Cas. Ins. Co.*, 584 So.2d 12 (Fla. 3d DCA 1991).
[30] *See Thompson v. Commercial Union Ins. Co.* 250 So.2d 259 (Fla. 1971)(recognizing a direct third-party claim under the common law before the enactment of s. 624.155, F.S.); *State Farm Fire and Cas. Co. v. Zebrowski*, 706 So.2d 275 (Fla. 1997).
[31] Section 624.155(1)(b), F.S.
[32] Fla. Standard Jury Instr. 404.4 (Civil).
[33] Section 624.155(8), F.S.
[34] *Id*.
[35] *Id*.

contractual benefits or the insured prevails in the appraisal process and coverage is otherwise established by acceptance or court decision.[36] The underlying action against the insurer must be resolved in favor of the insured, because the insured cannot allege bad faith if it is not shown that the insurer should have paid the claim.

In order to bring a bad faith claim under the statute, a plaintiff must first give the insurer 60 days' written notice of the alleged violation.[37] The insurer has 60 days after the required notice is filed to pay the damages or correct the circumstances giving rise to the violation.[38] Because first-party claims are only statutory, that cause of action does not exist until the 60-day cure period provided in the statute expires without payment by the insurer.[39] However, because third-party claims exist both in statute and at common law, the insurer cannot guarantee avoidance of a third-party bad faith claim by curing within the statutory period.[40]

"Acting Fairly" to Settle Third-Party Claims

In interpreting what it means for an insurer to act fairly toward its insured, Florida courts have held that when the insured's liability is clear and an excess judgment is likely due to the extent of the resulting damage, the insurer has an affirmative duty to initiate settlement negotiations.[41] If a settlement is not reached, the insurer has the burden of showing that there was no realistic possibility of settlement within policy limits.[42] Failure to settle on its own does not mean that an insurer acts in bad faith.

The question of whether an insurer has acted in bad faith in handling claims against the insured is determined under the totality of the circumstances standard. Each case is determined on its own facts and ordinarily the question of failure to act in good faith with due regard for the interests of the insured is for the jury.[43]

In light of the heightened duty on the part of the insurer as a fiduciary, Florida courts focus on the actions of the insurer during the time when it was acting under a duty to the insured, not the claimant.[44]

Property Insurance Appraisers and Umpires

Insurance companies often include an appraisal clause in property insurance policies.[45] The appraisal clause provides a procedure to resolve disputes between the policyholder and the

[36] *Cammarata v. State Farm Florida Ins. Co.*, 152 So.3d 606 (Fla. 4th DCA 2014).
[37] Section 624.155(3)(a), F.S.
[38] Section 624.155(3)(d), F.S.
[39] *Talat Enterprises, Inc. v. Aetna Cas. & Sur. Co.,* 753 So.2d 1278, 1284 (Fla. 2000).
[40] *Macola v. Gov. Employees Ins. Co.*, 953 So.2d 451, 458 (Fla. 2007) (holding that an insurer's tender of the policy limits to an insured in response to the filing of a civil remedy notice, after the initiation of a lawsuit against the insured but before entry of an excess judgment, does not preclude a common law cause of action against the insurer for third-party bad faith).
[41] *See Powell v. Prudential Property and Casualty Insurance Company*, 584 So.2d 12, 14 (Fla. 3d DCA 1991).
[42] *Id*.
[43] *See Berges v. Infinity Ins. Co.*, 896 So.2d 665, 680 (Fla. 2004).
[44] *Id.* at 677.
[45] *Citizens Property Insurance Corporation v. Mango Hill Condominium Association 12 Inc*., 54 So.3d 578 (Fla. 3d DCA 2011) and *Intracoastal Ventures Corp. v. Safeco Ins. Co. of America*, 540 So.2d 162 (Fla. 3d DCA 1989), contain examples of appraisal clauses.

insurer concerning the value of a covered loss. The appraisal clause is used only to determine disputed values. An appraisal cannot be used to determine what is covered under an insurance policy. Coverage issues are litigated and determined by the courts.
The appraisal process *generally* works as follows:

- The insurance company and the policyholder each appoint an independent, disinterested appraiser.
- Each appraiser evaluates the loss independently.
- The appraisers negotiate and attempt to reach an agreed amount of the damages.
- If the appraisers agree as to the amount of the claim, the insurer pays the claim.
- If the appraisers cannot agree on the amount, they together choose a mutually acceptable umpire.
- Once the umpire has been chosen, the appraisers each present their loss assessment to the umpire.
- The umpire will subsequently provide a written decision to both appraisers. A decision agreed to by any two of the three will set the amount of the loss.
- The insurance company or the policyholder may challenge the umpire's impartiality and disqualify a proposed umpire based on criteria set forth in statute.[46]

Ripeness of Bad Faith Claims Following Increases in Property Damage Amounts Won Through the Appraisal Process (*Cammarata v. State Farm Florida Ins. Co.*[47])

In 2014, the Fourth District Court of Appeal (4th DCA) issued an opinion in *Cammarata v. State Farm Florida Ins. Co.* (*Cammarata*) dealing with the ripeness of bad faith actions against insurers, which resolved an apparent conflict between two prior 4th DCA cases.[48] Both cases involved property damage from Hurricane Wilma and followed a nearly identical fact pattern, including the use of the appraisal process following a lawsuit for breach of contract. In both cases, the insured achieved an increase in the assessed damages compared to the insurer's appraisal and the insurer paid both claims following the appraisal process. In both cases, the insurer, by paying following the appraisal process, admitted that coverage existed and the insured prevailed on the claim because more insurance benefits were paid than were offered in settlement. These are the two generally accepted prerequisites to a bad faith claim. However, both cases resulted in appeals related to the breach of contract claims.

In the first case, known as *Lime Bay*, the 4th DCA upheld a dismissal by the trial court. The 4th DCA found that the insured must win a breach of contract claim to be able to pursue the insurer for bad faith. In other words, a breach of contract was required to claim insurer bad faith. In the other case, known as *Trafalgar*, the 4th DCA found that since the insured won in the appraisal process, there was no requirement for a finding that the insurer breached the contract to support a bad faith claim. So, in the *Cammarata* case, in which the insured prevailed in the appraisal process but had not claimed there was a breach of contract, the insurer argued for summary using *Lime Bay's* required breach finding, while the insured countered with *Trafalgar's* finding that prevailing in the appraisal process was sufficient to support a bad faith

[46] *See* s. 627.70151, F.S.
[47] *Cammarata v. State Farm Florida Ins. Co.*, 152 So.3d 606 (Fla. 4th DCA 2014).
[48] *Lime Bay Condominium, Inc. v. State Farm Florida Insurance Co.*, 94 So.3d 698 (Fla. 4th DCA 2012) and *Trafalgar at Greenacres, Ltd. v. Zurich American Insurance Co.*, 100 So.3d 1155 (Fla. 4th DCA 2012).

claim. The trial court granted the insurer summary judgment, relying on *Lime Bay* and the breach of contract requirement. The *Cammarata* case was appealed to the 4th DCA.

Following a review and analysis of relevant case law,[49] the Court stated that "we stand by our numerous prior opinions holding that, where the insurer's liability for coverage and the extent of damages have not been determined in any form, an insurer's liability for the underlying claim and the extent of damages must be determined before a bad faith action becomes ripe."[50] The 4th DCA receded from *Lime Bay* and held that the insured's success in the appraisal process and the insurer's admission that coverage existed were sufficient to support a bad faith claim.

Unfair Insurance Trade Practices

The Unfair Insurance Trade Practices Act,[51] among other things, defines unfair methods of competition and unfair or deceptive acts in the business of insurance.[52] It provides an extensive list of prohibited methods and acts. Among these are prohibitions on certain inducements to the purchase of insurance, including rebates, dividends, stock, and contracts that promise to return profits to the prospective insurance purchaser. The law also describes prohibited discrimination. There are also many exceptions to the prohibitions defined by law.

Among the exceptions is authorization for insurers and their agents to offer and make gifts of charitable contributions, merchandise, goods, wares, store gift cards, gift certificates, event tickets, anti-fraud or loss mitigation services, and other items up to $100 per calendar year to an insured, prospective insured, or any person for the purpose of advertising.[53] There are several similar limitations on advertising gifts under the Florida Insurance Code related to the advertising practices of title insurance agents, agencies and insurers, public adjusters, group and individual health benefit plans, and motor vehicle service agreement companies.[54]

Discounts for Purchase of Multiple Insurance Policies

Florida law allows an insurer to include a discount in the premium charged for any policy, contract, or certificate of insurance, because another policy, contract, or certificate of any type has been purchased by the insured from the same insurer or insurer group.[55] Additionally, the discount is allowed when an agent is servicing both an open-market policy for the insured and

[49] *Blanchard v. State Farm Mut. Auto. Ins. Co*., 575 So.2d 1289 (Fla. 1991), *Vest v. Travelers Ins. Co*., 710 So.2d 982, 984 (Fla. 1st DCA 1998) and *Brookins v. Goodson*, 640 So.2d 110 (Fla. 4th DCA 1994).
[50] *Cammarata* at 613.
[51] Ch. 626, F.S., part IX.
[52] Section 626.9541, F.S.
[53] Rule 69B-186.010, F.A.C., Unlawful Inducements Related to Title Insurance Transactions, governs inducements related to title insurance, but exempts gifts within the value limitation of s. 626.9541(1)(m), F.S. However, federal law prohibits any fee, kickback or thing of value given for referral of real estate settlement services on mortgage loans related to federal programs. 12 U.S.C. s. 2607 (2017).
[54] Public adjusters, their apprentices, and anyone acting on behalf of the public adjuster are prohibited from giving gifts of merchandise valued in excess of $25 as an inducement to contract. Section 626.854(10), F.S. A group or individual health benefit plan may provide merchandise without limitation in value as part of an advertisement for voluntary wellness or health improvement programs. Section 626.9541(4)(a), F.S. Motor vehicle service agreement companies are prohibited from giving gifts of merchandise in excess of $25 to agreement holders, prospective agreement holders, or others for the purpose of advertising. Section 634.282(17), F.S.
[55] Section 627.0655, F.S.

one issued by Citizens or an insurer that removed the policy from Citizens through the takeout process.[56]

Secondary Notice Prior to Life Insurance Policy Lapse

Insurance coverage may lapse for non-payment of premium. The Florida Insurance Code provides a number of protections to insureds before a lapse in coverage can be enforced by the insurer through a cancellation or denial of coverage following expiration of a grace period. Generally, this occurs through a notice of lapse or notice of cancellation sent by the insurer to the insured. Cognitive impairment, loss of functional capacity, or extended convalescence can prevent individuals from receiving the notice or understanding that their insurance policy may lapse due to non-payment.

In the case of long-term care insurance, the insurer must allow a grace period of no less than 30 days and issue the notice of lapse to the insured and a second person, designated by the insured, at least 30 days before the effective date of the cancellation.[57] Additionally, the long term care policy must be reinstated during a minimum 5-month period following cancellation, in certain circumstances.[58]

In the case of life insurance, the insured is entitled to a minimum 30-day grace period for non-payment.[59] A notice of lapse must be issued after expiration of the grace period and at least 21 days prior to the effective date of the lapse. If the policy provides a grace period greater than 51 days (the standard minimum 30-day grace period, plus the 21-day pre-lapse notice period), then the insurer must issue the notice of lapse at least 21 days prior to the expiration of the grace period.[60] In addition, the insured is entitled to name a second person to receive the notice of lapse on their behalf.

Property Insurance Claim Mediation

The Department of Financial Services (DFS) administers alternative dispute resolution programs for various types of insurance. DFS has mediation programs for property insurance[61] and automobile insurance[62] claims. DFS has a neutral evaluation program, similar to mediation, for sinkhole insurance claims.[63] DFS approves mediators used in the two mediation programs and certifies the neutral evaluators used in neutral evaluations for sinkhole insurance claims.[64]

[56] Florida law provides two methods to depopulate Citizens policies: 1) insurers may "takeout" policies currently issued by Citizens through offers of coverage, and 2) insurance applicants may be prevented from being issued a Citizens policy if an insurer offers the applicant coverage for no more than 15 percent more than the Citizens' premium through a clearinghouse listing process prior to being issued a Citizens policy. Sections 627.351(6) and 627.3518, F.S.
[57] Section 627.94073(1) and (2), F.S.
[58] Section 627.94073(3), F.S.
[59] Section 627.453, F.S.
[60] Section 627.4555, F.S.
[61] Section 627.7015, F.S.
[62] Section 626.745, F.S.
[63] Section 627.7074, F.S.
[64] Sections 627.7015, 627.7074, and 627.745, F.S.

For property insurance claims[65] involving personal lines and commercial residential claims, only the policyholder, as a first-party claimant, or the insurer may request mediation under DFS' program.[66] This means that third parties cannot utilize the program; however, an insurer may elect to mediate with the third party. This is true even if the policyholder assigns their policy benefit rights to the third party.[67] The insurer must notify the policyholder of the right to mediation under the program upon receipt of the claim. The mediation costs are generally the responsibility of the insurer.

III. Effect of Proposed Changes:

Section 1. Names the act "Omnibus Prime."

The Florida Hurricane Catastrophe Fund

Section 2. Amends s. 215.555, F.S., to provide that the loss adjustment expenses paid by the Florida Hurricane Catastrophe Fund are to be the lesser of 15 percent of the insurer's reimbursed losses or the uniform loss adjustment expense percentage of the insurer's reimbursed losses adopted by rule by the Financial Services Commission.

This section is effective January 1, 2020.

Section 3. Creates s. 215.55953, F.S., to require the Financial Services Commission (FSC) to establish by rule a uniform loss adjustment expense reimbursement percentage for the reasonable reimbursement by the FHCF of loss adjustment expenses (LAE) incurred by insurers in adjusting losses for policies covered by the FHCF. The uniform loss adjustment expense reimbursement percentage is to be adopted by rule by December 1, 2019; for future contract years, however, the percentage can be changed by recommendation of the OIR by March 1 of the calendar year following a covered event. When determining the percentage the FSC is to take into account:

- The total losses and loss adjustment expenses that have been incurred by authorized insurers related to losses caused by covered events.
- The actual claims paying capacity of the Florida Hurricane Catastrophe Fund.
- Other information the commission finds is relevant to determining the reasonable loss expenses incurred in adjusting losses reimbursable by the Florida Hurricane Catastrophe Fund.

[65] An eligible claim is one that does not involve: suspected fraud; there is no coverage under the policy; one where the insurer reasonably believes the policyholder has made material misrepresentations relevant to the claim and request for payment has been denied for that reason; one for less than $500 (unless agreed to by the parties); or, windstorm or hurricane loss if the required notice of claim was not issued in compliance with law. Section 627.7015(9), F.S.

[66] Policyholders may have the assistance of legal counsel during the mediation process. Litigants in the county and circuit court may be referred to the program. Commercial coverages, private passenger motor vehicle coverages, and liability coverages of property insurance policies are not eligible for the property insurance mediation program. Section 627.7015(1), F.S.

[67] Section 627.7015(1), F.S.

Workers Compensation Sworn Statements

Section 4. Amends s. 440.381, F.S., to provide that workers' compensation insurance applicants and their agents are no longer required to have their sworn statements notarized as currently required by 69O-189.003, F.A.C.

Civil Remedies Against Insurers

Section 5. Amends s. 624.155, F.S., to prohibit the filing of a civil remedy notice for a bad faith action under s. 624.155, F.S., during the first 60 days of the appraisal process outlined in the insurance contract. The bill also repeals current law that allows the Department of Financial Services to return a civil remedy notice for lack of specificity.

Unfair Insurance Trade Practices

Section 6. Amends s. 626.9541(5), F.S., to allow insurers to offer and give insureds goods or services of any value for the purposes of loss control or loss mitigation related to covered risks. Currently it is an unfair insurance trade practice to provide items or services to an insured valued at more than $100 per year.

Discounts for Purchase of Multiple Insurance Policies

Section 7. Amends s. 627.0655, F.S., to allow an insurer to offer multiple policy discounts on property, casualty, and surety insurance based on the fact that another policy has been purchased from another insurer under a joint marketing arrangement or an insurer that issued the policy pursuant to the Citizens clearinghouse program.

Secondary Notice Prior to Life Insurance Policy Lapse

Section 8. Amends s. 627.4555, F.S., to require a life insurer to provide a notice of lapse to the agent servicing a life insurance policy 21 days prior to the effective date of the lapse. The insurer is not required to issue secondary notice to the agent servicing the life insurance policy, if: 1) the insurer provides an online method for the agent to identify lapsing policies, 2) the insurer has no record of the agent servicing the policy, or 3) the agent is employed by the insurer or its affiliate. Receipt of the notice does not make the agent responsible for any lapse.

Property Insurance Claim Mediation

Section 9. Amends s. 627.7015, F.S., to allow the insurer to, at the time the insurer applies coverage and determines payment or, as currently provided, at the time a claim is filed, provide notice to the policyholder of the policyholder's right to participate in the mediation program for disputed property insurance claims.

Effective Date

Section 10. Except as otherwise expressly provided, the effective date of the bill is July 1, 2019.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Increasing the amount of reimbursement for LAE from the Florida Hurricane Catastrophe Fund should have a positive impact for insurers as some insurers obtain private market reinsurance to cover LAE expenses that often costs more than FCHF premiums. Increasing the amount of loss adjustment expenses covered by the Florida Hurricane Catastrophe Fund, however, could result in drawing down the fund quicker, and increasing the risk of assessments being needed. If assessments are needed they would be levied to all lines of insurance excluding medical malpractice and workers compensation.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

Section 6 regarding notice for mediation does not appear to require the notice to be sent when a claim is denied. Mediation is available for most reasons for denial; some of the exceptions are suspected fraud, no coverage under the policy, or material misrepresentation by the policyholder.[68]

[68] s. 627.7015(9), F.S.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 624.155, 626.9541, 627.0655, 627.4555, and 627.7015.

IX. Additional Information:

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

CS by Banking and Insurance on March 11, 2019:
The CS:

- Revises the reimbursement that insurers receive from the FHCF for loss adjustment expenses from 5 percent of losses to the lesser of15 percent of losses or the uniform loss adjustment percentage established by rule.
- Deletes a requirement that workers compensation insurance applicants and their agents must have their sworn statements notarized.
- Prohibits filing during the first 60 days of the appraisal process outlined in the insurance contract a civil remedy notice for a bad faith action under s. 624.155, F.S.
- Repeals current law that allows the Department of Financial Services to return for lack of specificity a civil remedy notice.

B. Amendments:

None.

917258

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/11/2019	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Brandes) recommended the following:

Senate Amendment (with title amendment)

Between lines 29 and 30
insert:

Section 2. Effective January 1, 2020, paragraph (b) of subsection (4) of section 215.555, Florida Statutes, is amended to read:

215.555 Florida Hurricane Catastrophe Fund.—

(4) REIMBURSEMENT CONTRACTS.—

(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, for the purpose of covering loss adjustment expenses, the lesser of 15 percent of the reimbursed losses or the uniform loss adjustment expense percentage adopted pursuant to s. 215.55953 ~~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.

Section 3. Section 215.55953, Florida Statutes, is created to read:

215.55953 Uniform loss adjustment expense percentage.—

(1) No later than December 1, 2019, the Financial Services Commission shall establish by rule a uniform loss adjustment expense percentage for the reasonable reimbursement by the Florida Hurricane Catastrophe Fund of loss adjustment expenses incurred in adjusting losses for covered policies under s. 215.555. In determining the reasonable loss adjustment expenses

917258

incurred in adjusting such losses, the commission shall consider:

(a) The total losses and loss adjustment expenses that have been incurred by authorized insurers related to losses caused by covered events as defined in s. 215.555(2)(b).

(b) The actual claims paying capacity of the Florida Hurricane Catastrophe Fund.

(c) Other information the commission finds is relevant to determining the reasonable loss expenses incurred in adjusting losses reimbursable under s. 215.555.

(2) No later than March 1 of the calendar year following a covered event under s. 215.555, the Office of Insurance Regulation shall advise the commission as to the necessity of adopting a new uniform loss adjustment expense percentage. Upon a recommendation from the Office of Insurance Regulation that the commission adopt a new uniform loss adjustment percentage, the commission shall do so by rule no later than December 1 of the year such recommendation is made.

(3) Rules adopted pursuant to this section are not subject to the requirements of s. 120.541.

Delete line 122

and insert:

Section 9. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2019.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Between lines 2 and 3

917258

insert:

amending s. 215.555, F.S.; revising the reimbursement of loss adjustment expenses by the Florida Hurricane Catastrophe Fund; creating s. 215.55953, F.S.; requiring the Financial Services Commission, by a specified date, to adopt a certain uniform loss adjustment expense percentage by rule; specifying information the commission must consider in determining certain incurred expenses; requiring the Office of Insurance Regulation, under certain circumstances, to advise the commission on certain matters; requiring the commission to adopt certain rules under certain circumstances; providing that adopted rules are not subject to requirements for a statement of estimated regulatory costs;

Delete line 25

and insert:

program; providing effective dates.

474272

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/11/2019	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Perry) recommended the following:

Senate Amendment (with title amendment)

Between lines 29 and 30
insert:

Section 2. Subsection (2) of section 440.381, Florida Statutes, is amended to read:

440.381 Application for coverage; reporting payroll; payroll audit procedures; penalties.—

(2) Submission of an application that contains false, misleading, or incomplete information provided with the purpose

474272

of avoiding or reducing the amount of premiums for workers' compensation coverage is a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. The application must contain a statement that the filing of an application containing false, misleading, or incomplete information provided with the purpose of avoiding or reducing the amount of premiums for workers' compensation coverage is a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. The application must contain a sworn statement by the employer attesting to the accuracy of the information submitted and acknowledging the provisions of former s. 440.37(4). The application must contain a sworn statement by the agent attesting that the agent explained to the employer or officer the classification codes that are used for premium calculations. The sworn statements by the employer and the agent are not required to be notarized.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Between lines 2 and 3

insert:

amending s. 440.381, F.S.; providing that certain sworn statements in employer applications for workers' compensation coverage are not required to be notarized;

738068

LEGISLATIVE ACTION

Senate	.	House
Comm: RS	.	
03/11/2019	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Brandes) recommended the following:

Senate Amendment (with title amendment)

Delete lines 30 - 38
and insert:
Section 2. Subsection (3) of section 624.155, Florida Statutes, is amended to read:
624.155 Civil remedy.—
(3)(a) As a condition precedent to bringing an action under this section, the department and the authorized insurer must have been given 60 days' written notice of the violation. ~~If the~~

738068

~~department returns a notice for lack of specificity, the 60-day time period shall not begin until a proper notice is filed.~~

(b) The notice shall be on a form provided by the department and shall state with specificity the following information, and such other information as the department may require:

1. The statutory provision, including the specific language of the statute, which the authorized insurer allegedly violated.

2. The facts and circumstances giving rise to the violation.

3. The name of any individual involved in the violation.

4. Reference to specific policy language that is relevant to the violation, if any. If the person bringing the civil action is a third party claimant, she or he shall not be required to reference the specific policy language if the authorized insurer has not provided a copy of the policy to the third party claimant pursuant to written request.

5. A statement that the notice is given in order to perfect the right to pursue the civil remedy authorized by this section.

~~(c) Within 20 days of receipt of the notice, the department may return any notice that does not provide the specific information required by this section, and the department shall indicate the specific deficiencies contained in the notice. A determination by the department to return a notice for lack of specificity shall be exempt from the requirements of chapter 120.~~

(c) ~~(d)~~ No action shall lie if, within 60 days after filing notice, the damages are paid or the circumstances giving rise to the violation are corrected.

738068

(d) ~~(e)~~ The authorized insurer that is the recipient of a notice filed pursuant to this section shall report to the department on the disposition of the alleged violation.

(e) ~~(f)~~ The applicable statute of limitations for an action under this section shall be tolled for a period of 65 days by the mailing of the notice required by this subsection or the mailing of a subsequent notice required by this subsection.

(f) As to first-party residential property insurance claims, an insured may not file the notice required under this subsection earlier than 90 days after the insurer receives notice of an initial, reopened, or supplemental first-party residential property insurance claim from an insured. This paragraph does not apply if the insurer denies coverage on the entire claim.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete lines 3 - 5

and insert:

Amending s. 624.155, F.S.; deleting a provision that tolls, under certain circumstances, a period before a civil action against an insurer may be brought; deleting authority for the Department of Financial Services to return a civil remedy notice for lack of specificity; prohibiting insureds, in certain claims, from filing a certain presuit notice before a certain timeframe; providing applicability; amending s. 626.9541, F.S.;

548022

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/11/2019	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Brandes) recommended the following:

Senate Substitute for Amendment (738068) (with title amendment)

Delete lines 30 - 38
and insert:
Section 2. Subsection (3) of section 624.155, Florida Statutes, is amended to read:
624.155 Civil remedy.—
(3)(a) As a condition precedent to bringing an action under this section, the department and the authorized insurer must

548022

have been given 60 days' written notice of the violation. ~~If the department returns a notice for lack of specificity, the 60-day time period shall not begin until a proper notice is filed.~~

(b) The notice shall be on a form provided by the department and shall state with specificity the following information, and such other information as the department may require:

1. The statutory provision, including the specific language of the statute, which the authorized insurer allegedly violated.

2. The facts and circumstances giving rise to the violation.

3. The name of any individual involved in the violation.

4. Reference to specific policy language that is relevant to the violation, if any. If the person bringing the civil action is a third party claimant, she or he shall not be required to reference the specific policy language if the authorized insurer has not provided a copy of the policy to the third party claimant pursuant to written request.

5. A statement that the notice is given in order to perfect the right to pursue the civil remedy authorized by this section.

~~(c) Within 20 days of receipt of the notice, the department may return any notice that does not provide the specific information required by this section, and the department shall indicate the specific deficiencies contained in the notice. A determination by the department to return a notice for lack of specificity shall be exempt from the requirements of chapter 120.~~

(c) ~~(d)~~ No action shall lie if, within 60 days after filing notice, the damages are paid or the circumstances giving rise to

548022

the violation are corrected.

(d) ~~(e)~~ The authorized insurer that is the recipient of a notice filed pursuant to this section shall report to the department on the disposition of the alleged violation.

(e) ~~(f)~~ The applicable statute of limitations for an action under this section shall be tolled for a period of 65 days by the mailing of the notice required by this subsection or the mailing of a subsequent notice required by this subsection.

(f) A notice required under this subsection may not be filed within 60 days after appraisal is invoked by any party in a residential property insurance claim.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete lines 3 - 5

and insert:

amending s. 624.155, F.S.; deleting a provision that tolls, under certain circumstances, a period before a civil action against an insurer may be brought; deleting a provision authorizing the Department of Financial Services to return a civil remedy notice for lack of specificity; prohibiting the filing of the notice within a certain timeframe under certain circumstances; amending s. 626.9541, F.S.;

437860

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
03/11/2019	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Brandes) recommended the following:

Senate Amendment (with title amendment)

Delete lines 39 - 48
and insert:
Section 3. Paragraph (m) of subsection (1) of section 626.9541, Florida Statutes, is amended to read:
626.9541 Unfair methods of competition and unfair or deceptive acts or practices defined.—
(1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS.—The following are defined as unfair methods of competition

437860

and unfair or deceptive acts or practices:

(m) *Permissible advertising and promotional gifts, ~~and~~ charitable contributions, and loss mitigation services or loss control items ~~permitted~~.*—

1. The provisions of paragraph (f), paragraph (g), or paragraph (h) do not prohibit a licensed insurer or its agent from:

a. Giving to insureds, prospective insureds, or others any article of merchandise, goods, wares, store gift cards, gift certificates, event tickets, anti-fraud ~~or loss mitigation~~ services, or other items having a total value of $100 or less per insured or prospective insured in any calendar year.

b. Making charitable contributions, as defined in s. 170(c) of the Internal Revenue Code, on behalf of insureds or prospective insureds, of up to $100 per insured or prospective insured in any calendar year.

c. Giving to insureds, for free or at a discounted price, loss mitigation services or loss control items of value that relate to the risks covered under the policy.

2. The provisions of paragraph (f), paragraph (g), or paragraph (h) do not prohibit a title insurance agent or title insurance agency, as those terms are defined in s. 626.841, or a title insurer, as defined in s. 627.7711, from giving to insureds, prospective insureds, or others, for the purpose of advertising, any article of merchandise having a value of not more than $25. A person or entity governed by this subparagraph is not subject to subparagraph 1.

========== T I T L E A M E N D M E N T ==========

437860

And the title is amended as follows:

Delete lines 6 - 11

and insert:

providing that insurers and agents may give insureds certain free or discounted loss mitigation services or loss control items; deleting a limitation on loss mitigation services given to insureds; amending s. 627.0655,

545368

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
03/11/2019	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Brandes) recommended the following:

Senate Amendment (with title amendment)

Delete lines 115 - 117
and insert:
(2) At the time of issuance and renewal of a policy or at the time a first-party claim within the scope of this section is filed by the policyholder, the insurer shall

================ T I T L E A M E N D M E N T ================
And the title is amended as follows:

Delete lines 22 - 25

and insert:

providing that certain property insurers may provide required notice to policyholders of their right to participate in a certain mediation program at issuance or renewal of a policy; providing an effective date.

By Senator Brandes

24-00756B-19 2019714__

A bill to be entitled

An act relating to insurance; providing a short title; amending s. 624.155, F.S.; revising circumstances under which a person may not bring a civil action against an insurer; amending s. 626.9541, F.S.; providing that provisions relating to unfair methods of competition and unfair or deceptive insurance acts or practices do not prohibit insurers or agents from offering or giving to insureds certain free or discounted services or offerings relating to loss control or loss mitigation; amending s. 627.0655, F.S.; revising circumstances under which insurers or certain authorized persons may provide certain premium discounts to insureds; amending s. 627.4555, F.S.; requiring life insurers that are required to provide a specified notice to policyowners of an impending lapse in coverage to also notify the policyowner's agent of record within a certain timeframe; providing that the agent is not responsible for any lapse in coverage; exempting the insurer from the requirement under certain circumstances; amending s. 627.7015, F.S.; adding circumstances under which certain property insurers may provide required notice to policyholders of their right to participate in a certain mediation program; providing an effective date.

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

Section 1. This act may be cited as "Omnibus Prime."

24-00756B-19 2019714__

Section 2. Paragraph (d) of subsection (3) of section 624.155, Florida Statutes, is amended to read:

624.155 Civil remedy.—

(3)

(d) An ~~No~~ action may not be brought ~~shall lie~~ if, within 60 days after filing the notice, the damages are paid; the appraisal is in process and a payment, if required, is timely made; or the circumstances giving rise to the violation are corrected.

Section 3. Subsection (5) is added to section 626.9541, Florida Statutes, to read:

626.9541 Unfair methods of competition and unfair or deceptive acts or practices defined.—

(5) LOSS CONTROL OR LOSS MITIGATION SERVICES OR OFFERINGS; CONSTRUCTION.—This section does not prohibit an insurer or agent from offering or giving to an insured, for free or at a discounted price, services or other offerings relating to loss control or loss mitigation with respect to the risks covered under the policy.

Section 4. Section 627.0655, Florida Statutes, is amended to read:

627.0655 Policyholder loss or expense-related premium discounts.—An insurer or person authorized to engage in the business of insurance in this state may include, in the premium charged an insured for any policy, contract, or certificate of insurance, a discount based on the fact that another policy, contract, or certificate of any type has been purchased by the insured from:

(1) The same insurer or insurer group, or another insurer

under a joint marketing agreement;

(2) The Citizens Property Insurance Corporation created under s. 627.351(6), if the same insurance agent is servicing both policies; or

(3) An insurer that has removed the policy from the Citizens Property Insurance Corporation or issued a policy pursuant to the clearinghouse program under s. 627.3518, if the same insurance agent is servicing both policies.

Section 5. Section 627.4555, Florida Statutes, is amended to read:

627.4555 Secondary notice.—

(1) Except as provided in this section, a contract for life insurance issued or issued for delivery in this state on or after October 1, 1997, covering a natural person 64 years of age or older, which has been in force for at least 1 year, may not be lapsed for nonpayment of premium unless, after expiration of the grace period, and at least 21 days before the effective date of any such lapse, the insurer has mailed a notification of the impending lapse in coverage to the policyowner and to a specified secondary addressee if such addressee has been designated in writing by name and address by the policyowner. An insurer issuing a life insurance contract on or after October 1, 1997, shall notify the applicant of the right to designate a secondary addressee at the time of application for the policy, on a form provided by the insurer, and at any time the policy is in force, by submitting a written notice to the insurer containing the name and address of the secondary addressee. For purposes of any life insurance policy that provides a grace period of more than 51 days for nonpayment of premiums, the

notice of impending lapse in coverage required by this section must be mailed to the policyowner and the secondary addressee at least 21 days before the expiration of the grace period provided in the policy. This section does not apply to any life insurance contract under which premiums are payable monthly or more frequently and are regularly collected by a licensed agent or are paid by credit card or any preauthorized check processing or automatic debit service of a financial institution.

(2) If the policyowner has a life agent of record or any agent of record, the insurer must also notify the agent of the impending lapse in coverage or mail or send electronically a copy of the notification of the impending lapse in coverage under subsection (1) to the agent at least 21 days before the effective date of such lapse. Receipt of such notice does not make the agent responsible for any lapse in coverage. An insurer is not required to notify the agent under this subsection if any of the following applies:

(a) The insurer maintains an online system that allows an agent to independently determine if a policy has lapsed.

(b) The insurer has no record of the current agent of record.

(c) The agent is employed by the insurer or an affiliate of the insurer.

Section 6. Subsection (2) of section 627.7015, Florida Statutes, is amended to read:

627.7015 Alternative procedure for resolution of disputed property insurance claims.—

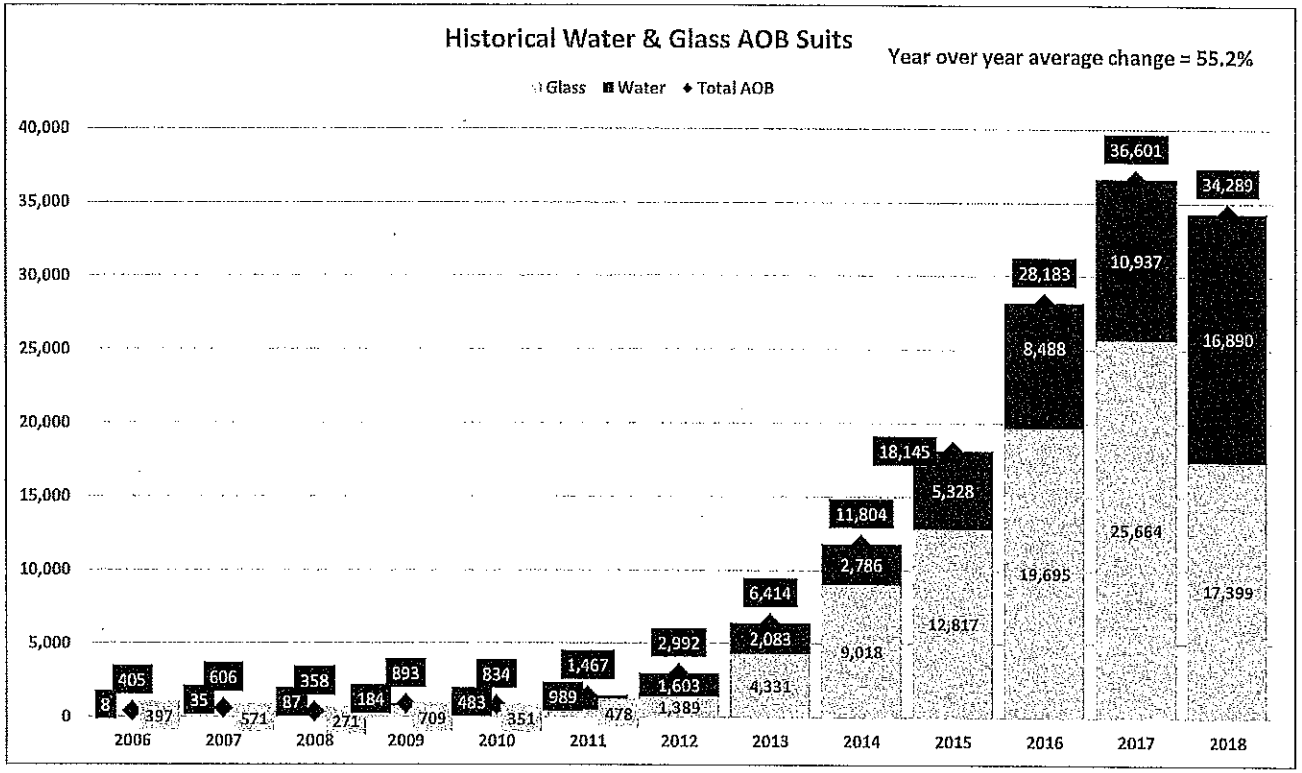
(2) Either at the time a first-party claim within the scope of this section is filed by the policyholder or at the time

coverage is applied and payment is determined, the insurer shall notify the policyholder of its right to participate in the mediation program under this section. The department shall prepare a consumer information pamphlet for distribution to persons participating in mediation.

Section 7. This act shall take effect July 1, 2019.

DEPARTMENT OF FINANCIAL SERVICES

Year	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Glass	397	571	271	709	351	478	1,389	4,331	9,018	12,817	19,695	25,664	17,399
Water	8	35	87	184	483	989	1,603	2,083	2,786	5,328	8,488	10,937	16,890
Total AOB	405	606	358	893	834	1,467	2,992	6,414	11,804	18,145	28,183	36,601	34,289



CFO JIMMY PATRONIS

Restoring Balance in Insurance Litigation

Curbing Abuses of Assignments of Benefits and Reaffirming Insureds' Unique Right to Unilateral Attorney's Fees

Mark Delegal
Holland & Knight LLP
315 South Calhoun Street, Suite 600
Tallahassee, Florida 32301
Phone: (850) 425-5685
E-mail: mark.delegal@hklaw.com

Ashley Kalifeh
Capital City Consulting, LLC
101 East College Avenue, Suite 502
Tallahassee, Florida 32301
Phone: (850) 222-9075
E-mail: akalifeh@capcityconsult.com

Contents

Executive Summary

Certain providers have partnered with attorneys to create a profitable litigation arrangement. In this arrangement, a service provider agrees to make a repair potentially covered by an insurance policy in exchange for the insurance policyholder's right to sue his insurer via an assignment of insurance policy benefits. These service providers are typically associated with home and auto repairs. The service provider then often uses that acquired right to force the insurer to pay grossly inflated costs or risk even higher litigation costs. While policyholders simply seek to be made whole for losses, service providers and their attorneys are likely motivated to increase scope of work and to maximize profit and litigation fees.

What makes this arrangement particularly lucrative for attorneys are the "one-way" attorney's fees awarded to the attorneys that represent prevailing service providers. Under Section 627.428, Florida Statutes, a prevailing party in a dispute with an insurer is entitled to his attorney's fees and costs. The fees are "one way" because insurers that prevail are not entitled to fees under the statute.

Florida courts have consistently held that the legislature may not prohibit an assignment of insurance policy benefits when assignment is made after a loss. This is because of the strong common law tradition and public policy that favors the free assignment of contractual rights. However, the one-way attorney fee is in derogation of the common law and is a creature of

statute, which the legislature may regulate, change, or take away entirely. The one-way attorney fee statute's underlying purpose was to level the playing field between individual insureds and economically powerful insurers so that litigation for individual insureds is worthwhile. This report will show that the one-way attorney fee statute is no longer serving that purpose and is instead benefiting third parties to the underlying insurance contract.[1] Consequently, the one-way attorney fee statute should be amended to clarify that it was intended for the protection of named and omnibus insureds and named beneficiaries only, and that service providers holding assignments of benefits may not obtain attorney's fees pursuant to Section 627.428.

I. The Primary Purpose of Florida's One-Way Attorney Fee Statute is to Level the Playing Field

Under the well-established common law rule, neither prevailing plaintiffs nor prevailing defendants are entitled to recover attorney's fees unless authorized by contract or statute.[2] Section 627.428, Florida Statutes, is an exception to that common law rule. Called herein the one-way attorney fee statute, Section 627.428 authorizes an award of attorney's fees to certain prevailing parties in disputes with insurers.[3] Under Section 627.428 "any named or omnibus insured or the named beneficiary under a policy or contract executed by the insurer" is entitled to an award of attorney's fees if it prevails in a dispute with an insurer.[4]

A number of purposes have been ascribed to the one-way attorney fee statute. Traditionally, one-way attorney fee statutes operate to "compensate the prevailing plaintiff, promote public interest litigation, punish or deter the losing party for misconduct, or prevent abuse of the judicial system."[5] Attorney fee statutes that categorically shift fees to only one type of losing party are intended to avoid "grave injustices" that arise with "strict adherence to the [common law] rule [that each party bears its own attorney's fees], indiscriminate to the equities of particular cases."[6] Exceptions have been built to the common law rule for certain defendants perceived to have

> ***"It is clear to us that the purpose of this provision is to level the playing field so that the economic power of insurance companies is not so overwhelming that injustice may be encouraged because people will not have the necessary means to seek redress in the courts."***
>
> Justice R. Fred Lewis writing for the Florida Supreme Court in *Ivey v. Allstate Insurance Co.* (2000)

[1]This report often refers to this service provider-initiated litigation as "third party litigation." To be clear, these particular third parties are initiating first-party litigation by stepping into the shoes of the policyholder and thus receiving the policyholder's unique benefits and rights, for which the policyholder has paid. This is distinct from the colloquial use of third party litigation, initiated by a party injured by a policyholder who, as a result of such injury, is seeking entitlement to the policyholder's coverage which extends to injuries inflicted on others.

[2]*See Rivera v. Deauville Hotel, Emps. Serv. Corp.*, 277 So. 2d 265, 266 (Fla. 1973); *Stone v. Jeffres*, 208 So. 2d 827, 828-29 (Fla. 1968).

[3]*See Stone*, 208 So. 2d at 828-29; *see also* § 627.428, Fla. Stat. (2015).

[4]§ 627.428(1), Fla. Stat.; *see also, e.g., Danis Indus. Corp. v. Ground Imp. Techniques, Inc.*, 645 So. 2d 420, 421 (Fla. 1994) (Section 627.428 "is a one-way street offering the potential for attorney's fees only to the insured or beneficiary.").

[5]John F. Vargo, *The American Rule on Attorney Fee Allocation: The Injured Person's Access to Justice*, 42 Am. U. L. Rev. 1567, 1588 (1993).

[6]Lawrence J. Hollander & Michael H. Cramer, *Attorney's Fees—Should They Be Taxed as Costs?*, 8 Miami L.Q. 573 (Summer 1954).

greater economic power, like railroads and, in this case, insurance companies.[7]

In *Feller v. Equitable Life Assurance Society of the United States*,[8] the Florida Supreme Court described the purposes of the one-way attorney fee statute as follows: "to discourage the contesting of policies . . . and to reimburse successful plaintiffs reasonably for their outlays for attorney's fees when a suit is brought against them, or they are compelled to sue, in Florida Courts to enforce their contracts."[9] According to the Court, reimbursing individual insureds and beneficiaries is necessary because "[i]t is an undue hardship upon beneficiaries of policies to be compelled to reduce the amount of their insurance by paying attorney's fees when suits are necessary in order to collect that to which they are entitled."[10] Large insurance companies do not incur the same hardship. The one-way attorney fee statute "level[s] the playing field so that the economic power of insurance companies is not so overwhelming that injustice may be encouraged because people will not have the necessary means to seek redress in the courts."[11] This economic power flows from not only the insurer's oft-superior resources in defending litigation, but also by virtue of the fact that the insurer has the most control in writing the contract of insurance, to which the two parties—the insurer and the policyholder—are held.

The public policy underlying the statute is best served when the statute is used to award fees to the other party to the insurance contract, the policyholder, or any beneficiaries specifically designated by the policyholder at the time of contract formation. As Florida courts have emphasized, the purpose of the statute is to reimburse those for which the insurance policy was contracted to protect in the first place.[12] In order for the one-way attorney fee statute to apply, "[t]he paramount condition is the entry of a judgment against the insurer and in favor of the *insured*."[13]

---

[7] *Id.* at 573 (citing § 356.04, Fla. Stat. (1953) (railroads); § 625.08, Fla. Stat. (1953) (insurance companies)); *see also, e.g.*, John Leubsdorf, *Toward a History of the American Rule on Attorney Fee Recovery*, 47 Law & Contemp. Probs. 9, 25 (1984) (with the creation of one-way attorney fee statutes, legislatures "were beginning to look at realistic attorney fee awards less as bounties for greedy lawyers and more as aids to needy plaintiffs or sanctions against corporate defendants").

[8] 57 So. 2d 581 (Fla. 1952).

[9] *Id.* at 586; *accord State Farm Fire & Cas. Co. v. Palma*, 629 So. 2d 830, 831 (Fla. 1993); *Ins. Co. of N. Am. v. Lexow*, 602 So. 2d 528, 531 (Fla. 1992).

[10] *Feller*, 57 So. 2d at 586.

[11] *Ivey v. Allstate Ins. Co.*, 774 So. 2d 679, 684 (Fla. 2000).

[12] *See Fewox v. McMerit Constr. Co.*, 556 So. 2d 419, 423 (Fla. 2d DCA 1989) (statute's purpose is to "reimburse successful *policyholders* forced to sue to enforce their policies" (emphasis added) (quoting *Zac Smith & Co. v. Moonspinner Condo. Ass'n*, 534 So. 2d 739, 743 (Fla. 1st DCA 1988))); *see also Stone*, 208 So. 2d at 829 ("Section 627.0127, F.S.A., . . . authorizes attorneys' fees where *insureds* are successful in maintaining suits on certain types of insurance policies . . . ." (emphasis added)); *Fewox*, 556 So. 2d at 423 ("The legislative policy underlying Section 627.428 is served by requiring insurers to pay attorney's fees to a prevailing *insured or beneficiary* . . . ." (emphasis added)); *Zac Smith & Co.*, 534 So. 2d at 743 (explaining that the policy underlying the one-way attorney fee statute is to "discourage the contesting of coverage by insurers and to reimburse successful *policy holders* when they are compelled to sue to enforce their policies" (emphasis added)); Robert O. Stripling, Jr., *Recovery of Attorney's Fees Under the Bussey Decision*, Fla. B.J., July 1970, at 386-87.

[13] *Lexow*, 937 F.2d at 573 (quoting *Travelers Indem. Co. v. Chisholm*, 384 So. 2d 1360, 361 (Fla. 1st DCA 1980)) (emphasis added).

II. Application of the Statute Beyond the "Narrow Statutory Class"

As a derogation of the common law rule that a party must bear its own attorney's fees, the one-way attorney fee statute should be strictly construed.[14] Yet the statute has at times been broadly construed to authorize fee awards to more than just the class of entities specifically identified in the statute. However, the Florida Supreme Court has recently suggested that the statute should be construed as limited to those designated by the legislature.

The Florida Supreme Court's 1969 decision in *Shingleton v. Bussey*[15] provided an early signal that the term "beneficiary" would be broadly interpreted, although the case did not involve application of the one-way attorney fee statute. In *Shingleton*, the Court held that a plaintiff injured by an insured vehicle could sue the automobile liability insurer directly because the injured was a third party beneficiary of the insurance contract. Florida district courts of appeal soon concluded that *Shingleton* applied with equal force to all types of liability insurance, not just automobile liability.[16] Given this expansive view of the term "beneficiary," and despite the one-way attorney fee statute's clear omission of non-policyholders and unnamed beneficiaries, the *Shingleton* case had obvious implications for the category of entities entitled to fees under the one-way attorney fee statute.[17]

However, the Florida Supreme Court held that the one-way attorney fee statute should not be interpreted as broadly as suggested by *Shingleton*. In *Wilder v. Wright*,[18] the Court decided that the one-way attorney fee statute did not permit a tort claimant like the plaintiff in *Shingleton* to recover attorney's fees. This is because in such cases, the plaintiff is not making a claim in the name of the insured but is instead "seeking attorney's fees in his own right."[19] According to the Court, it was clear that the one-way attorney fee statute "was intended to govern the relationship between the *contracting parties* to the insurance policy. While the injured party may become a third party beneficiary under the policy, as stated in *Shingleton*, that third party may not automatically invoke all the provisions of the contract or statutes governing the rights and responsibilities flowing between insurer and insured."[20] The Court cautioned that *Shingleton* "cannot be read to allow the injured party to enforce any and every provision of law or of the insurance contract."[21] Four years later, the Florida Supreme Court reiterated in *Roberts v. Carter*[22] that an award of attorney's fees under the statute is available only to a "narrow statutory class": "the contracting insured, the insured's estate, specifically named policy beneficiaries, and third parties who claim policy coverage by assignment from the insured."[23]

---

[14] *Pepper's Steel & Alloys, Inc. v. United States*, 850 So. 2d 462, 465 (Fla. 2003); *see also, e.g.*, *Great Sw. Fire Ins. Co. v. DeWitt*, 458 So. 2d 398, 400 (Fla. 1st DCA 1984) (citing *Lumbermens Mut. Ins. Co. v. Am. Arbitration Ass'n*, 398 So. 2d 469, 461 (Fla. 4th DCA 1981)).

[15] 223 So. 2d 713 (Fla. 1969).

[16] *See Liberty Mut. Ins. Co. v. Roberts*, 231 So. 2d 235 (Fla. 3d DCA 1970); *Beta Eta House Corp. v. Gregory*, 230 So. 2d 495 (Fla. 1st DCA 1970).

[17] *See* Stripling, *supra*, at 385-87 (describing the application of *Shingleton v. Bussey* to the one-way attorney fee statute as likely).

[18] 278 So. 2d 1 (Fla. 1973).

[19] *Wilder*, 278 So. 2d at 2-3.

[20] *Id.* at 3 (internal citation omitted) (emphasis added).

[21] *Id.*

[22] 350 So. 2d 78 (Fla. 1977).

[23] *Id.* at 79.

Wilder and *Roberts* caused confusion in Florida's district courts of appeal, prompting some to conclude that only the contractual parties to an insurance policy were entitled to fees under the statute. In *Industrial Fire & Casualty Insurance Co. v. Prygrocki*,[24] the Florida Supreme Court addressed this confusion. The Court in *Pyrgrocki* held that an injured pedestrian may obtain attorney's fees under the one-way attorney fee statute because the pedestrian was an "insured" under the provisions of the personal injury protection ("PIP") coverage of an automobile policy.[25] The Court explained that the term "contracting insured" means "those persons insured under an insurance contract rather than the plaintiff third-party claimant discussed in *Roberts*."[26] The plaintiff in *Prygrocki* was not a third party claimant but was, instead, an omnibus insured under the policy's PIP protection.[27] The Florida Legislature had recently amended the one-way attorney fee statute to make this clear, adding an "omnibus insured" to the category of persons entitled to fees under the statute.[28]

Despite the return to a more expansive interpretation of the statute, in the 2008 decision *Continental Casualty Co. v. Ryan Inc. Eastern*[29] the Florida Supreme Court reaffirmed that the one-way attorney fee statute authorizes fees "in a discrete set of circumstances."[30] The Court refused to extend the statute to a surety that paid money on behalf of the surety's principal, emphasizing the plain language of the statute, which states that "a *named* or *omnibus insured* or the *named beneficiary*" is entitled to attorney's fees.[31] The Court acknowledged that the statute may have been interpreted too broadly in the past in contravention of the statute's plain language, observing that "[*d*]*espite the express limitations* in Section 627.428 as to the class of designated entities entitled to recover attorney's fees, this Court has previously approved an award of attorney's fees in situations where policy coverage was obtained through an assignment from the insured."[32]

The Court also made clear that the persons and entities entitled to fees under the statute are a *legislative* decision. Addressing an argument that the statute should be construed to cover sureties, the Court said: "If there is an injustice that requires the expansion of the statutory class of entities entitled to recover attorney's fees under section 627.428, that argument is one best addressed by the Legislature."[33]

III. The Intersection Between Assignments of Benefits and the One-Way Attorney Fee Statute

Despite the statute's plain language, assignees of insureds and beneficiaries have historically been permitted to recover attorney's fees under the statute. Allowing third parties to the insurance policy to benefit from the one-way attorney fee statute by virtue of an assignment has contributed to distortions in the insurance market. Such distortions are seen no more

[24]422 So. 2d 314 (Fla. 1982).
[25]*Id.* at 314.
[26]*Id.* at 316.
[27]*Id.*
[28]*Id.* at 316 n.*.
[29]974 So. 2d 368 (Fla. 2008).
[30]*Id.* at 374.
[31]*Id.*
[32]*Id.* at 375 (emphasis added).
[33]*Id.* at 379.

frequently than in the context of post-loss assignments of insurance policies. Assigning an insurance policy after a loss is premised on the idea that accrued benefits may be assigned to a noninsured, who then "steps into the shoes" of the insured. Over time, case law has developed allowing insureds to assign all post-loss rights, including that of their legal standing, to a third party by virtue of an assignment of benefits ("AOB"). An AOB has been found to entitle a third party, who initiates first party litigation by virtue of the assignment, to the protections offered by the one-way attorney fee statute, likely altering the equilibrium that Section 627.428 was designed to achieve.

Assignments of Benefits

An assignment is a transfer of some right or interest in property from one person to another.[34] All contractual rights are assignable unless the contract prohibits assignment, the contract involves obligations of a personal nature, or public policy dictates against assignment.[35] So, for example, a chose in action—which is "the right to bring an action to recover a debt, money, or thing"[36]—arising out of contract is assignable and "may be sued upon and recovered by the assignee in his own name and right."[37] A claim arising under an insurance policy is a chose in action and is thus assignable.[38] Once an assignment is made, the assignor no longer has a right to enforce the interest assigned.[39]

Florida law provides that an insurance policy "may be assignable, or not assignable, as provided by its terms."[40] Where there is no policy provision prohibiting assignment of a policy, it is clear that a claim under an insurance policy "may be assigned as any other chose in action."[41] But, even where there is a policy provision that would bar assignment or render an assignment invalid, courts have refused to enforce such provisions in certain circumstances. Courts distinguish between pre-loss assignments and post-loss assignments to determine whether a provision that requires insurer consent or a provision prohibiting assignment—often called an "anti-assignment clause"—validly bars an assignment.

Pre-loss assignments are made before a claim arises; post-loss assignments are made after a loss. An anti-assignment clause or provision requiring insurer consent may validly prohibit *pre*-loss assignments. However, courts have held that an anti-assignment clause may not prohibit *post*-loss assignments.[42] The idea is that "post-loss assignments merely transfer an accrued right to payment and do nothing to alter the risk originally assumed by the insurance company," and thus the general right to assign contractual rights should control over the policy's

---

[34]*Id.* at 376.
[35]*Kohl v. Blue Cross & Blue Shield of Fla., Inc.*, 988 So. 2d 654, 658 (Fla. 4th DCA 2008).
[36]Black's Law Dictionary (9th ed. 2009).
[37]*Spears v. W. Coast Builders' Supply Co.*, 133 So. 97, 98 (Fla. 1931).
[38]*United Cos. Life Ins. Co. v. State Farm & Fire Cas. Co.*, 477 So. 2d 645, 646 (Fla. 1st DCA 1985).
[39]*Cont'l Cas. Co.*, 974 So. 2d at 376.
[40]§ 627.422, Fla. Stat. (2015). A provision requiring insurer consent prior to assignment is typically called a "consent to assignment clause" and is enforceable in Florida. *See Cordis Corp. v. Sonics Int'l*, 427 So. 2d 782, 783 (Fla. 3d DCA 1983).
[41]*Kohl*, 955 So. 2d at 1143.
[42]*See W. Fla. Grocery Co. v. Teutonia Fire Ins. Co.*, 77 So. 209, 210-11 (Fla. 1917) ("The policy was assigned after loss, and it is a well-settled rule that the provision in a policy relative to the consent of the insurer to the transfer of an interest therein does not apply to an assignment after loss."); *see also, e.g., Lexington Ins. Co. v. Simkins Indus.*, 704 So. 2d 1384, 1386 n.3 (Fla. 1998) (Insurer "concedes that an insured may assign insurance proceeds to a third party after a loss, even without the consent of the insurer."); *Citizens Prop. Ins. Corp. v. Ifergane*, 114 So. 3d 190, 195 (Fla. 3d DCA 2012) ("Post-loss insurance claims are freely assignable without the consent of the insurer.").

prohibition.[43] In contrast, a policy may validly prohibit pre-loss assignments to "protect an insurer against unbargained-for risks."[44]

The freedom to assign post-loss claims has long been the common law of Florida since *West Florida Grocery Co. v. Teutonia Fire Insurance Co.*[45] In *Teutonia*, the Court held that a post-loss assignment of the proceeds of a fire insurance policy was valid, even though the insurer's consent was not obtained as required by the policy. The Court observed that "[i]t is a well-settled rule that the provision in a policy relative to the consent of the insurer to the transfer of an interest therein does not apply to an assignment *after loss*."[46]

Recent Case Law Developments on AOBs

A series of 2015 Florida state court cases illustrates the growing problems associated with AOBs, particularly their use by certain service providers, and that these problems are best addressed by the Florida Legislature.

In *Accident Cleaners, Inc. v. Universal Insurance Co.*,[47] the Fifth District Court of Appeal held that an assignee of a homeowner's insurance policy could bring a breach of contract claim under Section 627.405, Florida Statutes, even though the assignee had no insurable interest in the home at the time of loss.[48] Section 627.405 provides that "[n]o contract of insurance of property . . . shall be enforceable . . . . except for the benefit of persons having an insurable interest in the things insured as of the time of the loss."[49] The court rejected the insurer's argument that the assignee did not have an insurable interest at the time of the loss since the policy had been assigned only post loss. The court explained that the insurer's "argument ignores that the right to recover is freely assignable after loss and that an assignee has a common-law right to sue on a breach of contract claim."[50] Because Section 627.405 did not explicitly state that it was displacing the common law of free assignability of contractual rights or the inability for insurers to restrict post-loss assignments,[51] the insurer consequently could "not overcome the presumption that the Legislature did not intend in Section 627.405 to alter common law."[52] Instead, so long as the policyholder had an insurable interest at the time of the loss, that interest was imputed to the post-loss assignee and could be enforced by the assignee.[53]

---

[43] *In re Katrina Canal Breaches Litig.*, 63 So. 2d 955, 959 (La. 2011) (discussing the issue's treatment in the majority of jurisdictions); *see also id.* at 961 ("In differentiating between [pre-loss and post-loss assignments], courts reason that allowing an insured to assign the right to coverage (pre-loss) would force the insurer to protect an insured with whom it had not contracted—an insured who might present a greater level of risk than the policyholder. However, allowing an insured to assign its rights to the proceeds of an insurance policy (post-loss) does not modify the insurer's risk. The insurer's obligations are fixed at the time the loss occurs, and the insurer is obligated to cover the loss agreed to under the terms of the policy. This obligation is not altered when the claimant is not the party who was originally insured.").

[44] *Lexington Ins. Co.*, 704 So. 2d at 1386.

[45] 77 So. 209 (Fla. 1917).

[46] *Teutonia*, 77 So. at 210-11.

[47] --- So. 3d ---, No. 5D14-352, 2015 WL 1609973 (Fla. 5th DCA Apr. 10, 2015).

[48] *Id.* at *1.

[49] *Id.* at *2 (quoting § 627.405, Fla. Stat. (2014)).

[50] *Id.*

[51] *Id.*

[52] *Id.*

[53] *Id.*

The Fourth District Court of Appeal in *One Call Property Services Inc. v. Security First Insurance Co.*[54] confronted the issue whether payment must be due under an insurance policy before an insured may assign a post-loss claim. The court held that an assignable right to policy benefits accrues on the date of the loss even though payment is not due under the policy's loss payment clause, and the policy did not prohibit the assignment.[55] Thus, the assignee—which obtained the AOB after performing emergency water removal services for the insured following a water event—had standing to state a claim under the policy.

The Fourth District Court of Appeal acknowledged arguments that AOBs given to service providers like the plaintiff are spurring concerns of fraud and abuse. The Fourth District stated that the issue of service provider AOBs "boils down to two competing public policy considerations."[56] On one side are insurers that "argue[] that assignments of benefits allow contractors to unilaterally set the value of a claim and demand payment for fraudulent or inflated invoices."[57] On the other side are contractors that "argue that assignments of benefits allow homeowners to hire contractors for emergency repairs immediately after a loss, particularly in situations where the homeowners cannot afford to pay the contractors up front."[58] While sympathetic to the insurers' concerns, the court stated that it was not in a position to evaluate them. The court pointed out that "[i]f studies show that these assignments are inviting fraud and abuse, then the legislature is in the best position to investigate and undertake comprehensive reform."[59]

In *Security First Insurance Co. v. State of Florida, Office of Insurance Regulation*,[60] an insurer appealed the decision of Florida's Office of Insurance Regulation ("OIR") to deny its request to amend its homeowner's policies to restrict the ability of policyholders to assign post-loss rights without consent.[61] OIR had denied the amendment as misleading on the basis that Florida law does not allow enforcement of an anti-assignment provision with respect to post-loss rights. The First District Court of Appeal agreed with OIR, citing "an unbroken string of Florida cases over the past century holding that policyholders have the right to assign such claims without insurer consent."[62] Like the Fourth District in *One Call*, the First District was mindful of the serious concerns that have arisen as a result of a "cottage industry of vendors, contractors, and attorneys . . . that use the assignment of benefits and the threat of litigation to extract higher payments from insurers."[63] But like its sister court, the First District Court of Appeal said the issue is one left to the legislature to resolve.[64]

---

[54]165 So. 3d 749 (Fla. 4th DCA 2015).
[55]*Id.* at 754; *see also Emergency Servs. 24 v. United Prop. & Cas. Ins. Co.*, 165 So. 3d 756 (Fla. 4th DCA 2015) (same); *ASAP Restoration & Constr. v. Tower Hill Signature Ins. Co.*, 165 So. 3d 736 (Fla. 4th DCA 2015) (same).
[56]*One Call Prop. Servs.*, 165 So. 3d at 755.
[57]*Id.*
[58]*Id.*
[59]*Id.*
[60]No. 1D14-1864, 2015 WL 3824166 (Fla. 1st DCA June 22, 2015).
[61]*Id.* at *1.
[62]*Id.*
[63]*Id.* at *2 (internal quotation marks omitted).
[64]*Id.*

More recently, the First District Court of Appeal in *United Water Restoration Group v. State Farm Insurance Co.*[65] found that a court had improperly dismissed assignee United Water Restoration Group's complaint based on an argument raised by State Farm that United Water could not satisfy the conditions of coverage under the policy.

United Water provided remediation services in exchange for an AOB from the policyholder whose home was damaged by water. State Farm refused to pay the bill because it found that the damage arose from conditions that fell within a policy exclusion. United Water responded by filing a county court action pursuant to the assignment. State Farm moved to dismiss the complaint due to the coverage issue, contending that only the policyholder, not the remediation company, could satisfy the conditions for coverage. The county court dismissed the complaint, and the circuit court upheld the dismissal. The First District reversed, concluding that the dismissal violated established principles of Florida law that an assignee of an insurance policy may sue for breach. According to the court, "[c]learly established law permits United Water to bring suit to seek recovery under the State Farm policy, and if necessary, seek a coverage determination. The dismissal order had the harsh effect of barring United Water's enforcement of its bargained-for right to pursue assigned benefits, which amounts to a miscarriage of justice."[66]

The One-Way Attorney Fee Statute Incentivizes AOB Litigation

As acknowledged by the Fourth District Court of Appeal in *One Call* and the First District Court of Appeal in *Security First Insurance*, there are many that argue service providers armed with AOBs are "unilaterally set[ting] the value of a claim and demand[ing] payment for fraudulent or inflated invoices"[67] from insurers and using "the threat of litigation to extract [these] higher payments."[68] Service providers are incentivized to do this because, as an assignee of the insured or beneficiary, they are entitled to attorney's fees under the one-way attorney fee statute, and in turn the exposure to attorney's fees discourages insurers from fighting the assigned claim.

Florida courts have held that with an AOB comes an assignment of the insured's or beneficiary's right to recover fees under the one-way attorney fee statute.[69] The one-way attorney fee statute likely fuels AOB litigation because the statute offers distinct advantages over other attorney's fee payment arrangements. For example, in a contingency fee arrangement, payment of the attorney's fees by the client is contingent on the outcome of the case.[70] The

---

[65]No. 1D14-3797, 2015 WL 4111662 (Fla. 1st DCA July 8, 2015).
[66]*Id.* at *2.
[67]*See One Call Prop. Servs.*, 165 So. 3d at 755.
[68]*See Sec. First*, 2015 WL 3824166, at *2.
[69]*See, e.g., Roberts*, 350 So. 2d at 79; *All Ways Reliable Bldg. Maint., Inc. v. Moore*, 261 So. 2d 131, 132 (Fla. 1972); *Magnetic Imaging Sys., I, Ltd., v. Prudential Prop. & Cas. Ins. Co.*, 847 So. 2d 987, 989-90 (Fla. 3d DCA 2003); *Superior Ins. Co. v. Liberty*, 776 So. 2d 360, 365 (Fla. 5th DCA 2001); *Travelers Ins. Co. v. Tallahassee Bank & Trust Co.*, 133 So. 2d 463, 467 (Fla. 1st DCA 1961) (assignee entitled to attorney's fees under statute even though it was not a named beneficiary under the policy because it effectively became a beneficiary pursuant to the assignment); *see also, e.g., Liberty Mut. Ins. Co. v. Davis*, 412 F.2d 475, 486 (5th Cir. 1969) (applying Florida law) (assignee stands "in the shoes of the insured" with respect to the entire action, "including [the insured's] right to attorneys' fees" under the statute). "[A]n assignee of an insurance claim stands to all intents and purposes in the shoes of the insured and logically should be entitled to an attorney's fee when he sues and recovers on the claim." *All Ways Reliable*, 261 So. 2d at 132.
[70]R. Regulating the Fla. Bar 4-1.5(f)(1)-(2); *see also Brickell Place Condo. Ass'n v. Joseph H. Ganguzza & Assocs., P.A.*, 31 So. 3d 287, 290 (Fla. 3d DCA 2010).

attorney agrees to accept a part of the money the client recovers in the case as the fee for services, generally fixed at a percentage of the client's recovery. Although attractive to clients because they do not have to pay unless they win, contingency fees are subject to strict requirements and may not be used in certain types of cases.[71] And ultimately, the client reduces his recovery by the amount of the fee he must pay his attorney. The client will also likely be responsible for paying court filing fees and other costs, regardless of whether he prevails.

In contrast, under the one-way attorney fee statute, the prevailing party is awarded his attorney's fee and costs in addition to the damages he is awarded by the court.[72] The prevailing party's attorney recovers his full fee, no matter what amount of damages is awarded to his client. In a contingency fee arrangement resulting in a low damages award by the court, neither the client nor the attorney fully recovers.

The one-way attorney fee statute also offers a greater recovery than that authorized under other attorney's fee statutes available to prevailing parties.[73] For example, the one-way attorney fee statute permits a greater recovery than the offer of judgment statute since the one-way attorney fee statute awards the prevailing insured *all* fees and costs and not just those incurred after an offer of judgment is made.[74] The one-way attorney fee statute is also more appealing than Section 57.105, Florida Statutes, because it guarantees recovery without any requirement that the plaintiff demonstrate the insurer presented a claim or defense that was essentially frivolous.[75]

These advantages make AOB litigation all too enticing, and courts have acknowledged that the one-way attorney fee statute may spur litigation which the Florida Legislature did not contemplate.

In *Allstate Insurance Co. v. Regar*,[76] the Second District Court of Appeal held that the assignee of a bad faith claim was entitled to attorney's fees under the statute, although the assignee was not a named or omnibus insured or the named beneficiary, because the entire cause of action had been assigned to him. Standing in the shoes of the insured, the assignee was entitled to all remedies to which the insured would otherwise be entitled. However, the court was "not unsympathetic" to the defendant insurer's plight given the "exponential[] increas[e]" in the number of bad faith cases filed without any apparent link to the conduct of insurers. "Instead, plaintiff's attorneys are filing bad faith actions over issues that it seems could be simply resolved, like the wording of the release in this case."[77] The court observed that "[t]hese attorneys are

---

[71] *See, e.g.*, R. Regulating the Fla. Bar 4-1.5(f)(3)-(5).

[72] Relatedly, the ability to obtain a contingency fee multiplier is not exclusive to contingency fee arrangements and may be obtained in a proper case under Section 627.428 as a contingency risk multiplier. *See Standard Guar. Ins. Co. v. Quanstrom*, 555 So. 2d 828, 834 (Fla. 1990) (use of multiplier under statute may be appropriate "when a risk of nonpayment is established"); *see also Allstate Ins. Co. v. Regar*, 942 So. 2d 969, 974-75 (Fla. 2d DCA 2006) (holding that trial court properly determined that it had discretion to award a multiplier to the attorney's fees awarded under Section 627.428).

[73] *See State Farm Mut. Auto. Ins. Co. v. Nichols*, 932 So. 2d 1067, 1075 (Fla. 2006) (holding that existence of one-way attorney fee statute does not preclude the application of other attorney's fee provisions).

[74] *Cf.* § 765.79(1), Fla. Stat. (2015) (awarding attorney's fees incurred by a plaintiff after a demand for judgment is made in certain circumstances).

[75] *Cf.* § 57.105(1), Fla. Stat. (2015) (authorizing an award of attorney's fees to a prevailing party when the court finds that the losing party or losing party's attorney knew or should have known that a claim or defense presented to the court was unsupported by material facts or would not be supported by the application of then-existing law to material facts).

[76] 942 So. 2d 969.

[77] *Id.* at 973.

perhaps motivated by the promise of fees under Section 627.428 upon prevailing in this action. Certainly this case has mushroomed into over $200,000 in attorney's fees plus an as-yet-undetermined amount of appellate attorney's fees from an initial offer of settlement for meager policy limits of $25,000."[78] While expressing concern that it was "not certain that outcomes like today's were contemplated at the time of the statute's enactment," the Florida court acknowledged "that issue is for resolution by the legislature."[79]

Although public policy favors the free assignment of contract rights, at least post-loss, such a policy does not apply to the one-way attorney fee statute, a legislatively-created right and indeed a derogation of the common law rule that parties bear their own attorney's fees. Turning to the data underlying the exponential increase in AOB cases filed in Florida, it is clear that it is time for the Florida Legislature to curb the abuse of AOBs and AOB litigation by restricting use of the tool that incentivizes it—the one-way attorney fee statute.

IV. Explosion of Assignments of Benefits to Service Providers

Enticed by the prospect of attorney's fees, a growing number of lawyers have partnered with various types of service providers to solicit AOBs from policyholders. The effects are most pronounced in three segments of the insurance industry discussed below.

The typical AOB relationship begins when a policyholder signs a contract assigning rights, benefits, proceeds, and causes of action arising under his insurance policy to a third party. This third party is often a service provider that agrees to make the repair or provide the service for which insurance coverage will be sought. Indeed, often the repair or service is conditioned upon the assignment. In many cases the AOB includes language which divests the policyholder of any benefits under the policy, privacy rights, and any direct payment of insurance proceeds.[80] Based on a survey conducted of various insurance trade associations, most assignments reviewed shared the following characteristics:

- Irrevocable in nature, meaning the policyholder, insured, or beneficiary had no ability to rescind the assignment (79.55%);
- Transferred all causes of action, divesting the policyholder of any legal recourse under the insurance policy (79.55%);
- Waived the policyholder's privacy rights (37.5%); and

---

[78] *Id.* at 973-74.

[79] *Id.* at 974.

[80] *See, e.g.*, *See, e.g.*, Harvey V. Cohen, PowerPoint Presentation: Insider Secrets: Legal Assignment of Insurance Benefits 18 (on file with authors) (providing example AOB: "Assignment of Insurance Benefits: I, hereby, assign any and all insurance rights, benefits, proceeds and any causes of action under *any* applicable insurance policies to [Insert Your Company Name], for services rendered or to be rendered by Company. In this regard, I waive my privacy rights. . . . I also hereby direct my insurance carrier(s) to release any and all information requested by Company, its representative, and/or its Attorney for the direct purpose of obtaining actual benefits to be paid by my insurance carrier(s) for services rendered or to be rendered. I believe the appropriate insurance carrier to be (Insert Property Owners Insurance Company)."); Erickson's Drying Systems, Inc., Contract for Services, Assignment of Benefits, http://ericksonsdrying.com/contact-us/contract-for-services-assignment-of-benefits/ (last visited Aug. 13, 2015) (providing example AOB for drying repair company); ELR Restoration Inc., Certificate of Completion & Assignment of Benefits, http://elrrestoration.com/uploads/2/8/8/6/2886421/elr_repair_assignment_forms.pdf (last visited Aug. 13, 2015) (providing example AOB for home restoration services).

- Included a "hold harmless" provision for the benefit of the service provider (53.4%).[81]

Once executed, the newly assigned service provider performs work for which reimbursement is then sought directly from an insurer, usually in the form of a demand letter. Demand letters provide an insurer a certain number of days to pay and "avoid any potential legal action in this matter."[82] When the insurer fails to pay, the service provider brings a lawsuit against the insurer.

A telltale sign that an AOB is sought to be enforced through litigation is the use of "a/a/o" or "as assignee of" in the plaintiff's name in the case caption or style. A case caption might indicate that it is being brought by "Auto Glass Company a/a/o John Smith," which means Auto Glass Company is suing as an assignee of John Smith. However, searching "a/a/o" in the plaintiff name field may not capture all AOB litigation because an assignee may bring a lawsuit in its own name, without reference to the assignor in the case style.[83] A review of AOB complaints substantiates the claim that attorneys for assignees are asking for fees under Section 627.428 as a matter of course.[84]

Using the "a/a/o" search criterion, a search was conducted through the Florida Department of Financial Services Service of Process website.[85] The Department has created an online searchable service of process ("SOP") database in which lawsuits against insurers for which the Department has received service of process are logged.[86] However, just as the "a/a/o" search criterion is not the exclusive way to identify all lawsuits filed as the result of AOBs, the SOP database is not representative of all AOB claims, as some claims never make it to litigation. With those caveats, the data extracted from the SOP database is compelling.

---

[81]Insurance Trade Association Survey Responses, Sept. 2015 (on file with authors); *see also infra* Section VI. Out of 116 total surveys received, 88 surveys included a response to a question requesting the characteristics of the AOB.

[82]Cohen, *supra* at 22.

[83]Searching cases for the use of "a/a/o" in the plaintiff's name field may not capture all AOB cases as the "a/a/o" designation may be a relatively recent phenomenon. The earliest use of this plaintiff-naming convention found in Westlaw is a 2003 case, *Prof'l Consulting Servs., Inc. a/a/o Susan Berlinghoff v. Hartford Life & Accident Ins. Co.*, 849 So. 2d 446 (Fla. 2d DCA 2003), which involved an assignment of PIP benefits. Many of the other early "a/a/o" cases also dealt with PIP assignments. *E.g.*, *Advanced Diagnostic Testing, Inc. a/a/o Will Turcios v. Allstate Ins. Co.*, No. 2002-4740-SP-05, 2003 WL 23868672 (Fla. Cir. Ct. Oct. 21, 2003); *Nationwide Gen. Ins. Co. v. Family Chiropractic Health Ctr. a/a/o Ruth Morningred*, No. 03-4825, 2003 WL 23148880 (Fla. Cir. Ct. Dec. 1, 2003); *Vincent DiCarlo, M.D. & Assocs. a/a/o Bonita Thurston v. Am. Home Assur. Co.*, No. 03-4949, 2004 WL 326746 (Fla. Cir. Ct. Jan. 20, 2004); *Nationwide Prop. & Cas. Ins. Co. v. Drs. Sheer, Ahearn & Assocs., P.A. a/a/o Sherry Holdaway*, No. 03-4596, 2004 WL 326751 (Fla. Cir. Ct. Jan. 21, 2004). A search of the Florida Department of Financial Services Service of Process database indicates that "a/a/o" cases were filed as early as 2000. But an assignee is not required to use "a/a/o" in the case name and may bring an AOB suit in his or her own name. *See Harris v. Smith*, 7 So. 2d 343, 346 (Fla. 1942) ("It is well settled that an assignee of a chose in action arising out of contract may sue in his own name and right."). Consequently, while "a/a/o" serves as an easy indicator of an AOB case, and as shown through case searches, appears very frequently, it may still only display a subset of all AOB litigation.

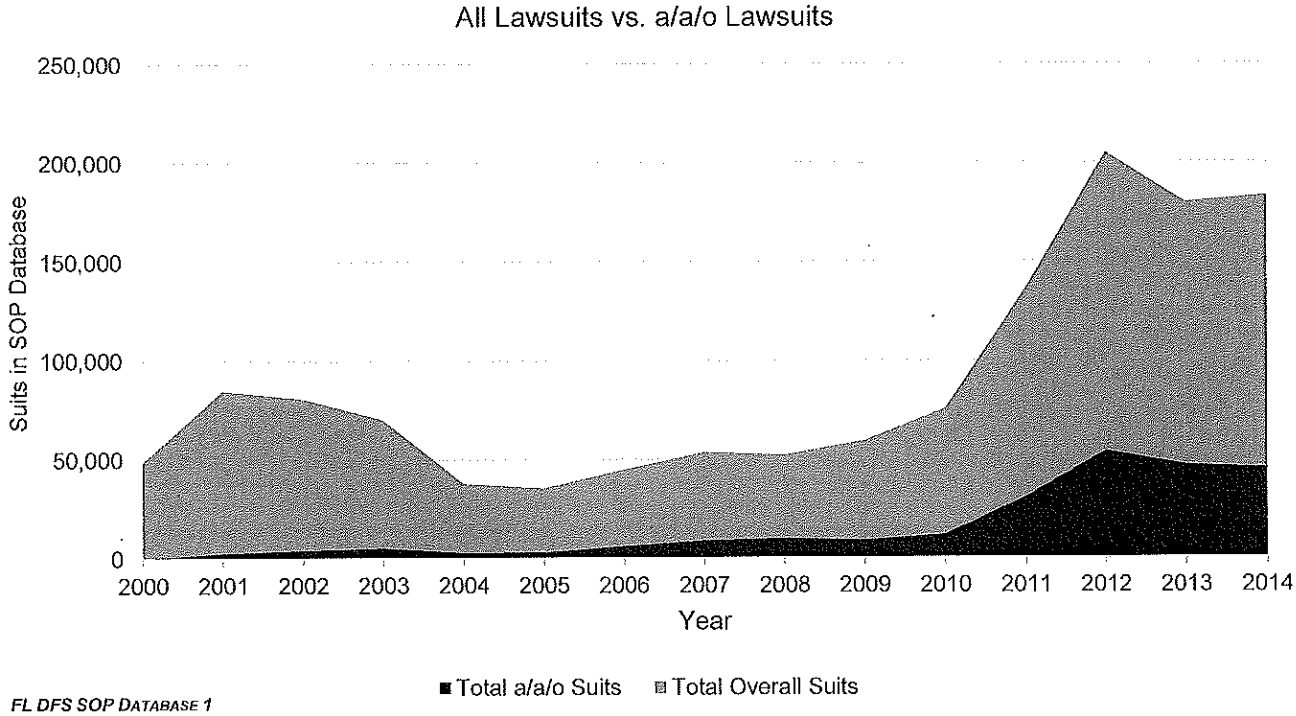
[84]*See, e.g.*, Complaint, *Express Auto Glass, LLC a/a/o Amber Tyer v. Allstate Fire & Ins.Co.*, Case No. 2013-SC-007075-0 (Fla. 9th Cir. Ct.) (filed Aug. 1, 2013). The complaint and attachments were accessed via the Orange County Clerk of Courts MyEClerk website, https://myeclerk.myorangeclerk.com/.

[85]Licensed insurers must appoint the Chief Financial Officer, as head of the Department of Financial Services, to receive service of all legal process in any civil action filed against a licensed insurer in Florida. § 624.422, Fla. Stat. (2015).

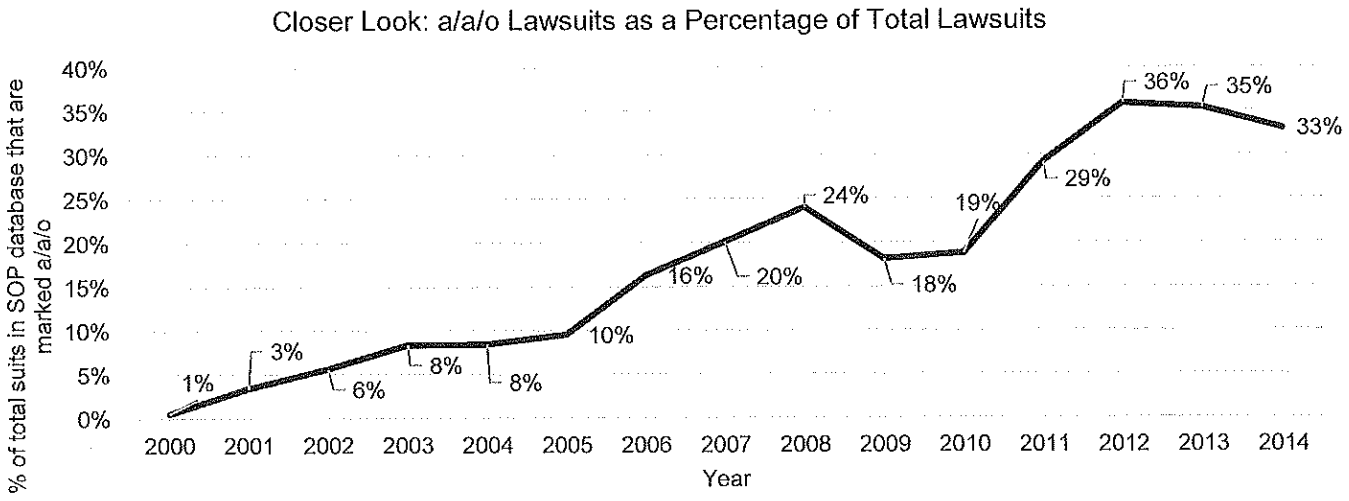
[86]*See* § 624.423, Fla. Stat. (2015).

AOB Cases Increasing at Staggering Rate

When searching just for cases that include "a/a/o" in the plaintiff's name, the database reports a **16,000% increase** in such lawsuits since 2000. Only 281 "a/a/o" cases were served in 2000; 45,490 were served in 2014. Notably, the *total* amount of all service of process notices served only increased by 183% during this same timeframe. As a percentage of total lawsuits served, "a/a/o" cases comprised less than 1% in 2000 but comprised 33% of all lawsuits served in 2014. This means that about one in three lawsuits filed against an insurer is an "a/a/o" lawsuit.

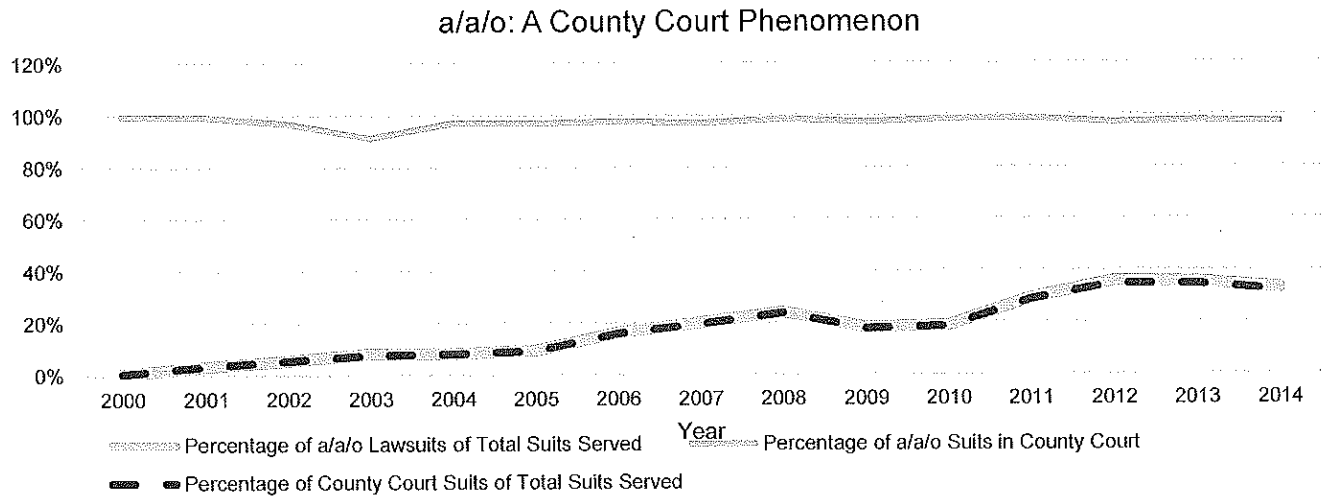


FL DFS SOP DATABASE 1



FL DFS SOP DATABASE 2

Since 2000, roughly 97% of all "a/a/o" cases have been filed in county court. Florida county court jurisdiction lies in actions where the amount in controversy does not exceed $15,000, exclusive of interest, costs, and attorney's fees.[87] The fact that nearly all "a/a/o" cases are filed in county court indicates that these are lawsuits involving relatively low amounts in controversy.



FL DFS SOP DATABASE 3

Given that most AOB cases are relatively small dollar cases, attorneys do not receive blockbuster damages verdicts from which they'll take their fees. The difference? Attorneys do not need to obtain significant damages in order to make money in AOB cases. Rather, attorneys are able to bill for time spent on a case and receive their fees through the one-way attorney fee statute, which, when billed hourly, can be significant when paired with a high volume of claims. Contingency fee multipliers can be added to these awards, inflating them even further.[88]

Attorney's Fee Shifting Results in a Costly Power Shift to Unintended Parties

Aside from the data obtained from the SOP database, surveys were sent to two insurance trade associations with members that include property and casualty insurers that write a high volume of automobile and/or property insurance policies in Florida. The purpose of these surveys was to obtain a more qualitative view of insurers' experiences with AOBs. Insurers (through their trade associations) were asked to identify claims and then to complete a survey for each identified claim. Each survey solicited information on numerous aspects of the AOB claim, including, among other things, whether an assignee was paid for the claim and what amount if any was paid to the assignee's attorney in fees.[89]

---

[87] § 34.01, Fla. Stat. (2015).
[88] *See Quanstrom*, 555 So. 2d at 834; *see also Regar*, 942 So. 2d at 974-75.
[89] A chart summarizing the information collected from these surveys is included as the final section of this report. *See infra* Section VI.

Out of the 116 surveys received, 60 claims were identified that provided both the final amount paid to the assignee on the claim and the amount paid in attorney's fees to the assignee's attorney. Of these 60 claims, attorney's fees represented an average of **274%**[90] of the total amount paid to the assignee on the insurance claim. Most interesting is that in 48 of these claims, the assignee originally demanded more than what was ultimately paid by the insurer.

Ninety-two of the surveys listed both an amount demanded for payment on an assigned claim and an amount of final payment, separate from any other fees or costs. For purposes of this particular analysis, the authors only reviewed those surveys where some amount was paid on the claim, not, for example, where a claim was denied. Of the claims reviewed, it was found that the final amounts paid, on average, represented a 28.62% savings to the insurer from the amount first demanded by the assignee.[91] Most of these claims were resolved in settlement, showing that assignees are settling for less than they demand, and in the case of service provider-assignees that performed the work for which they are seeking reimbursement from the insurer pursuant to an AOB, they are settling for less than what they "billed" the insured for services.

Settling claims by assignees and even paying attorney's fees in settlement is likely incentivized by the one-way attorney fee statute. The insurer's damages exposure would be significant if the assignee were to take its claim to court and to recover even just $1. As the issues involved in this type of litigation are largely jury questions, an insurer's winning on the merits is an uncertainty. And even a minor victory for the insured exposes the insurer to attorney's fees. As a result, this uncertainty and exposure likely results in a payment to the assignee's attorney in settlement to discourage further litigiousness.

The motivating factor behind the AOB industry appears to be the fee-shifting offered by the one-way attorney fee statute. Specifically, in materials coaching service providers on the availability of AOBs, one law firm assures service providers that the AOB is preferable to other payment mechanisms since it "[c]onveys legal standing," "[a]llows the assignor to stand in the shoes of the insured," and, citing Section 627.428, "[a]llows [the] law firm to obtain their fees and costs separately from any client funds" without "tak[ing] a penny of your money."[92] Moreover, the law firm reminds service providers that "[b]ad faith becomes an option" with an AOB, unlike with a simple direction to pay the service provider.[93] The risk of a bad faith claim also significantly increases an insurer's damages exposure.

---

[90]Insurance Trade Association Survey Responses, Sept. 2015 (on file with authors); *see also infra* Section VI. These 60 claims included 48 property insurance claims and 12 auto glass-related insurance claims. The median percentage of attorney's fees of final reimbursement amount was 127.44% and the mode was 250%.

[91]Insurance Trade Association Survey Responses, Sept. 2015 (on file with authors); *see also infra* Section VI. The claims reviewed include 54 property insurance related claims and 38 auto glass-related claims. The total amount requested for these property claims was $516,979.67. The total amount paid for those same property claims was $371,661.75. Of the auto glass-related claims reviewed, the total amount requested was $19,961.11, and the total amount paid was $15,851.87. The median savings to the insurer on all these claims was 36.58% of the amounts first demanded. The average savings was 28.62%.

[92]Cohen, *supra* at 28, 34.

[93]*Id.* at 27.

So are attorneys the only ones benefiting by this scheme? It is hard to tell, given that such an analysis requires an examination of invoices submitted by service provider-assignees and a comparison with pricing and other standards. However, the same law firm presentation also advertises to service providers that they can "charge more than Xactimate."[94] The surveys reflected that, in nearly 60% of the cases reviewed, pricing deviations did exist. One of the most frequent deviations cited? In excess of Xactimate. Other frequent deviations include excessive scope, inappropriate use of overhead and profit, incomplete logs, and discrepancies with peer reviews.

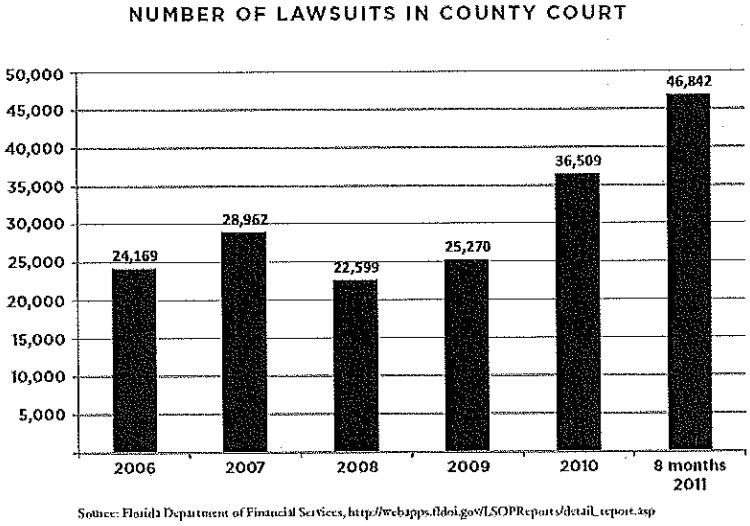
Unfortunately, Section 627.428's intent—to shield policyholders from an insurer's superior economic power—is being used as a sword by an altogether different set of persons.

AOB Litigation Plagues Personal Lines Insurance in Florida

The explosion of AOB litigation is no more pronounced than in personal lines insurance, particularly in three lines: motor vehicle personal injury protection insurance ("PIP"), motor vehicle physical damage coverage insurance (specifically, auto glass repair coverage), and property insurance.

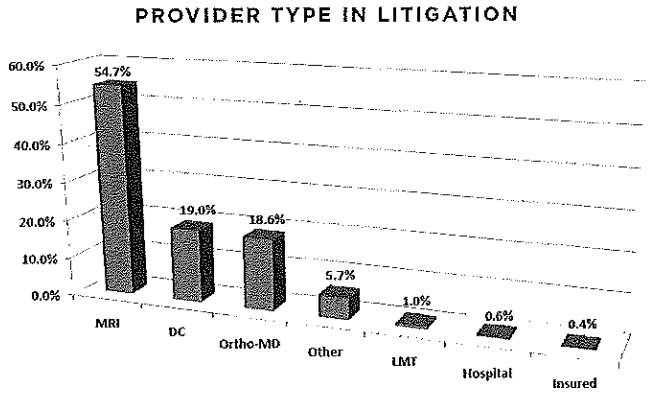
Case Study: Personal Injury Protection Claims

Historically, AOBs have dominated litigation concerning PIP. In 2011, Florida's Insurance Consumer Advocate assembled a working group to study the issues troubling the PIP industry and used the SOP database to study the rise in PIP litigation.[95] The workgroup's report estimated that about 95% of the 36,509 cases filed against insurance companies in 2010 were related to PIP coverage.[96] The working group was primarily concerned with what therapies or modalities are driving this increase. It determined that the modalities of chiropractic care, physical therapy, and massage therapy were most frequently billed,[97] and that providers of these modalities were increasingly becoming the actual plaintiffs in PIP litigation.[98] One insurer reported to the working group that based on its litigation experience, 99.6% of PIP AOB litigation is



Source: Florida Department of Financial Services, http://webapps.fldfs.gov/LSOPReports/detail_report.asp

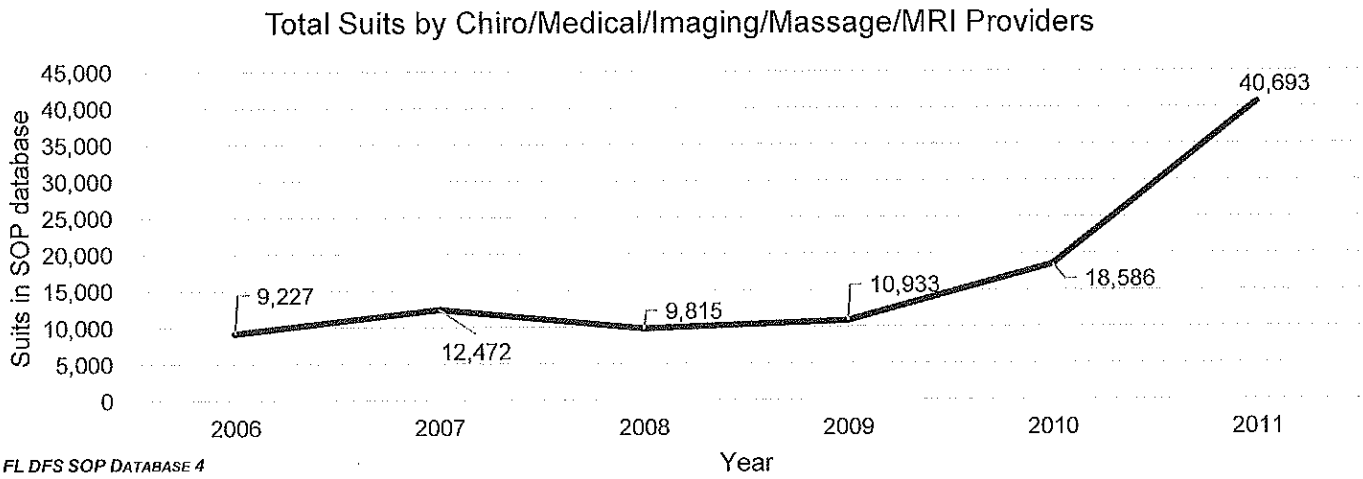
[94]Cohen, *supra* at 42. Xactimate is a pricing software widely used by insurance industry stakeholders to estimate repair costs. *See* Xacimate website, http://www.xactware.com/en-us/solutions/claims-estimating/xactimate/28/professional/.
[95]Florida Department of Financial Services, Office of the Insurance Consumer Advocate, *Report on Florida Motor Vehicle No-Fault Insurance (Personal Injury Protection)* (Dec. 2011), http://www.myfloridacfo.com/ica/docs/PIP%20Working%20Group%20Report%2012.14.2011.pdf.
[96]*Id.* at 36.
[97]*Id.* at 2.
[98]*Id.* at 35.



Source: Single insurer's litigation experience not independently verified.

driven by MRI providers, chiropractors, and similar service providers, while only 0.4% of PIP AOB litigation is generated by insureds.[99]

In conducting our own search of the SOP database for the top providers of modalities most commonly attributed to PIP care (including chiropractors, MRI/imaging centers, and massage therapists), in 2011 these providers served 40,693 lawsuits on insurers.



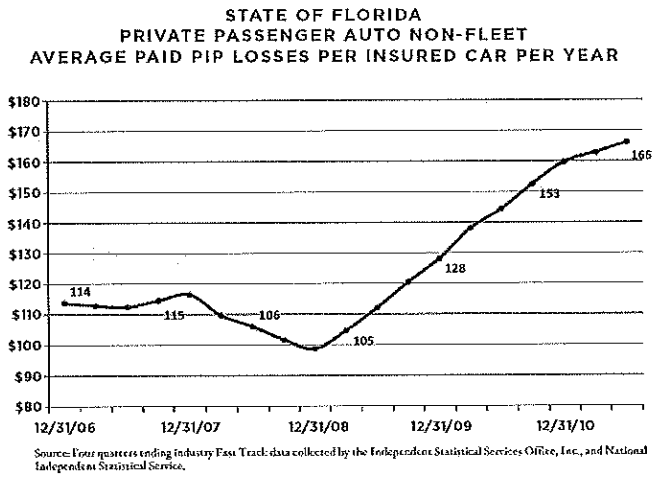
FL DFS SOP DATABASE 4

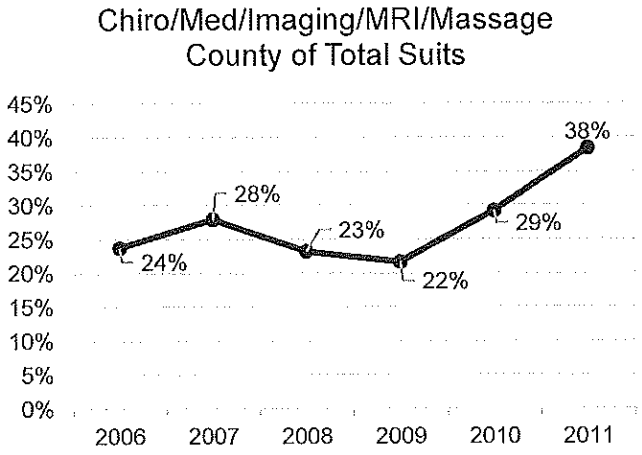
Interestingly, the line illustrating the number of lawsuits served by those providers catalogued by the SOP database parallels the line showing the average paid PIP losses per insured car, per year. The positive relationship between average paid PIP losses per car annually and lawsuits by service providers armed with AOBs is troubling and suggests that litigation is the main driver of the losses. As Florida Insurance Commissioner Kevin McCarty stated regarding PIP litigation more generally, "From 2008 to 2010, the amount Florida insurers paid for PIP benefits increased from $1.45 billion to $2.45 billion—a 70 percent increase. This increase is even more astounding when you consider the number of drivers was constant and the overall number of reported traffic accidents actually declined during the same period. Ironically, the number of lawsuits also doubled in the last two years, which undermines the entire premise of the 'no-fault' legal system."[100]

---

[99] *Id.* at 35.

[100] Kevin McCarty, *Getting Back to Basics: Fixing the PIP Problem*, Sunshine State News (Jan. 25, 2012), *available at* http://www.sunshinestatenews.com/story/getting-back-basics-fixing-pip-problem.





FL DFS SOP DATABASE 5

In the 2012 regular session, the Florida Legislature passed PIP reform. The chief reforms included lowering the allowed claims payments for non-emergency conditions, excluding massage and acupuncture from covered medical benefits, strengthening the discovery mechanism requirements for insureds, and providing standards for reasonableness in attorney fee awards including elimination of the use of a contingent fee multiplier in some cases.[101] The PIP reform bill was passed on May 9, 2012 with an effective date of January 1, 2013.[102] In late 2012, certain chiropractors, acupuncturists, and massage therapists challenged the statute, prompting a series of stays and appeals that stretched into late 2013.[103] On October 23, 2013, the First DCA lifted the injunction placed on the implementation of the legislation based on the plaintiffs' lack of standing.[104] The plaintiffs' attempt to obtain review by the Florida Supreme Court was rejected on April 21, 2014.[105]

---

[101] Fla. CS for CS for HB 119 (2012) (Third Engrossed) (An Act Relating to Motor Vehicle Personal Injury Protection Insurance), *available at* http://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?FileName=_h0119er.docx&DocumentType=Bill&BillNumber=0119&Session=2012.

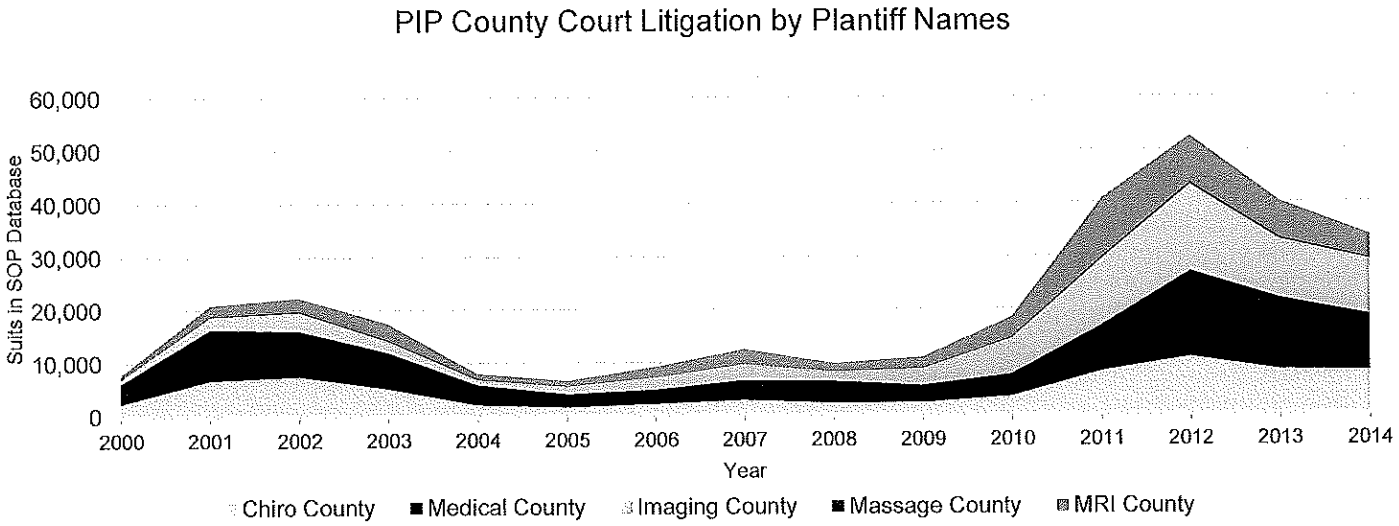
[102] *Id.*

[103] *See McCarty v. Myers*, 125 So. 3d 333, 334-35 (Fla. 1st DCA 2013).

[104] *Id.* at 337.

[105] *Myers v. McCarty*, 143 So. 3d 921 (Fla. 2014).

With the implementation of reform, overall PIP lawsuit data from the top modalities reflects a decline that may correspond to these reforms.[106] This is not the first time this has occurred. As shown in the next chart, overall PIP litigation decreased in volume in 2002 and 2003, and decreased again in 2007. In 2001, enhanced fraud protections, including clinic licensure and limited third-party access to crash reports, were passed,[107] and in 2003, additional anti-fraud measures were added.[108] Another short decrease occurred in 2007, when the PIP law was repealed briefly as a result of a sunset provision in the law but was soon reenacted with additional reforms.[109]



FL DFS SOP DATABASE 6

Some of the "dips" reflected in the overall number of AOB lawsuits filed may be attributable to the declines in PIP AOB litigation as the result of reform. However, despite reforms, PIP AOB litigation still represents a significant portion of all AOB litigation.

Case Study: Auto Glass Claims

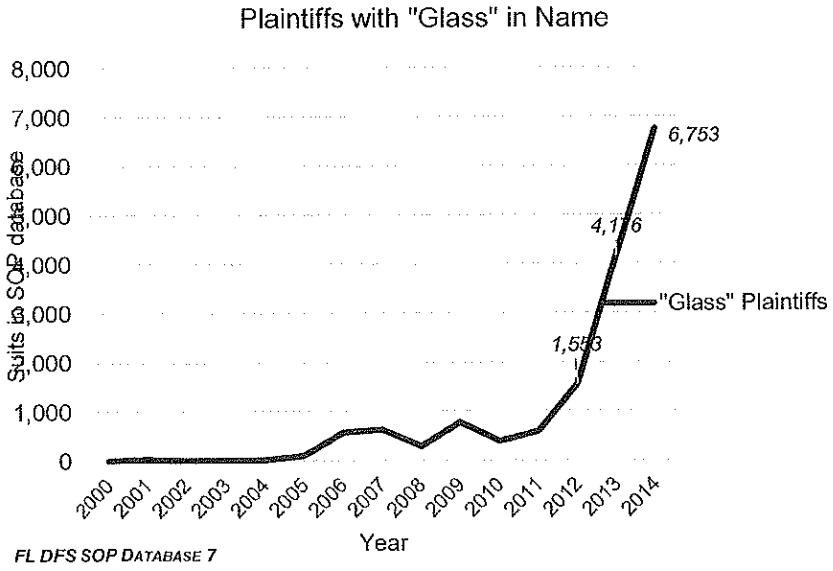
Auto insurance policies often provide physical damage coverage, meaning coverage for loss to the vehicle that resulted from an occurrence other than a collision. Events covered by physical damage insurance include fire, theft, vandalism, falling objects, natural disasters, and the like.[110] Windshields are excepted from an auto insurance policy's deductible requirements by law.[111] Unfortunately, the prospect of a "no risk" or "free" windshield has fueled a very predictable moral hazard: manufactured windshield repair claims. Several auto glass repair

---

[106] *See infra* PIP County Court Litigation by Plaintiff Names Chart, Florida Department of Financial Services Service of Process Database.
[107] *See* Ch. 2001-271, Laws of Fla.; Ch. 2001-163, Laws of Fla.
[108] *See* Ch. 2003-411, Laws of Fla.
[109] Florida Office of Insurance Regulation, Cabinet Presentation—Personal Injury Protection 6 (Aug. 2011), http://www.floir.com/siteDocuments/PIPPresentation08162011.pdf.
[110] Florida Department of Financial Services, *Automobile Insurance: A Toolkit for Consumers* 7, http://www.myfloridacfo.com/Division/Consumers/understandingCoverage/Guides/documents/AutoToolkit.pdf (last visited Aug. 13, 2015).
[111] § 627.7288, Fla. Stat. (2015).

shops have developed a niche market of promising "free" windshields in exchange for an AOB and the right to sue an insurer.

In 2013, a Tampa news station completed a two-year undercover investigation into windshield repairs and replacements. The news station discovered windshield repair shops that offered gift cards, steaks, and cash in exchange for a car owner's right to file an insurance claim for a "free" windshield replacement. Often undamaged windshields were targeted, but windshield repair shops alleged damage in order to seek insurer payment for replacement work.[112]



FL DFS SOP DATABASE 7

Unfortunately, a search of the SOP database suggests that this practice has boomed in Florida. From 2000 to 2005, only 92 services of process from plaintiffs with names containing the word "glass" were received. Over the next five years, 2,249 were received. From 2010 to 2014, **13,100** were filed. In 2014 alone, 6,722[113]—or almost 26 services of process per day—were logged into the SOP database.

Advertisements on the Auto Glass America Website, Aug. 15, 2015

Much of this litigation is being filed by the same small class of vendors. Express Auto Glass, which contributed about 600 lawsuits to the 2014 total, advertises a "FREE Gift Card with Windshield Replacement Insurance Claim!" on its website.[114] As another example, Auto Glass America, which promises a $100 restaurants.com gift card with the words "Have Any Auto Glass Service Done by Us and this Valuable Gift Card is Yours Absolutely Free!"[115] on its website, filed 1,485 lawsuits in 2014. Mobile Auto Glass Repair, LLC—

[112]First Coast News, *Glass companies push unnecessary windshield replacements* (May 3, 2013), *available at* http://www.firstcoastnews.com/story/news/local/florida/2014/01/17/4600895/.

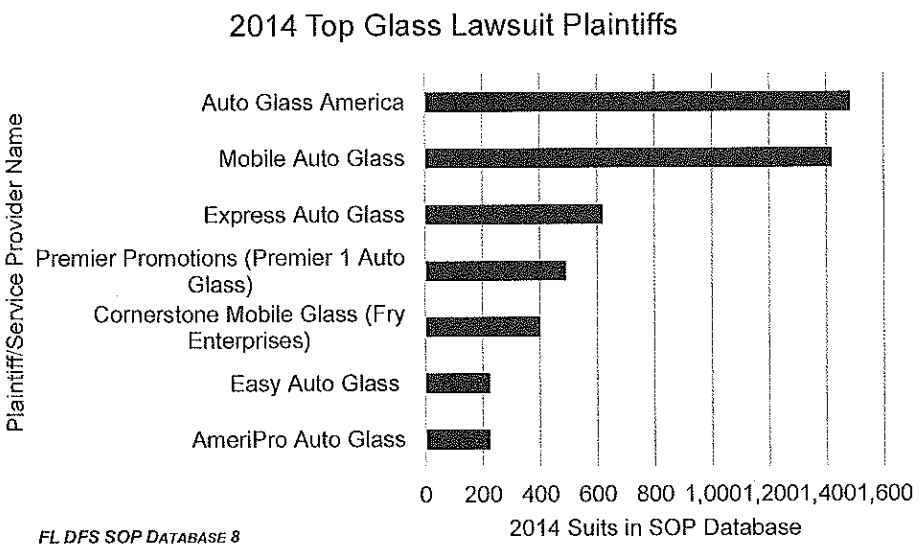
[113]The source for this data is the SOP database. Individuals who happen to have the word "glass" in their names but did not appear affiliated with auto glass repair were not removed from the results. However, such individuals likely represent a very small percentage of the results. For instance, examining cases filed in 2014, only about 0.046% of cases were filed by plaintiffs that appeared unrelated to the auto glass industry and happened to have the word "glass" in their name.

[114]Express Auto Glass, *Get your FREE Gift Card*, http://www.expressautoglass.biz/windshield-replacement-gift-card.php (last visited Aug. 13, 2015).

[115]Auto Glass America Homepage, http://www.auto-glassamerica.com/free-windshield-clearwater.html (last visited Aug. 13, 2015).

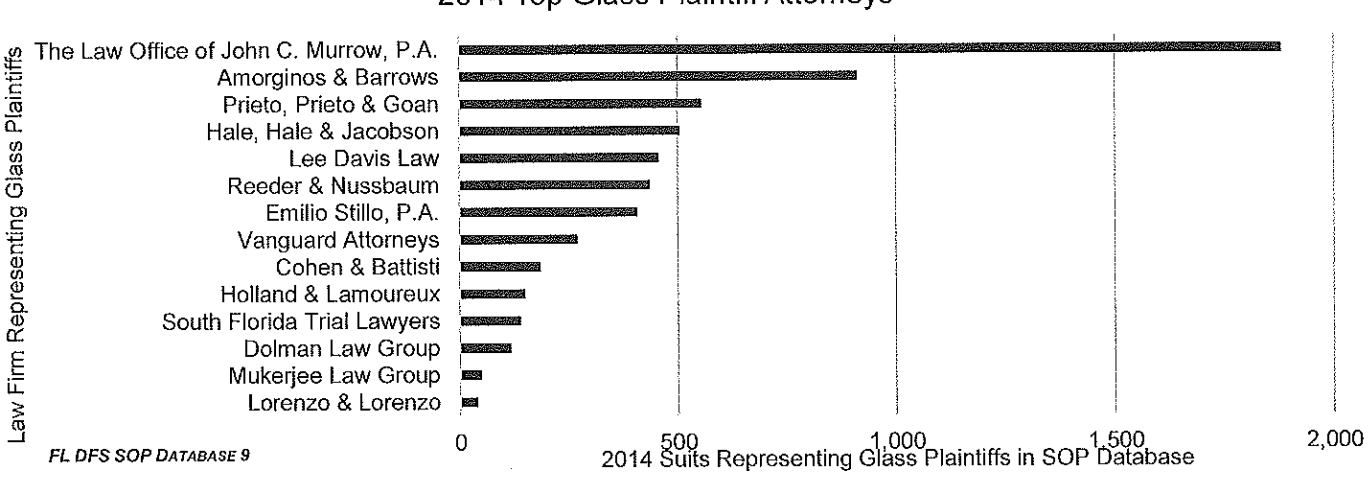
fronted by "Mr. Auto Glass"—filed 1,421 lawsuits in 2014, all by the same lawyer.[116]

Comprehensively, about 91% of the 6,722 likely auto glass AOB lawsuits filed in 2014 were brought by one of 16 attorneys—from 14 firms—in the state. One might presume that windshields are fixed soon after they are broken, and that the propensity for broken windshields is not associated in any significant way with a particular region, person, or entity. However, the auto glass AOB litigation phenomenon appears to defy such logic, given its concentration among a small group of plaintiffs and an even smaller group of attorneys. The chart below shows the 14 law firms most commonly responsible for likely auto glass AOB litigation as reflected in the SOP database.



FL DFS SOP DATABASE 8

Again, these cases—predominantly filed in county court—are not high dollar cases. But these lawsuits are likely worthwhile because of the volume. For example, the Law Office of John C. Murrow filed 1,882 "glass"-affiliated plaintiff lawsuits in 2014. That amounts to a little more than **five lawsuits per day.**[117]



FL DFS SOP DATABASE 9

[116]Mr. Auto Glass, About Us, http://www.fixmyquack.com/about-us.html (last visited Aug. 13, 2015); John C. Murrow, The Law Office of John C. Murrow, P.A. (attorney filing suits on behalf of Mobile Auto Glass Repair, LLC determined by review of SOP database).

[117]Since services of process cannot be served on the Department of Financial Services on weekends, this calculation is based on the number of weekdays in a calendar year and does not exclude holidays when the Department may be closed and thus not accepting services of process.

In addition to being high volume, these cases are relatively simple. A review of the complaint filed in *Express Auto Glass, LLC a/a/o Amber Tyer v. Allstate Fire & Insurance Co.*,[118] initiated by frequent auto glass plaintiff's firm Hale, Hale & Jacobson, P.A., is illustrative. The complaint alleges damages greater than $750 but less than $1,000, exclusive of interest and attorney's fees. The plaintiff Express Auto Glass asserts it has the right to sue defendant Allstate Fire & Insurance Company by virtue of an AOB, which is attached to the complaint. The AOB signed by the policyholder broadly assigns "any and all insurance rights, benefits and proceeds under any applicable insurance policies to Express Auto Glass LLC" and "direct[s] [the] insurance carrier to release any and all information requested by Express Auto Glass LLC." Very often—and this complaint is no different—the policyholder waives the right to a written estimate of the cost to repair the windshield at the time the AOB is signed. In the complaint Express Auto Glass alleges it has presented a "reasonably priced bill" to the insurer that has not been paid. As proof the complaint attaches an invoice. The invoice is identical to the AOB except it is not signed by the policyholder and it includes the actual estimate of cost. The invoice is also dated the same day as the AOB was signed by the policyholder. Finally, a staple of these complaints is an allegation that the plaintiff auto glass shop is entitled to attorney's fees pursuant to Section 627.428, Florida Statutes.

A review of the cases filed by plaintiffs like Express Auto Glass and Atlas Auto Glass demonstrate that attorneys can essentially copy and paste a new complaint from an old one, making it relatively easy to file five or more of these lawsuits in a single day. And the promise of attorney's fees and costs by virtue of the one-way attorney fee statute makes pursuit of these cases potentially lucrative.

The one-way attorney fee is also used as leverage to get higher amounts for work performed. Again, the prospect of awarding attorney's fees if a plaintiff wins just one cent more than was offered presents a Hobson's choice for insurers: pay what the service provider-assignee is asking for or try to negotiate a lower cost and get sued, creating exposure for attorney's fees.

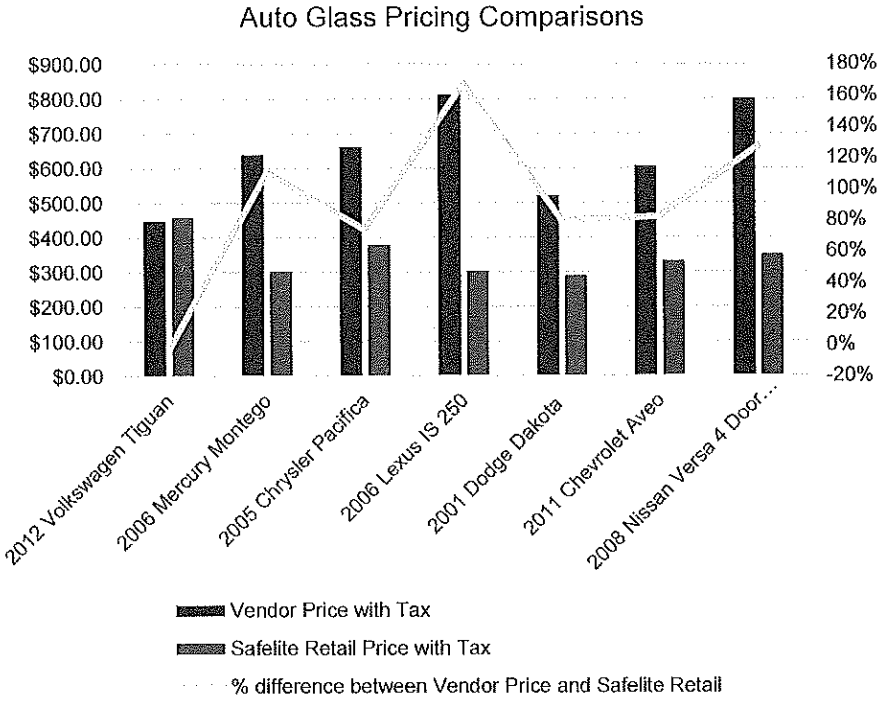
Safelite® Solutions, an affiliate of Safelite® Auto Glass, the largest windshield repair company in the United States, provides claims management solutions for many of the country's largest property and casualty insurance companies. As part of this service, they review auto glass repair invoices submitted to their customer-insurers and compare them to related estimates to ensure equitable pricing. Given the spike in auto glass litigation from several service providers mentioned above, it is worth mentioning that the volume of auto glass claims reviewed by Safelite Solutions has remained relatively stable. From 2012 to 2013, Safelite Solutions reported a 4.74% increase and from 2013 to 2014, reported an 11.82% increase.[119] This contrasts with the litigation statistics mentioned above, which reflect a 162.77% and 168.90%

[118]Case No. 2013-SC-007075-0 (Fla. 9th Cir. Ct.) (filed Aug. 1, 2013). The complaint and attachments were accessed via the Orange County Clerk of Courts MyEClerk website, https://myeclerk.myorangeclerk.com/.
[119]Email to Authors from Safelite Solutions (on file with authors). Safelite Solutions reported the following: Total Claims, 2012: 227,931; 2013: 238,737; 2014: 266,967.

increase during those same time periods. The percentage of year over year growth between the two data sets, while both increasing, are doing so at drastically different growth rates.

Safelite Solutions was asked to review a small sample of invoices submitted by auto glass service providers as attachments to seven AOB lawsuits filed in Florida, illustrating the amount the service provider-assignee was claiming the defendant-insurer was refusing to pay on an assigned insurance claim.[120] Safelite Solutions compared these invoices to the retail price charged by Safelite Auto Glass for the same year and model vehicle. The Safelite retail prices reflect cash prices—not prices negotiated by insurer partners—for purposes of making a fair comparison. In all but one case, the markup by the service providers evidenced in the complaint invoices was at least 74% more than the Safelite retail price, including taxes and all fees.[121]

Given the Hobson's choice presented insurers today, settling for a higher amount to avoid additional litigation costs is most likely the economically efficient option for cost containment. Even when such option is taken though, the power wielded by service providers who have stepped into a first party's shoes and can assert first party protections to get above market reimbursements still results in additional costs for insurers and, eventually, policyholders.



SAFELITE/COUNTY COURT DOCUMENTS 1

[120]The invoices reviewed were taken from the following, randomly-selected cases filed in Florida's Ninth Judicial Circuit by Express Auto Glass, Auto Glass America, and Atlas Auto Glass from the Orange County Clerk's website: *Express Auto Glass, LLC a/a/o Consilio v. Progressive Am. Ins. Co.*, Case No. 2013-SC-9744 (Fla. 9th Cir. Ct.) (filed Oct. 23, 2013) (complaint for breach of contract premised on unpaid claim on auto insurance policy for 2011 Chevrolet Aveo); *Express Auto Glass, LLC a/a/o Lopez v. Progressive*, Case No. 2013-SC-2544 (Fla. 9th Cir. Ct.) (filed March 13, 2013) (complaint for breach of contract premised on unpaid claim on auto insurance policy for 2008 Nissan Versa); *Auto Glass Am. LLC a/a/o Moore v. GEICO Cas. Co.*, Case No. 2015-SC-5814 (Fla. 9th Cir. Ct.) (filed May 15, 2015) (complaint for breach of contract premised on unpaid claim on auto insurance policy for 2005 Chrysler Pacifica); *Auto Glass Am. LLC a/a/o Colosky v. GEICO*, Case No. 2015-SC-5803 (Fla. 9th Cir. Ct.) (filed May 14, 2015) (complaint for breach of contract premised on unpaid claim on auto insurance policy for 2006 Lexus IS); *Auto Glass Am. LLC a/a/o Murtaugh v. Auto-Owners Ins. Co.*, Case No. 2015-SC-5379 (Fla. 9th Cir. Ct.) (filed May 13, 2014) (complaint for breach of contract premised on unpaid claim on auto insurance policy for 2001 Dodge Dakota); *Lusnia d/b/a Atlas Auto Glass a/a/o Costa v. Lib. Mut. Ins. Co.*, Case No. 2012-SC-6875 (Fla. 9th Cir. Ct.) (filed Aug. 10, 2012) (complaint for breach of contract premised on unpaid claim on auto insurance policy for 2006 Mercury Montego); *Lusnia d/b/a Atlas Auto Glass a/a/o Lotz v. Allstate Indem. Ins. Co.*, Case No. 2012-SC-6864 (Fla. 9th Cir. Ct.) (filed August 10, 2012) (complaint for breach of contract premised on unpaid claim on auto insurance policy for 2012 Volkswagen Tiguan).

[121]The one outlier—the Volkswagen Tiguan—is likely attributable to the newness of the model.

Case Study: Property Insurance Claims

Florida's geographic orientation as a peninsula, surrounded by two oceans, makes it more prone to windstorm risk than most other states.[122] In 1992, South Florida was forever changed by Hurricane Andrew. In 2004 and 2005, a confluence of Hurricanes Charley, Frances, Ivan, Jeanne, Dennis, Katrina, Rita, and Wilma left a wake of bruised, battered, and destroyed structures. Tens of thousands of homes had to be repaired or rebuilt and, as a result, the composition of insurers willing to underwrite these losses changed dramatically. Legislative and regulatory actions were swift, with an eye to increased mitigation. But an unintentional side effect was the expansion of Florida's residual market.[123]

Unfortunately, Florida's property insurance market has also been hit with other, albeit manmade, disasters. In 2011, Florida's "insurer of last resort," Citizens Property Insurance Corporation, was one of several insurers battered by a dramatic growth in sinkhole claims. The frequency of claiming activity was concentrated in three southwest Florida counties and contributed to loss ratios specific to those counties in the range of 300% to nearly 700%. This increase in claims and losses was unrelated to any geologic activity, and anecdotally was driven by the incentive for policyholders to file claims and pocket the cash proceeds instead of making repairs.[124] Public adjusters, attorneys, and other third parties in this system advertised the availability of sinkhole claims to policyholders, and received commissions and other payouts when their services were used.[125] In a presentation to the Senate Banking and Insurance Committee, Senate staff surmised that insurers were reluctant to litigate questionable sinkhole claims because of Section 627.428's one-way attorney fee, which put "insurers in a position in which the most cost effective method of dealing with sinkhole claims [was] to simply pay them, rather than risk a judgment for claimant attorneys' fees and bad faith damages after already incurring large costs associated with adjusting these claims."[126]

Legislative action in the form of 2011 Senate Bill 408 stemmed the tide of sinkhole claims by reforming what qualified as covered sinkhole damage, requiring insurance proceeds to be devoted to repairs, and creating several risk management tools for insurers.[127]

---

[122]The Florida Catastrophic Storm Risk Management Center, *The State of Florida's Property Insurance Market 2nd Annual Report* 3 (Jan. 2013), http://www.stormrisk.org/sites/default/files/sites/default/files/2nd%20Annual%20Insurance%20Market%20Rpt-FSU%20Storm%20Risk%20CenterRev.pdf.

[123]*Id.* at 12.

[124]Fla. S. Banking & Ins. Comm., *Interim Report 2011-104 Issues Relating to Sinkhole Insurance* 2 (Dec. 2010), http://www.flsenate.gov/UserContent/Session/2011/Publications/InterimReports/pdf/2011-104bi.pdf.

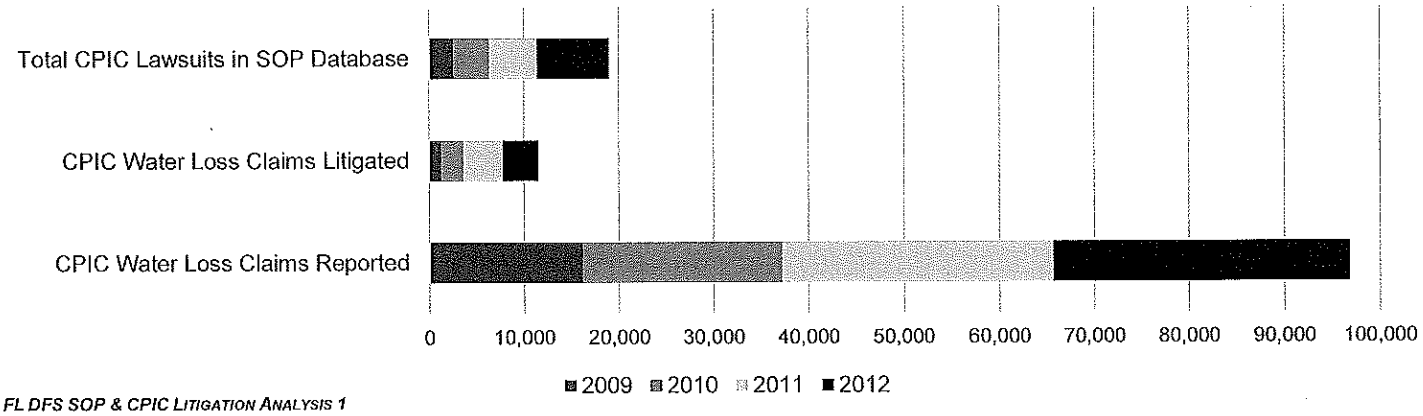
[125]*Id.*

[126]*Id.* at 10.

[127]*See* Fla. S. Banking & Ins. Comm., House Message Summary on CS for CS for CS for SB 408 (2011) (2nd Engrossed), http://flsenate.gov/Session/Bill/2011/0408/Analyses/2011s0408.hms.PDF.

Despite the reforms, there has been a disproportionate increase in the percentage of claims that result in litigation as compared to the percentage of policies in force with reported claims.[128] This is because non-sinkhole related claims are increasing.[129] When property insurance became more resistant to abusive practices related to sinkhole claims, the litigation template was exported to other scenarios. Now, the leading cause of loss for all reported claims to Citizens is water, growing from 38% of all reported claims to over 50% in just four years, followed by roof damage caused by wind or other weather, fire, and dropped objects.[130] For litigated claims, water leads the pack growing from 46% to 75% over that same four-year period.[131]

Citizens Property Insurance Corporation (CPIC):
Water Claims, Water Lawsuits, and Total Lawsuits

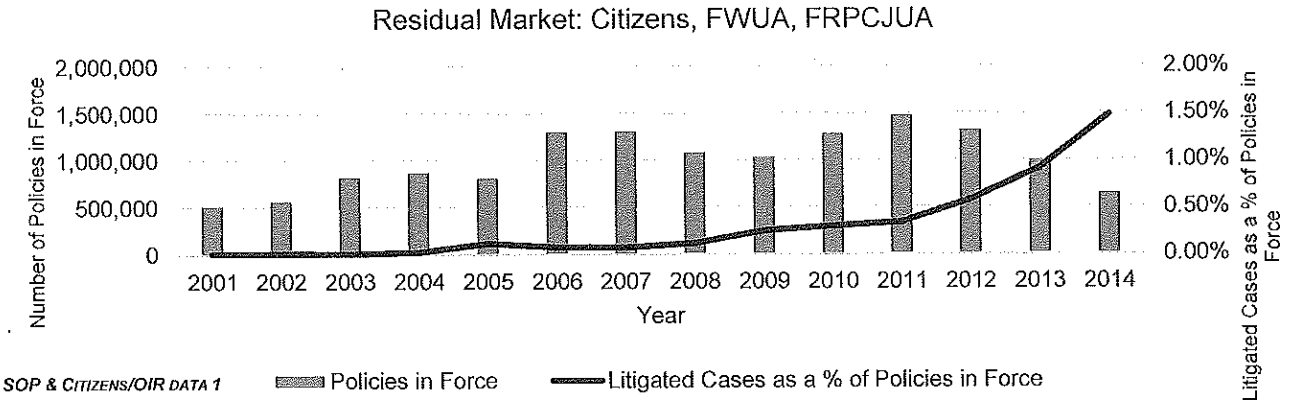


FL DFS SOP & CPIC LITIGATION ANALYSIS 1

Citizens' data makes for an interesting case study in litigation trends for two reasons. First, Citizens only sells property insurance, so its data should reflect how natural and unnatural causes have affected litigation trends in that market. Second, Citizens' policy count has varied sometimes dramatically over time, despite a continuous increase in the number of lawsuits. As displayed in the next chart, lawsuits as a percentage of policies in force was more than one full percentage point lower in the hurricane-battered 2004 and 2005 calendar years than it was in 2014. Even stranger is that lawsuits continued to spike after the statute of limitations for filing lawsuits for 2004 and 2005 storm claims had expired.[132, 133]

---

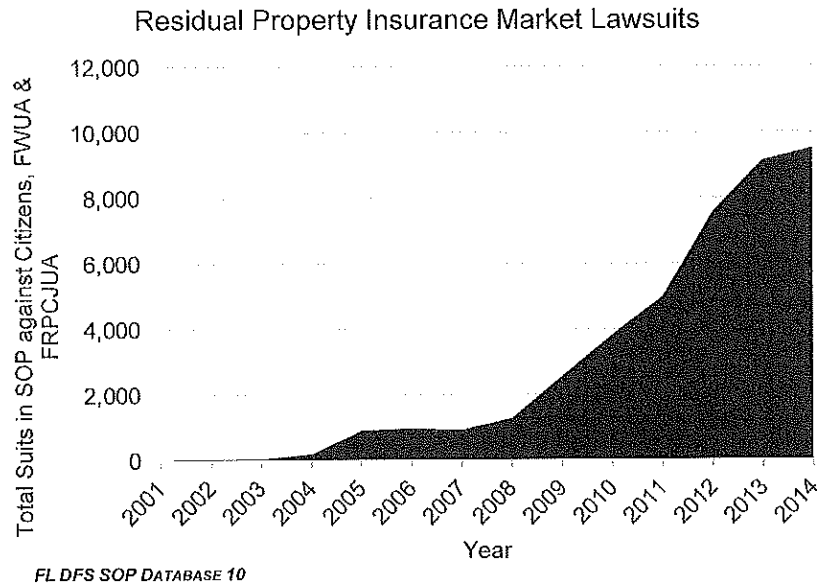
[128]Citizens Property Insurance Corporation, *Litigation Analysis* 6 (Oct. 2013), https://www.citizensfla.com/shared/press/documents/LitigationAnalysis_10-2013.pdf.
[129]*See id.* at 7.
[130]*Id.* at 10.
[131]*Id.* at 11.
[132]*See* § 95.11, Fla. Stat. (2015) (providing a five-year statute of limitations for breach of contract claims). In 2011, section 627.70132, Florida Statutes, was enacted, requiring insurers to be notified about windstorm and hurricane claims within three years of the storm's landfall, but was not made retroactive.
[133]The chart below contains lawsuit and policy count information from Citizens Property Insurance Corporation, as well as the Florida Windstorm Underwriting Association ("FWUA") and the Florida Residential Property and Casualty Joint Underwriting Association ("FRPCJUA"). The latter organizations were merged in 2002, creating Citizens Property Insurance Corporation.



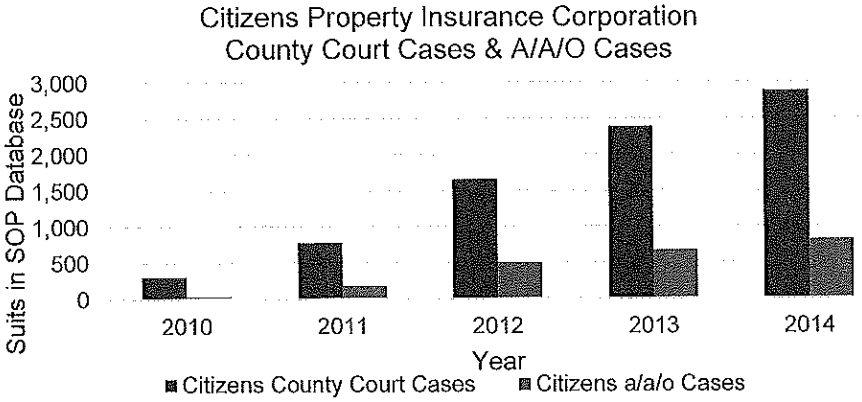
FL DFS SOP & CITIZENS/OIR DATA 1

The continued increase in lawsuits after 2005 has two common characteristics: the lawsuits are increasingly for lower dollar amounts (as they are predominantly filed in county court) and assignee litigation is becoming more prevalent, based on the number of cases involving an "a/a/o" plaintiff.

Regrettably, Newton's third law applies as equally in insurance as it does in physics, and the increase in litigation in the absence of storms has prompted a reaction in the form of Citizens' 2016 rate filing. Thirty percent of Citizens policyholders are likely to see a rate increase based on "a significant number of water claims, which drives rate indications higher for those areas."[134]



FL DFS SOP DATABASE 10

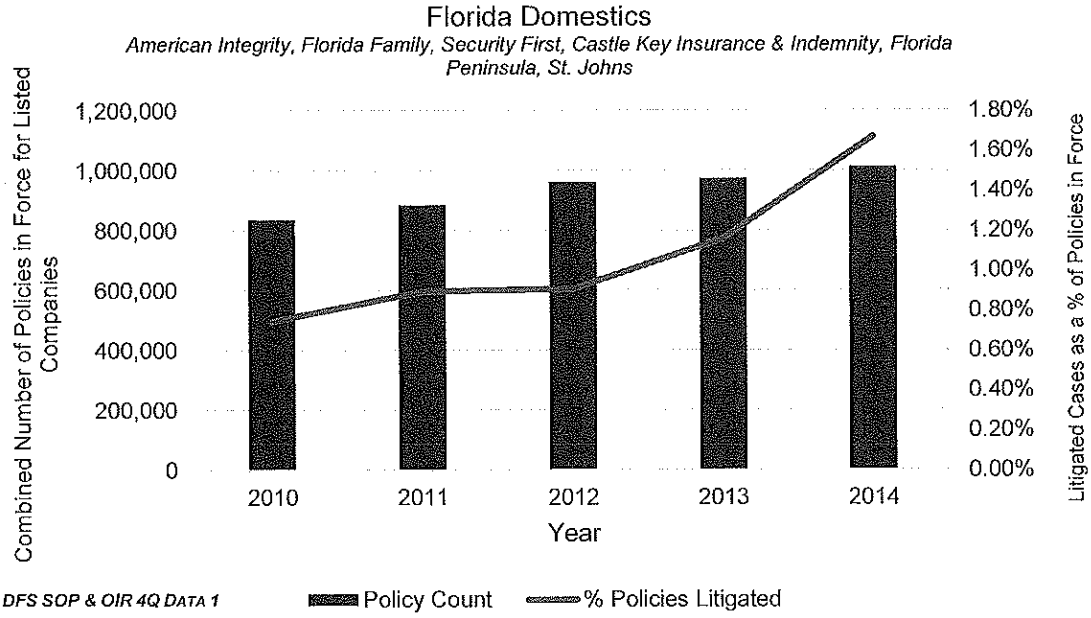


FL DFS SOP DATABASE 11

This was foreshadowed in a February 2015 presentation by Citizens' Chief Claim Officer, who reported that 72% of water claims arise from the tri-county area of the state (Miami-Dade, Broward, and Palm Beach counties)—the same area that will be affected by the proposed rate increases.[135] Of those water claims, 98% had attorney representation. Based on a

[134]Citizens Property Insurance Corporation, 2015 Rate Kit 2, https://www.citizensfla.com/shared/press/documents/2015RateKit.pdf.

[135]Jay Adams, Chief Claims Officer, Citizens Property Insurance, Citizens Presentation on Assignment of Benefits 2 (Feb. 9, 2015), http://piff.net/wp-content/uploads/2015/03/Citizens-Presentation-on-Assignment-of-Benefits.pdf.

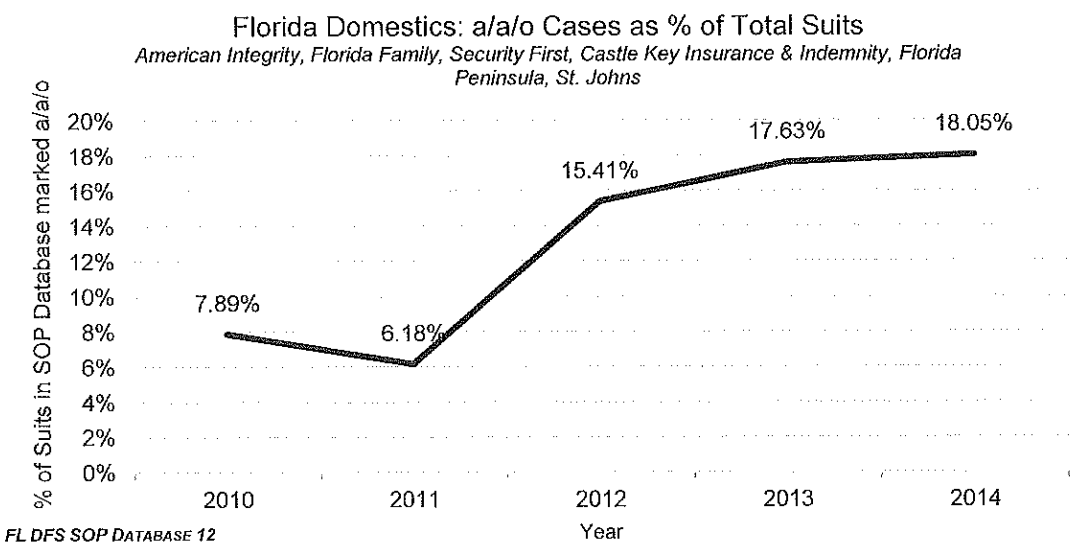


FL DFS SOP & OIR 4Q DATA 1

review of the lawsuits received as of December 2014,[136] Citizens found that 91% of the lawsuits were based on water claims, and that 98% of the lawsuits arose from claims in the tri-county area.[137] Notably, 85% of all the suits reviewed had an attorney involved before the claim was even reported to the insurer, suggesting a coordinated—and potentially manufactured—effort to churn claims into litigation.[138]

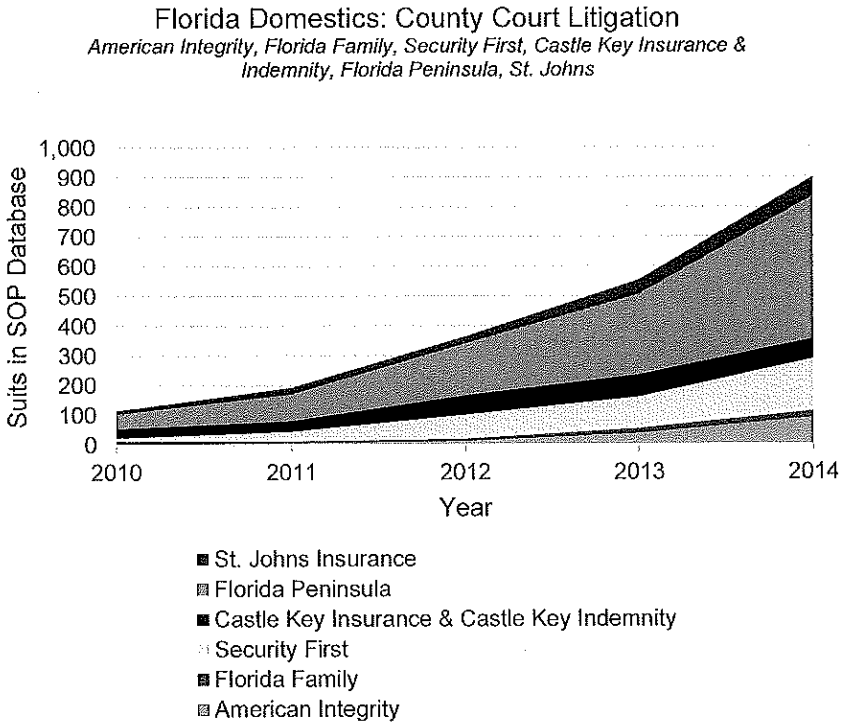
Anticipating the arguments of those who believe that this data does not, in and of itself, demonstrate an alarming trend exists, Citizens' data can be compared and contrasted to that of the private market. Since the early 2000s, domestic, mono-line property insurers have entered the market more frequently and have collected similar data, providing yet another property insurance-only glimpse at lawsuit data. This data is nearly a mirror image of Citizens' data, with litigation growing a full percentage point from 2010 to 2014 when controlled for policy count fluctuation.

Digging deeper, it appears that cases brought by assignees are a contributing factor. Cases that include an a/a/o in the plaintiff's name have grown by about 10% of total litigated cases in a five-year period.

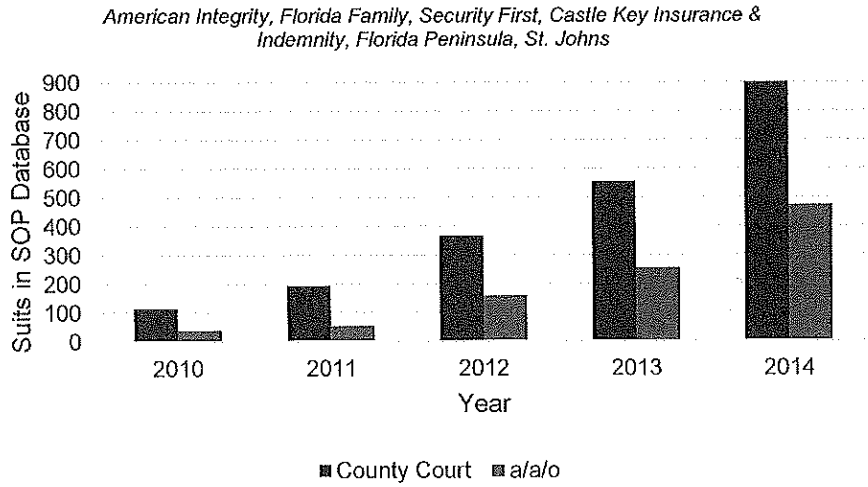


FL DFS SOP DATABASE 12

[136] *See id.* at 9.
[137] *Id.* at 6.
[138] *Id.* at 9 (stating that 479 of 562 suits had attorney representation at the first notice of loss).



FL DFS SOP DATABASE 13



FL DFS SOP DATABASE 14

So is the influx of water claims occurring naturally? The data again shows that these claims concentrate in certain areas and are advanced by a relatively small class of service providers, suggesting that some other factor is at work. Would this large influx of naturally occurring, sudden, and accidental[139] water leaks and bursts really be serviced by the same set of providers?

Based on a review of lawsuit data provided by several property insurers, companies with names that included words such as "water," "restoration," "restore," "flooring," "remediation," "mitigation," "mold," "carpet," and "emergency" were frequently plaintiffs in lawsuits brought against insurers.[140] Accordingly, searches done in the SOP database with one or more of these search terms in the plaintiff field confirm that such service providers are comprising an increasing amount of insurance lawsuits.[141,142]

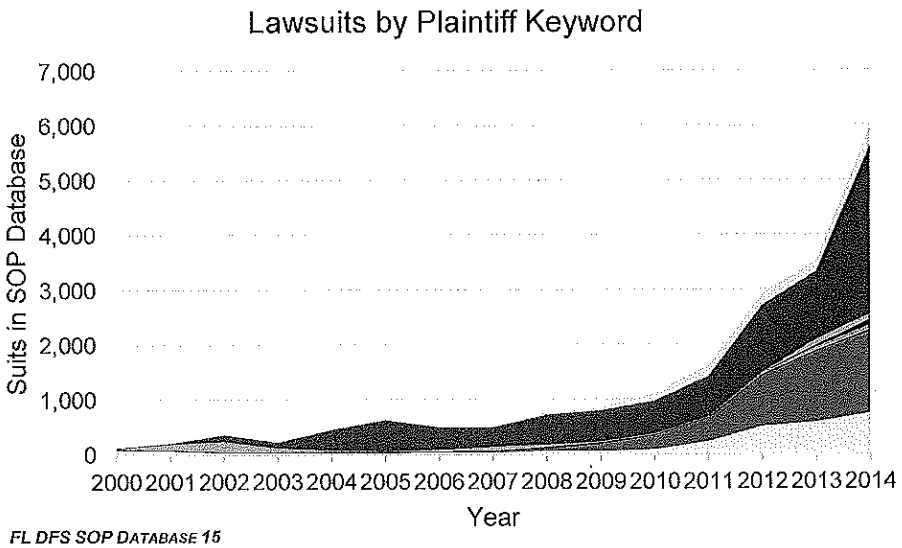
[139]Most property insurance policies cover sudden and/or accidental water damage, but not leaks that have been constant, continuous, or occurring over a period of time and thus were preventable or capable of being easily corrected by mitigation efforts. For example, commonly covered perils under homeowners' insurance include "[a]ccidental discharge or overflow of water or steam," "a sudden and accidental discharge of water—such as a burst pipe or other plumbing failure, or claims that arise from water damage due to water instructions due to hurricanes." Florida Department of Financial Services, Homeowners' Insurance: A Toolkit for Consumers 5, 12, http://www.myfloridacfo.com/division/Consumers/UnderstandingCoverage/Guides/documents/HomeownersToolkit.pdf.

[140]Insurance Trade Association Survey Responses, Sept. 2015 (on file with authors).

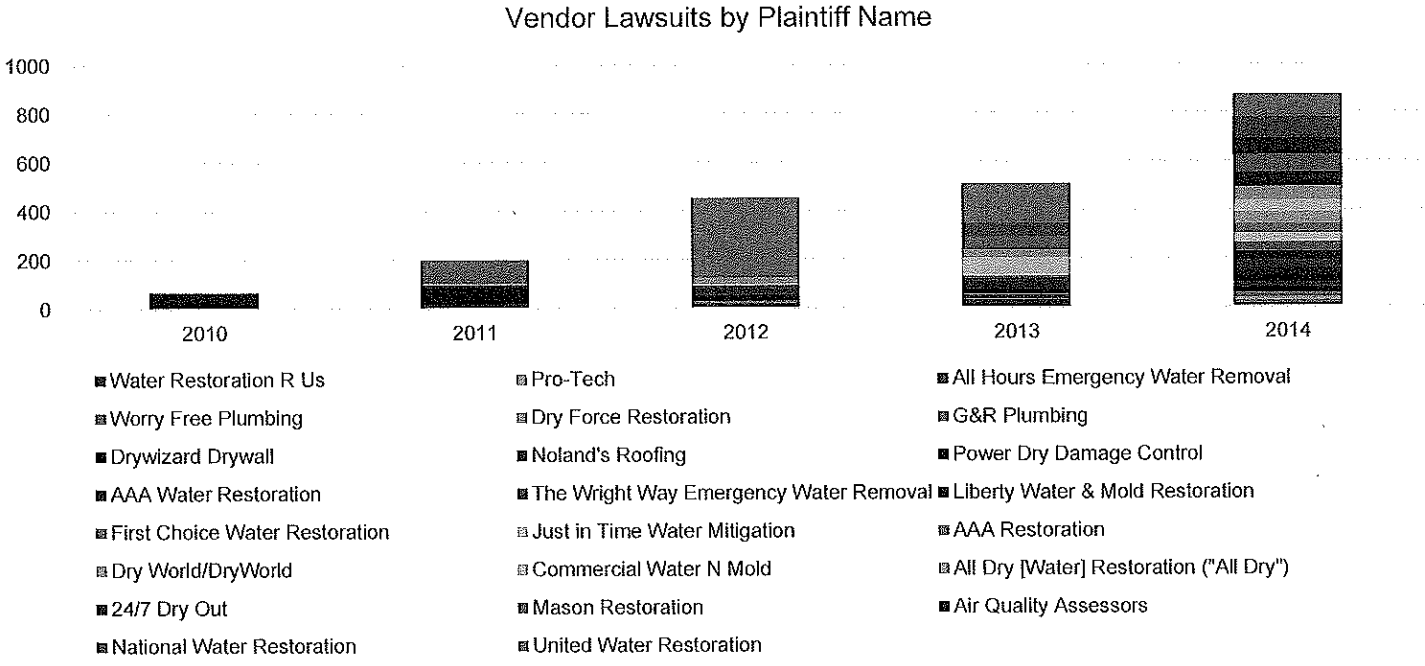
[141]It should be noted that companies such as "Carpet Cleaning & Restoration" and "United Water Restoration" may be represented in this chart twice because their names include two of the search terms; however, even removing these types of names, the graph still represents a significant spike in assignee lawsuits. Individual plaintiffs with names that include the search terms were also not removed.

[142]Truncated versions of words were used in some instances to capture two variations of the same word. For example, the search term "restor" was used to capture companies that used either the word "restoration" or "restore" in their business name.

Akin to auto glass AOB litigation, a group of lawyers and plaintiffs—albeit a larger group in this context—dominate the property insurance AOB litigation landscape. Most of these companies either did not exist or did not file lawsuits before 2008.



FL DFS SOP DATABASE 15



FL DFS SOP DATABASE 16

V. Conclusions & Recommendations

This report has identified the following trends:

(1) Despite a decline in extreme weather events, and despite no other apparent increases in naturally-occurring and damage-causing events, insurance litigation continues to increase.

(2) Decreases in AOB PIP litigation appear to coincide with legislative reform of PIP.

(3) Assignee plaintiffs—often those service providers repairing the insured damage—are increasingly becoming the plaintiffs in lawsuits filed against insurers.
(4) Indeed, a third of all lawsuits filed against insurers are brought by apparent assignee-plaintiffs.
(5) Lawyers filing cases on behalf of these litigants are concentrated in a relatively small subset of all lawyers, yet represent an overwhelming majority of the counsel in these cases.
(6) More qualitative data obtained from insurers suggests that insurers are reacting by settling these service provider-AOB claims out of court, often paying *less* than what the assignee originally demanded but paying comparatively high assignee's attorney's fees.

Logically, there must be some explanation for these trends. While litigation initiated by assignees has consistently been pervasive in certain lines such as PIP for many years, this litigation has only recently grown to include auto glass and property insurance litigation. Below are a few conclusions that we will posit for consideration, understanding that it is difficult to determine any causal or correlative link:

- PIP legislative reforms over the last decade may have made that line of insurance a less profitable source of litigation for third parties and attorneys.
- AOB litigation began increasing for other lines of insurance that were not impacted by significant or comprehensive legislative reform.
- AOB litigation is profitable because AOBs are relatively easy to obtain, AOB litigation involves relatively simple pleading, and prevailing plaintiffs are entitled to attorney's fees and costs while prevailing insurers are not. Insurers are incentivized to settle inflated claims to avoid paying a plaintiff's attorney's fees and costs.
- Insurers are even paying assignee's attorney's fees in settlement to avoid excessive litigation costs that are essentially promised by the presence of the one-way attorney fee statute and the potential for bad faith damages.

With those conclusions in mind, this report recommends the following to disincentivize this litigation and to return the one-way attorney fee statute to its original mission of making named insureds, omnibus insureds, and named beneficiaries whole:

- Clarify that the one-way attorney fee statute was intended for the protection of named and omnibus insureds and named beneficiaries only, and that service providers holding AOBs may not obtain attorney's fees pursuant to Section 627.428, Florida Statutes.
- Curb incentives for potentially fraudulent claiming behavior with reforms, such as:
  - ✓ Prohibiting the offering of things of value like gift cards in exchange for receiving an assignment of benefits.
  - ✓ Considering a shortened statute of limitations for non-catastrophic claims.

- ✓ Allowing policyholders a window of time for rescission of contracts assigning benefits, after the insurer is notified about the contract, akin to what is done for public adjuster contracts.
- ✓ Ensuring full and fair informed consent regarding the transfer of legal rights is obtained in the event of a transfer of all post-loss benefits.

However, the first recommendation gets at the root of what makes this form of litigation profitable: the availability of attorney's fees. Importantly, amending the statute to exclude third parties like service providers from its protection would eliminate only one avenue for holders of AOBs to obtain their attorney's fees.[143] Essentially, this recommendation would place holders of AOBs on equal footing with most other businesses involved in litigation. As noted above, parties are traditionally entitled to attorney's fees if provided by contract or statute. A plaintiff can agree by contract to a contingency fee arrangement with counsel, ensuring his attorney is paid in the event he prevails but also permitting the plaintiff to walk away without losing money in the event he does not. There are also other statutes that permit the award of attorney's fees to a prevailing party.[144] In short, such plaintiffs may still recover attorney's fees in a number of ways.

This report demonstrates that the one-way attorney fee statute is no longer serving its original purpose of ensuring litigation for individual insureds, named beneficiaries, and omnibus insureds is worthwhile. Instead, the statute is fueling an increase in litigation brought by sophisticated service providers and attorneys that do not require the protection of a one-way attorney fee. The Florida Legislature should consider amending the one-way attorney fee statute to curb the abuse of assignments of benefits by service providers and attorneys.

---

[143]Indeed, the Florida Supreme Court has previously stated that it has "not interpreted section 627.428 as precluding the application of other attorney's fee provisions." *State Farm Mut. Auto. Ins. Co. v. Nichols*, 932 So. 2d 1067, 1075 (Fla. 2006).

[144]There are two notable statutory avenues to obtain attorney's fees in civil litigation. Section 57.105, Florida Statutes, permits a court to award a reasonable attorney's fee, including prejudgment interest, to a prevailing party if the court finds that the losing party or the losing party's attorney knew or should have known that a claim or defense presented to the court: (a) was not supported by material facts necessary to establish the claim or defense; or (b) would not be supported by the application of then-existing law to those material facts. Another statutory avenue for obtaining partial attorney's fees is the offer of judgment statute, Section 768.79, Florida Statutes. If a plaintiff files a demand for judgment in compliance with the statute which is not accepted by the defendant within 30 days, and the plaintiff recovers a judgment in an amount at least 25% greater than the demand, the plaintiff is entitled to recover reasonable costs and attorney's fees incurred from the date of the demand's filing. § 768.79(1), Fla. Stat. (2015); *see also id.* § 768.79(6)(b); *Nichols*, 932 So. 2d at 1075-76 (holding that the offer of judgment statute applies to suits for PIP benefits and does not conflict with the one-way attorney fee statute).

VI. Survey Data

The following table catalogues the claims examples provided by the insurer trade associations surveyed that were collected by the authors in September 2015. Original copies of the surveys summarized in the table may be obtained from the authors.

Loss	Date of Loss	Date First Notice of Loss Rec'd	Who Sent First Notice of Loss	AOB Date	Date Insurer Rec'd AOB	AOB Content	Amount Requested for Payment	Deviation from Pricing Standards, if applicable	Time Req'd for Payment	Amount of Final Payment	Amount Req'd in Attorney Fees	Attorney Fee Award	Venue of Resolu-tion
Auto glass damage from rock in road	5/18/2015	6/1/2015	Insured	5/21/2015	7/27/2015	Limited to Services Rendered, Assigned All Causes of Action, Waived Privacy, Irrevocable	$ 1,118.48	n/a	30	N/A		Pending in court	
Cracked windshield, unknown cause	3/10/2015	5/19/2015		5/13/2015	5/19/2015	Limited to Services Rendered, Irrevocable	$ 754.94	$ 137.72		$ 617.22			
Water leak in shower	1/27/2015	1/30/2015	Insured	1/30/2015	2/3/2015	Assigned All Causes of Action, Waived Privacy, Irrevocable, Hold Harmless Provision	$ 19,644.00	Dry time of 5 days, additional fees for supervisory charges and overhead/profit	30	$ 15,494.00		$ -	
Auto glass damage from rock in road	1/24/2015	1/28/2015	Vendor	1/24/2015	1/26/2015	Assigned All Causes of Action, Limited to Services Rendered	$ 159.75	Uncertain	Not specified	$ 159.75		$ 1,600.00	Settlement
Water damage in kitchen	1/23/2015	1/30/2015	Attorney	1/23/2015	6/23/14 (when lawsuit was received)	Limited to Services Rendered, Waived Privacy, Irrevocable	$ 3,766.01	n/a	15	$ 3,500.00		$ 8,500.00	Settlement

Loss	Date of Loss	Date First Notice of Loss Rec'd	Who Sent First Notice of Loss	AOB Date	Date Insurer Rec'd AOB	AOB Content	Amount Requested for Payment	Deviation from Pricing Standards, if applicable	Time Req'd for Payment	Amount of Final Payment	Amount Req'd in Attorney Fees	Attorney Fee Award	Venue of Resolu-tion
Water loss	1/20/2015	1/21/2015	Insured	1/21/2015	2/5/2015	Limited to Services Rendered, Assigned All Causes of Action, Waived Privacy, Hold Harmless Provision	$ 6,511.25	Carpet Cleaning Repair Installation Certifications violations based on extended drying time and lack of equipment removal as areas dried	10	$ -	Global demand of $10k including fees and work performed	$ 3,500.00	Settlement
Auto glass damage from rock	12/10/2014	12/22/2014	Vendor	12/10/2014	12/22/2014	Assigned All Causes of Action, Limited Services Rendered	$ 159.00	Uncertain	Not specified	$ 159.00		$ 1,600.00	Settlement
Windshield replacement	12/3/2014	10/27/2014	Vendor	2/28/2014	10/29/2014	Limited to Services Rendered, Assigned All Causes of Action, Irrevocable	$ 356.45	$ -		$ 356.45	$1,500.00	$ 750.00	
Windshield replacement	11/20/2014	1/29/2015	Vendor	11/22/2014	1/28/2015	Limited to Services Rendered, Assigned All Causes of Action, Irrevocable, Hold Harmless Provision	$ 635.63	$ 283.39		$ 352.24	$750.00		
Cracked windshield	10/14/2014	11/13/2014		10/23/2014	11/13/2014	Limited to Services Rendered, Irrevocable	$ 710.80	$ 322.79		$ 388.01			
Property damage from raccoon in attic	10/13/2014	10/20/2014	Insured	10/13/2014	10/20/2014	Limited to Services Rendered, Waived Privacy	$ 14,525.00	Amount demanded deviated from Xactimate; peer review necessary $8,290.72		$7,290.72 (presuit offer)			Litigation ongoing

Loss	Date of Loss	Date First Notice of Loss Rec'd	Who Sent First Notice of Loss	AOB Date	Date Insurer Rec'd AOB	AOB Content	Amount Requested for Payment	Deviation from Pricing Standards, if applicable	Time Req'd for Payment	Amount of Final Payment	Amount Req'd in Attorney Fees	Attorney Fee Award	Venue of Resolu-tion
Cracked windshield, unknown cause	8/23/2014	9/3/2014			9/4/2014	Irrevocable	$ 738.75	$ 314.22		$ 424.53			
Wind/hail damage to roof, interior rain damage	8/8/2014	8/12/2014	Other	8/12/2014	8/26/2014	Limited to Services Rendered, Waived Privacy	$ 4,730.83				$3,500.00		Settlement
Cracked windshield, unknown cause	7/29/2014	8/5/2014		8/6/2014	8/5/2014	Limited to Svcs. Rendered, Irrevocable	$ 692.38	$ 331.16		$ 361.16			
Lead from supply line in slab; damage to rooms	7/27/2014	7/29/2014	Insured	1/9/2014	8/18/2014	Assign All Causes of action, Waive Privacy, Hold Harmless	$ 5,807.16	Excessive fees for admininstration, supply/materials, fuel surcharge, and supervisory charges; moisture inspection fee and overhead/profit	30	$ 1,509.14		Pending in court	
Glass chip in windshield	7/2/2014	7/8/2014	Vendor	7/2/2014	7/3/2014	Limited to Svcs. Rendered, Assign all Causes of action, Irrevocable, Hold Harmless	$ 85.20	$ 74.90			$1,250.00		
Water shower pan leak	6/28/2014	7/2/2014	Insured	7/2/2014	7/9/2014	Limited to Svcs. Rendered, Assign all Causes of action, Hold Harmless	$ 1,808.80			$5500 (global settlement)	$8351.43 (global demand)	$5500 (global settlement)	Settlement; claim excluded under policy, damages to insured denied
Auto glass damage from rock in road	6/24/2014	10/28/2014	Attorney	6/25/2014	10/28/2014	Assign All Causes of action, Waive Privacy, Irrevocable	$ 160.50	n/a	30	$ 1,500.00	$1,339.50	$ 1,339.50	Settlement

Loss	Date of Loss	Date First Notice of Loss Rec'd	Who Sent First Notice of Loss	AOB Date	Date Insurer Rec'd AOB	AOB Content	Amount Requested for Payment	Deviation from Pricing Standards, if applicable	Time Req'd for Payment	Amount of Final Payment	Amount Req'd in Attorney Fees	Attorney Fee Award	Venue of Resolu-tion
Kitchen supply line leak	6/24/2014	6/25/2014	Other	6/25/2014	8/4/2014	Limited to Svcs. Rendered, Waive Privacy , Irrevocable, Hold Harmless	$ 4,650.33	Xactimate price deviation		$ 3,400.00		$ 4,350.00	Settlement
Water mitigation	6/22/2014	6/26/2014	Insured	6/22/2014	7/17/2014	Limited to Svcs. Rendered, Assign all Causes of action	$ 25,824.75	Peer review found price should've been $5,762.72		$ 27,000.00	$6,000.00	Apportioned from settlement balance	Settlement
Auto glass damage from rock in road	6/19/2014	6/24/2014	Insured	6/21/2014	8/7/2014	Assign All Causes of action, Waive Privacy, Irrevocable	$ 539.80	n/a	30	$ 2,039.80	$1,500.00	$ 1,500.00	Settlement
Roof leak, damage to drywall and paint	6/12/2014	6/12/2014	Vendor	6/12/2014	6/21/2014	Assign all Causes of action, Waive Privacy , Irrevocable	$ 4,293.72	Excessive equipment and scope, incomplete logs, pricing higher than Xactimate		$ 1,629.39		$ 3,500.00	Settlement
Windshield repair	6/10/2014	9/22/2014	Vendor	6/10/2014	11/5/2014	Limited to Svcs. Rendered, Assign all COAs, Irrevocable, Hold Harmless	$ 80.25	$ 5.35		$ 74.90	$2,500.00	$ 1,250.00	
Windshield replaced due to chip	6/10/2014	9/22/2014	Vendor	6/10/2014	11/5/2014	Limited to Svcs. Rendered, Assign all COAs, Irrevocable, Hold Harmless	$ 80.25	$ 5.35		$ 74.90	$1,250.00		
Shower drain leak	6/6/2014	6/16/2014	Insured	6/10/2014	6/30/2014	Assign all COAs, Waive Privacy , Irrevocable	$ 11,590.53	Excessive equipment and scope, incomplete logs, pricing higher than Xactimate		$ -		$ 2,500.00	Claim denied; settlement

Loss	Date of Loss	Date First Notice of Loss Rec'd	Who Sent First Notice of Loss	AOB Date	Date Insurer Rec'd AOB	AOB Content	Amount Requested for Payment	Deviation from Pricing Standards, if applicable	Time Req'd for Payment	Amount of Final Payment	Amount Req'd in Attorney Fees	Attorney Fee Award	Venue of Resolu-tion
Biohazard clean up	6/3/2014	6/4/2014	Other		6/25/2014	Limited to Svcs. Rendered, Waive Privacy , Irrevocable, Hold Harmless	$ 26,421.00	Peer review found pricing irregularities, procedural issues with clean-up, and redundant work invoiced	10	$ 20,000.00	$32,000.00	$ 5,000.00	Settlement
Repair due to multiple chips in windshield	5/22/2014	6/13/2014	Vendor	5/22/2014	9/11/2014	Limited to Svcs. Rendered, Assign all Causes of action, Irrevocable, Hold Harmless	$ 160.50	$ -		$ 160.50	$0.00		
Cracked windshield, unknown cause	5/17/2014	5/29/2014		5/21/2014	5/29/2014	Limited to Svcs. Rendered, Assign all Causes of action, Irrevocable	$ 652.43	$ 237.11		$ 415.28			
Property damage due to racoon in attic; damage to insulation	5/1/2014	5/20/2014	Insured	5/2/2014	5/22/2014	Limited to Svcs. Rendered, Assign all Causes of action, Waive Privacy , Irrevocable, Hold Harmless	$ 13,973.75			$ 1,669.00	$4,000.00	$ 2,500.00	Settlement
Pipe leak, water damage throughout home	4/27/2014	4/27/2014	Insured	4/27/2014	5/22/2014	Assign all Causes of action, Irrevocable	$ 9,696.26	Excessive equipment and scope, incomplete logs, pricing higher than Xactimate	30	$ 7,875.74		$ 2,500.00	Settlement
Unknown	4/24/2014	4/29/2014	Other	4/24/2014	5/3/2014	Assign all Causes of action, Irrevocable	$ 159.00			$ -			Plaintiff dismissed lawsuit
Unknown	4/8/2014	4/8/2014	Other	4/4/2014	4/7/2014	Assign all Causes of action, Irrevocable	$ 159.00						Dismissed

Loss	Date of Loss	Date First Notice of Loss Rec'd	Who Sent First Notice of Loss	AOB Date	Date Insurer Rec'd AOB	AOB Content	Amount Requested for Payment	Deviation from Pricing Standards, if applicable	Time Req'd for Payment	Amount of Final Payment	Amount Req'd in Attorney Fees	Attorney Fee Award	Venue of Resolu-tion
Cracked windshield repaired	4/3/2014	4/7/2014	Vendor	4/3/2014	4/4/2014	Limited to Svcs. Rendered, Assign all Causes of action, Irrevocable, Hold Harmless	$ 159.00	$ 105.50		$ 53.50	$1,500.00		
Damage to windshield due to rock	4/3/2014	4/4/2014	Other	4/3/2014	4/4/2014	Assign all Causes of action, Irrevocable	$ 159.00			$ 14.20			Plaintiff dismissed
Windshield replaced	3/28/2014	4/1/2014	Vendor	3/31/2014	3/31/2014	Limited to Svcs. Rendered, Assign all Causes of action, Irrevocable, Hold Harmless	$ 159.00	$ 105.50		$ 53.50	$2,500.00	$ 1,250.00	
Windshield replaced	3/25/2014	8/6/2014	Vendor	3/25/2014	8/18/2014	Limited to Svcs. Rendered, Assign all Causes of action, Irrevocable, Hold Harmless	$ 327.40	$ -		$ 327.40	$0.00		
Toilet supply line damage, damage to carpet, vinyl, and paint	3/2/2014	3/2/2014	Insured	3/2/2014	3/7/2014	Limited to Svcs. Rendered, Assign all Causes of action, Irrevocable, Hold Harmless	$ 3,860.39	Excessive equipment and scope, incomplete logs, pricing higher than Xactimate		$ 1,766.24		$ 3,364.80	Settlement
Leak from supply line in slab damaged rooms in home	2/15/2014	2/17/2014	Insured	2/20/2014	2/27/2014	Assign All Causes of action, Waive Privacy, Irrevocable, Hold Harmless	$ 5,094.66	Drying time of 4 days; additional fees for unnecessary administrative charges and supplies	30	$ 3,967.07		Pending in court	
Wind damage to roof	2/12/2014	2/17/2014	Insured	2/13/2014	2/18/2014	Limited to Svcs. Rendered, Waive Privacy, Waive Privacy	$ 32,039.19			$ 7,779.94	$4,000.00	$ 1,800.00	Settlement

Loss	Date of Loss	Date First Notice of Loss Rec'd	Who Sent First Notice of Loss	AOB Date	Date Insurer Rec'd AOB	AOB Content	Amount Requested for Payment	Deviation from Pricing Standards, if applicable	Time Req'd for Payment	Amount of Final Payment	Amount Req'd in Attorney Fees	Attorney Fee Award	Venue of Resolu-tion
Windshield replaced	1/30/2014	2/13/2014	Vendor	2/6/2014	2/27/2014	Limited to Svcs. Rendered, Assign all Causes of action, Irrevocable, Hold Harmless	$ 451.49	$ 280.36		$ 171.13	$0.00		
Slab leak, damage to wood floors	1/21/2014	1/27/2014	Vendor	1/27/2014	2/12/2014	Assign all Causes of action, Waive Privacy , Irrevocable	$ 18,993.09			$ -		$ 4,500.00	Claim denied; settlement
Property loss due to mold	1/15/2014	2/27/2014	Insured	6/26/2014	10/9/2014	Limited to Svcs. Rendered, Waive Privacy , Irrevocable	$ 15,399.75	Lack of itemized invoice, simply a flat rate entry for amount requested		Litigation ongoing	$4,500.00	Litigation ongoing	Litigation ongoing
Fire from lightning, soot/smoke damage	12/17/2013	12/18/2013	Vendor	12/17/2013	12/27/2013	Assign all Causes of action, Irrevocable	$ 7,079.46	Excessive equipment and scope, incomplete logs, pricing higher than Xactimate	30	$ 6,472.07		$ -	Dismissed
Windshield replaced	12/10/2013	10/24/2014	Vendor	1/21/2014	10/24/2014	Limited to Svcs. Rendered, Assign all Causes of action, Irrevocable, Hold Harmless	$ 772.84			$ -	$2,500.00	$ 750.00	
Cracked windshield	12/1/2013	12/17/2013		12/11/2013	12/17/2013	Limited to Svcs. Rendered, Assign all Causes of action, Irrevocable	$ 602.25	$ 290.90		$ 311.35			
Auto glass damage	11/28/2013	10/27/2014	Attorney	6/6/2014	10/27/2014	Assign All Causes of action, Lmtd. Svcs. Rendered	$ 544.34	no		$ 544.34	$1,800.00	$ 1,800.00	
Windshield replaced	10/5/2013	8/5/2014	Vendor	4/29/2014	8/5/2014	Limited to Svcs. Rendered, Assign all Causes of action,	$ 337.66	$ -		$ 337.66	$0.00		

Loss	Date of Loss	Date First Notice of Loss Rec'd	Who Sent First Notice of Loss	AOB Date	Date Insurer Rec'd AOB	AOB Content	Amount Requested for Payment	Deviation from Pricing Standards, if applicable	Time Req'd for Payment	Amount of Final Payment	Amount Req'd in Attorney Fees	Attorney Fee Award	Venue of Resolu-tion
						Irrevocable, Hold Harmless							
Windshield replaced	10/2/2013	10/16/2013	Vendor	10/8/2013	11/8/2013	Limited to Svcs. Rendered, Assign all Causes of action, Irrevocable, Hold Harmless	$ 615.58	$ 615.58		$ -	$0.00		
Wind damage to roof	9/6/2013	11/18/2013	Insured	11/16/2013	11/22/2013	Limited to Svcs. Rendered, Waive Privacy	$ 34,566.07						
Wind/hail damage to roof	8/31/2013	4/16/2014	Insured			Assign all Causes of action, Limited to Svcs. Rendered, Waive Privacy	$ 13,029.50			$ 9,953.57		$ 2,000.00	Global settlement
Windshield replaced	8/15/2013	8/6/2014	Vendor	9/5/2013	8/7/2014	Limited to Svcs. Rendered, Assign all Causes of action, Irrevocable, Hold Harmless	$ 258.76	$ -		$ 258.76	$750.00		
Windshield replaced	8/15/2013	2/14/2014	Vendor	9/29/2013	2/20/2014	Limited to Svcs. Rendered, Assign all Causes of action, Irrevocable, Hold Harmless	$ 447.47	$ 175.06		$ 272.41	$0.00		
Dishwasher leak, flooring damage	7/10/2013	7/10/2013	Insured	7/11/2013	7/23/2013	Assign all Causes of action, Waive Privacy , Irrevocable, Hold Harmless	$ 3,576.75	Excessive equipment and scope, incomplete logs, pricing higher than Xactimate		$ 2,070.68		$ 2,000.00	Settlement

Loss	Date of Loss	Date First Notice of Loss Rec'd	Who Sent First Notice of Loss	AOB Date	Date Insurer Rec'd AOB	AOB Content	Amount Requested for Payment	Deviation from Pricing Standards, if applicable	Time Req'd for Payment	Amount of Final Payment	Amount Req'd in Attorney Fees	Attorney Fee Award	Venue of Resolu-tion
Broken drain line, damage to laminate flooring	6/25/2013	6/25/2013	Insured	6/24/2013	7/8/2013	Assign all Causes of action, Waive Privacy , Irrevocable, Hold Harmless	$ 3,046.60	Excessive equipment and scope, incomplete logs, pricing higher than Xactimate		$ 1,807.03		$ 2,000.00	Settlement
Pipe leak, carpet damage	5/30/2013	5/30/2013	Insured	5/31/2013	6/21/2013	Assign all Causes of action, Irrevocable, Hold Harmless	$ 4,724.12	Excessive equipment and scope, incomplete logs, pricing higher than Xactimate	10	$ 2,984.86		$ 2,000.00	Settlement
Toilet leak, damage to ceilings and walls	5/13/2013	5/13/2013	Insured	5/13/2013	5/16/2013	Assign all Causes of action, Irrevocable, Hold Harmless	$ 2,313.78	Excessive equipment and scope, incomplete logs, pricing higher than Xactimate	10	$ 1,226.25		$ 2,000.00	Settlement
Pipe leak, damage to carpet, drywall and paint	4/13/2013	4/15/2013	Insured	4/13/2013	4/19/2013	Assign all Causes of action, Irrevocable, Hold Harmless	$ 2,396.64	Excessive equipment and scope, incomplete logs, pricing higher than Xactimate		$ 1,575.49		$ 2,000.00	Settlement
Long term shower leak	4/10/2013	4/10/2013	Insured	4/10/2013	4/25/2013	Assign all Causes of action, Waive Privacy , Irrevocable, Hold Harmless	$ 2,568.05	Excessive equipment and scope, incomplete logs, pricing higher than Xactimate		$ 1,770.80		$ 2,000.00	Settlement
Pipe leak, damage to floor, cabinets and vanities	4/5/2013	4/8/2013	Insured	4/6/2013	4/19/2013	Assign all Causes of action, Irrevocable, Hold Harmless	$ 5,453.15		10	$ 1,363.85		$ 2,000.00	Settlement
Wind damage to roof	3/24/2013	4/8/2013	Insured	1/30/2014	2/20/2014	Irrevocable	$ 10,884.61	Excessive scope, higher than Xactimate		$ 10,000.00		$ 3,250.00	Settlement

Loss	Date of Loss	Date First Notice of Loss Rec'd	Who Sent First Notice of Loss	AOB Date	Date Insurer Rec'd AOB	AOB Content	Amount Requested for Payment	Deviation from Pricing Standards, if applicable	Time Req'd for Payment	Amount of Final Payment	Amount Req'd in Attorney Fees	Attorney Fee Award	Venue of Resolu-tion
Rock or pebble hit windshield	3/15/2013	3/25/2013	Vendor				$ 687.11			$ 407.40	$1,650	$ 1,500.00	Global settlement
Plumbing leak in bathroom	3/14/2013	3/15/2013	Insured	3/15/2013	3/20/2013	Assign all Causes of action, Waive Privacy , Irrevocable, Hold Harmless	$ 3,044.77	Excessive equipment and scope, incomplete logs, pricing higher than Xactimate		$ 1,854.56		$ 2,000.00	Settlement
Windshield damage	3/11/2013	3/25/2013	Vendor		3/22/2013	Assign all Causes of action, Irrevocable	$ 560.22			$ 320.37		$ -	Settlement
Water heater leak, interior water damage	2/25/2013	2/27/2015	Insured	2/26/2015	3/4/2015	Lmtd. Svcs. Rendered, Assign All Causes of action, Hold Harmless	$ 4,983.12	no					
Unknown	2/12/2013	5/8/2013	Attorney	2/15/2013	5/8/2013		$ 746.16			$ 750.64			Negotiated
Rear view mirror fell and cracked glass	2/1/2013	5/8/2013	Vendor		7/9/2013		$ 531.36			$ -	$1,650.00	1500 (global settlement)	Settlement
Pipe break, damage to carpet, drywall, and paint	1/23/2013	1/23/2013	Insured	1/23/2013	1/31/2013	Assign all Causes of action, Waive Privacy , Irrevocable	$ 9,283.13	Excessive equipment and scope, incomplete logs, pricing higher than Xactimate	15	$ 4,013.06		$ 67,000.00	Settlement
Rock hit windshield	1/20/2013	1/31/2013	Insured	1/21/2013	7/2/2013	Limited to Svcs. Rendered, Assign all Causes of action, Irrevocable	$ 908.98			$ 560.72	$1,650.00		
Pipe leak in wall, damage to carpet, drywall, paint, cabinets	1/13/2013	1/13/2013	Insured	1/14/2013	2/2/2013	Limited to Svcs. Rendered, Assign all Causes of action, Irrevocable, Hold Harmless	$ 3,722.04	Excessive equipment and scope, incomplete logs, pricing higher than Xactimate		$ 1,684.08		$ 1,800.00	Settlement

Loss	Date of Loss	Date First Notice of Loss Rec'd	Who Sent First Notice of Loss	AOB Date	Date Insurer Rec'd AOB	AOB Content	Amount Requested for Payment	Deviation from Pricing Standards, if applicable	Time Req'd for Payment	Amount of Final Payment	Amount Req'd in Attorney Fees	Attorney Fee Award	Venue of Resolu-tion
Rock hit windshield	1/2/2013	1/24/2013	Vendor	1/16/2013	1/24/2013	Limited to Svcs. Rendered, Assign all Causes of action, Waive Privacy , Hold Harmless	$ 556.70			$ 335.68	$1,650.00	$1500 (global settlement)	Settlement for fees only
Slab leak, damage to carpet, drywall and paint	12/21/2012	1/4/2013	Insured	12/21/2012	1/7/2013	Assign all Causes of action, Irrevocable, Hold Harmless	$ 5,634.46	Excessive equipment and scope, incomplete logs, pricing higher than Xactimate	10	$ 2,468.48		$ 2,000.00	Settlement
Rock cracked windshield	12/18/2012	8/8/2012	Vendor	5/9/2013	5/9/2013		$ 309.12			$ 309.12		$ -	Dismissed
Rock hit windshield	12/4/2012	12/5/2012	Vendor	12/6/2012	12/18/2012	Limited to Svcs. Rendered, Assign all Causes of action, Irrevocable	$ 626.86			$ 353.11	$1,650.00	$ 1,500.00	Global settlement
Unknown	11/9/2012			11/13/2012	8/22/2013		$ 869.91			$ 528.42			Negotiated
Slab leak, damage to tile, drywall, and paint	10/1/2012	10/15/2012	Insured	10/22/2012	10/30/2012	Limited to Svcs. Rendered, Assign all Causes of action, Irrevocable, Hold Harmless	$ 2,559.15	Excessive equipment and scope, incomplete logs, pricing higher than Xactimate		$ 1,399.78		$ 10,000.00	Settlement
Unknown	9/10/2012					Limited to Svcs. Rendered, Irrevocable, Hold Harmless	$ 801.18			$ 680.99			Negotiation
Mold in bathroom	9/5/2012	9/10/2012	Insured		9/24/2012	Limited to Svcs. Rendered, Assign all Causes of action, Hold Harmless	$ 2,342.44						Denied claim

Loss	Date of Loss	Date First Notice of Loss Rec'd	Who Sent First Notice of Loss	AOB Date	Date Insurer Rec'd AOB	AOB Content	Amount Requested for Payment	Deviation from Pricing Standards, if applicable	Time Req'd for Payment	Amount of Final Payment	Amount Req'd in Attorney Fees	Attorney Fee Award	Venue of Resolu-tion
Unknown	8/31/2012		Other			Limited to Svcs. Rendered, Irrevocable, Hold Harmless	$ 1,545.35			$ 1,480.31			Negotiation
Pipe leak, damage to carpet, cabinets and vanities	8/1/2012	9/29/2012	Insured	9/28/2012	10/9/2012	Assign all Causes of action, Irrevocable	$ 3,788.64	Excessive equipment and scope, incomplete logs, pricing higher than Xactimate	10	$ 1,413.32		$ 2,000.00	Settlement
Windshield hit by softball	7/21/2012	8/7/2012	Insured		9/14/2012	Assign all Causes of action, Waive Privacy , Irrevocable, Hold Harmless	$ 869.62			$ 549.49			Plaintiff dismissed lawsuit
Rock hit windshield	6/12/2012	4/12/2012	Vendor	4/5/2013	4/12/2013	Assign all Causes of action, Waive Privacy , Irrevocable, Hold Harmless	$ 570.83			$ 369.84		$ -	Dismissed
Unknown	5/17/2012			6/6/2012	7/17/2012		$ 399.87			$ 418.86			Negotiated
Unknown	4/7/2012		Other	4/25/2012		Limited to Svcs. Rendered, Irrevocable, Hold Harmless				$ 445.61			Negotiation
Slab leak, damage to carpet, drywall, and paint	10/11/2011	10/13/2011	Insured	10/13/2011	10/18/2011	Assign all Causes of action, Waive Privacy , Irrevocable, Hold Harmless	$ 4,624.08	Excessive equipment and scope, incomplete logs, pricing higher than Xactimate	15	$ 2,495.75		$ 10,000.00	Settlement
A/C leak, damage to walls and ceilings	8/4/2011	8/5/2011	Insured	8/5/2011	8/8/2011	Assign all Causes of action, Irrevocable, Hold Harmless	$ 4,033.70	Excessive equipment and scope, incomplete logs, pricing higher than Xactimate		$ 3,500.00		$ 4,500.00	Settlement

Loss	Date of Loss	Date First Notice of Loss Rec'd	Who Sent First Notice of Loss	AOB Date	Date Insurer Rec'd AOB	AOB Content	Amount Requested for Payment	Deviation from Pricing Standards, if applicable	Time Req'd for Payment	Amount of Final Payment	Amount Req'd in Attorney Fees	Attorney Fee Award	Venue of Resolu-tion
Property damage in attic due to raccoon	6/9/2011	6/16/2011	Vendor		6/27/2011	Limited to Svcs. Rendered, Assign all Causes of action, Waive Privacy , Irrevocable, Hold Harmless	$ 8,710.00			$ 8,843.06		$ 43,220.57	Settlement
No facts obtained	6/4/2011	1/31/2013	Other	6/6/2011	1/31/2013	Limited to Svcs. Rendered, Assign all Causes of action, Waive Privacy , Irrevocable	$ 319.68			$ -		$ -	Dismissed
Damage to windshield prior to policy cancellation	5/19/2011	5/28/2012	Insured	6/11/2012	7/2/2012	Limited to Svcs. Rendered, Assign all Causes of action	$ 516.95			$ 315.15	$3,000.00	$ 1,500.00	Global settlement
Hail damage to roof	4/28/2011	11/27/2012	Insured	11/27/2012	12/7/2012	Limited to Svcs. Rendered, Assign all Causes of action	$ 26,891.22	Different in scope, higher than Xactimate	30	$ 15,727.25		$ 4,500.00	Settlement
Damage to windshield prior to policy cancellation	2/25/2011	5/31/2012	Other	6/12/2012	6/19/2012	Limited to Svcs. Rendered, Assign all Causes of action, Waive Privacy	$ 824.95			$ 543.78	$2,500.00	$ 1,500.00	Global settlement
Toilet overflow, damage to floor, baseboards, and walls	12/13/2010	12/16/2013	Insured		12/17/2010	Assign all Causes of action, Irrevocable	$ 13,753.04	Excessive scope, higher than Xactimate	10	$ 8,529.17		$ 5,223.87	Settlement

Loss	Date of Loss	Date First Notice of Loss Rec'd	Who Sent First Notice of Loss	AOB Date	Date Insurer Rec'd AOB	AOB Content	Amount Requested for Payment	Deviation from Pricing Standards, if applicable	Time Req'd for Payment	Amount of Final Payment	Amount Req'd in Attorney Fees	Attorney Fee Award	Venue of Resolu-tion
Pipe leak, cabinet damage	10/7/2010	10/8/2010	Insured	10/12/2010	11/1/2010	Assign all Causes of action, Irrevocable, Hold Harmless	$ 14,521.11	Excessive equipment and scope, incomplete logs, pricing higher than Xactimate, inappropriate use of O&P (Ova & Parasite)		$ 10,000.00		$ 5,000.00	Settlement
Garbage disposal leak		1/9/2015	Insured	1/9/2015	1/12/2015	Waive Lien Law, Assign All Causes of action, Waive Privacy, Irrevocable, Hold Harmless	$ 1,420.74	no	3				
Auto glass damage		2/14/2012	Insured	2/14/2012	unknown	Irrevocable	$ 264.28	no	19	pending			
Water mold							$ 2,000.00						Withdrawn
Water Mitgation Rebuild							$ 12,537.33	$ 3,537.33		$ 9,000.00		$ 8,250.00	Settlement
Contractor Rebuild							$ 21,061.00	$ 4,123.90		$ 8,800.00		$ 3,400.00	Settlement
Water Mitigation Rebuild							$ 19,021.22	$ 2,753.00		$ 21,774.22		$ 6,975.78	Settlement
Water Mitigation Remediation							$ 7,134.97	$ 7,134.97		$ 5,800.00		$ 2,400.00	Settlement
Water Mitigation							$ 7,154.51	$ 4,905.94		$ 3,500.00		$ 2,500.00	Settlement
Water Mitigation							$ 16,525.06	$ 14,598.18		$ 4,000.00		$ 3,500.00	Settlement
Water Mitigation							$ 6,653.09	$ 3,997.57		$ 2,842.90		$ 3,950.00	Settlement

Loss	Date of Loss	Date First Notice of Loss Rec'd	Who Sent First Notice of Loss	AOB Date	Date Insurer Rec'd AOB	AOB Content	Amount Requested for Payment	Deviation from Pricing Standards, if applicable	Time Req'd for Payment	Amount of Final Payment	Amount Req'd in Attorney Fees	Attorney Fee Award	Venue of Resolu-tion
Water Mitigation							$ 54,543.40	$ 46,690.67		$ 62,500.00	$ 12,500.00	$ 12,500.00	Settlement
Water Mitigation Mold							$ 2,000.00	$ 2,000.00	15	$ 2,000.00	$ 500.00	$ 5,000.00	Settlement
Water Mitigation							$ 5,631.62	$ 3,114.69	15	$ 4,500.00			Settlement
Water Mitigation							$ 4,900.09	$ 900.09		$ 3,000.00	$ 3,000.00	$ 3,000.00	Settlement
Water Mitigation							$ 6,279.79	$ 4,278.79		$ 2,001.00		$ 2,500.00	Settlement
Water Mitigation							$ 2,860.54	$ 860.54		$ 2,000.00		$ 3,000.00	Settlement
Roof Replacement							$ 16,000.00	$ 2,500.00		$ 31,500.00		$ 8,000.00	Settlement
Water Mitigation							$ 6,151.98	$ 2,651.98		$ 1,000.00		$ 2,500.00	Settlement
Water Mitigation							$ 2,832.51	$ 1,228.51		$ 1,000.00		$ 3,000.00	Settlement
Water/mold							$ 22,422.00						Withdrawn
Water Mitigation							$ 2,500.00	$ 500.00		$ 2,000.00		$ 5,000.00	Settlement
Water Mitigation							$ 6,541.00	$ 3,541.00	15	$ 3,000.00		$ 3,500.00	Settlement
Water Mitigation							$ 3,742.34	$ 7,114.82		$ 3,000.00		$ 3,000.00	Settlement
Remediation							$ 2,200.00	$ 2,200.00	10	$ 1,700.00		$ 2,500.00	Settlement

Florida Office of Insurance Regulation

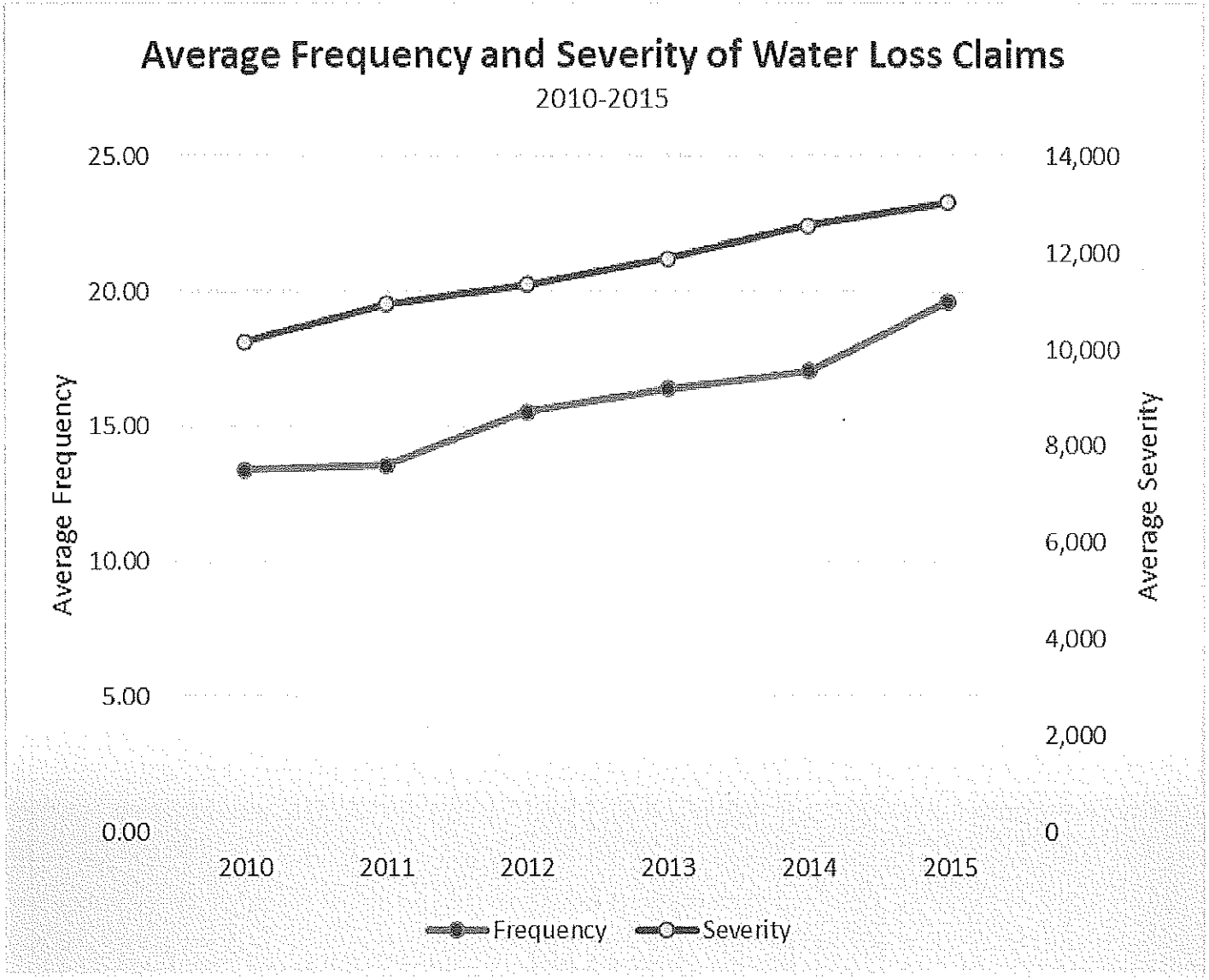
Florida's Assignment of Benefits (AOB) Crisis

Presented to:

Senate Banking and Insurance Committee
January 22, 2019

Florida Office of Insurance Regulation

2015 AOB Study

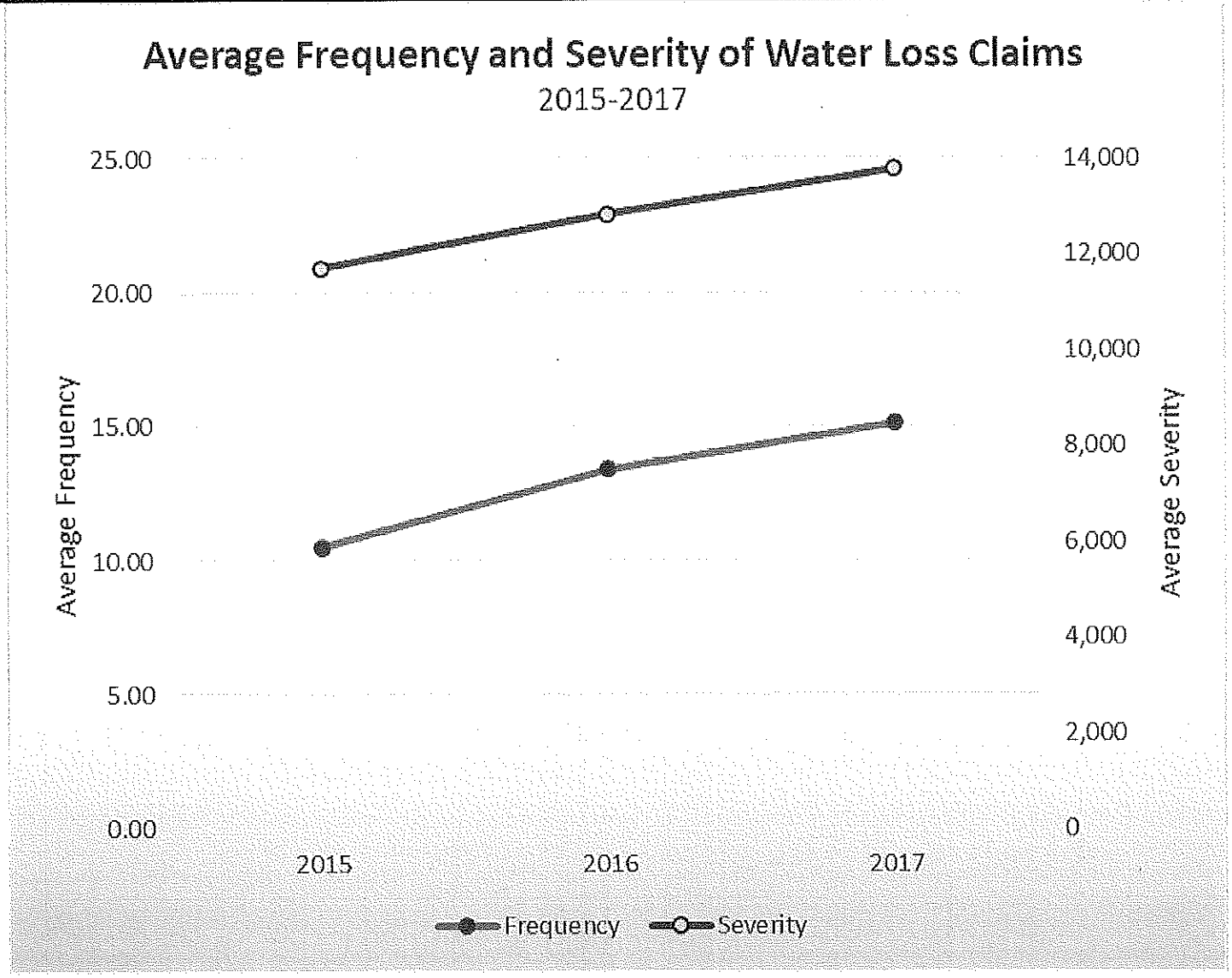


Source: Office Assignment of Benefits Data Call. Data based on claims for voluntary carriers with dates closed between 1/1/2010 and 9/30/2015. Insurer must have been able to provide information to determine the frequency and severity of HO-3/DF claims for water losses.

**Data is only shown for insurers that were able to consistently indicate for a given year that a claim had or did not have an (AOB).*

Florida Office of Insurance Regulation

2017 AOB Study

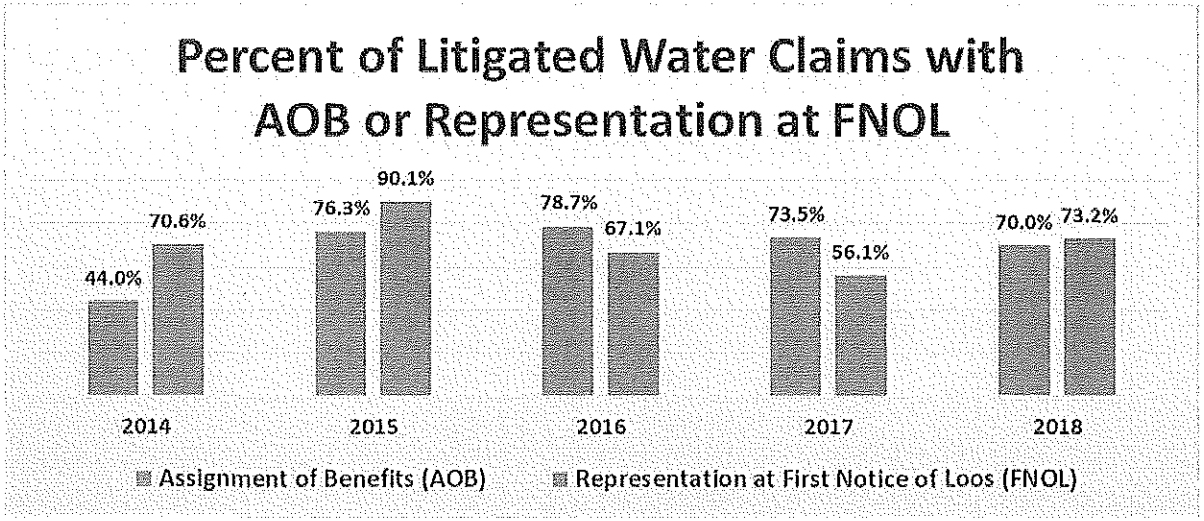


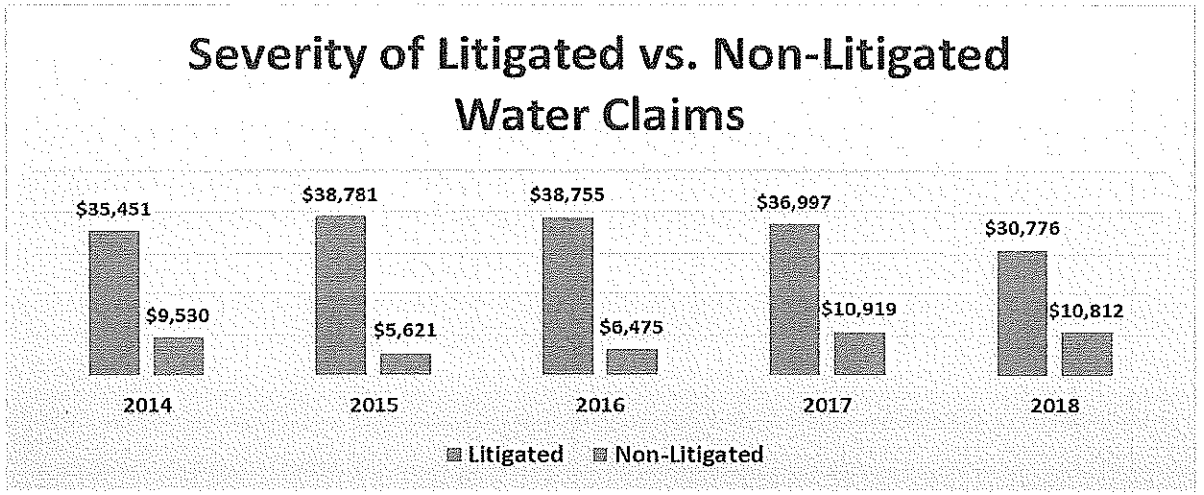
Source: Office Assignment of Benefits Data Call. Data based on claims for voluntary carriers with dates closed between 1/1/2015 and 6/30/2017. Insurer must have been able to provide information to determine the frequency and severity of HO-3/DF claims for water losses.

**Data is only shown for insurers that were able to consistently indicate for a given year that a claim had or did not have an (AOB).*

Florida Office of Insurance Regulation

Experience: Citizens Property Insurance Corporation 2014-2018



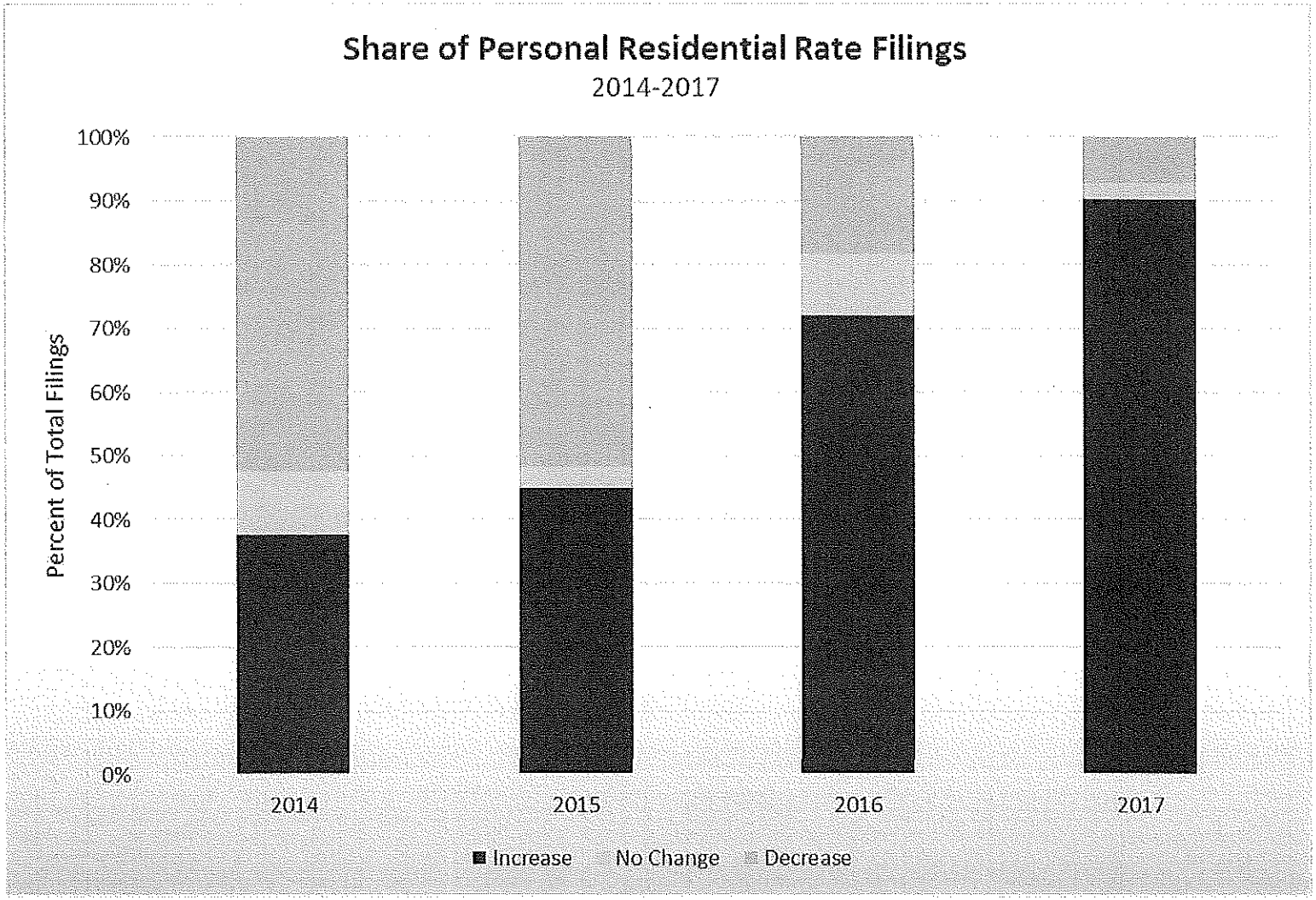


Notes:
1) Claims data is based on non-weather related water claims by report year for Homeowners policies.
2) Severity of litigated and non-litigated claims are based on undeveloped report year incurred loss and allocated loss adjustment expense (ALAE)

Source: Citizens Property Insurance Corporation (2018)

Florida Office of Insurance Regulation

Property Insurance Affordability



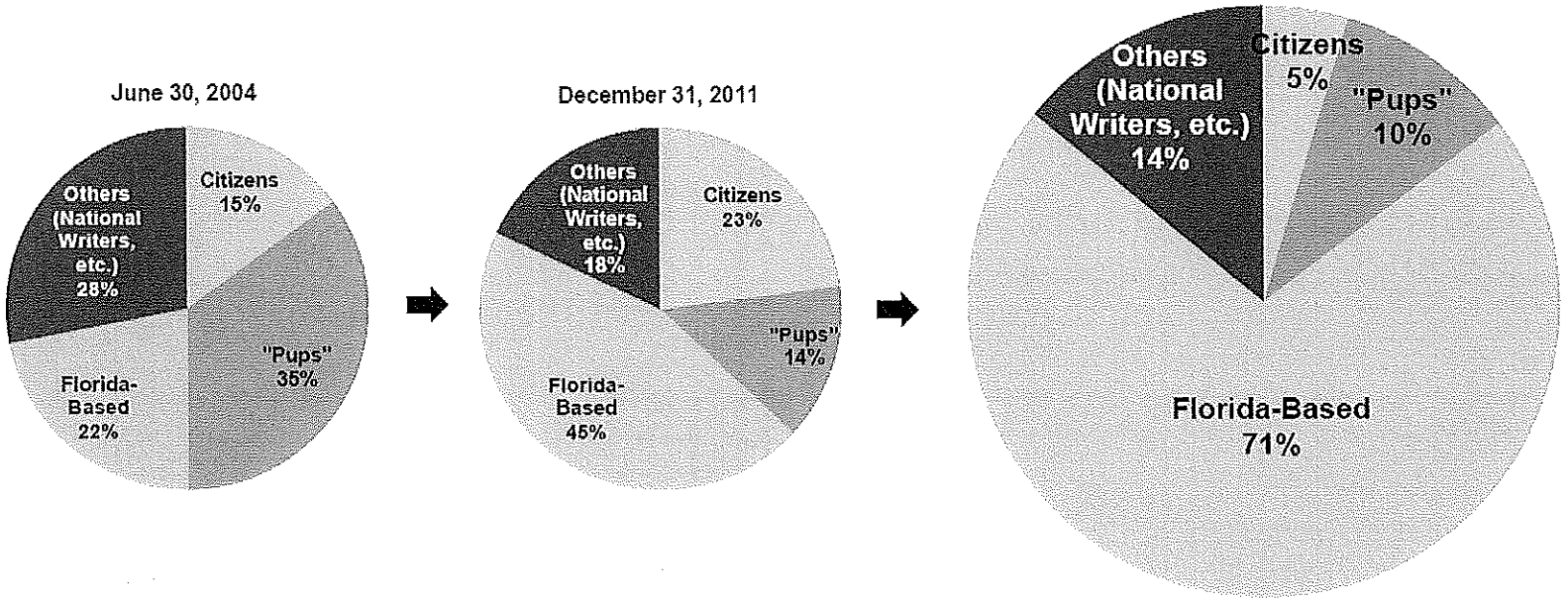
Citizens Property Insurance Corporation
Overview

Barry Gilway
President

CITIZENS
PROPERTY INSURANCE CORPORATION

Market Share

For Policies that Include Wind Coverage
Florida Residential Property Insurance Market
Includes State Farm Florida
QUASR data as of June 30, 2018

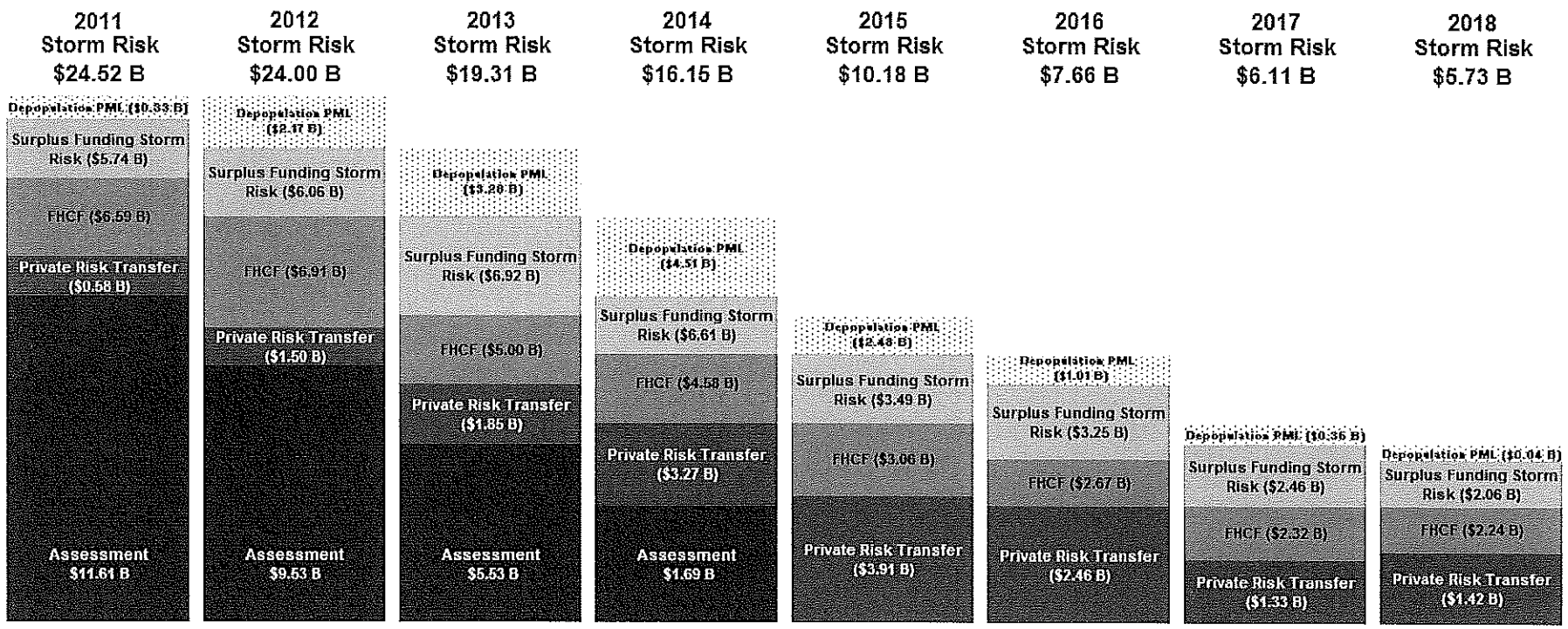


Insurer Category	Total Insured Value
Citizens	$106,284,553,696
"Pups"	$233,041,758,285
Florida-Based	$1,612,889,890,922
Others	$319,869,629,249
Total	**$2,272,085,832,151**

The Florida Residential Property Insurance Admitted Market is divided into 4 major parts: (i) Citizens; (ii) Florida only subsidiaries "pups" of major national writers; (iii) Florida-based domestic companies; and (iv) non-domestic nationwide property writers, such as USAA, etc.

Storm Risk: 1 in 100 year PML

Public Summary of Citizens Assessment Reduction Efforts Over Time



Notes:

1. Storm Risk is as measured by 1-in-100 year probable maximum loss (PML) plus estimated loss adjustment expenses using the Florida Hurricane Catastrophe Fund (FHCF) account allocation where PLA and CLA are combined. PLA/CLA combined PMLs are added to the Coastal PMLs to be consistent for surplus distribution. In general, the PMLs presented are as projected at the beginning of storm season; with the exception of 2017 which is as of August 31, 2017.
2. Surplus and Assessments are as projected at beginning of storm season. Not all PLA/CLA surplus is needed to fund storm risk in 2014. In 2015 - 2018, not all surplus in PLA/CLA and the Coastal Account is needed to fund storm risk. Remaining surplus is available to fund a second event.
3. Florida Hurricane Catastrophe Fund (FHCF) is as projected at beginning of storm season; with the exception of 2017 and 2018 which are Citizens' initial data submission to the FHCF.
4. Depopulation PMLs are not included in storm risk totals and are presented as year end totals; with the exception of 2018, which is as of May 31, 2018. PMLs from 2011-2014 use a weighted average of 1/3 Standard Sea Surface Temperature (SSST) and 2/3 Warm Sea Surface Temperature (WSST). 2015 - 2018 PMLs reflect only SSST event catalog.

Carrier Litigation Expense

Litigation has been increasing steadily for all carriers.

	2013	2014	2015	2016	2017	2018
Citizens Property Insurance Company						
All	9,146	9,525	7,653	10,061	7,624	13,363
AOB	860	1,062	1,250	3,242	2,718	3,631
AOB %	9%	11%	16%	32%	36%	27%
All Other Carriers						
All	18,270	22,122	30,167	31,790	41,524	69,300
AOB	4,613	4,820	6,645	5,968	9,772	17,421
AOB %	25%	22%	22%	19%	24%	25%
Total All	**27,416**	**31,647**	**37,820**	**41,851**	**49,148**	**82,663**
Total AOB	**5,473**	**5,882**	**7,895**	**9,210**	**12,490**	**21,052**
Total AOB %	**20%**	**19%**	**21%**	**22%**	**25%**	**25%**

Data source – DFS LSOP 2013-2018 Q4

Note: 2018 Q3 data includes Hurricane Irma which represents around 60% of all new Litigation for Citizens Property Insurance in 2018.

Legal Service of Process – All Litigation

CITIZENS
PROPERTY INSURANCE CORPORATION

Legal Service of Process 2013-2018 All State of Florida Carriers							
	Miami-Dade	Broward	Palm Beach	Orange	Hillsborough	Duval	Polk
2013	10,759	4,383	2,116	1,578	2,064	725	326
2014	12,287	5,932	2,337	1,815	2,025	780	401
2015	13,133	8,309	3,184	2,101	2,019	960	363
2016	14,718	9,605	3,493	1,994	2,424	1,047	449
2017	13,993	11,137	4,403	2,980	2,913	1,487	623
2018	25,736	17,281	6,139	6,232	3,594	2,027	1,284

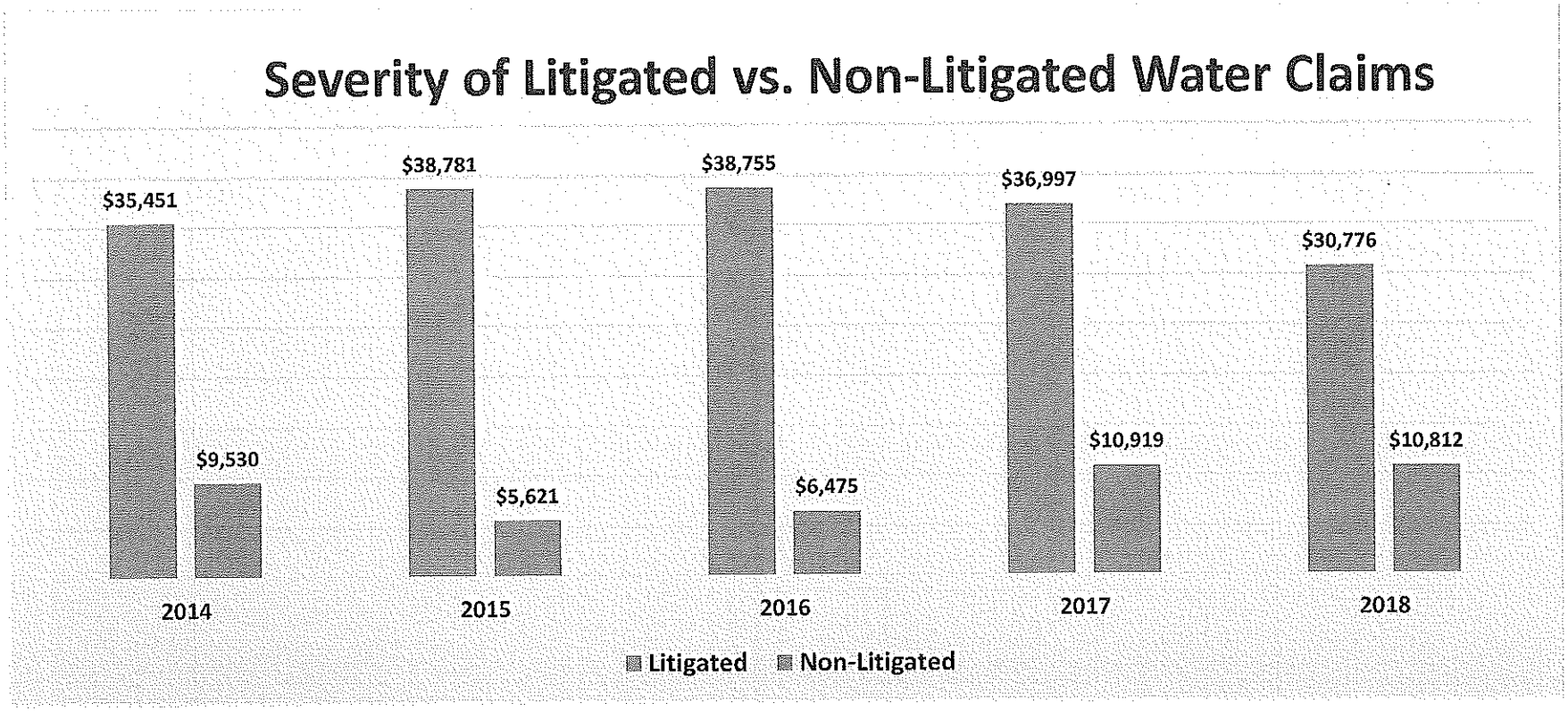
Legal Service of Process – AOB Litigation

CITIZENS
PROPERTY INSURANCE CORPORATION

	Miami-Dade		Broward		Palm Beach		Orange		Hillsborough		Duval		Polk	
	AOB	%	AOB	%	AOB	%	AOB	%	AOB	%	AOB	%	AOB	%
2013	2,782	26%	775	18%	355	17%	723	46%	133	6%	65	9%	47	14%
2014	2,872	23%	1,155	19%	286	12%	766	42%	34	2%	94	12%	44	11%
2015	3,240	25%	2,170	26%	580	18%	536	25%	26	1%	95	10%	65	18%
2016	3,772	25%	2,886	30%	719	21%	413	21%	95	4%	58	6%	63	14%
2017	4,464	32%	3,821	34%	1,052	24%	658	22%	209	7%	193	13%	76	12%
2018	6,940	27%	5,227	30%	1,346	22%	2,276	37%	636	18%	440	22%	263	20%

Litigated vs. Non-Litigated Water Claims

CITIZENS
PROPERTY INSURANCE CORPORATION

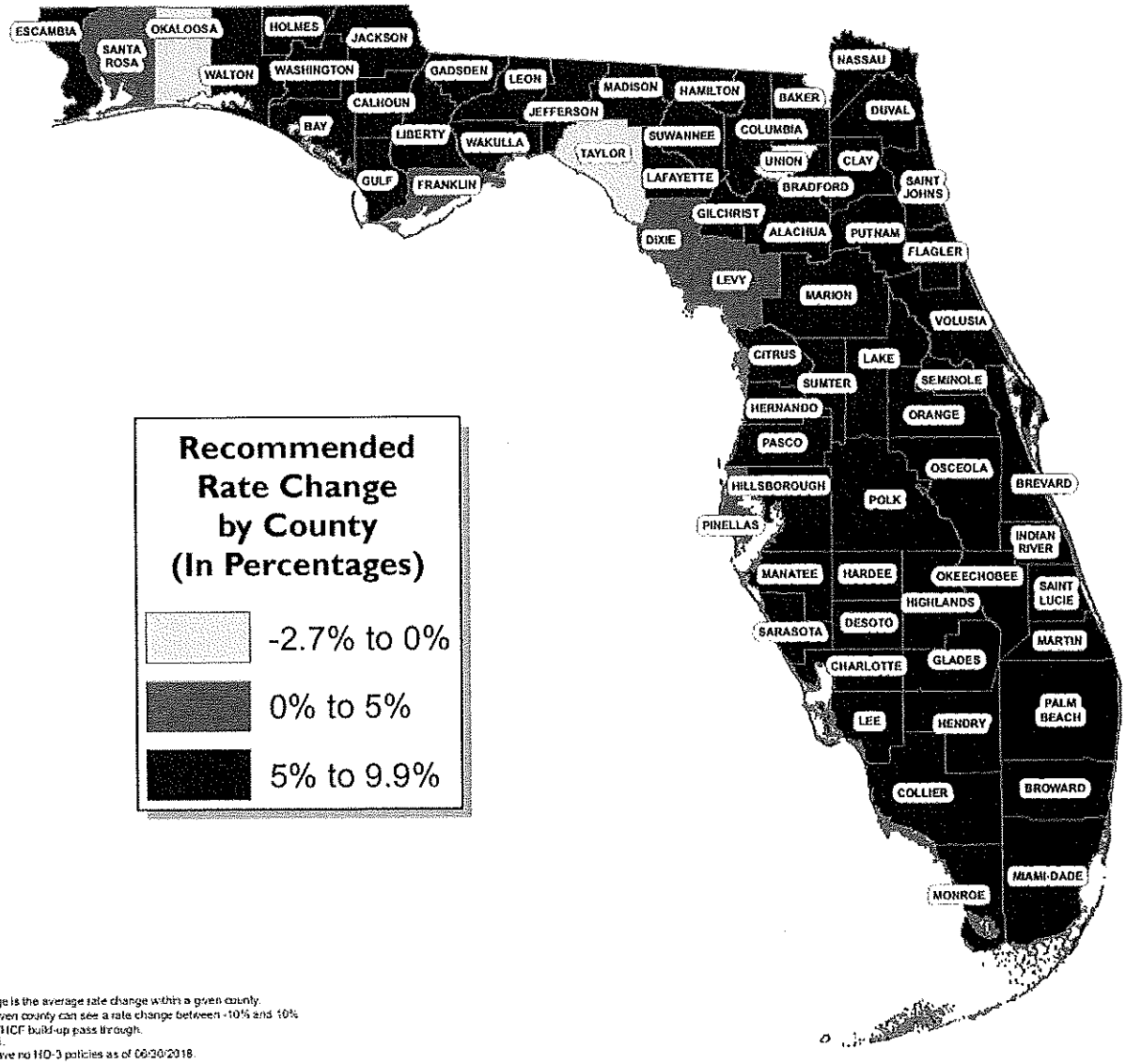


Homeowners Multiperil Rates

CITIZENS
PROPERTY INSURANCE CORPORATION

Exhibit 2 - Percent of 2019 Recommended Rate Change by County

Multi-Peril HO-3 Policies



Notes:

1. Percentage of rate change is the average rate change within a given county.
2. Policy holders within a given county can see a rate change between -10% and 10% excluding effects of the FHCF build-up pass through.
3. In force as of 06/30/2018.
4. Counties with no color have no HO-3 policies as of 06/30/2018.

CITIZENS
PROPERTY INSURANCE CORPORATION

Rates

- Citizens current average actuarial rate indication for multiperil homeowners is 25.2% with a capped indication of 8.5%
- Actuarial rate need for homeowners multiperil policies ranges among Senate districts from 0.1% to 51.6%
- 97% of homeowners multiperil policyholders will see rate increases in 2019
- 70% of homeowners customers received rate decreases in 2015
- If AOB reform is successful the actuarial rate indication for homeowners multiperil would be reduced from 25.2% to 10.1%
- If overall litigation rates can be reduced to pre-2015 levels the actuarial rate indication for homeowners multiperil would be reduced from 25.2 to 1.5%

CITIZENS
PROPERTY INSURANCE CORPORATION

Managed Repair Program

Available for Non-Weather Water Losses for Citizens' HO-3 and DP-3 Policies

- Voluntary program offered at time of loss for water losses caused by accidental discharge or overflow of water or steam from a plumbing, heating, air conditioning, automatic fire protective sprinkler system or household appliance
- **Emergency Water Removal Services**
    - No deductible
    - No cost to policyholder even if loss is not covered by Citizens
    - If the policyholder agrees to participate, Citizens provides a Citizens-approved contractor(s) to provide water removal and drying services to protect insured structures from further damage
- **Managed Repair Contractor Network Program**
    - Provides permanent repair services for covered damage
    - Policyholder works with licensed and insured contractors within the network
    - All contractors' claim related work is guaranteed for three years

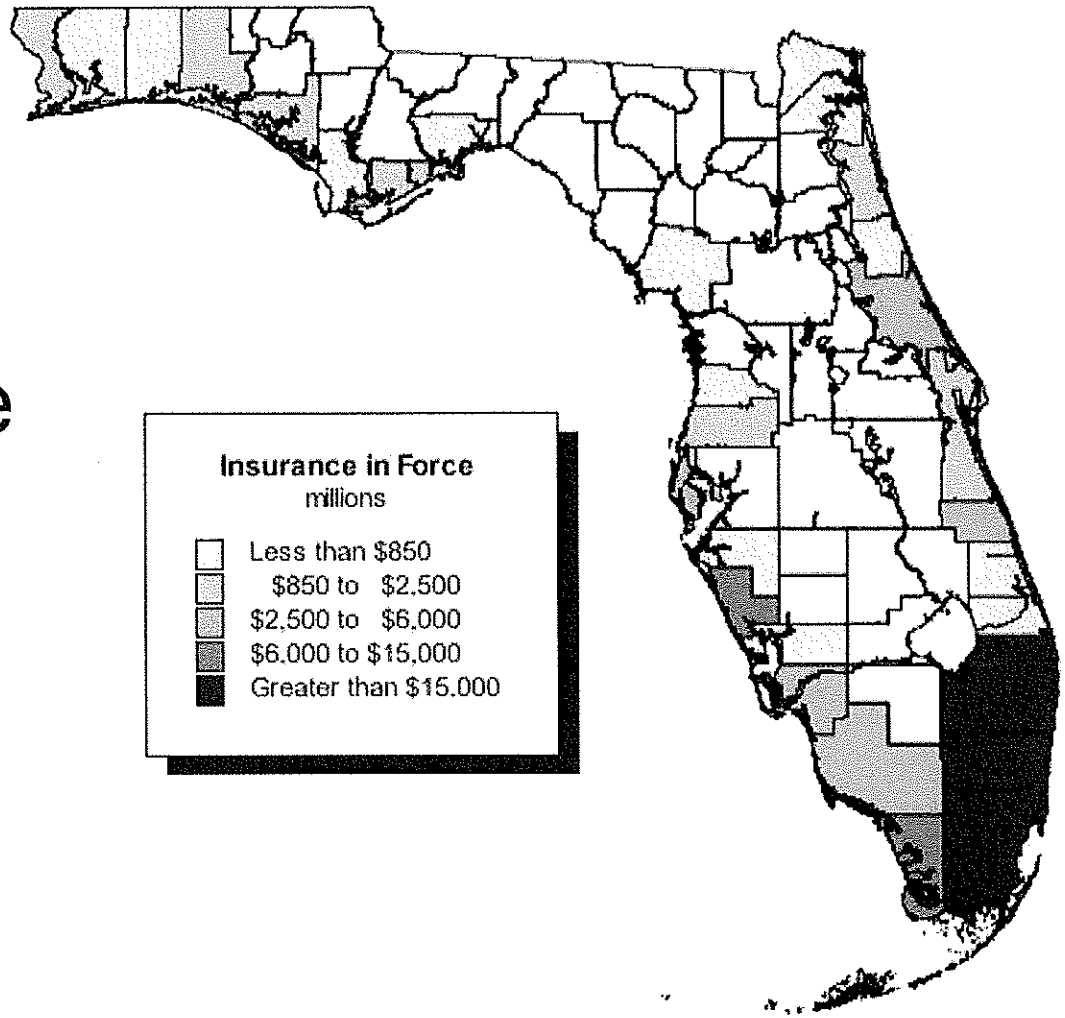
2018 Policy Changes

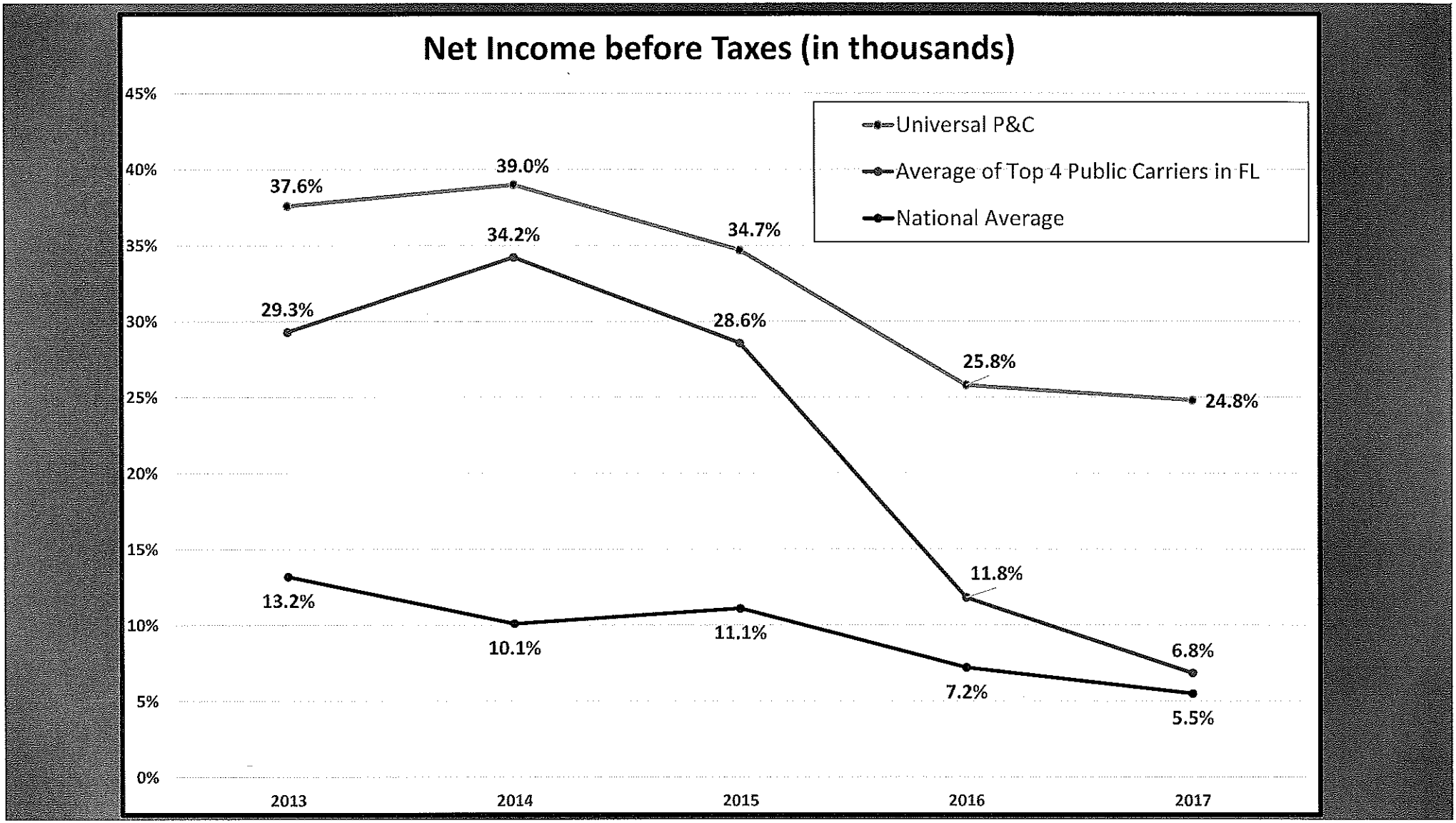
- Effective for HO-3 and dwelling DP-3 new business and renewals August 1, 2018
- $10,000 Sublimit for Coverages A and B if Managed Repair Contractor Network not used
- Requires all claimants other than insured, their agent, representative or a public adjuster representing claimant to:
    - Provide documentation supporting the right to make a claim
    - Provide documentation detailing the scope and amount of loss
    - Participate in appraisal or alternative dispute resolution

Value of the AOB during Insurance Claims for Contractors to Help Customers

Insurance Companies Charge a Premium with a Promise to Make Customers Whole

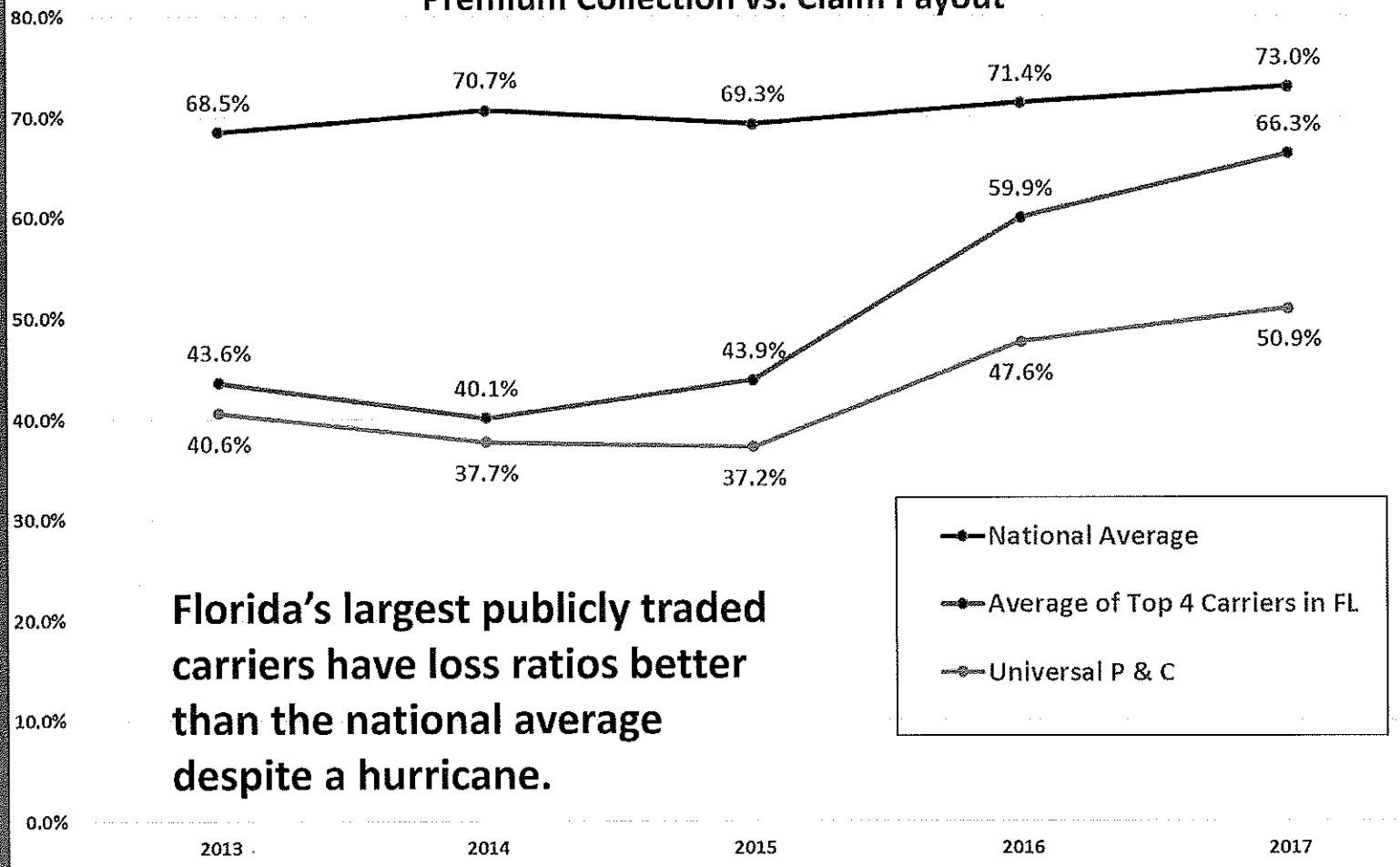
Citizens Insurance Policies in Force




Net Income before Taxes (in thousands)
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
2013
2014
2015
2016
2017
Universal P&C
Average of Top 4 Public Carriers in FL
National Average
37.6%
39.0%
34.7%
25.8%
24.8%
29.3%
34.2%
28.6%
11.8%
6.8%
13.2%
10.1%
11.1%
7.2%
5.5%

Loss Ratio

Premium Collection vs. Claim Payout



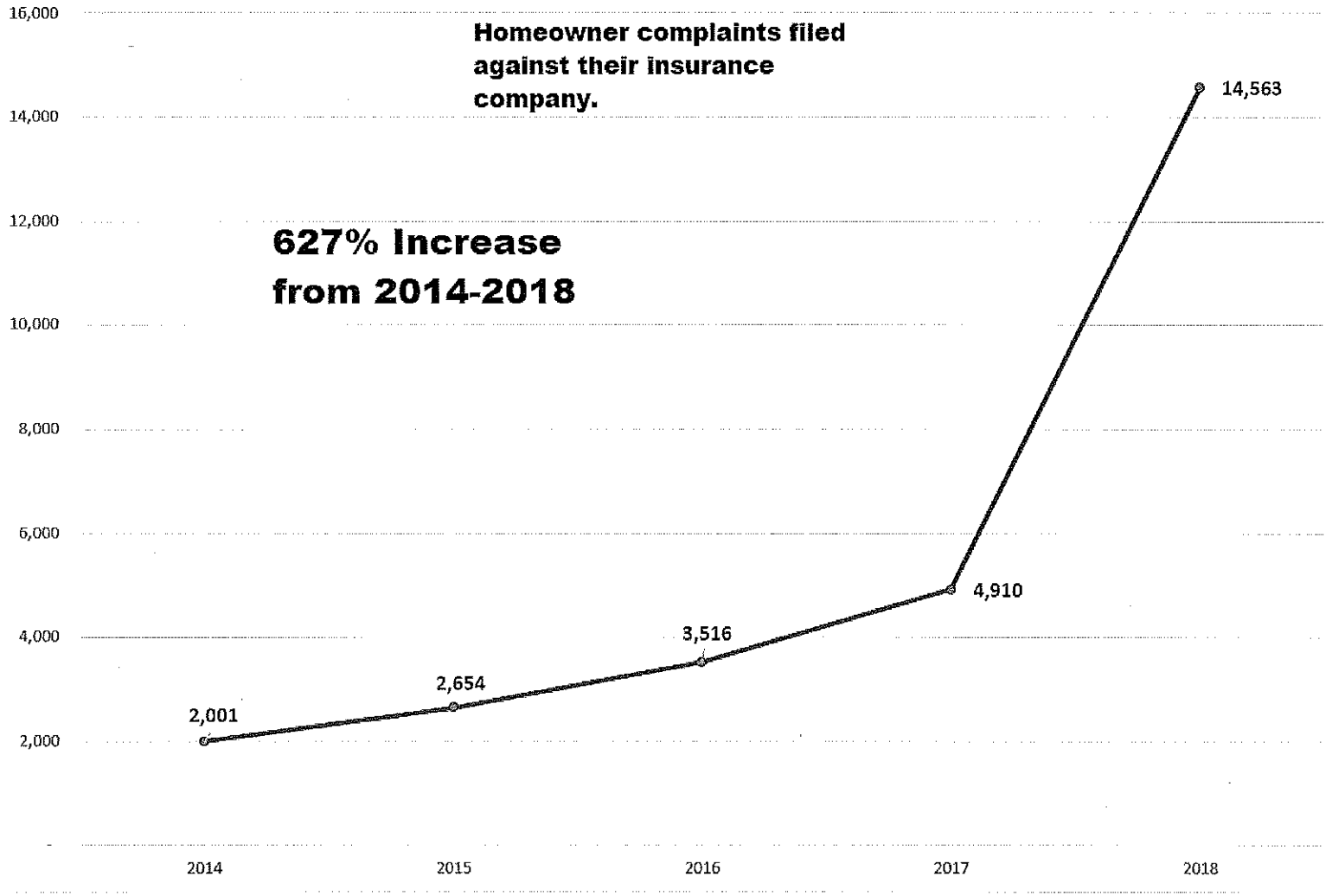
Florida's largest publicly traded carriers have loss ratios better than the national average despite a hurricane.

Decline in Payments Over Last 5 Years

Year	Job Count	Original Invoice	Undisputed from Carrier	Undisputed %	Amount Paid	% Rec'd	Delay in Payment
2013	16	$ 380,449.91	$ 296,064.01	**78%**	$ 376,973.93	99%	651
2014	61	$ 1,224,057.62	$ 701,603.88	**57%**	$ 1,148,978.40	94%	439
2015	55	$ 1,306,743.03	$ 512,583.53	**39%**	$ 1,184,700.51	91%	483
2016	115	$ 3,254,174.28	$1,387,447.71	**43%**	$ 2,921,703.52	90%	335
2017	40	$ 619,933.53	$ 198,715.77	**32%**	$ 572,295.02	92%	251
2018	40	$ 512,869.12	$ 116,485.26	**23%**	$ 446,125.84	87%	138
Totals	**327**	**$ 7,298,227.49**	**$3,212,900.16**	**44%**	**$ 6,650,777.22**	**91%**	**383**

	Job Count	Invoiced Amount	Undisputed from Carrier	Undisputed %
Currently in Suit	52	$ 2,473,098.93	$ 469,521.63	19%
Current AR	208	$ 4,115,451.90	$ 863,232.05	21%
Total Work Completed	**260**	**$ 6,588,550.83**	**$ 1,332,753.68**	**20%**

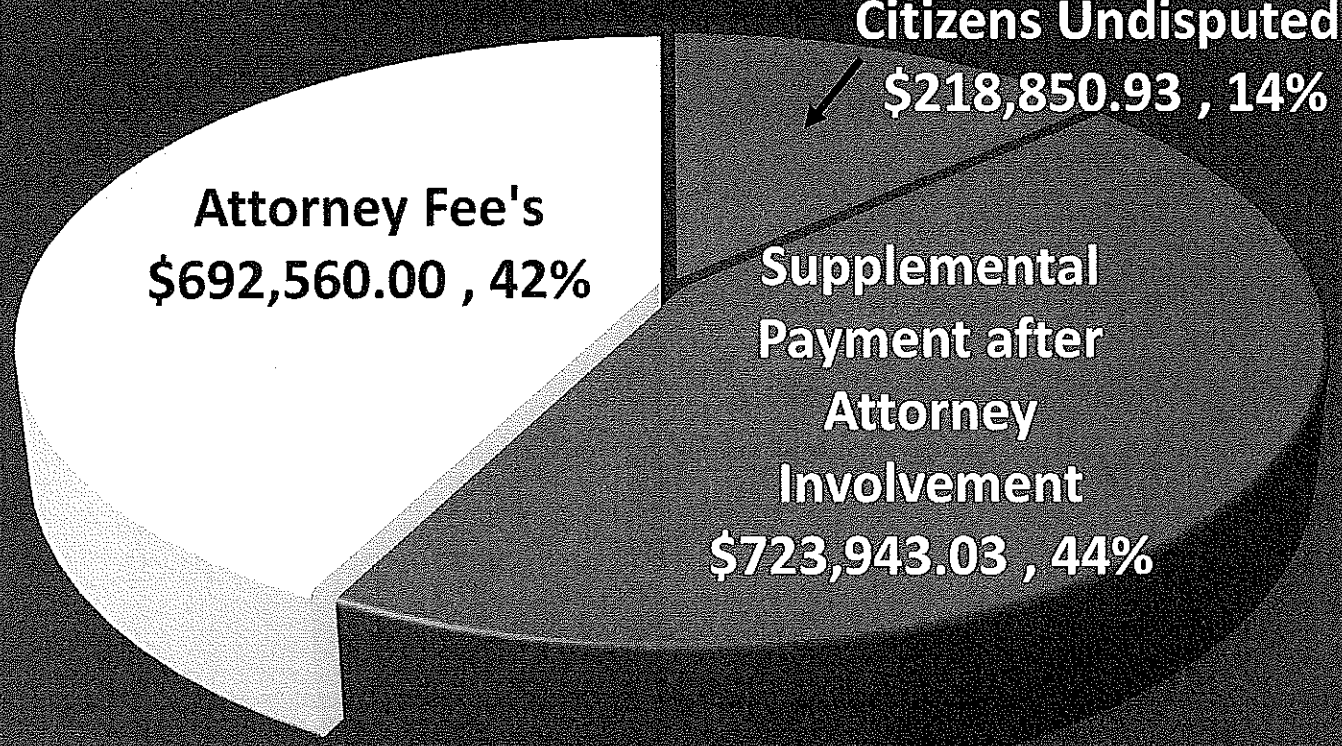
Florida Civil Remedy Notices



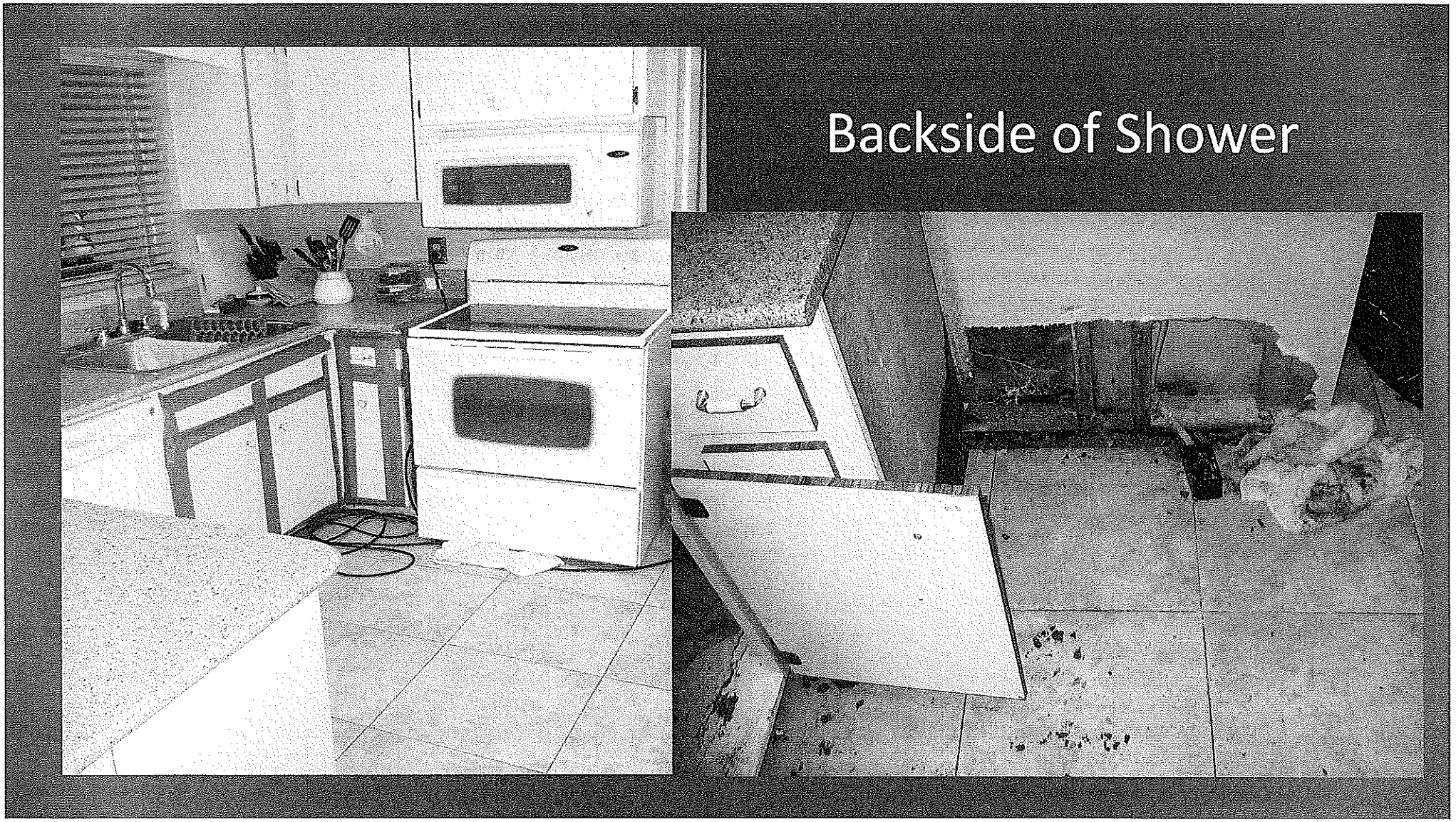
South Florida Contractor Claims with Citizens

The average invoice to Citizens was $ 5,584.90 .

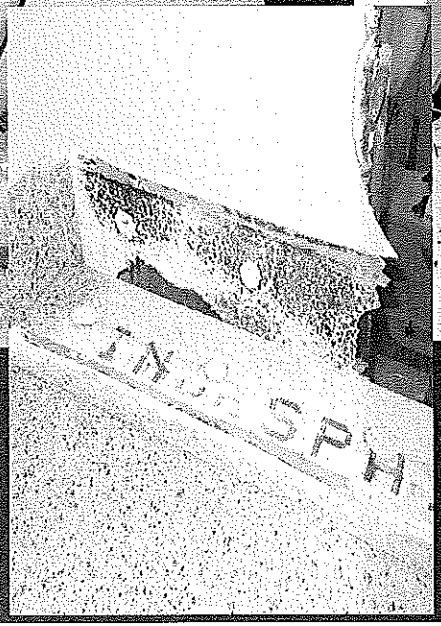
Between 2012-2016 the national average for a water claim was $ 9,633 according to the Insurance Information Institute.




Vendor Programs


Backside of Shower

Vendor Program Restraints



Response from Insurance Company's Director of Customer Field Services

Good morning Josh,

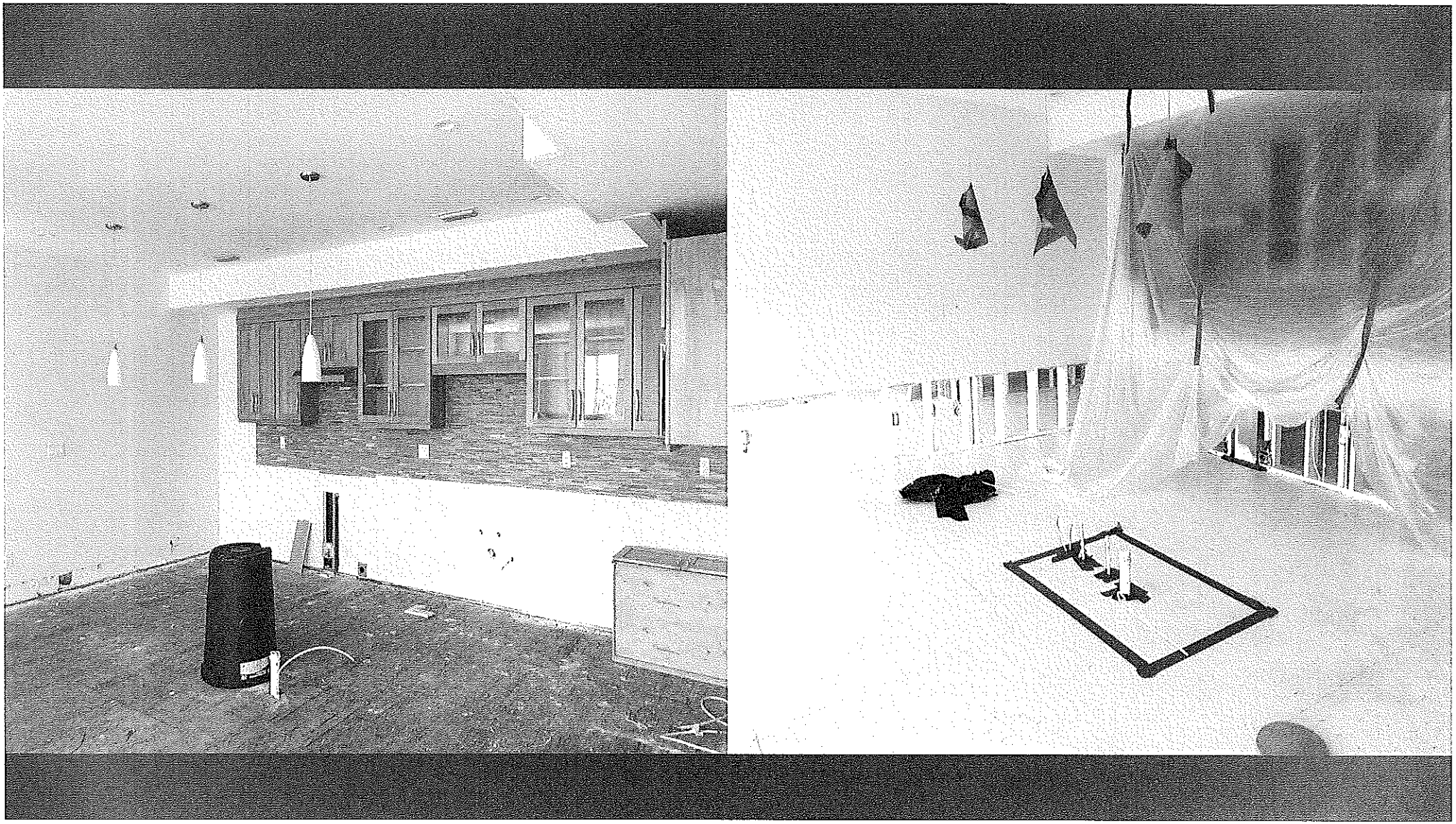
Could you look at this claim, I have several issues with the way Wright Way handled it. My first concern is there appears to be a minimal amount of mold and we have turned this into a full blown mold claim causing unnecessary concern on the part of the insured. There seems to less than 8 or 10 sq ft of mold normally contained and taken out with no muss or fuss. Another concern is that you went in there and wrote a pretty large water mit estimate, mold remediation estimate and build back estimate when all that we needed was a simple dry out. Our vendors usually communicate with the Examiner about these issues and are definitely not that aggressive. If I am missing something that would justify your handling of this claim please enlighten me. Thank you.

Best Regards

DIRECTOR OF CUSTOMER FIELD SERVICES


Sanibel Island Insurance Vendor Program Disaster

Sanibel Island Property



Proposed Solutions

1. Regulation of Restoration Contractors
2. Qualified and Educated Claims Staff
3. Serious Penalties for Insurance Fraud
   -Contractors and Carriers
4. Penalties for Underpayment and Delayed Claims
5. Proposal For Settlement

The Florida Senate

Committee Agenda Request

To: Senator Doug Broxson
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: February 15, 2019

I respectfully request that **Senate Bill #714**, relating to **Insurance**, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Jeff Brandes
Florida Senate, District 24

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date	Bill Number (if applicable)
	SB 714

Amendment Barcode (if applicable)

Topic INSURANCE

Name TANYA M. HANKS

Job Title PASTOR

Address 612 NW 4th PLACE (Street)

Phone (352) 622-3815

OCALA (City) FL. (State) 34474 (Zip)

Email revtmhanks@aol.com

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Greater New Bethel Baptist Church of Ocala, FL. / MYSELF

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

March 11, 2019
Meeting Date

SB 714
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Anne Bert

Job Title Chief Operating Officer - Florida Hurricane Catastrophe Fund

Address 1801 Hermitage Blvd.
Street

Phone 850 413-1340

Tallahassee
City

FL
State

32308
Zip

Email anne.bert@sbafla.com

Speaking: ☐ For ☐ Against ☑ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Hurricane Catastrophe Fund

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/2019
Meeting Date

714
Bill Number (if applicable)

Topic INSURANCE

Amendment Barcode (if applicable)

Name Christian R. Camara - R Street Institute

Job Title Senior Fellow

Address 1212 New York Ave. NW, Suite 900
Street

Phone 202-525-5717

Washington DC 20005
City *State* *Zip*

Email ccamara@rstreet.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing R Street Institute

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

March 11, 2019
Meeting Date

714
Bill Number (if applicable)

Topic Insurance

Amendment Barcode (if applicable)

Name Josh Aubuchon

Job Title Attorney

Address 315 S. Calhoun
Street

Phone 222-7000

Tallahassee FL 32301
City *State* *Zip*

Email

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing State Farm Insurance

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3-11-14
Meeting Date

714
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Insurance

Name Michael Carlson

Job Title President | CEO

Address 215 S. Monroe Ste. 835
Street

Phone 850 597 7425

Tall FL 32301
City *State* *Zip*

Email Michael.Carlson@piff.net

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing The Personal Insurance Federation of Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

03.11.19
Meeting Date

Topic Insurance

Bill Number 714 *(if applicable)*

Name Johanna Clark

Amendment Barcode 738068 *(if applicable)*

Job Title

Address 450 S. Orange Ave.
Street

Phone 407-849-0300

Orlando FL 32801
City *State* *Zip*

E-mail jclark@carltonfields.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Florida Justice Reform Institute

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

03-11-19
Meeting Date

Topic Insurance

Bill Number 714 *(if applicable)*

Name Johanna Clark

Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 450 S. Orange Ave.
Street

Phone 407-849-0300

Orlando FL 32801
City *State* *Zip*

E-mail jclark@carltonfields.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Florida Justice Reform Institute

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this ...

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/19
Meeting Date

714
Bill Number (if applicable)

Topic Insurance

Amendment Barcode (if applicable)

Name Paul Handerhan

Job Title Consultant

Address 120 S Monroe Street
Street

Phone 561 704 0428

Tallahassee FL 32301
City *State* *Zip*

Email paul@rmba consulty.com

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FAIR

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/18
Meeting Date

714
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Insurance

Name Jennifer H. Ashton

Job Title ~~Lobbyist~~ Consultant

Address 2337 Lobelia Drive
Street
Lake Mary, FL 32746
City *State* *Zip*

Phone 941-773-2112

Email Jennifer@Ashton-Advocacy.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Frontline Insurance

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/19
Meeting Date

714
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic INSURANCE

Name KYLE ULRICH

Job Title SVP

Address 3159 SHAMROCK S.
Street

Phone 566-4204

TALLAHASSEE FL 32309
City *State* *Zip*

Email KULRICH@FAIA.COM

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FL ASSOC. OF INSURANCE AGENTS

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/12/19
Meeting Date

714
Bill Number (if applicable)

Topic INSURANCE

549022
Amendment Barcode (if applicable)

Name TIMOTHY J. CORNETT

Job Title PRESIDENT ELECT

Address 4420 LAKE IN THE WOODS DR.
Street

Phone 352-345-1377

Spring Hill FL 34607
City *State* *Zip*

Email TIMC@TLC-PA.COM

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing FAPIA FLORIDA ASSOCIATION OF PUBLIC INS ADJ

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [ ] Yes [X] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

SB 714
Bill Number (if applicable)

Topic Insurance #SB 714 (Compromise Language)

548022
Amendment Barcode (if applicable)

Name Chris Merrill

Job Title President, Merrill Law Group

Address 777 South Harbour Island Blvd #750
Street

Phone 813 695 8733

Tampa FL 33602
City State Zip

Email

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing MyScar

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [ ] Yes [X] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/19
Meeting Date

714
Bill Number (if applicable)

Topic CRN

548022
Amendment Barcode (if applicable)

Name Paul Hanbrahan

Job Title Consultant

Address 120 S Monroe Street
Street

Phone 561 704 0428

Tallahassee FL 32301
City *State* *Zip*

Email Paul@ranbrahanconsulting.com

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/19
Meeting Date

7141
Bill Number (if applicable)

Topic Insurance

917258
Amendment Barcode (if applicable)

Name Katie Webb

Job Title

Address 119 E Park Ave
Street

Phone

Tall FL 32301
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Peninsula Insurance Co.

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

03.11.19
Meeting Date

Topic Insurance

Bill Number 714 *(if applicable)*

Name Johanna Clark

Amendment Barcode 548022 *(if applicable)*

Job Title

Address 450 S. Orange Ave.
Street

Phone 407-849-0300

Orlando FL 3281
City *State* *Zip*

E-mail jclark@carltonfields.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Florida Justice Reform Institute

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/19
Meeting Date

714
Bill Number (if applicable)

474272
Amendment Barcode (if applicable)

Topic WORK COMP APPLICATIONS

Name KYLE ULRICH

Job Title SVP

Address 3159 SHAMROCK S.
Street

TALLAHASSEE FL 32309
City *State* *Zip*

Phone 566-4204

Email KULRICH@FAIA.COM

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FL. ASSOC. OF INSURANCE AGENTS

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/12
Meeting Date

714
Bill Number (if applicable)

474272
Amendment Barcode (if applicable)

Topic Insurance

Name Brewster Bevis

Job Title Senior Vice President

Address 516 N Adams
Street

Phone 224-7173

Tallahassee FL 32301
City *State* *Zip*

Email bbevis@afi.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Associated Industries of Florida

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/19
Meeting Date

SB 714
Bill Number (if applicable)

917258
Amendment Barcode (if applicable)

Topic Insurance

Name Kevin Comerer (Ko-Mer)

Job Title Legislative Director

Address 5426 Bay Center, Suite 600 (*Street*)

Phone

Tampa (*City*) FL (*State*) 33609 (*Zip*)

Email

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing American Integrity Insurance

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	SB 754
INTRODUCER:	Senator Stewart
SUBJECT:	Motor Vehicle Insurance Coverage for Windshield Glass
DATE:	March 8, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Billmeier	Knudson	BI	**Favorable**
2.			CM	
3.			RC	

I. Summary:

SB 754 prohibits motor vehicle repair shops and their employees from offering an inducement to a customer in exchange for making an insurance claim for motor vehicle glass replacement or repair. This prohibition also applies to individuals who are not employees of the repair shop, but are compensated for their solicitation of insurance claims.

II. Present Situation:

Automobile Insurance

A consumer who purchases only the minimum insurance coverages required by law, personal injury protection coverage and property damage liability coverage, does not have first-party insurance coverage for the repair or replacement of a windshield. Conversely, a consumer who purchases comprehensive coverage, which generally pays for damages to the insured automobile caused by events other than a collision, has insurance coverage if his or her windshield is damaged or broken.[1] Lenders often require borrowers to purchase comprehensive coverage, so consumers who owe money on their vehicles will often qualify for windshield repair or replacement without having to pay a deductible.[2]

A "deductible" is the amount the insured must pay before the insurance company pays any amount on an insurance claim. Section 627.7288, F.S. states:

[1] *See*, Florida Department of Financial Services, *Automobile Insurance A Toolkit for Consumers*, https://www.myfloridacfo.com/division/consumers/UnderstandingCoverage/Guides/documents/AutoToolkit.pdf (last visited March 3, 2019).
[2] Florida Department of Financial Services, *Automobile Insurance A Toolkit for Consumers*, https://www.myfloridacfo.com/division/consumers/UnderstandingCoverage/Guides/documents/AutoToolkit.pdf (last visited March 3, 2019).

> The deductible provisions of any policy of motor vehicle insurance, delivered or issued in this state by an authorized insurer, providing comprehensive coverage or combined additional coverage shall not be applicable to damage to the windshield of any motor vehicle covered under such policy.[3, 4]

Windshield Replacement and Repair

Florida law does not have specific requirements applicable to insurance claims made as a result of a damaged windshield. The claims are handled according to the terms of the insurance policy. Current law does not prohibit an insurer from requiring an inspection of a damaged windshield before it authorizes its repair as a term of the insurance policy.

Many Florida insurers set up a network of providers that will provide windshield repair or replacement services at negotiated rates. Some glass shops do not participate in the insurer's provider network. To claim benefits from an insured's automobile insurer, the "out-of-network" shop often obtains an assignment of benefits from the insured. Florida law allows an insured to assign the benefits (payment) of his or her insurance policy to a third party, in this case, the out-of-network glass shop. The assignee glass shop can negotiate with the insurer or file a lawsuit against the insurance company if the two sides do not agree on the claim amount. [5]

Windshield Litigation

The Department of Financial Services provided the following information on the number of auto glass lawsuits brought pursuant to an assignment.[6]

Year	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Auto Glass Lawsuits	397	571	271	709	351	478	1,389	4,331	9,018	12,817	19,695	26,664	17,399

Section 627.428, F.S., allows the insured or the assignee to obtain attorney fees from the insurer if the insured or assignee obtains a judgment against an insurer.[7] The statute does not allow an insurer that prevails in a case involving an insured or assignee to recover attorney fees.[8] The purpose of the statute is to "discourage contesting of valid claims of insureds against insurance companies . . . and to reimburse successful insureds reasonably for their outlays for attorney's fees when they are compelled to defend or to sue to enforce their contracts."[9]

---

[3] Language similar to s. 627.7288, F.S., has been part of Florida law since 1979. *See* Ch. 79-241, Laws of Florida.
[4] At least seven other states have provisions prohibiting insurers from requiring a deductible for windshield claims or allow insureds to purchase a policy with no deductible for windshield claims.
[5] Dale Parker and Brendan McKay, *Florida Auto Glass Claims: A Cracked System*, Trial Advocate Quarterly Fall 2016 (Westlaw Citation: 35 No. 4 Trial Advoc. Q. 20).
[6] Data provided by the Department of Financial Services for calendar years 2006-2018 (on file with the Senate Committee on Banking and Insurance).
[7] The Florida Supreme Court has recognized the right of assignees to obtain attorney fees under s. 627.428, F.S. (and its predecessor statute) since at least 1972. *See All Ways Reliable Building Maintenance, Inc. v. Moore*, 261 So.2d 131 (Fla. 1972). The First District Court of Appeal has recognized the right since at least 1961. *See Travelers Insurance Co. v. Tallahassee Bank and Trust Co.*, 133 So.2d 463 (Fla. 1st DCA 1961).
[8] Insurers can recover attorney fees in some cases by using offers of judgment and proposals for settlements. *See* s. 768.79, F.S., and Fla.R.Civ.P. 1.442.
[9] *Roberts v. Carter*, 350 So.2d 78, 79 (Fla. 1977).

Some insurers argue that the increase in litigation is caused by the ability of some vendors to execute an assignment of benefits and recover attorney fees under s. 627.428, F.S. They allege that some vendors obtain an assignment of benefits from the insured and inflate the cost of the claim when they bill the insurance company.[10] Insurers also believe that many windshield claims brought by assignees are fraudulent.[11] In such cases, the insurer must determine whether to pay what it believes to be an inflated or fraudulent claim or pay its own attorneys to litigate the case and risk having to pay the other side's attorney fees if it does not prevail.[12]

Some auto glass vendors argue that litigation is necessary because insurers enter into agreements with preferred vendors and will not pay the "prevailing competitive price" for windshield repair or replacement. Instead, some vendors contend, insurers will only pay the price they pay to the preferred vendors and that litigation is necessary to force the insurers to pay the "prevailing competitive price" pursuant to the insurance policy language.[13]

Florida Motor Vehicle Repair Act

Motor vehicle repair shops in Florida are regulated by the Department of Agriculture and Consumer Services (DACS) under the Florida Motor Vehicle Repair Act.[14] This Act requires that all motor vehicle repair shops, with limited exceptions, register with the DACS.[15] A motor vehicle repair shop may be fixed or mobile and includes a person or business that does motor vehicle glass work for compensation.[16] Under the Act, it is unlawful for a motor vehicle repair shop or its employee to engage in various activities such as misrepresenting that repairs have been made to a motor vehicle or fraudulently altering any customer contract, estimate, invoice, or other document.[17] The Act provides for various remedies for unlawful acts by motor vehicle repair shops, including notices of noncompliance, administrative fines, orders to cease and desist, probation of registrants, and suspension or revocation of registrations.[18] In addition, a customer injured by a violation of the Motor Vehicle Repair Act may bring an action against a repair shop. The prevailing party is entitled to damages plus court costs and reasonable attorney fees.[19]

[10] One provider offers cash rebates and restaurant gift cards to customers "with qualifying insurance" for windshield repair or replacement. *See* http://www.auto-glassamerica.com (last visited March 3, 2019).
[11] *Government Employees Insurance Co. v. Clear Vision Windshield Repair, L.L.C.*, 2017 WL 1196438 (M.D. Florida March 29, 2017).
[12] Florida Justice Reform Institute, White Paper: *Restoring Balance in Insurance Litigation* (2015)(on file with the Senate Committee on Banking and Insurance).
[13] *See VIP Auto Glass, Inc. v. Geico General Insurance Co.*, 2017 WL 3712918 (M.D. Florida March 17, 2017) at p. 1. (discussing a class action lawsuit against Geico by VIP Auto Glass).
[14] *See* ss. 559.901-559.9221, F.S.
[15] *See* s. 559.904, F.S.
[16] *See* s. 559.903(6) and (7), F.S.
[17] *See* s. 559.920, F.S.
[18] *See* s. 559.921, F.S.
[19] *See* s. 559.921(1), F.S.

Inducements

Some auto glass repair and replacement shops currently offer "rewards" for service, such as a prepaid gift card, if a consumer files a qualified insurance claim for his or her windshield replacement.[20]

Several industries bar incentives or inducements in exchange for an act that would earn the inducer additional income. For example:

- Healthcare providers are prohibited from offering a kickback to any person in exchange for patient referrals (s. 456.054, F.S.);
- Athlete agents may not offer anything of value to a student athlete to induce him or her to enter into an agreement of representation (s. 468.456(1)(f), F.S.);
- Public adjusters are subject to prosecution for an unfair and deceptive insurance practice if he or she offers an inducement to an insured in exchange for the insured's submission of an insurance claim (s. 626.854(7)(a)2., F.S.); and
- Insurance agents are barred from offering inducements in many settings, including offering a rebate to induce a consumer to enter into an insurance contract, or offering a reduced fee for provision of title insurance.[21]

III. Effect of Proposed Changes:

The bill provides that a motor vehicle repair shop may not provide an inducement in the form of a rebate, gift, gift card, cash, coupon, or any other thing of value, in exchange for making an insurance claim for motor vehicle glass replacement or repair. An employee of the motor vehicle repair shop and a nonemployee who is compensated for soliciting insurance claims based on the repair of a motor vehicle glass replacement or repair are both also prohibited from offering such inducements. Motor vehicle repair shops would be subject to disciplinary actions by the DACS for violations of the bill's provisions.

Section 2 provides an effective date of July 1, 2019.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

[20] *See, e.g.*: https://www.americanautoglass.biz/auto-glass-replacement.html, and https://expressautoglass.biz/windshield-replacement-gift-card.php (last visited Jan. 30, 2018).
[21] Section 626.9541, F.S.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Motor vehicle repair shops will be prohibited from providing certain inducements to customers; this may negatively affect their businesses.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 559.920 of the Florida Statutes:

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Stewart

13-01096-19 2019754__

A bill to be entitled

An act relating to motor vehicle insurance coverage for windshield glass; amending s. 559.920, F.S.; prohibiting motor vehicle repair shops or their employees from offering anything of value to a customer in exchange for making an insurance claim for motor vehicle glass replacement or repair, including offers made through certain persons; providing an effective date.

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

Section 1. Section 559.920, Florida Statutes, is amended to read:

559.920 Unlawful acts and practices.—It shall be a violation of this act for any motor vehicle repair shop or employee thereof to:

(1) Engage or attempt to engage in repair work for compensation of any type without first being registered with or having submitted an affidavit of exemption to the department;

(2) Make or charge for repairs which have not been expressly or impliedly authorized by the customer;

(3) Misrepresent that repairs have been made to a motor vehicle;

(4) Misrepresent that certain parts and repairs are necessary to repair a vehicle;

(5) Misrepresent that the vehicle being inspected or diagnosed is in a dangerous condition or that the customer's continued use of the vehicle may be harmful or cause great

13-01096-19 2019754__

damage to the vehicle;

(6) Fraudulently alter any customer contract, estimate, invoice, or other document;

(7) Fraudulently misuse any customer's credit card;

(8) Make or authorize in any manner or by any means whatever any written or oral statement which is untrue, deceptive or misleading, and which is known, or which by the exercise of reasonable care should be known, to be untrue, deceptive or misleading;

(9) Make false promises of a character likely to influence, persuade, or induce a customer to authorize the repair, service, or maintenance of a motor vehicle;

(10) Substitute used, rebuilt, salvaged, or straightened parts for new replacement parts without notice to the motor vehicle owner and to her or his insurer if the cost of repair is to be paid pursuant to an insurance policy and the identity of the insurer or its claims adjuster is disclosed to the motor vehicle repair shop;

(11) Cause or allow a customer to sign any work order that does not state the repairs requested by the customer or the automobile's odometer reading at the time of repair;

(12) Fail or refuse to give to a customer a copy of any document requiring the customer's signature upon completion or cancellation of the repair work;

(13) Willfully depart from or disregard accepted practices and professional standards;

(14) Have repair work subcontracted without the knowledge or consent of the customer unless the motor vehicle repair shop or employee thereof demonstrates that the customer could not

reasonably have been notified;

(15) Conduct the business of motor vehicle repair in a location other than that stated on the registration certificate;

(16) Rebuild or restore a rebuilt vehicle without the knowledge of the owner in such a manner that it does not conform to the original vehicle manufacturer's established repair procedures or specifications and allowable tolerances for the particular model and year; ~~or~~

(17) Offer to a customer a rebate, gift, gift card, cash, coupon, or any other thing of value in exchange for making an insurance claim for motor vehicle glass replacement or repair, including an offer made through a nonemployee who is compensated for the solicitation of insurance claims; or

(18)~~(17)~~ Perform any other act that is a violation of this part or that constitutes fraud or misrepresentation.

Section 2. This act shall take effect July 1, 2019.

Restoring Balance in Insurance Litigation

*An **Update** on the Abuse of Assignments of Benefits and its Correlation with One-Way Attorney's Fees*

FLORIDA Justice Reform INSTITUTE

by: Ashley Kalifeh & Mark Delegal[i]

Contents

Executive Summary

As discussed in FJRI's 2015 paper,[1] the prospect of one-way attorney's fees has encouraged a growing number of lawyers to partner with various service providers to solicit assignments of benefits ("AOBs") from policyholders. The typical AOB relationship begins when a policyholder signs a contract assigning rights, benefits, proceeds, and causes of action arising under her insurance policy to a third party. This third party is often a service provider that agrees to make a repair or provide care for which insurance coverage will be sought. Indeed, often the repair or care is conditioned upon the assignment, which the provider will then enforce against the insurer in its own right. This transforms first party litigation—in which a policyholder enforces her own rights against the insurer from whom she purchased coverage—into a mutated first party litigation, whereby a third party purports to act as the policyholder.

One reason AOB litigation is so lucrative is because of the statutory, "one-way" attorney's fees available for attorneys that represent prevailing service providers. Notably, the one-way attorney fee statute[2] speaks to a "named insured," "omnibus insured," or "named beneficiary" being afforded the benefits of that one-way attorney's fee. In fact, the Florida Supreme Court has recently reiterated that this fee-shifting statute was intended "to 'level the playing field' between the economically-advantaged and sophisticated insurance companies and the individual citizen," as "the average policyholder has neither the finances nor the expertise to single-handedly take on an insurance carrier."[3] This goal is

[1] *Restoring Balance in Insurance Litigation: Curbing Abuses of Assignments of Benefits and Reaffirming Insureds' Unique Right to Unilateral Attorney's Fees*, Florida Justice Reform Institute, October 2015 ("*Restoring Balance*").
[2] § 627.428, Fla. Stat.
[3] *Johnson v. Omega Ins. Co.*, 200 So. 3d 1207, 1215 (Fla. 2016).

best served when the statute is used to award fees to the policyholder, or any beneficiaries specifically designated by the policyholder at the time of contract formation—not sophisticated service providers and their attorneys.

However, as discussed in our previous paper, Florida courts have consistently expanded this interpretation to include non-insureds to whom an insured has given an assignment. Courts have also indicated that one policyholder can give multiple AOBs. Essentially, this transforms first party policyholder litigation into multiple third party litigation whereby each third party has the policyholder's rights, including the right to sue the insurer.

The Department of Financial Services' Service of Process ("SOP") database[4] provides a comprehensive look at both insurance litigation and the subset of that litigation which represents AOB suits. The database logs all lawsuits against insurers for which service of process is required.[5] Using specific search criteria, one may cull lawsuits filed against insurers by plaintiff, attorney, county, court, and date. AOB litigation often is denoted in the plaintiff field by "a/a/o," and since the first paper was written, it was learned that "assignee" and "aao" are also commonly used. Searching the SOP database for lawsuits by party using the terms "a/a/o," "assignee," and "aao" has provided an even deeper look into the scope and scale of AOB litigation in Florida. It is important to note that the SOP database is not representative of all AOB *claims*, as many claims never to make it to litigation. Rather, this only captures the amount of AOB claims that have ripened into litigation, whereby a notice of service of process was required.

This paper provides a summary of legal developments since October 2015 concerning AOBs, as well as enhanced data extracted from the Department of Financial Services' SOP database to empirically illustrate the ongoing use of AOBs across insurance markets.

AOB Case Law Update

Absent direction from the Legislature, Florida courts continue to enforce AOBs, placing the responsibility for change with the Legislature.

In *Bioscience West Inc. v. Gulfstream Property & Casualty Insurance Co.*,[6] the Second District Court of Appeal reaffirmed that Florida law prohibits an insurer from restricting an insured's post-loss

[4] https://apps.fldfs.com/LSOPReports/Reports/Report.aspx.
[5] § 624.423, Fla. Stat.
[6] 185 So. 3d 638 (Fla. 2d DCA 2016).

assignment of policy benefits. Armed with an AOB, a water mitigation company sued after the insurer denied coverage for the claim. The court rejected the insurer's argument that the policy prohibited post-loss assignments, based on the policy's language as well as the "unbroken string of Florida cases" holding that an insured has the right to assign post-loss claims without insurer consent. The insurer's public policy concern that post-loss assignments may allow service providers to unduly influence the adjustment process was misplaced, the Second District said. Such influence did not prevent the insurer from denying coverage, an option the court said was "available to any insurer if done in good faith."[7] The court also deemed it "imprudent to place insured parties in the untenable position of waiting for the insurance company to assess damages any time a loss occurs," as "insurance benefits represent the most ready means of paying for post-loss emergency repairs."[8] If competing policy considerations demanded a different result, the court said, those "policy considerations are for the legislature to decide, not our court."[9] A few months later, the Second District rejected almost identical arguments in *Start to Finish Restoration, LLC v. Homeowners Choice Property & Casualty Insurance Co.*,[10] continuing to adhere to the principle that post-loss insurance claims are freely assignable without insurer consent.

Allstate Indemnity Co. v. Markley Chiropractic Acupuncture, LLC[11] illustrates that AOB litigation is being driven by something other than the pursuit of unpaid benefits, and that multiple service providers may obtain AOBs under the same policy. In *Markley*, a chiropractor billed a personal injury protection ("PIP") insurer $3,522 and a diagnostic imaging center billed $165; the insurer paid $2,628.44 and $57.74, respectively, based on statutes limiting PIP reimbursement according to the Medicare fee schedule of maximum charges. The insured executed AOBs in favor of the chiropractor and diagnostic imaging center, who in turn sued the insurer. The dispute centered on whether the policy language sufficiently noticed the election to use the statutory Medicare fee schedule; the insurer won, but only after defending a full appeal.

The Fifth District Court of Appeal confirmed in *Restoration 1 CFL v. State Farm Florida Insurance Company*[12] that an AOB entitles the service provider to fully participate in a lawsuit to determine coverage under the policy. The trial court had previously rejected this view, observing that, based on the insured's deposition, the insured intended to retain control of her right to participate in the lawsuit.

---

[7] *Id.* at 643.
[8] *Id.*
[9] *Id.*
[10] 192 So. 3d 1275 (Fla. 2d DCA 2016).
[11] Nos. 2D14-3818, 2D14-6058, 2016 WL 1238533 (Fla. 2d DCA March 30, 2016).
[12] 189 So. 3d 340 (Fla. 5th DCA 2016).

On appeal, the Fifth District overruled this finding in the face of the "clear" language of the AOB, which had assigned all rights to the service provider.

In *Certified Priority Restoration v. State Farm Florida Insurance Co.*,[13] the Fourth District Court of Appeal rebuffed a service provider's attempt to resist the appraisal process provided for in the policy. The service provider argued that the trial court had erroneously compelled an appraisal with the named insured and not the assignee service provider. The Fourth District affirmed, noting that the policy did not preclude assignment of benefits, including the appraisal process, to a service provider and thus the trial court appropriately compelled appraisal.

One type of anti-assignment provision has been upheld. In *La Ley Recovery Systems-OB, Inc. v. United Healthcare Insurance Co.*,[14] the Third District upheld a health insurance policy's provision prohibiting reimbursement for third parties that had been assigned benefits under the policy by a physician. Although the policy's payment of benefits provision permitted a subscriber to assign benefits to the provider upon written authorization, the court said that the provision specifically precluded the physician or other provider from further assigning the benefits to third parties, such as La Ley.

Other Considerations

AOBs Also Affect the Nonadmitted Market

Section 626.9373, Florida Statutes, contains a nearly identical fee-shifting provision in the context of surplus lines insurers. Just like the one-way attorney fee statute in section 627.428, this statute entitles the named or omnibus insured or named beneficiary of a policy to reasonable attorney's fees "[u]pon the rendition of a judgment or decree by any of the courts of this state" in its favor. Although section 626.9373 applies to surplus lines insurers and section 627.428 applies more broadly to "insurers,"[15] the statutes are otherwise applied identically.[16] Consequently, if section 627.428 is amended to exclude third parties like service providers from the protection of the unilateral attorney's fee, section 626.9373 should likewise be amended.

[13] 191 So. 3d 961 (Fla. 4th DCA 2016).
[14] 193 So. 3d 16 (Fla. 3d DCA 2016).
[15] *Century Sur. Co. v. Korkoske*, 8:14-CV-616-T-23MAP, 2014 WL 8844500, at *1 n.4 (M.D. Fla. July 14, 2014).
[16] *See Arvat Corp. v. Scottsdale Ins. Co.*, 14-CV-22774, 2016 WL 5795122, at *2 n.3 (S.D. Fla. Sept. 12, 2016), *report and recommendation adopted*, 14-CV-22774, 2016 WL 5661633 (S.D. Fla. Sept. 30, 2016) ("Because they are virtually the same, whether the fees are predicated upon Florida Statute § 626.9373 or § 627.428 is a distinction without a difference. These two fee-shifting statutes are applied using the same analytical framework and require an award of fees to the prevailing insured in coverage matters.").

One Insurance Policy Can Often Be the Source of Multiple AOB Claims

Exacerbating the problems with post-loss AOBs is that multiple AOBs (and multiple lawsuits) may arise from a single policy or even a single claim because insureds may assign their post-loss rights to multiple service providers.

Ordinarily, an insured's unconditional AOB deprives the insured of standing to sue the insurer.[17] That is because, "once transferred, the assignor no longer has a right to enforce the interest because the assignee has obtained all rights to the thing assigned."[18] Thus, in the typical case, only one party can own a claim and maintain a lawsuit under the policy, and with an unconditional AOB given to a service provider, that right belongs to the provider.[19] This is so even though the insured may continue to be on the hook to perform post-loss duties under the policy.[20]

That said, it is clear that multiple AOBs may arise under the same policy and potentially from a single claim. For instance, in *Allstate Indemnity Co. v. Markley Chiropractic Acupuncture, LLC*,[21] the insured executed two AOBs under a single PIP policy—one to the insured's chiropractor and another to a diagnostic imaging center, for different claims made under the PIP policy. Such AOBs are typically treated as partial in nature, with each assignment to a particular service provider bestowing only the right to pursue a claim associated with that provider's work.

To defend against partial AOBs, insurers often cite a line of cases for the proposition that a partial assignment cannot be enforced against a "debtor"—such as the insurer—without the debtor's consent or joining all persons entitled to the various parts of the debt in an equitable proceeding.[22] In more recent reported decisions, Florida courts have declined to rule on the issue of whether a partial assignment is valid,[23] although the Second District has opined that the case law barring partial assignments "would likely be subsumed in this context by Florida's longstanding precedent that insurance policy benefits are freely assignable, even without the insurer's consent."[24]

---

[17] *Olgesby v. State Farm Mut. Auto. Ins. Co.*, 781 So. 2d 469 (Fla. 5th DCA 2001).
[18] *Continental Cas. Co. v. Ryan Inc. E.* 974 So. 2d 368, 376 (Fla. 2008).
[19] *See id.*; *Livingston v. State Farm Mut. Ins. Co.,* 774 So. 2d 716, 718 (Fla. 2d DCA 2000); *Garcia v. State Farm Mut. Ins. Co.*, 766 So. 2d 430, 432-433 (Fla. 5th DCA 2000).
[20] *Citizens Prop. Ins. Corp. v. Ifergane*, 114 So. 3d 190, 196 (Fla. 3d DCA 2012).
[21] Nos. 2D14-3818, 2D14-6058, 2016 WL 1238533 (Fla. 2d DCA March 30, 2016).
[22] *See Space Coast Credit Union v. Walt Disney World Co.*, 483 So. 2d 35, 36 (Fla. 5th DCA 1986).
[23] *Start to Finish Restoration, LLC v. Homeowners Choice Prop. & Cas. Ins. Co.*, 192 So. 3d 1275, 1276 n.1 (Fla. 2d DCA 2016); *One Call Prop. Servs. Inc. v. Sec. First Ins. Co.*, 165 So. 3d 749, 755 (Fla. 4th DCA 2015).
[24] *Start to Finish Restoration*, 192 So. 3d at 1276 n.1.

Thus, courts seem willing to honor multiple, partial AOBs which permit numerous providers to sue an insurer pursuant to the same policy, and case law barring partial assignments may no longer be a refuge for insurers. Moreover, even though most AOBs should deprive the insured of a right to sue, that does not necessarily prevent an insurer from having to defend against multiple lawsuits from holders of AOBs as well as the insured.

For instance, one Florida insurer reported to the Institute anecdotally of eight instances in which it has had to defend against multiple suits regarding the same claim under the same policy:

- Six of these instances involved two lawsuits resulting from one claim (i.e., one lawsuit filed by the holder of an AOB and one lawsuit filed by the insured)
- One instance involved four lawsuits arising out of one claim (three AOB lawsuits and one lawsuit by the insured)
- One instance involved three lawsuits arising from one claim (two AOB lawsuits and one lawsuit by the insured)

Citizens Property Insurance Company shared similar stories. For instance, in one case Citizens was confronted with two suits by holders of AOBs resulting from one claimed loss—one suit by a plumber and the other by a mitigation company. The AOB in favor of the plumber was executed two years after the loss. In another case, one claimed window leak gave rise to three AOBs and consequently individual lawsuits by a mitigation company, a mold testing company, and a mold remediation company. Citizens also reported numerous instances in which the insured filed its own lawsuit against Citizens, in addition to lawsuits filed by multiple AOB holders such as mold remediation and water mitigation companies.

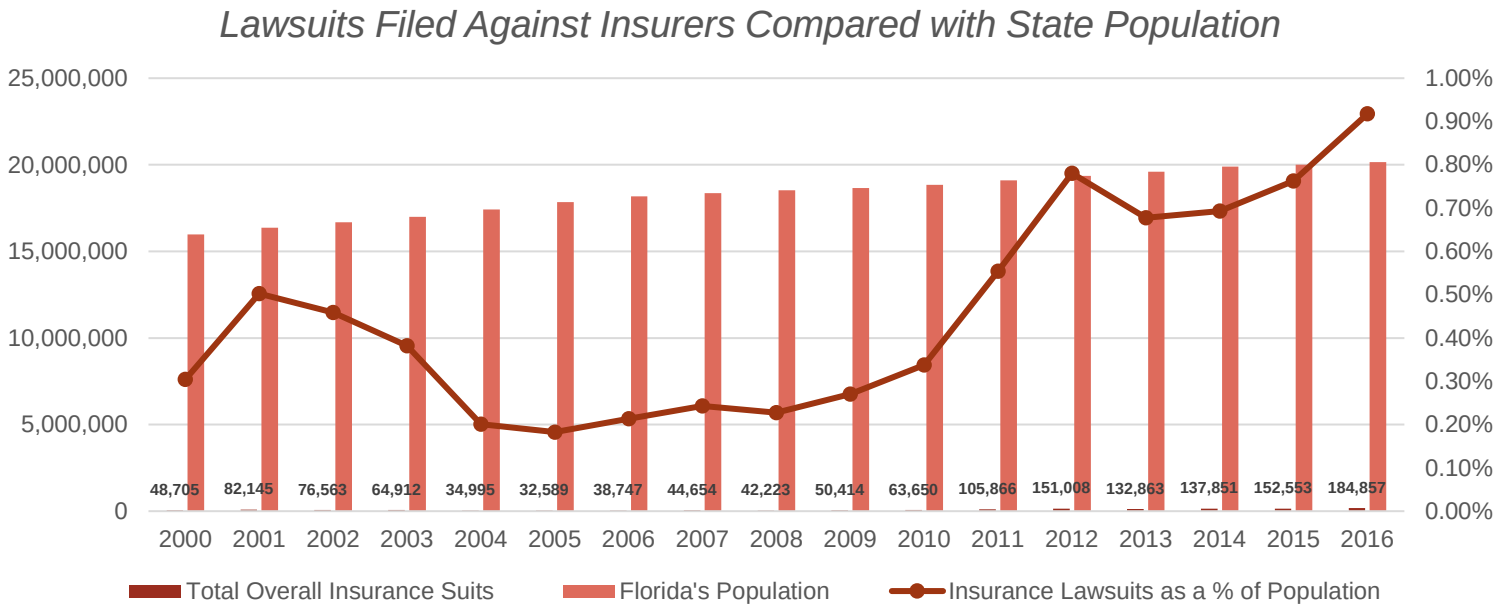
Insurance & AOB Litigation Continues to Increase Rapidly

Overall, the SOP database demonstrates an increase in Florida's litigiousness as it relates to insurers. From 2000 to 2016, Florida's population has increased by 26%,[25] while total litigation filed against insurance companies has increased by approximately 280%.[26]

[25] The author estimates Florida's 2000 population at 15,982,824 and its 2016 population at 20,148,654. *See* http://edr.state.fl.us/Content/population-demographics/data/MSA-2016.pdf.
[26] The SOP database reflects total overall suits at 48,705 in 2000 and 184,857 in 2016.

There are significant peaks leading up to 2001 and 2012, both which decline rapidly thereafter. We attribute this to the passage of PIP reform in the 2001 and 2012 legislative sessions, which is explored in more detail later in this paper. In addition, the litigation trend begins to spike again around 2014, which coincides with anecdotal information presented by insurers and other stakeholders alleging a dramatic increase in property insurance and auto glass AOB litigation, also explored in more detail later in this paper.

Regarding AOB lawsuits particularly, our data has been updated to include 2015 and 2016 information. Additionally, new search terms were identified and utilized to get a fuller picture of AOB litigation trends; while our previous paper searched by plaintiff term "a/a/o," a frequently used term in



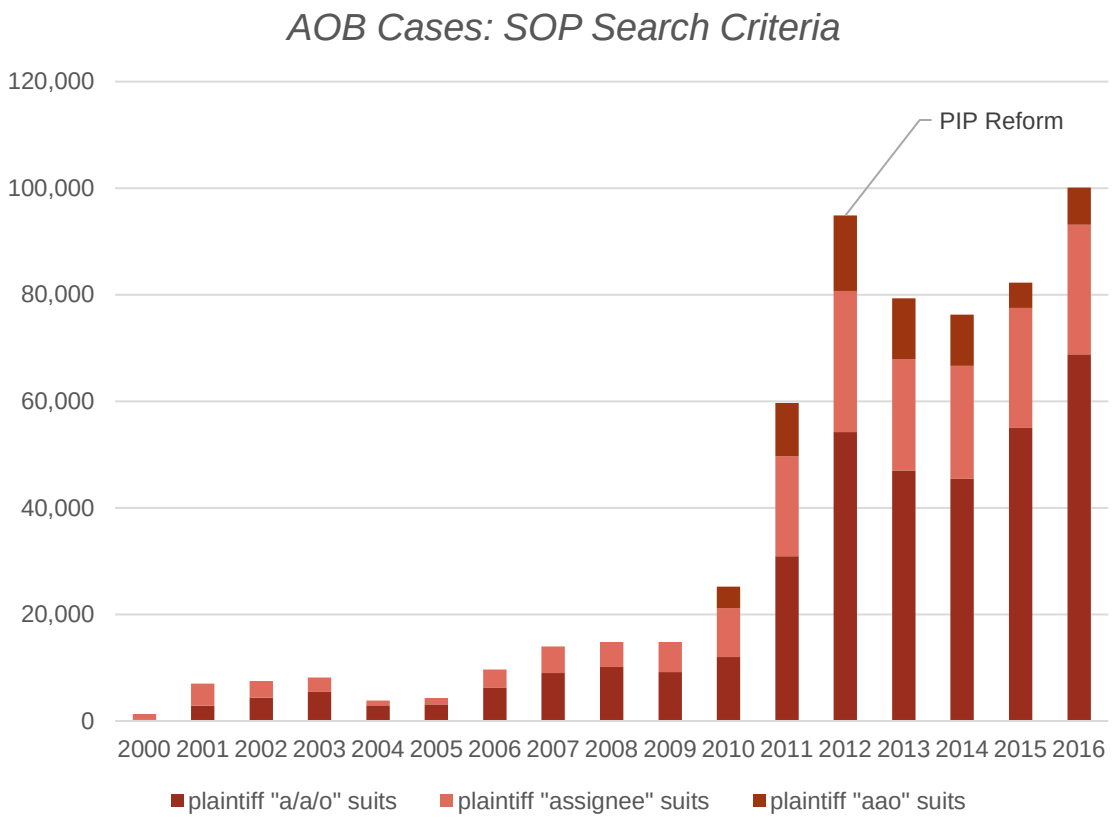
case styles denoting "as assignee of," we have discovered that many lawsuits also use the full phrase, necessitating searching by the word "assignee," while other lawsuits omit the backslashes in "a/a/o" and simply use "aao."

While we discovered the use of "assignee" last year and updated our data accordingly, we recently began using "aao" as a search term. Unfortunately, sometime in late 2016, the Department of Financial Services cleared data prior to 2010, meaning we were unable to cull cases prior to that date that included the plaintiff term "aao."[27] For cases from 2010 and on, that term is now included. Below

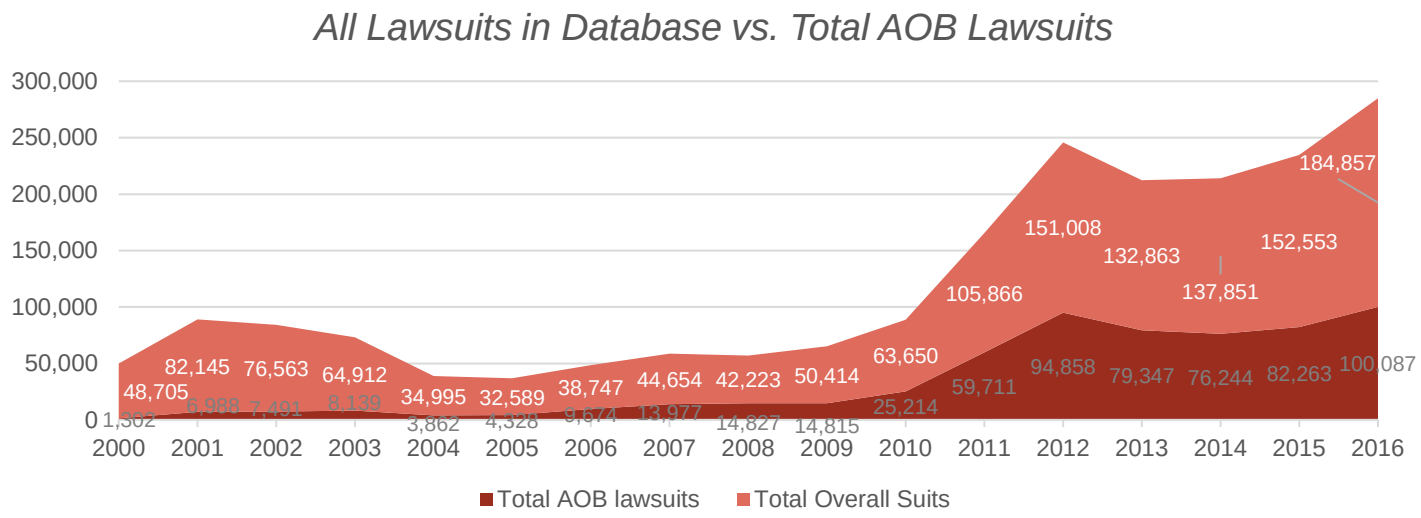
[27] State agencies are only required by law to store public records for a certain number of years. It is our understanding from the Department that older records were cleared to preserve information storage availability and reduce associated storage costs, and that this was done in accordance with Chapter 119, Florida Statutes, and all applicable rules.

is a chart displaying the multiple search criteria used to identify AOB cases. Because “aao” is a more infrequently used abbreviation, and because AOB litigation was less common prior to 2010, we do not believe that its omission in years prior to 2010 is significant.

A search of AOB litigation demonstrates sharp increases in AOB litigation corresponding with the “PIP Crisis”[28] for which legislation was crafted in response prior to 2012. For example, from 2010 to 2011, AOB litigation increased by over 66%. From 2012 to 2013, after the PIP legislation became effective, a decline of 12% is noted. Later, corresponding to public conversations about the increase in the use of AOBs in property insurance and auto glass litigation, an increase of 10.7% is seen from 2014 to 2015 and a subsequent increase of over 21% is seen from 2015 to 2016.

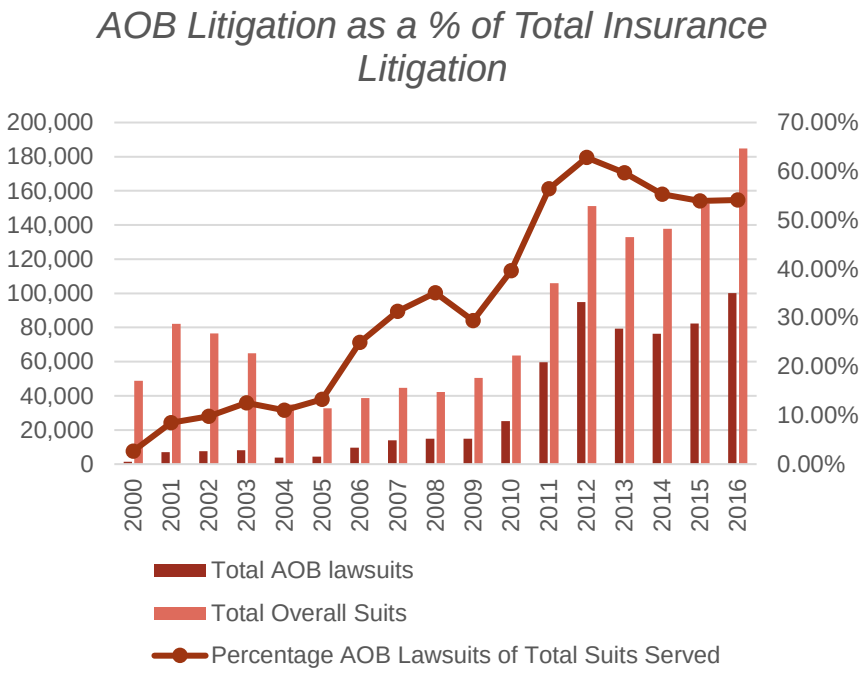


[28] Office of Insurance Regulation, *Cabinet Presentation—Personal Injury Protection*, August 2011, http://floir.com/siteDocuments/PIPPresentation08162011.pdf



The ebbs and flows of insurance litigation are most visible when viewed as a percentage of overall insurance litigation, as seen on this page.

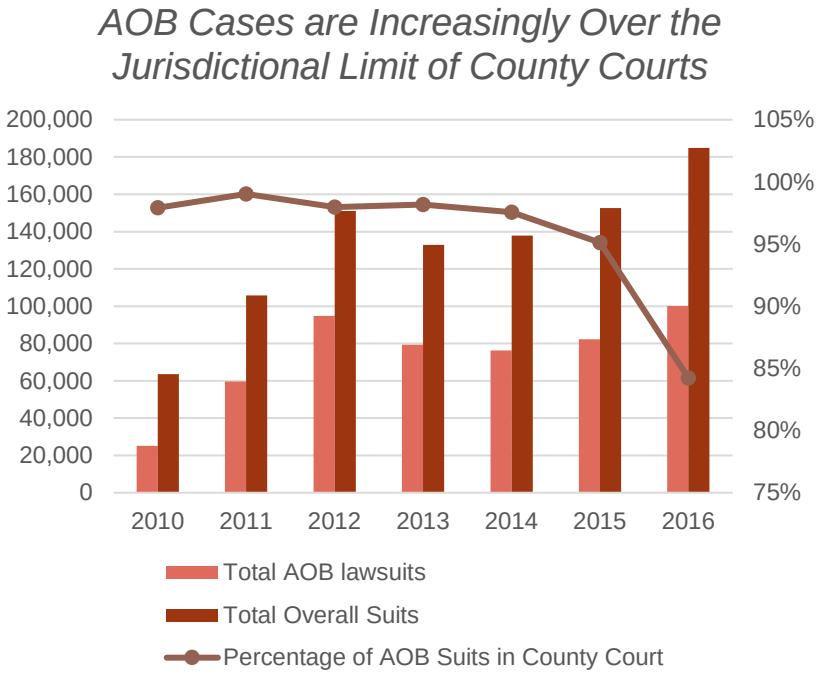
In Florida, lawsuits involving an amount in controversy of $15,000 or less—exclusive of interest, costs, and attorney's fees—must be filed in county court.[29] Therefore, searching county court records is a meaningful way to identify low value cases, and cases involving relatively low amounts of coverage. PIP suits, wherein the value of the insurance coverage does not exceed $10,000, are a good example.[30]



The interesting dynamic is that while the overwhelming majority of AOB cases are relatively low value cases filed in county court, the available attorney's fees in these cases are essentially unlimited. In the absence of a fee-shifting statute, plaintiff's lawyers are often compensated through a contingency fee arrangement, whereby an attorney agrees to take a percentage of the total proceeds secured

[29] § 34.01, Fla. Stat.
[30] *See* § 627.736, Fla. Stat.

for his client as his fee.[31] However, in these cases, a prevailing plaintiff's attorney is entitled to collect his fee from the losing insurer under the one-way attorney fee statute, and the statute imposes no limitation on attorney's fees. Instead, the attorney is able to submit the entirety of his bill, most often calculated on an hourly basis, for payment by the losing insurer.

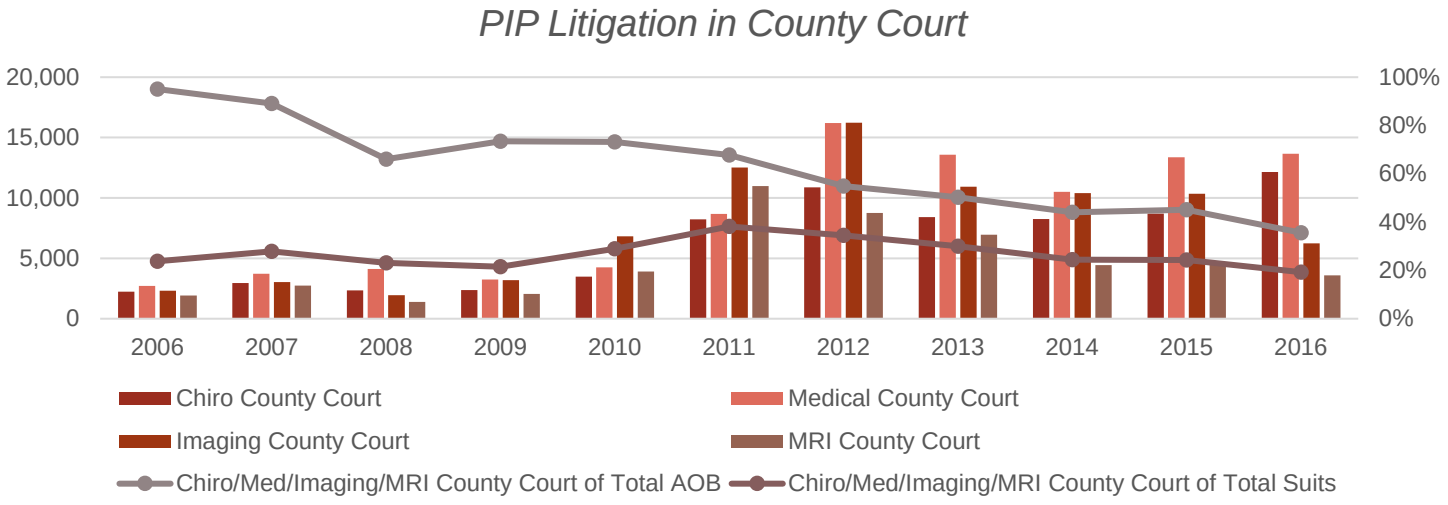


While section 627.428, Florida Statutes, speaks to a "reasonable sum as fees or compensation," anecdotal and empirical evidence suggests an imbalance between the amount secured by an attorney for his client and the amount secured by an attorney for his own fees. In our last paper, we reviewed claim surveys sent to insurers and found that, based on that sample, attorney's fees represented an average of 274% of the total amount paid to the assignee on the insurance claim.[32]

SOP data also demonstrates that AOB cases are becoming more expensive. This could be attributable to a number of factors, but one that is particularly apparent to us is that, due to a decline in the number of PIP cases as a result of the 2012 PIP reform, other AOB cases, such as against property insurers, have filled the void. Given that property insurance coverage amounts are more expensive, claims are correspondingly higher.

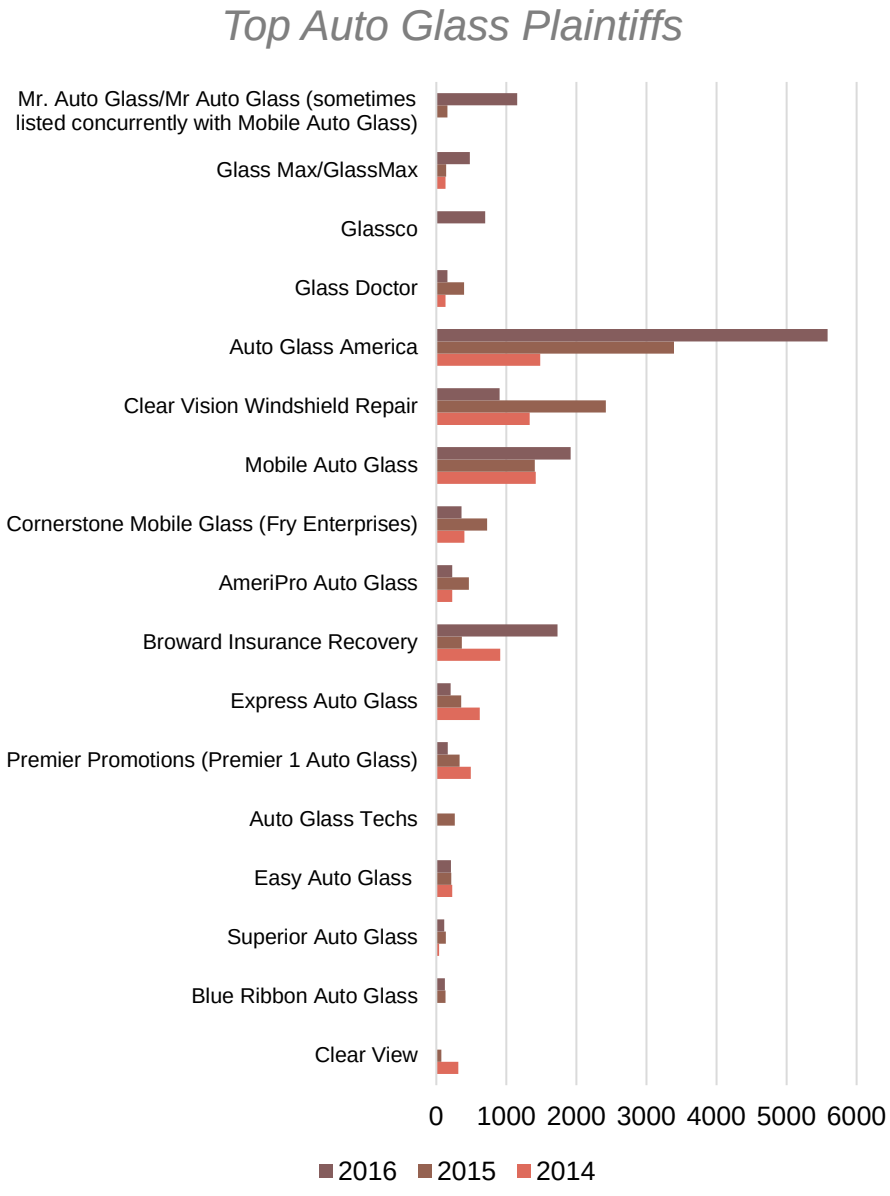
A more in-depth look at litigation (below) from common PIP providers—including chiropractors, imaging/MRI centers, and medical providers—appears to support this connection. Cases brought by these service providers have become a smaller share of both total AOB litigation and of county court litigation. Because PIP is first party coverage, the mere fact that litigation on a PIP policy is initiated by a chiropractor, imaging/MRI center, or medical provider means that an AOB under the PIP policy was given to that respective provider or center.

[31] *See* R. Regulating the Fla. Bar 4-1.5(f)(1)-(2); *see also Brickell Place Condo. Ass'n v. Joseph H. Ganguzza & Assocs., P.A.*, 31 So. 3d 287, 290 (Fla. 3d DCA 2010).
[32] *See Restoring Balance*, page 16.



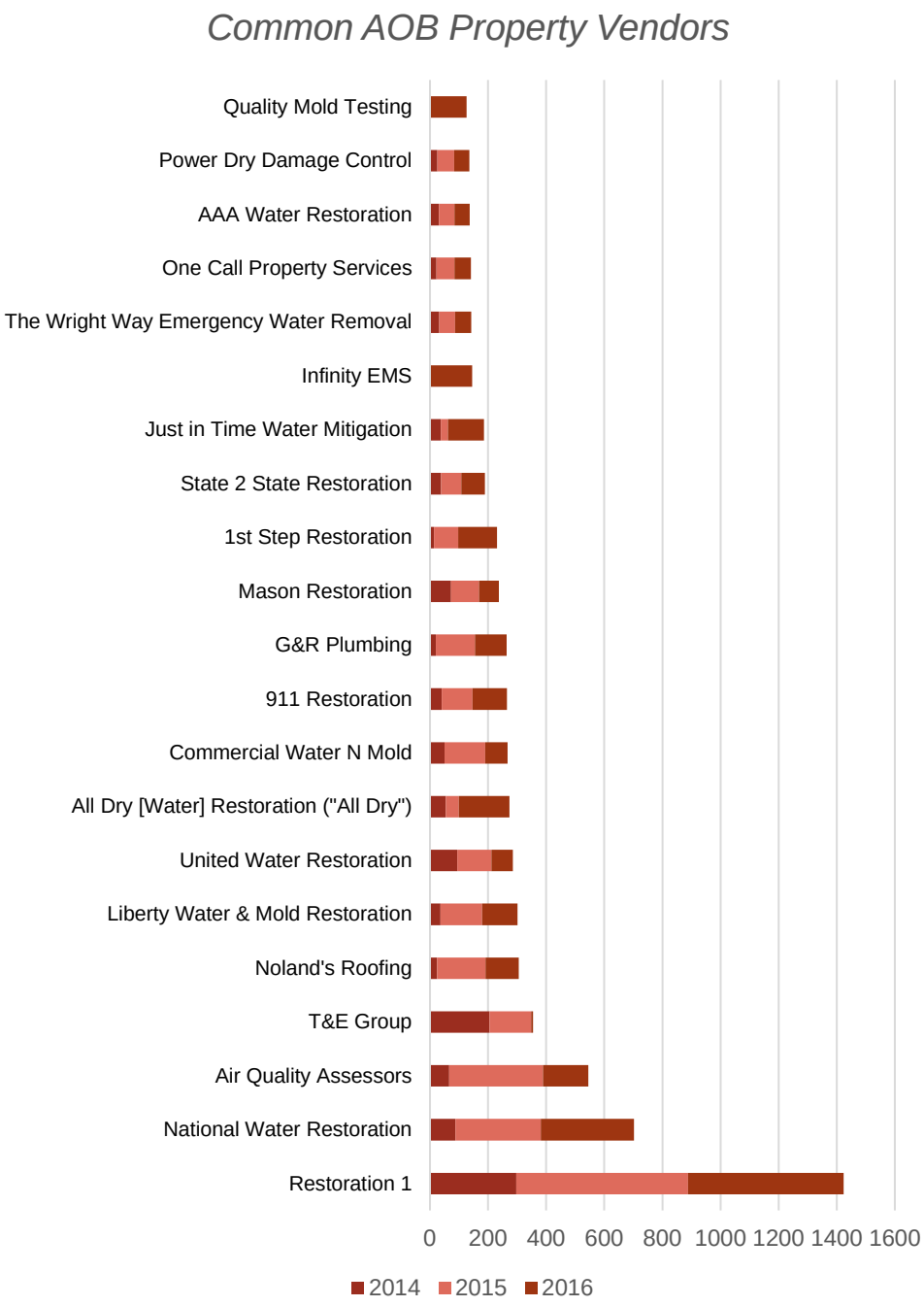
AOB Litigation is Concentrated within a Small Subset of Vendors & Attorneys

Litigation involving AOBs is unique in that it is abundant, yet derives from a very small set of attorneys, law firms, and vendors. Given that PIP reform has typically been discussed in a separate conversation than this, we have not focused on those vendors (e.g., imaging/MRI centers, chiropractors, etc.) here.



However, our review of the data shows identical trends in PIP as it does in auto glass and property, in that a few vendors file hundreds, sometimes thousands, of AOB cases each year. Contained herein is information about common plaintiffs in both auto glass and property litigation that were identified as part of our review of

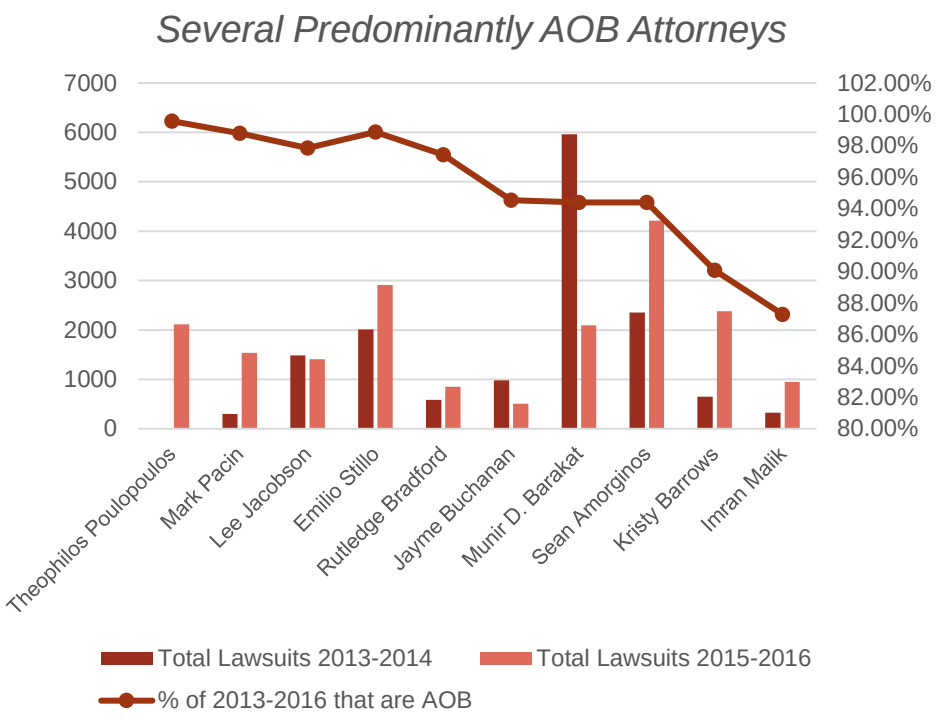
the SOP data. Interestingly, data provided by Safelite Solutions,[33] a claims management solutions provider for many large auto insurance companies, saw 218,114 auto glass claims in 2015 and 251,676 in 2016. Of those claims, for both years, less than 15% of those claims came from the vendors below, as well as others that overwhelmingly sue insurers through AOBs. However, our review of the SOP data shows that these vendors represent almost all auto glass litigation in Florida. In other words, 85% of auto glass shops do not have to employ litigation in order to be reimbursed. Similar findings can be made in the property insurance marketplace as well, as shown here.



Logically, it follows that the lawyers involved in these cases are similarly a small group of individuals who also file a great deal of lawsuits each year. In the chart on the next page, 7 of the 10 attorneys listed filed thousands of cases in a two-year period. Additionally, these are all lawyers whose cases are predominantly AOB cases, and therefore the representation is on behalf of vendors rather than policyholders. Nearly 25%[34] of ALL AOB cases—from PIP to auto glass to property—filed in Florida between 2013 and 2016 were filed by 11 attorneys. These lawyers predominately represent property insurance service firms, auto glass

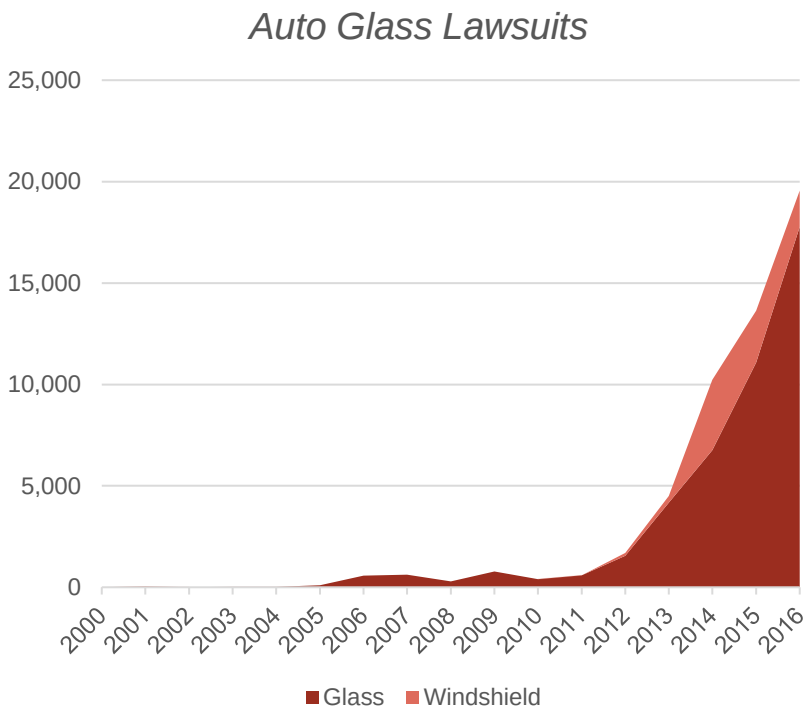
[33] https://www.safelitesolutions.com/
[34] 23.53%.

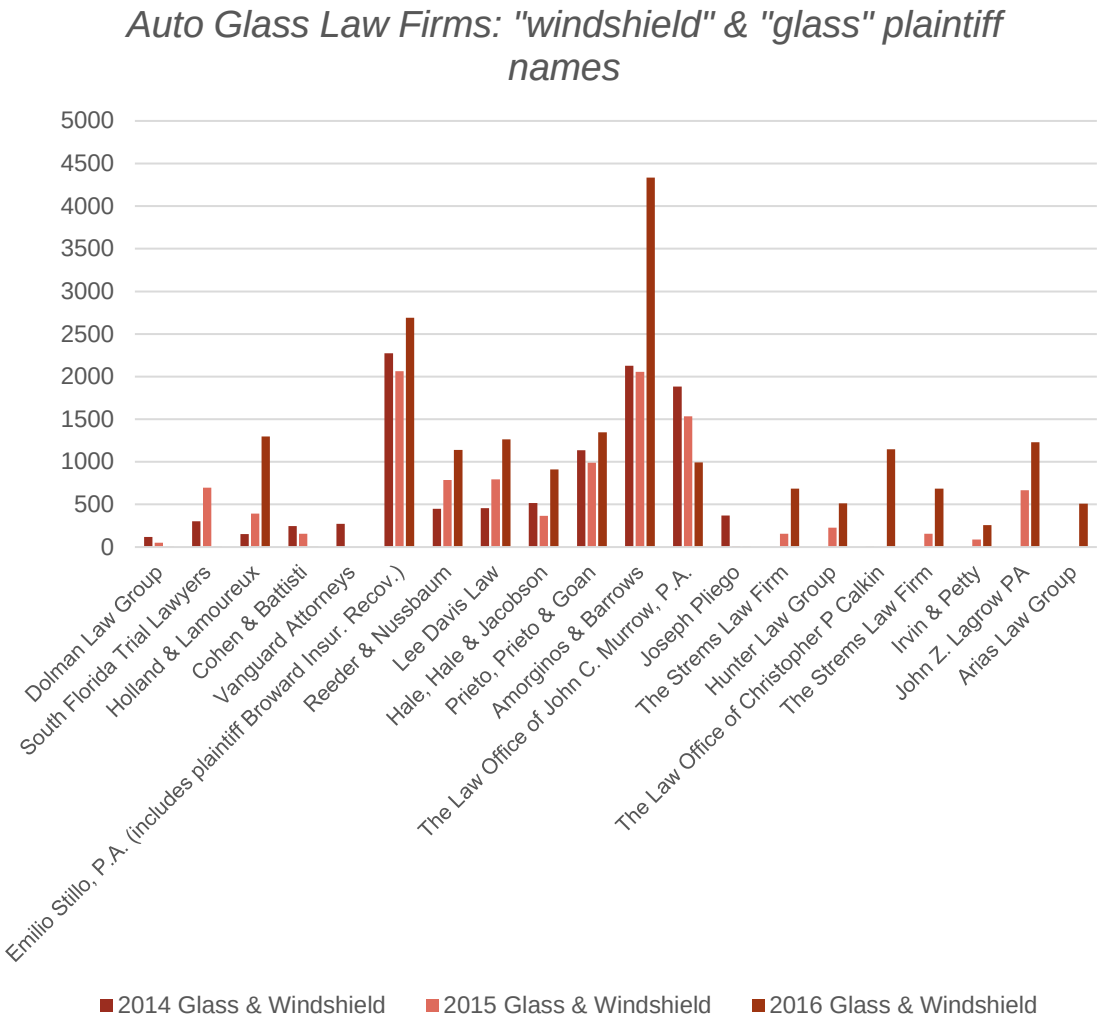
repair shops, and PIP providers. Ten of these attorneys are shown in the next chart.



The eleventh attorney, and also the attorney who has filed far and away the most AOB lawsuits that we could identify, is Todd Landau with Landau & Associates, who filed 20,386 lawsuits from 2013 to 2014 and 31,792 from 2015 to 2016, with AOB cases representing 96.22% of those. A review of Mr. Landau's data from the SOP database indicates that his practice is predominantly PIP-oriented.

Auto glass litigation provides us a compelling look at the AOB problem because searching for "glass" and "windshield" plaintiff names provides us a near comprehensive picture of that subset of litigation, whereas property insurance vendors can take many different names, from construction to emergency (which is also commonly used for PIP vendors), carpet, dry, restoration, mitigation, remediation, and the like. The finite nature of the search terms in auto glass litigation allows us to, with a great deal of confidence, extrapolate trends and numbers. Like PIP and property, auto glass coverage is a first party coverage. Therefore, when a plaintiff's name includes "auto glass,"





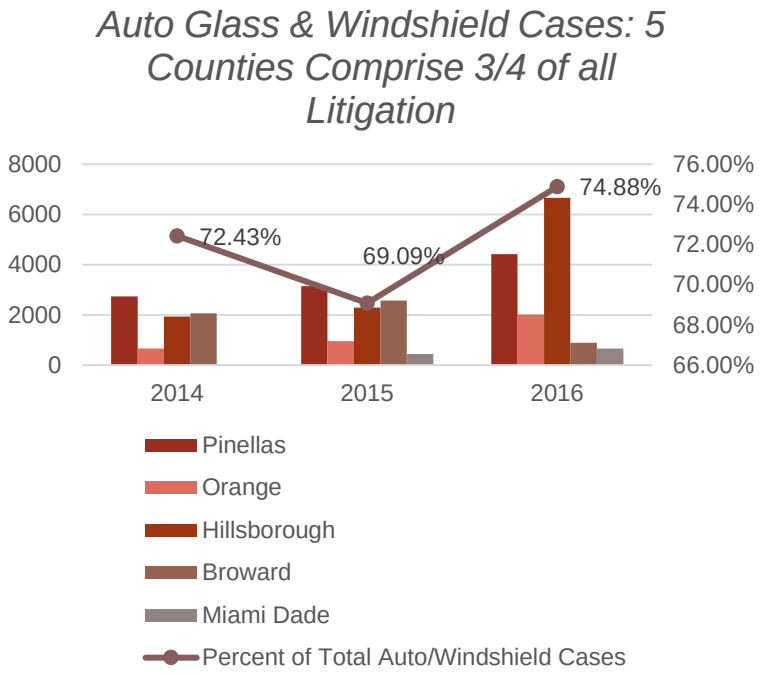
"glass" (except for last names), or "windshield," the policyholder has allowed a vendor to step into her shoes and litigate on her behalf.

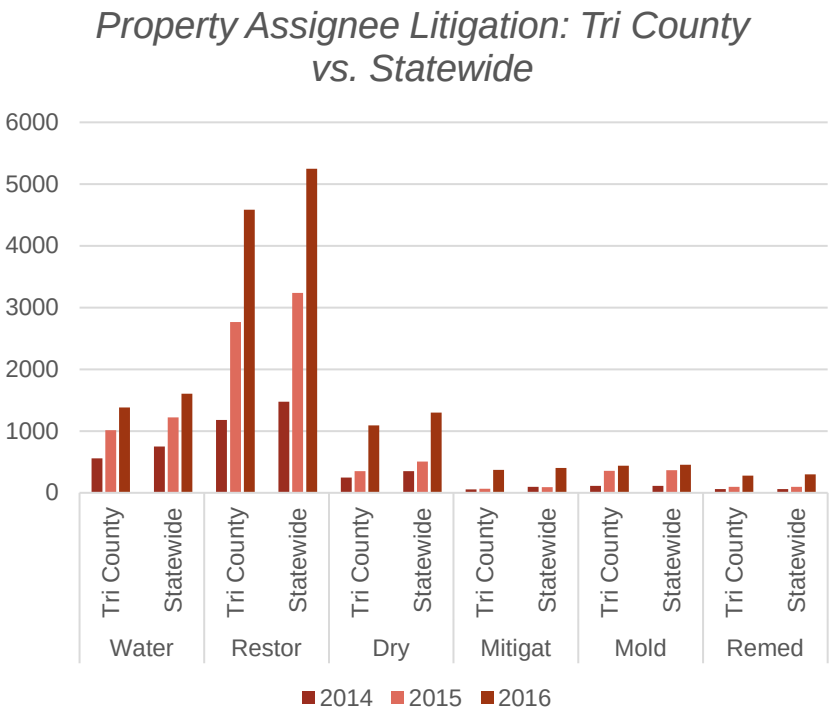
In this chart, we identified the most common glass and windshield attorneys and identified their respective firms, in order to provide a firmwide glimpse of auto glass litigation, instead of only a snapshot of the individual attorney's lawsuits. Again, this information shows the abundance of litigation coming from a small number of firms.

AOB Litigation is Localized

An expected byproduct of AOB litigation being from a small number of vendors and lawyers is that it is also localized. Data bears this out, and the chart below illustrates that three-quarters of auto glass litigation statewide comes from 5 counties.

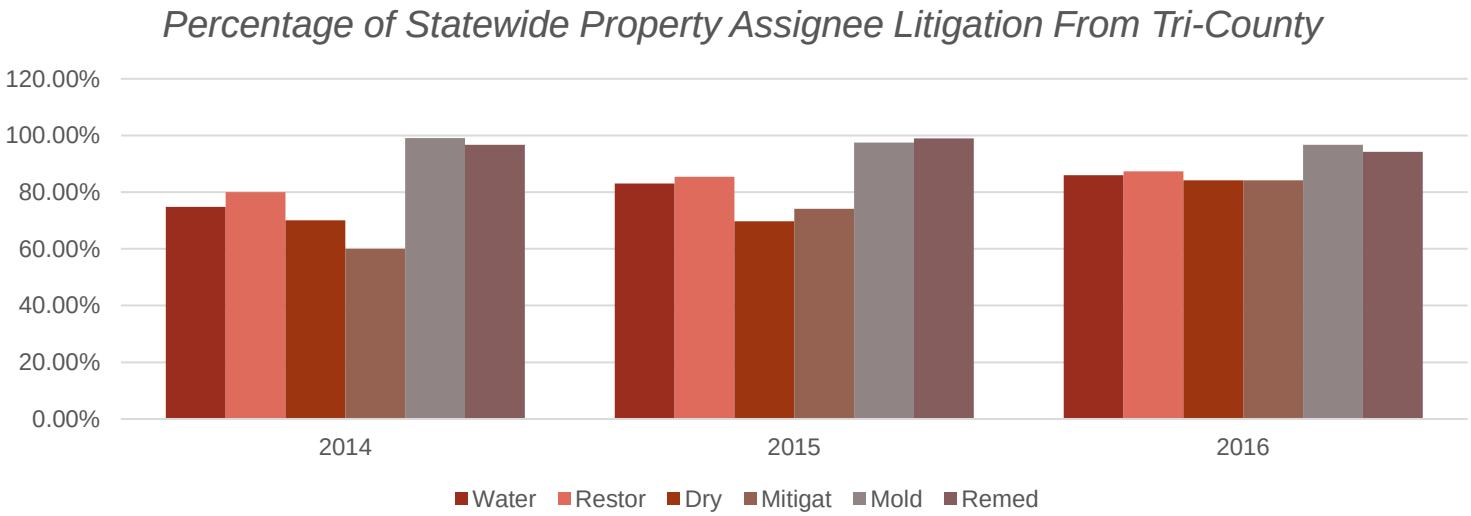
Similarly, AOB lawsuits initiated by vendors who provide water cleanup, restoration, drying, mitigation, mold detection, or remediation services were overwhelming concentrated in Palm Beach, Broward, and Miami Dade counties. On average,





80.12%, 84.83%, and 88.79% of litigation from these vendors was in the tri-county area in 2014, 2015, and 2016, respectively.

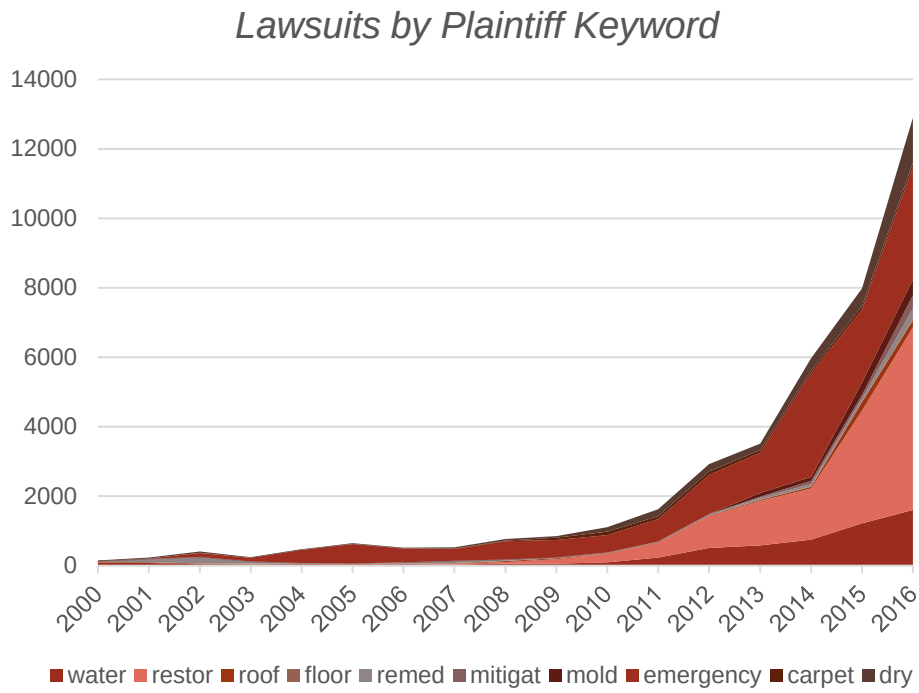
While we made attempts to determine the existence of severe weather over the last few years in the tri-county area, and similarly, any geological or meteorological event that may have caused windshields to break more frequently in these five counties, we have been unable to identify any explanation—except for litigation



incentives and changing dynamics in other markets that have caused litigation to spill into new markets—to explain these trends.

Property Insurance Litigation

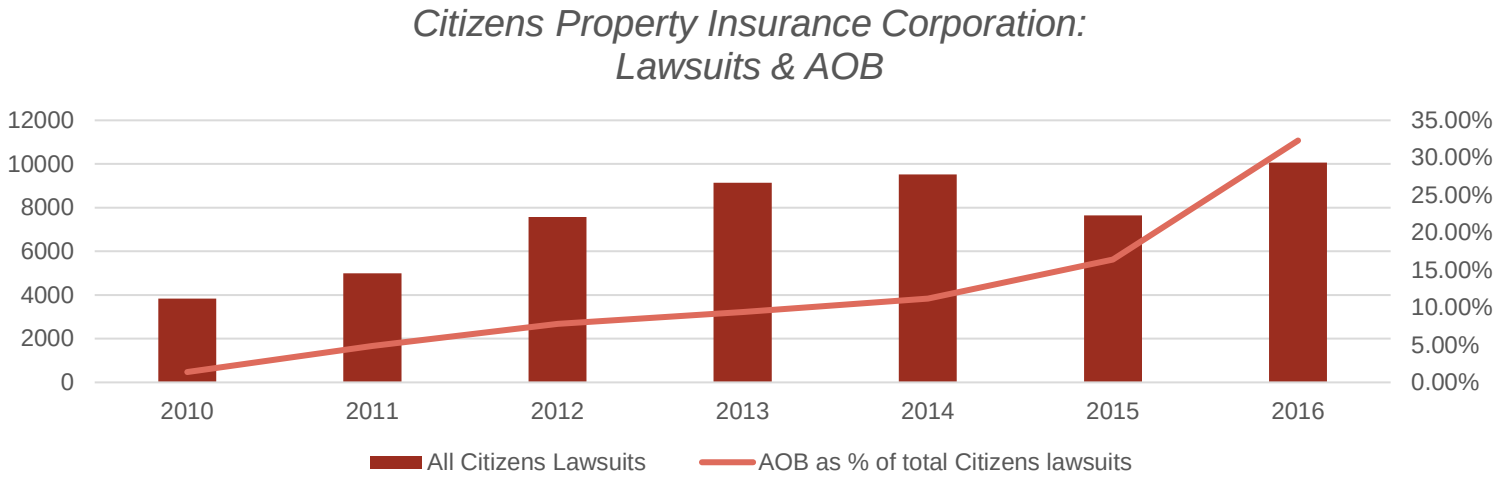
While this paper has discussed AOB litigation, the consistent usage of AOBs in PIP and the increasing utilization of AOBs in auto glass litigation, property insurance has been a particular focus of the Florida Legislature. The attention is warranted, as demonstrated by the increasing number of



lawsuits against property insurers brought by water, restoration, roofing, flooring, remediation, mitigation, mold, emergency,[35] carpet, and drying service vendors.

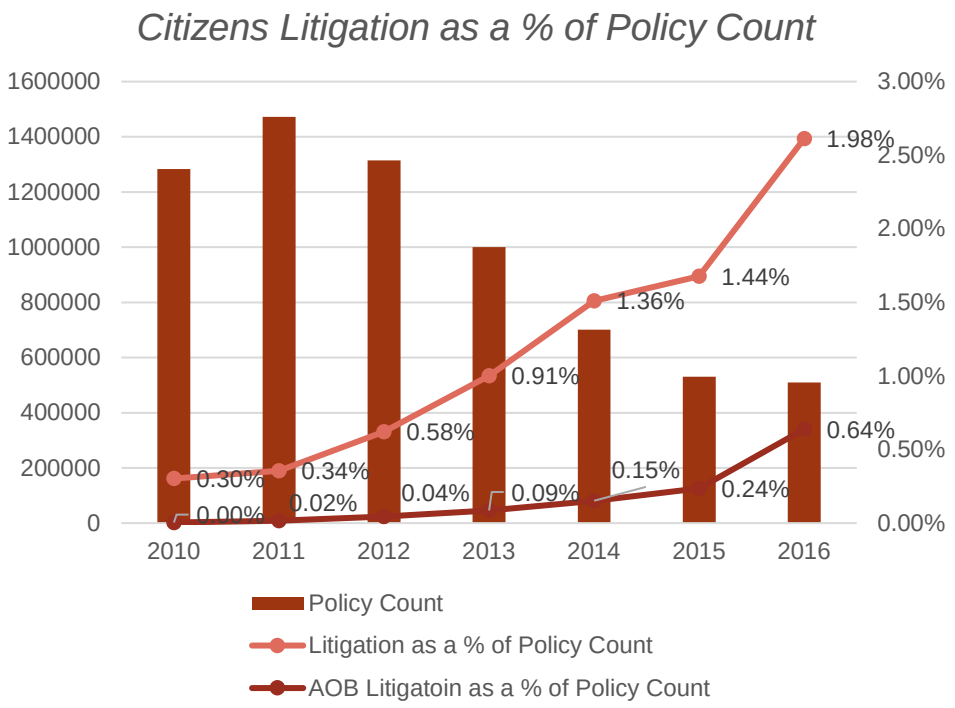
Due to property AOB litigation's concentration in the tri-county area, and because Citizens Property Insurance Corporation only writes property insurance, an analysis of SOP data specific to that insurer supports the supposition that property insurance AOB usage is increasing, it is far outpacing population growth, it is not attributable to events in years when significant weather events have occurred, and that overall litigiousness is also growing.

In fact, while Citizens' policy count has been shrinking, its litigation, including AOB litigation, has been increasing rapidly. We anticipate those in opposition to AOB reform to allege that this is due to changed claims behavior on behalf of this insurer; however, a look at AOB claims and litigation against



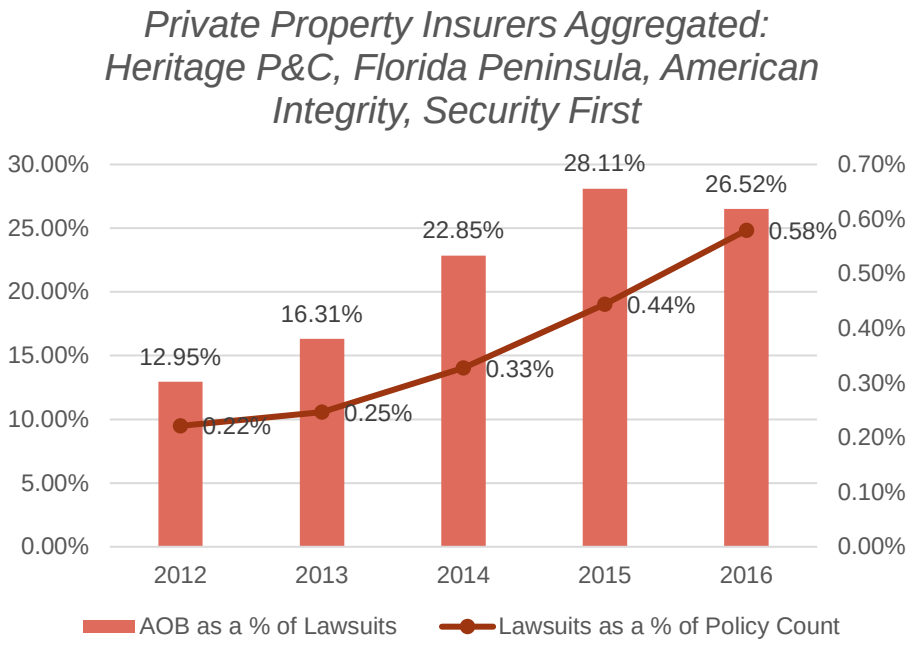
[35] "Emergency" is a common term for many vendors. It is pervasive in the property insurance litigation space, and is also common in PIP litigation. However, because we equally note the prevalence of this term in each year, the demonstrated increase in litigation is still accurate because we used consistent search methodology for each year.

other domestic property insurance companies bears similar trends. Therefore, in order for that claim to be true, it must also be true that every property insurer has made similar changes in claims behavior.



Therefore, to test the possible hypothesis that Citizens "could" be an outlier based on possible changes in its behavior, we also measured the experience of four private companies. As with Citizens, litigation data was measured against policy count to ensure a true comparison. What the graph below shows is that private property insurers are experiencing similar upticks in AOB litigation, and similar upticks in litigation as a percentage of policy count.

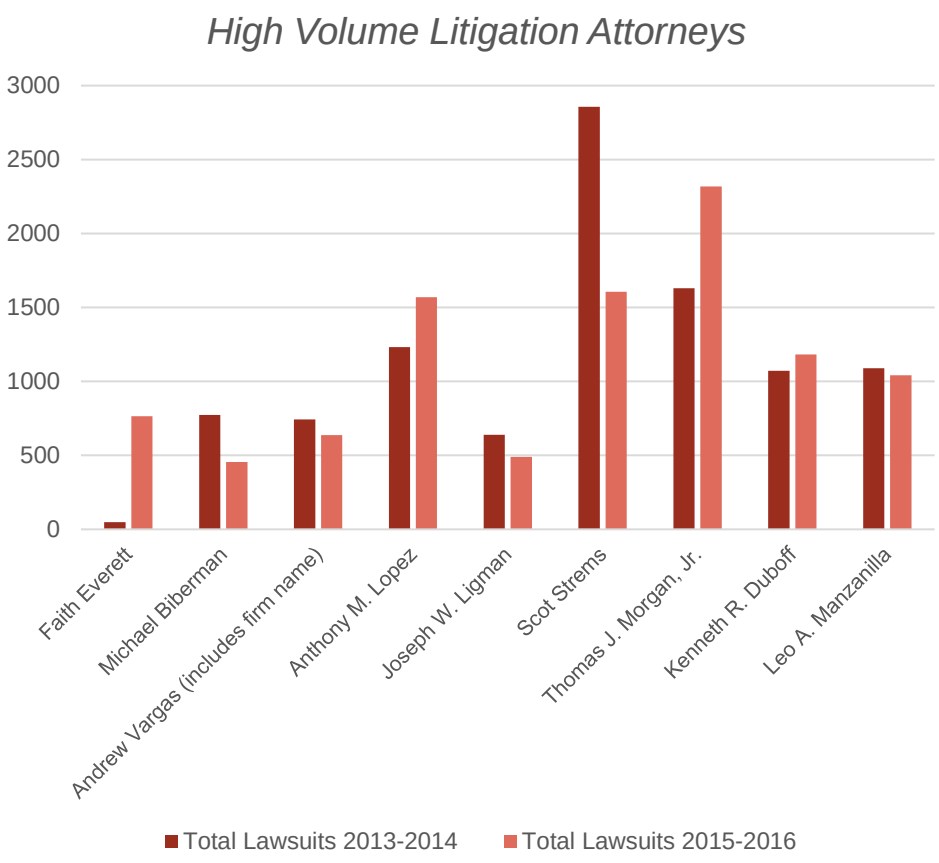
While Citizens' experience appears to be more acute in sheer volume than that of private insurers, much of that can likely be attributed to policy mix in various geographic regions. For example, Citizens *must* write certain policies whereby private insurers may exclude those policies in their underwriting guidelines. Based on a geographic analysis of property AOB litigation, we know that much of that is concentrated in the tri-county area. We also know that Citizens writes a disproportionate share of policies in that same tri-county area than in other areas of the state, which are more diversified with private carriers. However, because of the trendlines showing upticks in litigation generally as a percent of policy count, and in AOB litigation specifically, the



allegation that Citizens' litigation experience is different than the private market as a whole does not hold water.

Speaking of water, we cannot forego speaking about the general litigation problem experienced by property insurers, particular in the tri-county area concerning water loss claims,[36] as well as other first party litigation issues.

This is borne out by high volume litigation that is unassociated with AOBs and defies variation in policy counts, but that shares the localized, centralized nature of litigation brought by a small group of firms and in concentrated geographic areas. Many of the "high volume" attorneys on the chart below also filed AOB lawsuits; however, AOB does *not* represent more than *half* of their litigation volume.



The frequency of lawsuits within a small group of attorneys may demonstrate that there is a way to circumvent any 'fix' of the one-way attorney fee statute, whereby lawyers convince policyholders to file suit against their insurer in their own name, also allowing the attorney to collect one-way fees. However, we cannot argue that this would be against the spirit or intent of the one-way statute, in the way that AOB litigation is.

Notwithstanding this point, the fact that individual attorneys file close to a thousand, or more, lawsuits a year, may be an indication that some other type of imbalance currently exists. Because that is beyond the scope of this paper, we do not speculate on what that is, absent empirical research to support such a theory.

[36] Citizens Property Insurance Company/Barry Gilway, *ICA Forum: Finding a Balanced Approach to Florida's Water Loss Crisis*, June 2016, https://www.citizensfla.com/documents/20702/1633811/20160614_ICA+Forum/9310c827-eb99-4a03-9347-5504b05e40d0.

Conclusion

Despite the Florida Supreme Court's recent reminder that the one-way attorney fee statute is designed to "'level the playing field' between the economically-advantaged and sophisticated insurance companies and the **individual citizen**,[37]" courts continue to allow third party vendors to avail themselves of this statute, generating substantial sums of money in attorney's fees, which are unfortunately losses passed onto consumers.

This litigation-for-profit scheme permeates the property insurance, auto glass, and PIP marketplaces. While this scheme has been prevalent for many years in PIP, contributing significantly to the problems with that coverage over the years, it has recently been exported to the property and auto glass marketplaces. Often, consumers who are asked to sign AOBs are unaware of the full consequence of this transfer of rights.

Concurring with a number of courts that have encouraged legislative action on this topic, we believe it is critically important for the Legislature to return the one-way attorney fee statute to its original intent, as summarized above by the Florida Supreme Court, and affirm that it is a tool *exclusively designed* for policyholders/insureds.

[37] See footnote 3 (emphasis added).

The Florida Senate

Committee Agenda Request

To: Senator Doug Broxson, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: February 19, 2019

I respectfully request that **Senate Bill #: 754** relating to Motor Vehicle Insurance Coverage for Windshield Glass, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Linda Stewart

Senator Linda Stewart
Florida Senate, District 13

c.c. James Knudson, Staff Director
Sheri Green, Committee Administrative Assistant

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3.11.19
Meeting Date

754
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic inducements

Name Ashley Kalifeh

Job Title attorney

Address 101 E College Ave #302
Street

Tallahassee FL
City *State* *Zip*

Phone 222-9075

Email akalifeh@capcitycrowd.com

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Sufelite

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/19
Meeting Date

754
Bill Number (if applicable)

Topic Auto glass

Amendment Barcode (if applicable)

Name Logan Mcfaddin

Job Title Regional Manager

Address 215 S. Monroe St. Suite 720
Street

Phone 850 681 2615

Tallahassee FL 32301
City *State* *Zip*

Email logan.mcfaddin@apci.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing APCIA - American Property Casualty Insurance Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE

APPEARANCE RECORD

3-11-19
Meeting Date

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

S 754
Bill Number (if applicable)

Topic ~~AOP~~ Glass

Amendment Barcode (if applicable)

Name Bonny Gordon

Job Title Senior Counsel

Address ~~[illegible]~~ GEICO
Street

Phone 301-986-2653

Washington, DC
City *State* *Zip*

Email ~~bgor~~bgordon@geico.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing GEICO

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3-11-14
Meeting Date

754
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Windshield Glass

Name Michael Carlson

Job Title President/CEO

Address 2155 S. Monroe St. Ste. F35
Street

Tall. FL 32301
City *State* *Zip*

Phone 850 597 7425

Email Michael.carlson@pifi.net

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing The Personal Insurance Federation of Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/19
Meeting Date

754
Bill Number (if applicable)

Topic Windshield Glass

Amendment Barcode (if applicable)

Name Beth Vecchioli (pronounced Vetch-ee-o-lee)

Job Title Sr. Director Gov't. Consulting

Address 255 S. Monroe St, Ste 500
Street

Tallahassee, FL
City *State* *Zip*

Phone 850-425-3393

Email bvecchioli@carltonfields.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing National Association of Mutual Insurance Companies

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

March 11, 2019
Meeting Date

SB 754
Bill Number (if applicable)

Topic Windshield

Amendment Barcode (if applicable)

Name Bruce Kershner

Job Title

Address 231 West Bay Ave
Street

Phone 407 830 1882

Longwood FL 32750
City *State* *Zip*

Email BKershner@att.net

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☒ Against
(The Chair will read this information into the record.)

Representing Southeast Glass Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/19
Meeting Date

754
Bill Number (if applicable)

Topic WINDSHIELD GLASS

Amendment Barcode (if applicable)

Name KEITH SEAMANN

Job Title GLASS REPLACEMENTS LLC

Address 6034 CHESTER AVE STE. 208
Street

JACKSONVILLE FL. 32217
City *State* *Zip*

Phone 904.608.3940

Email KEITH.SEAMANN@GMAIL.COM

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing GLASS REPLACEMENTS LLC

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	CS/SB 1070
INTRODUCER:	Banking and Insurance Committee and Senator Lee
SUBJECT:	Continuing Care Contracts
DATE:	March 12, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.			CF	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1070 revises provisions within ch. 651, F.S., of the Insurance Code governing continuing care retirement communities (CCRC) or providers, which are regulated by the Office of Insurance Regulation (OIR). The CCRCs provide lifelong housing, household assistance, and nursing care in exchange for a significant entrance fee and monthly fees. The CCRCs appeal to older Americans because they offer an independent lifestyle for as long as possible but also provide the reassurance that, as residents age or become unable to care for themselves, they will receive the additional care they need.

The bill provides the following changes relating to CCRCs:

Regulatory Oversight

- Creates an early intervention system, based on the CCRC's performance, designed to identify, mitigate, or resolve financial issues so that a provider may avoid bankruptcy, as well as protect the interests of the residents. The bill revises monthly, quarterly, and annual reporting by CCRCs to provide more relevant and timely information about financial performance.
- Imposes an express duty on CCRCs to produce records during an examination and gives the OIR standing to petition a court for production of such records.
- Authorizes the OIR, under certain conditions, to issue an immediate suspension order on a CCRC as well as cease and desist order on a person that violates specified laws.

- Revises and streamlines provisions of law relating to applications for licensure and acquisition of a CCRC.
- Provides additional authority for the OIR to disapprove and remove unqualified management.

Protections and Transparency for Residents

- Requires providers to make additional information, notices, and reports available to the residents or residents' council.
- Revises the current process for the resolution of resident's complaints to provide greater transparency regarding the process.
- Revises the membership of the Continuing Care Advisory Council to increase the number of resident members from three to four.

The bill does not have a fiscal impact on the Office of Insurance Regulation.

The bill provides an effective date of July 1, 2020.

II. Present Situation:

Continuing Care Retirement Communities (CCRC)

A provider or a CCRC offer shelter and nursing care or personal services upon the payment of an entrance fee.[1] The CCRCs offer a transitional approach to the aging process, accommodating residents' changing level of care. A CCRC can include independent living apartments or houses, as well as an assisted living facility or a nursing home. The CCRCs may also offer at-home programs that provide residents CCRC services while continuing to live in their own homes until they are ready to move to the CCRC.[2] A CCRC enters into contracts with seniors (residents) to provide housing and medical care in exchange for an entrance fee and monthly fees. Entrance fees are a significant commitment by the resident as entrance fees range from around $100,000 to over $1 million.

Regulation of CCRCs

In Florida, regulatory oversight responsibility of CCRCs is shared between the Agency for Health Care Administration (AHCA) and the Office of Insurance Regulation (OIR).[3] The OIR regulates CCRC providers[4] as specialty insurers. The AHCA regulates aspects of CCRCs related to the provision of health care, such as nursing facilities, assisted living facilities, home health agencies, quality of care, and medical facilities.[5] There are currently 70 licensed continuing care retirement communities in Florida.[6] About 30,000 residents live in CCRCs.[7]

[1] Section 651.011(2), F.S.
[2] Sections 651.057 and 651.118, F.S.
[3] Chapter 651, F.S., and s. 20.121, F.S.
[4] Section 651.011(12), F.S., a provider means an owner or operator.
[5] Agency for Health Care Administration reports, available at *http://www.floridahealthfinder.gov/reports-guides/nursinghomesfl.aspx* (last viewed Feb. 7, 2019) and s. 651.118, F.S.
[6] Office of Insurance Regulation, *Presentation to the Governor's Continuing Care Advisory Council* (Aug. 2017), available at https://www.floir.com/siteDocuments/CCRCAdvisoryCouncilOIRPresentation08172017.pdf (last viewed Feb. 28, 2019).
[7] *Id.*

Oversight by the Office of Insurance Regulation

The OIR has primary responsibility to license, regulate and monitor the operation of CCRCs and to determine facilities' financial condition and the management capabilities of their managers and owners.[8] Continuing care services are governed by a contract between the facility and the resident of a CCRC, which are subject to approval by the OIR.[9] If a provider is accredited through a process "substantially equivalent" to the requirements of ch. 651, F.S., the OIR may waive requirements of the chapter.[10]

In order to operate a CCRC in Florida, a provider must obtain from the OIR a certificate of authority predicated upon first receiving a provisional certificate of authority.[11] The application process involves submitting various financial statements and information, feasibility studies, and copies of contracts.[12] Further, the applicant must provide evidence that the applicant is reputable and of responsible character.[13] A certificate of authority will be issued once a provider meets the requirements prescribed in s. 651.023, F.S.[14]

If a provider fails to meet the requirements of ch. 651, F.S., relating to a provisional certificate of authority or a COA, the OIR must notify the provider of any deficiencies and require the provider to take corrective action within a period determined by the OIR. If the provider does not correct the deficiencies by the expiration of such time required by the OIR, the OIR may initiate delinquency proceedings as provided in s. 651.114, F.S., or seek other relief provided under ch. 651, F.S. The OIR may deny, suspend, or revoke the provisional certificate of authority or the certificate of authority of any applicant or provider for grounds specified in s. 651.106, F.S**.**

Continuing Care Contracts

All CCRC contracts provide for a refund of a declining portion of the entrance fee if the contract is cancelled for reasons other than the death of the resident, during the first 4 years of occupancy in the CCRC by the resident.[15] However, some contracts may exceed this requirement and contain minimum refund provisions that guarantee a refund of a specified portion of the entrance fee upon the death of the resident or termination of the contract regardless of the length of occupancy by the resident.

Financial Requirements/Solvency

Each CCRC is required to file an annual report with the OIR, which includes an audited financial report and other detailed financial information, such as a listing of assets maintained in the liquid reserve, as required under s. 651.035, F.S., and information about fees required of residents.[16] Providers are required to maintain a minimum liquid reserve, as applicable, as prescribed in s. 651.035, F.S., and provide quarterly reports to the OIR.

[8] See ss. 651.021, 651.22, and 651.023, F.S.
[9] Section 651.055(1), F.S.
[10] Section 651.028, F.S.
[11] Section 651.022, F.S.
[12] See ss. 651.021-651.023, F.S.
[13] Section 651.022(2)(c), F.S.
[14] Section 651.023(4)(a), F.S.
[15] Section 651.055, F.S.
[16] Section 651.026, F.S.

Rights of Residents in a Continuing Care Retirement Community

The OIR is authorized to discipline a provider for violations of residents' rights.[17] These rights include: a right to live in a safe and decent living environment, free from abuse and neglect; freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community; and the right to present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without restraint, interference, coercion, discrimination, or reprisal.[18]

Each CCRC must establish a resident's council to provide a forum for residents' input on issues that affect the general residential quality of life, such as the facility's financial trends, and problems, as well as proposed changes in policies, programs, and services.[19] The CCRCs are required to maintain and make available certain public information and records.[20]

Residents are also represented on the Continuing Care Advisory Council, which acts in an advisory capacity to OIR, meeting at least once a year to recommend to the OIR changes in statutes and rules, and upon the request of OIR to assist with any corrective action, rehabilitation or cessation of the business plan of a provider. The Council is composed of ten members, including:

- Three administrators of CCRC facilities;
- Three residents of CCRCs;
- An attorney;
- A certified public accountant;
- A representative of the business community whose expertise is in the area of management; and,
- A representative of the financial community who is not a facility owner or administrator.[21]

Department of Financial Services

The Department of Financial Services (DFS) may interact with a resident after a CCRC contractual agreement has been signed by both parties or during a mediation or arbitration process.[22] Typically, residents will contact the Division of Consumer Services of the Department of Financial Services, which receives inquiries and complaints involving products and entities regulated by the OIR or the DFS.[23] The DFS coordinates with the OIR in the resolution of complaints or inquiries.

States primarily regulate insurance companies, and the state of domicile serves as the primary regulator for insurers. Federal law provides that insurance companies may not file for

[17] Section 651.083, F.S.
[18] *Id*.
[19] Section 651.081, F.S.
[20] Section 651.091, F.S.
[21] Section 651.121, F.S.
[22] *See* Rules 69O-193.062 and 69O-193.063, F.A.C.
[23] Section 624.307, F.S.

bankruptcy.[24] Instead, the state, through the Division of Rehabilitation and Liquidation of the Department of Financial Services (DFS), is responsible for rehabilitating or liquidating an insurer.[25] If an insurer is found to be insolvent and is ordered to be liquidated by a court, a receiver takes over the insurer under court supervision and processes the assets and liabilities through liquidation. If the DFS institutes receivership or liquidation proceedings against a CCRC, the continuing care contracts are deemed preferred claims against assets of the provider.[26] Such claims are subordinate, however, to any secured claim. Florida law does not specify the claim status of continuing care contracts in a bankruptcy proceeding.

III. Effect of Proposed Changes:

Section 1 amends s. 651.011, F.S., to create definitions of the following terms: actuarial opinion, actuarial study, actuary, controlling company, corrective order, days cash on hand, debt service coverage ratio, department, impaired, manager, management, or management company, obligated group, occupancy, and regulatory action level event. The term, "impaired," means any of the following has occurred:

- A provider has failed to maintain its minimum liquid reserve as required in s. 651.035, F.S., unless the provider has received prior written approval from the office for a withdrawal pursuant to s. 651.035(6), F.S., and is compliant with the approved payment schedule; or
- Effective January 1, 2021:
  - For a provider with mortgage financing from a third-party lender or public bond issue, the provider's debt service coverage ratio is less than 1:1 and the provider's days cash on hand is less than 90; or
  - For a provider without mortgage financing from a third-party lender or public bond issue, the provider's days cash on hand is less than 90.

The term, "regulatory action level event," is defined to mean that any two of the following has occurred:

- The provider's debt service coverage ratio is less than the minimum ratio specified in the provider's bond covenants or lending agreement for long-term financing, or, if the provider does not have a debt service coverage ratio required by its lending institution, the provider's debt service coverage ratio is less than 1.20:1 as of the most recent report filed with the OIR. If the provider is a member of an obligated group having cross-collateralized debt, the obligated group's debt service coverage ratio must be used as the provider's debt service coverage ratio.
- The provider's days cash on hand is less than the minimum number of days cash on hand specified in the provider's bond covenants or lending agreement for long-term financing. If the provider does not have a days cash on hand required by its lending institution, the days cash on hand may not be less than 100 as of the most recent report filed with the OIR. If the provider is a member of an obligated group having cross-collateralized debt, the days cash on hand of the obligated group must be used as the provider's days cash on hand.

[24] The Bankruptcy Code expressly provides that "a domestic insurance company" may not be the subject of a federal bankruptcy proceeding. 11 U.S.C. s. 109(b)(2). The exclusion of insurers from the federal bankruptcy court process is consistent with federal policy generally allowing states to regulate the business of insurance. *See* 15 U.S.C. ss. 1011- 1012.
[25] Sections 631.051 and 631.061, F.S. Chapter 631, F.S., governs the receivership process for insurance companies in Florida.
[26] Section 651.071, F.S.

- The 12-month average occupancy of the provider's facility is less than 80 percent. The average occupancy is calculated using the facility's occupancy as of the last day of each month.

Sections 2 and 21 amend ss. 651.012 and 651.057, F.S., by providing technical, conforming changes.

Regulatory Oversight and Solvency

Section 3 amends s. 651.013, F.S., to expand the scope of laws applicable to continuing care retirement communities (CCRCs) to include ss. 624.307, 624.308, 624.310, 624.102, 624.311, 624.312, 624.318 and 624.422, F.S. These provisions provide the OIR with additional authority to take enforcement authority against licensed entities, affiliates, and unlicensed entities subject to OIR's regulation. Further, these provisions specify that CCRCs must appoint the Chief Financial Officer for service of process; clarify the role of the DFS Division of Consumer Services in resolving consumer complaints; specify requirements for the retention of records by the OIR; provide immunity from civil liability for persons providing the DFS, Financial Services Commission (FSC), or the OIR with information about the condition of an insurer, clarify the authority of the OIR in regards to examinations and investigations; and specify the duty of every person being examined to provide records during an examination or investigation. Finally, s. 624.312, F.S., provides that reproductions and certified copies of records are admissible as evidence.

Section 5 amends s. 651.021, F.S., which relates to the certificate of authority process,is amended to delete provisions relating to expansion of a certified facility. The provisions are transferred to the newly created s. 651.0246, F.S.

Section 6 creates s. 651.0215, F.S., to allow an applicant to qualify for a certificate of authority without first obtaining a provisional certificate of authority if certain conditions are met, including:

- Placement of all reservation deposits and entrance fees in escrow and not pledging initial entrance fees for construction or purchase of the facility or as a security for long-term financing.
- Compliance with reservation deposit requirements that it may not exceed the lesser of $40,000 or 10 percent of the then-current fee for the unit selected by a resident, which is refundable in certain circumstances.
- Submission of a feasibility study, financial forecasts or projections, an audited financial report, quarterly unaudited financial reports, and evidence of compliance with conditions of the lenders' conditions;
- Documentation evidencing that aggregate amount of entrance fee received by or pledged by the applicant and other specified sources equal at least 100 percent of the aggregate cost of constructing, acquiring, equipping, and furnishing the facility plus 100 percent of the anticipated start-up losses of the facility;
- Evidence that the applicant will meet minimum liquid requirements; and
- Such other reasonable data and information requested by the OIR.

The section provides a timeline for the review and approval or disapproval of the application.

Section 7 amends s. 651.022, F.S., which relates to the provisional certificate of authority process, to clarify that an applicant must disclose material changes that occur while a provisional certificate of authority application is pending before the OIR. The section provides a timeline for the review and approval or disapproval of the application.

Section 8 amends s. 651.023, F.S., relating to the requirements for a certificate of authority application. The section provides the OIR may not approve a COA if it includes in the financing plan any encumbrance on renewal or replacement reserves required by ch. 651, F.S. After issuance of a provisional certificate of authority, the OIR will issue the holder a certificate of authority if the holder provides certain information. The bill clarifies the deadlines for the OIR's approval or denial of completed applications. In order for a unit to be considered reserved, the provider must collect a minimum deposit of the lesser of $40,000 or 10 percent of the then-current entrance fee for that unit.

Section 9 amends s. 651.024, F.S., to clarify which filing or application for acquisition applies to each type of transaction, including the new, consolidated provisions of s. 651.0245, F.S. The section clarifies that the assumption of the role of a general partner of a CCRC or the assumption of ownership, or possession of, or control over, 10 percent or more of a provider's assets requires an acquisition filing. However, this type of acquisition is not subject to the filing requirements pursuant to s. 651.022, s. 651.023, or s. 651.0245, F.S. A person who seeks to acquire and become the provider for a facility will be subject to s. 651.0245, F.S., and is not required to make filings pursuant to ss. 651.4615, 651.022, and 651.023, F.S.

Section 10 creates s. 651.0245, F.S., to consolidate the application for the simultaneous acquisition of a facility and issuance of a certificate of authority into a single application. The section provides that a person must obtain the OIR's prior approval before acquiring a facility operating under an existing certificate of authority and engaging in the business of continuing care.

Section 11 creates s. 651.0246, F.S., relating to expansions, to clarify the requirements and approval process. The section establishes financial and reporting requirements for an expansion of a facility equivalent to the addition of at least 20 percent of the existing units or 20 percent more continuing care at-home contracts. If a facility meets certain conditions, an expansion is not subject to prior approval by the OIR.

Section 12 amends s. 651.026, F.S., to require a facility to submit on an annual basis, an audited financial report and the management's calculation of the provider's debt service coverage ratio occupancy rate, calculation of minimum liquid reserves, and day's cash on hand for the current reporting period. The OIR is required to publish an annual industry benchmarking report that contains specified information about the industry's performance.

Section 13 amends s. 651.0261, F.S., to codify the current discretionary monthly financial reporting rule[27] and revise the quarterly financial reporting requirements for providers. The section requires a provider to submit quarterly unaudited financial statements, day's cash on hand, debt service coverage ratio, occupancy rate, and a detailed listing of assets in the minimum

[27] Rule 69O-193.005, F.A.C.

liquid reserve with the quarterly and monthly unaudited financial statement filings, if applicable.. The OIR may waive the quarterly reporting requirements if a written request from a provider that is accredited or that has obtained an investment grade credit rating from a U.S. credit rating agency. This section specifies conditions that may trigger a monthly financial reporting to the OIR, such as the provider is subject to administrative supervision proceedings, a corrective action plan, or the provider or facility displays a declining financial condition. The OIR may not waive the quarterly reporting requirement for a period of 12 months for any provider that is impaired, or does not comply with a requirement for debt services coverage ratio, days cash on hand, or average facility occupancy as provided in s. 651.011(25), F.S.

Section 14 amends s. 651.028, F.S., to provides that if a provider or obligated group has obtained an investment grade credit rating from Moody's Investors Services, Standard & Poor's, or Fitch Ratings, the OIR may waive any requirements of ch. 631, F.S., if the OIR finds that such waivers are not inconsistent with the protections intended by this chapter. Currently, the OIR may waive ch. 631, F.S., requirements if a provider is accredited.

Section 15 amends s. 651.033, F.S., to clarify the terms and conditions relating to an escrow account, withdrawals, and the duties of escrow agents.

Section 16 creates s. 651.034, F.S., to establish a financial and operating framework of required actions if a regulatory action level event or an impairment occurs. Once a regulatory action level event is triggered, the OIR is required to examine the provider, review the provider's corrective action plan, and issue a corrective order specifying any corrective actions that the OIR deems necessary with exceptions. The OIR may consult with members of the Continuing Care Advisory Council and other consultants to review a provider's corrective action plan, examine a provider, and formulate the corrective order with respect to a provider. Further, this section details the information the provider must submit to the OIR if a regulatory action level event occurs, which would include the submission of a corrective action plan within 30 days after the regulatory action level event. The OIR must approve or disapprove the corrective plan within 15 days.

If an impairment of a provider occurs, the OIR may take action, which could include "any remedy available under ch. 631, F.S." An impairment is sufficient grounds for the Department of Financial Services to be appointed as receiver. The section provides that the OIR may exempt a provider from provisions relating to the regulatory action level event and impairment if certain conditions are met. This section does not preclude or limit any power or duty of the DFS or the OIR. The current intervention framework for CCRCs is triggered only after a provider becomes insolvent, meaning it is unable to pay its obligations as they come due in the normal course of business.

Section 17 amends s. 651.035, F.S., revises provisions relating to the minimum liquid reserve requirements. The section allows a provider to withdraw funds held in escrow without the approval of the OIR if the amount in escrow exceeds the requirements of this section and the withdrawal will not affect compliance with this section. For all other proposed withdrawals, the provider must file information documenting the necessity of the withdrawal, and within 30 days after the file is deemed complete, the OIR must notify the provider of its approval or disapproval of the request. The section also requires a provider that does not have a mortgage loan or other financing on the facility, to deposit monthly in escrow one-twelfth of its annual property tax

liability. The section authorizes the OIR to require the transfer of up to 100 percent of the funds held in the minimum liquid reserve to the custody of the Bureau of Collateral Management of the DFS if the OIR finds that the provider is impaired or insolvent in order to ensure the safety of those assets. The section provides that if the market value of the minimum liquid reserve is less than the required amount at the end of any fiscal quarter, the provider must fund the shortfall within 10 business days. The section requires a provider to fund any increases in the minimum liquid reserve not later than 61 days after the minimum liquid reserve calculation is due to be filed as provided in s. 651.026, F.S.

Section 18 creates s. 651.043, F.S., relating to changes in management. This section establishes criteria for the OIR to use in determining whether management meets minimum qualification standards and allows for the disapproval and removal of unqualified management. Providers are required to file notices of a change in management with the OIR within 10 days of the appointment of new management. The OIR must approve or disapprove the filing within 15 days after the filing is deemed complete. Disapproved management must be removed within 30 days after receipt of the OIR's notice. Currently, the OIR does not have authority to disapprove unaffiliated management except by taking action against the certificate of authority of the provider. Effective July 1, 2019, management contracts must be in writing and include a provision that the contract will be canceled, without application of a cancellation fee or penalty, upon issuance of an order pursuant to this section.

Section 19 amends s. 651.051, F.S., to clarify requirements for the maintenance of records and assets to provide that they must be maintained or readily accessible to the OIR.

Section 24 amends s. 651.095, F.S., to clarify that the terms, "life plan and life plan at-home" may not be used in advertisements by entities not licensed pursuant to ch. 651, F.S.

Section 25 amends s. 651.105, F.S., relating to examinations by the OIR. The section requires a provider to respond to written correspondence from the OIR. Further, the section provides that the OIR has standing to petition a circuit court for mandatory injunctive relief to compel access to and require a provider to produce requested records. Unless a provider or facility is impaired or subject to a regulatory level event, any parent, subsidiary, or affiliate is not subject to examination by the OIR as part of a routine examination. However, an exception is provided if a facility or provider relies on a contractual or financial relationship with a parent, subsidiary, or affiliate in order to demonstrate that the financial condition of the provider or facility is in compliance with ch. 651, F.S.

Section 26 amends s. 651.106, F.S., to provide additional grounds for the OIR to refuse, suspend, or revoke a COA. The section provides that the OIR may deny an application, suspend, or revoke the provisional certificate of authority or certificate of authority if the provider is impaired or the owners, managers, or controlling persons are not reputable or lack sufficient management expertise or experience to operate a CCRC.

Section 27 creates s. 651.1065, F.S., which prohibits an impaired or insolvent provider from soliciting or accepting new contracts after the proprietor, general partner, its member, officer, director, trustee, or manager knew, or reasonably should have known, that the CCRC is impaired or insolvent, even if a delinquency hearing had not been initiated. The section provides discretion

for the OIR to allow the issuance of new contracts where safeguards are adequate unless the facility has declared bankruptcy. A violation of this section is a felony of the third degree.

Section 29 amends s. 651.114, F.S., relating to delinquency proceedings and remedial rights. A provider must develop a plan for obtaining compliance or solvency within 30 days after a request from the advisory council or the office. The advisory council is required to respond within 30 days after receipt of a plan. The section clarifies that the OIR may take other regulatory action while a plan is under review. If the financial condition of the provider is impaired or the provider fails to submit a corrective plan within 30 days of the request or submits an insufficient plan, the OIR may specify a plan, and direct the provider to implement it.

The section requires a provider to give residents a written notice of a delinquency proceeding under ch. 631, F.S., within 3 business days of initiation. If a ch. 631, F.S., show a cause order is issued, the provider must respond within 20 days after service. Any hearing must be held within 60 days after the order to show cause. A hearing to determine whether cause exists for the DFS to be appointed a receiver must be commenced within 60 days after an order directing a provider to show cause.

Section 30 creates s. 651.1141, F.S., to provide that the following statutory violations are an immediate danger to the public health, safety, or welfare of the residents of this state:

- The installation of a general partner of a provider or assumption of ownership or possession or control of 10 percent or more of a provider's assets in violation of s. 651.024, F.S., or s. 651.0245, F.S.;
- The removal or commitment of 10 percent or more for the required minimum liquid reserve funds in violation of s. 651.035, F.S.; or
- The assumption of control over a facility's operations in violation of s. 651.043, F.S., has occurred.

If the OIR determines that a person or entity is engaging or has engaged in one or more of the above activities, the OIR may, pursuant to s. 120.569, F.S., issue an immediate final order directing that such person or entity cease and desist that activity; or suspend the certificate of authority of the facility. This provision will allow the OIR to take more expedited action to protect the assets of the provider and the significant investments of the residents.

Section 32 amends s. 651.125, F.S., to clarify that any person who assists in entering into, maintaining, or performing any continuing care or continuing care at-home contract subject to ch. 651, F.S., without a valid provisional certificate of authority or certificate of authority commits a felony of the third degree.

Increased Transparency and Protections for Residents

Section 4 amends s. 651.019, F.S., to require a provider to provide a general outline of the amount and terms of any new financing or refinancing to the residents' council at least 30 days before the closing date of the transaction. Such documents must be submitted to the OIR within 30 days after the closing date. Under current law, the residents' council receives notice of all financing documents filed with the OIR.

Section 20 amends s. 651.055, F.S., to require all contracts to include a notice that a copy of ch. 651, F.S., is on file at the facility, and disclose that an individual has a right to inspect financial statements and inspection report of the facility before signing the contract.

Section 22 amends s. 651.071, F.S., to deem all continuing care and continuing care at-home contracts preferred claims or policyholder loss claims pursuant to s. 631.271(1)(b), F.S., in the event the provider is liquidated or put into receivership.

Section 23 amends s. 651.091, F.S., to create additional provider notice and reporting requirements to the residents or residents' council. These reports assist residents and prospective residents to remain apprised of the status and stability of the provider and to take action to protect their interests. The section requires the provider to furnish information to the chair of the residents' council, such as, a notice of the issuance of any examination reports, a notice of the initiation of any legal or administrative proceedings by the OIR or the DFS, and the reasons for any increase in the monthly fee that exceeds the consumer price index. A facility is required to post in a prominent place the contact information for the OIR and the Division of Consumer Services of the Department of Financial Services.

Section 28 amends s. 651.111, F.S., by revising provisions relating to the OIR's authority to conduct inspections initiated by resident complaints. The section requires the OIR to acknowledge receipt of a complaint within 15 days and issue a written closure statement to the complainant upon the final disposition of the complaint.

Section 31 amends s. 651.121, F.S., relating to the Continuing Care Advisory Council, to increase the number of residents on the council from three to four and remove the requirement that one of the 10 members is an attorney.

Section 33 provides that, except as otherwise expressly provided in this bill and except for this section, the bill takes effect July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

The bill consolidates various applications, which may result in reduced application fees incurred by applicants.

B. Private Sector Impact:

The bill provides additional consumer protections for current and potential residents of a continuing care retirement community (CCRC). The establishment of the early intervention framework will allow the OIR to work with a provider much sooner in order to mitigate or resolve any potential issues that would put resident interests in jeopardy.

The consolidation of the acquisition filings may result in a reduction of administrative costs for affected CCRCs.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Some of the provisions in the bill relating or referencing to ch. 631, F.S., are inconsistent.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 651.011, 651.012, 651.013, 651.019, 651.021, 861.022, 651.023, 651.026, 651.0261, 651.028, 651.035, 651.051, 651.055, 651.057, 651.071, 651.091, 651.095, 651.105, 651.106, 651.111, 651.114, 651.121, and 651.125.

This bill creates the following sections of the Florida Statutes: 651.0215, 651.0245, 651.0246, 651.043, 651.034, 651.1065, and 651.1141.

IX. Additional Information:

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

CS by Banking and Insurance on March 11, 2019:
The CS:

- Revises the definition of regulatory action event level.
- Revises minimum liquid reserve requirements.
- Revises and clarifies reporting requirements.
- Clarifies the timeline and process for the approval or disapproval of applications.
- Provides technical and clarifying changes.

B. Amendments:

None.

436274

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/11/2019	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Lee) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 651.011, Florida Statutes, is amended to read:

651.011 Definitions.—As used in this chapter, the term:

(1) "Actuarial opinion" means an opinion issued by an actuary in accordance with Actuarial Standards of Practice No. 3 for Continuing Care Retirement Communities, Revised Edition,

436274

effective May 1, 2011.

(2) "Actuarial study" means an analysis prepared for an individual facility, or consolidated for multiple facilities, for either a certified provider, as of a current valuation date or the most recent fiscal year, or for an applicant, as of a projected future valuation date, which includes an actuary's opinion as to whether such provider or applicant is in satisfactory actuarial balance in accordance with Actuarial Standards of Practice No. 3 for Continuing Care Retirement Communities, Revised Edition, effective May 1, 2011.

(3) "Actuary" means an individual who is qualified to sign an actuarial opinion in accordance with the American Academy of Actuaries' qualification standards and who is a member in good standing of the American Academy of Actuaries.

(4) ~~(1)~~ "Advertising" means the dissemination of written, visual, or electronic information by a provider, or any person affiliated with or controlled by a provider, to potential residents or their representatives for the purpose of inducing such persons to subscribe to or enter into a contract for continuing care or continuing care at-home.

(5) ~~(2)~~ "Continuing care" or "care" means, pursuant to a contract, furnishing shelter and nursing care or personal services to a resident who resides in a facility, whether such nursing care or personal services are provided in the facility or in another setting designated in the contract for continuing care, by an individual not related by consanguinity or affinity to the resident, upon payment of an entrance fee.

(6) ~~(3)~~ "Continuing Care Advisory Council" or "advisory council" means the council established in s. 651.121.


436274

(7) ~~(4)~~ "Continuing care at-home" means, pursuant to a contract other than a contract described in subsection (5) ~~(2)~~, furnishing to a resident who resides outside the facility the right to future access to shelter and nursing care or personal services, whether such services are provided in the facility or in another setting designated in the contract, by an individual not related by consanguinity or affinity to the resident, upon payment of an entrance fee.

(8) "Controlling company" means any corporation, trust, or association that directly or indirectly owns 25 percent or more of:

(a) The voting securities of one or more providers or facilities that are stock corporations; or

(b) The ownership interest of one or more providers or facilities that are not stock corporations.

(9) "Corrective order" means an order issued by the office which specifies corrective actions that the office determines are required in accordance with this chapter or commission rule.

(10) "Days cash on hand" means the quotient obtained by dividing the value of paragraph (a) by the value of paragraph (b).

(a) The sum of unrestricted cash, unrestricted short-term and long-term investments, provider restricted funds, and the minimum liquid reserve as of the reporting date.

(b) Operating expenses less depreciation, amortization, and other noncash expenses and nonoperating losses, divided by 365. Operating expenses, depreciation, amortization, and other noncash expenses and nonoperating losses are each the sum of their respective values over the 12-month period ending on the

reporting date.

With prior written approval of the office, a demand note or other parental guarantee may be considered a short-term or long-term investment for the purposes of paragraph (a). However, the total of all demand notes issued by the parent may not, at any time, be more than the sum of unrestricted cash and unrestricted short-term and long-term investments held by the parent.

(11) "Debt service coverage ratio" means the quotient obtained by dividing the value of paragraph (a) by the value of paragraph (b).

(a) The sum of total expenses less interest expense on the debt facility, depreciation, amortization, and other noncash expense and nonoperating losses, subtracted from the sum of total revenues, excluding noncash revenues and nonoperating gains, and gross entrance fees received less earned entrance fees and refunds paid. Expenses, interest expense on the debt facility, depreciation, amortization, and other noncash expense and nonoperating losses, revenues, noncash revenues, nonoperating gains, gross entrance fees, earned entrance fees, and refunds are each the sum of their respective values over the 12-month period ending on the reporting date.

(b) Total annual principal and interest expense due on the debt facility over the 12-month period ending on the reporting date. For the purposes of this paragraph, principal excludes any balloon principal payment amounts, and interest expense due is the sum of the interest over the 12-month period immediately preceding the reporting date.

(12) "Department" means the Department of Financial


436274

Services.

(13) ~~(5)~~ "Entrance fee" means an initial or deferred payment of a sum of money or property made as full or partial payment for continuing care or continuing care at-home. An accommodation fee, admission fee, member fee, or other fee of similar form and application are considered to be an entrance fee.

(14) ~~(6)~~ "Facility" means a place where continuing care is furnished and may include one or more physical plants on a primary or contiguous site or an immediately accessible site. As used in this subsection, the term "immediately accessible site" means a parcel of real property separated by a reasonable distance from the facility as measured along public thoroughfares, and the term "primary or contiguous site" means the real property contemplated in the feasibility study required by this chapter.

~~(7) "Generally accepted accounting principles" means those accounting principles and practices adopted by the Financial Accounting Standards Board and the American Institute of Certified Public Accountants, including Statement of Position 90-8 with respect to any full year to which the statement applies.~~

(15) "Impaired" or "impairment" means that either of the following has occurred:

(a) A provider has failed to maintain its minimum liquid reserve as required under s. 651.035, unless the provider has received prior written approval from the office for a withdrawal pursuant to s. 651.035(6) and is compliant with the approved payment schedule.

(b) Beginning January 1, 2021:


436274

1. For a provider with mortgage financing from a third-party lender or a public bond issue, the provider's debt service coverage ratio is less than 1.00:1 and the provider's days cash on hand is less than 90; or

2. For a provider without mortgage financing from a third-party lender or public bond issue, the provider's days cash on hand is less than 90.

If the provider is a member of an obligated group having cross-collateralized debt, the obligated group's debt service coverage ratio and days cash on hand must be used to determine if the provider is impaired.

(16) ~~(8)~~ "Insolvency" means the condition in which a ~~the~~ provider is unable to pay its obligations as they come due in the normal course of business.

(17) ~~(9)~~ "Licensed" means that a ~~the~~ provider has obtained a certificate of authority from the office ~~department~~.

(18) "Manager", "management," or "management company" means a person who administers the day-to-day business operations of a facility for a provider, subject to the policies, directives, and oversight of the provider.

(19) ~~(10)~~ "Nursing care" means those services or acts rendered to a resident by an individual licensed or certified pursuant to chapter 464.

(20) "Obligated group" means one or more entities that jointly agree to be bound by a financing structure containing security provisions and covenants applicable to the group. For the purposes of this subsection, debt issued under such a financing structure must be a joint and several obligation of

each member of the group.

(21) "Occupancy" means the total number of occupied independent living units, assisted living units, and skilled nursing beds in a facility divided by the total number of units and beds in that facility, excluding units and beds that are unavailable to market or that are reserved by prospective residents.

(22) ~~(11)~~ "Personal services" has the same meaning as in s. 429.02.

(23) ~~(12)~~ "Provider" means the owner or operator, whether a natural person, partnership or other unincorporated association, however organized, trust, or corporation, of an institution, building, residence, or other place, whether operated for profit or not, which owner or operator provides continuing care or continuing care at-home for a fixed or variable fee, or for any other remuneration of any type, whether fixed or variable, for the period of care, payable in a lump sum or lump sum and monthly maintenance charges or in installments. The term does not apply to an entity that has existed and continuously operated a facility located on at least 63 acres in this state providing residential lodging to members and their spouses for at least 66 years on or before July 1, 1989, and has the residential capacity of 500 persons, is directly or indirectly owned or operated by a nationally recognized fraternal organization, is not open to the public, and accepts only its members and their spouses as residents.

(24) ~~(13)~~ "Records" means all documents, correspondence, and ~~the permanent~~ financial, directory, and personnel information and data maintained by a provider pursuant to this chapter,


436274

regardless of the physical form, characteristics, or means of transmission.

(25) "Regulatory action level event" means that any of the following has occurred:

(a) The provider's debt service coverage ratio is less than the minimum ratio specified in the provider's bond covenants or lending agreement for long-term financing, or, if the provider does not have a debt service coverage ratio required by its lending institution, the provider's debt service coverage ratio is less than 1.20:1 as of the most recent report filed with the office. If the provider is a member of an obligated group having cross-collateralized debt, the obligated group's debt service coverage ratio must be used as the provider's debt service coverage ratio.

(b) The provider's days cash on hand is less than the minimum number of days cash on hand specified in the provider's bond covenants or lending agreement for long-term financing. If the provider does not have a days cash on hand required by its lending institution, the days cash on hand may not be less than 100 as of the most recent report filed with the office. If the provider is a member of an obligated group having cross-collateralized debt, the days cash on hand of the obligated group must be used as the provider's days cash on hand.

(c) The 12-month average occupancy of the provider's facility is less than 80 percent. The average occupancy must be calculated using the facility's occupancy as of the last day of each month.

(26) ~~(14)~~ "Resident" means a purchaser of, a nominee of, or a subscriber to a continuing care or continuing care at-home

contract. Such contract does not give the resident a part ownership of the facility in which the resident is to reside, unless expressly provided in the contract.

(27)~~(15)~~ "Shelter" means an independent living unit, room, apartment, cottage, villa, personal care unit, nursing bed, or other living area within a facility set aside for the exclusive use of one or more identified residents.

Section 2. Section 651.012, Florida Statutes, is amended to read:

651.012 Exempted facility; written disclosure of exemption.—Any facility exempted under ss. 632.637(1)(e) and 651.011(23) ~~651.011(12)~~ must provide written disclosure of such exemption to each person admitted to the facility ~~after October 1, 1996~~. This disclosure must be written using language likely to be understood by the person and must briefly explain the exemption.

Section 3. Subsection (2) of section 651.013, Florida Statutes, is amended to read:

651.013 Chapter exclusive; applicability of other laws.—

(2) In addition to other applicable provisions cited in this chapter, the office has the authority granted under ss. 624.302 and 624.303, 624.307-624.312, 624.318 ~~624.308-624.312~~, 624.319(1)-(3), 624.320-624.321, 624.324, ~~and~~ 624.34, and 624.422 of the Florida Insurance Code to regulate providers of continuing care and continuing care at-home.

Section 4. Section 651.019, Florida Statutes, is amended to read:

651.019 New financing, additional financing, or refinancing.—

(1)(a) A provider shall provide a written general outline of the amount and the anticipated terms of any new financing or refinancing, and the intended use of proceeds, to the residents' council at least 30 days before the closing date of the financing or refinancing transaction. If there is a material change in the noticed information, a provider shall provide an updated notice to the residents' council within 10 business days after the provider becomes aware of such change.

(b) If the facility does not have a residents' council, the facility must make available, in the same manner as other community notices, the information required under paragraph (a) ~~After issuance of a certificate of authority, the provider shall submit to the office a general outline, including intended use of proceeds, with respect to any new financing, additional financing, or refinancing at least 30 days before the closing date of such financing transaction~~.

(2) Within 30 days after the closing date of such financing or refinancing transaction, ~~The provider shall furnish any information the office may reasonably request in connection with any new financing, additional financing, or refinancing, including, but not limited to, the financing agreements and any related documents, escrow or trust agreements, and statistical or financial data.~~ the provider shall ~~also~~ submit to the office copies of executed financing documents, escrow or trust agreements prepared in support of such financing or refinancing transaction, and a copy of all documents required to be submitted to the residents' council under paragraph (1)(a) ~~within 30 days after the closing date~~.

Section 5. Section 651.021, Florida Statutes, is amended to

436274

read:

651.021 Certificate of authority required.—

~~(1)~~ A ~~No~~ person may not engage in the business of providing continuing care, issuing contracts for continuing care or continuing care at-home, or constructing a facility for the purpose of providing continuing care in this state without a certificate of authority obtained from the office as provided in this chapter. This section ~~subsection~~ does not prohibit the preparation of a construction site or construction of a model residence unit for marketing purposes, or both. The office may allow the purchase of an existing building for the purpose of providing continuing care if the office determines that the purchase is not being made to circumvent the prohibitions in this section.

~~(2) Written approval must be obtained from the office before commencing construction or marketing for an expansion of a certificated facility equivalent to the addition of at least 20 percent of existing units or 20 percent or more in the number of continuing care at-home contracts. This provision does not apply to construction for which a certificate of need from the Agency for Health Care Administration is required.~~

~~(a) For providers that offer both continuing care and continuing care at-home, the 20 percent is based on the total of both existing units and existing contracts for continuing care at-home. For purposes of this subsection, an expansion includes increases in the number of constructed units or continuing care at-home contracts or a combination of both.~~

~~(b) The application for such approval shall be on forms adopted by the commission and provided by the office. The~~


436274

~~application must include the feasibility study required by s. 651.022(3) or s. 651.023(1)(b) and such other information as required by s. 651.023. If the expansion is only for continuing care at-home contracts, an actuarial study prepared by an independent actuary in accordance with standards adopted by the American Academy of Actuaries which presents the financial impact of the expansion may be substituted for the feasibility study.~~

~~(c) In determining whether an expansion should be approved, the office shall use the criteria provided in ss. 651.022(6) and 651.023(4).~~

Section 6. Section 651.0215, Florida Statutes, is created to read:

651.0215 Consolidated application for a provisional certificate of authority and a certificate of authority; required restrictions on use of entrance fees.—

(1) For an applicant to qualify for a certificate of authority without first obtaining a provisional certificate of authority, all of the following conditions must be met:

(a) All reservation deposits and entrance fees must be placed in escrow in accordance with s. 651.033. The applicant may not use or pledge any part of an initial entrance fee for the construction or purchase of the facility or as security for long-term financing.

(b) The reservation deposit may not exceed the lesser of $40,000 or 10 percent of the then-current fee for the unit selected by a resident and must be refundable at any time before the resident takes occupancy of the selected unit.

(c) The resident contract must state that collection of the

436274

balance of the entrance fee is to occur after the resident is notified that his or her selected unit is available for occupancy and on or before the occupancy date.

(2) The consolidated application must be on a form prescribed by the commission and must contain all of the following information:

(a) All of the information required under s. 651.022(2).

(b) A feasibility study prepared by an independent consultant which contains all of the information required by s. 651.022(3) and financial forecasts or projections prepared in accordance with standards adopted by the American Institute of Certified Public Accountants or in accordance with standards for feasibility studies for continuing care retirement communities adopted by the Actuarial Standards Board.

1. The feasibility study must take into account project costs, actual marketing results to date and marketing projections, resident fees and charges, competition, resident contract provisions, and other factors that affect the feasibility of operating the facility.

2. If the feasibility study is prepared by an independent certified public accountant, it must contain an examination report, or a compilation report acceptable to the office, containing a financial forecast or projections for the first 5 years of operations which take into account an actuary's mortality and morbidity assumptions as the study relates to turnover, rates, fees, and charges. If the study is prepared by an independent consulting actuary, it must contain mortality and morbidity assumptions as it relates to turnover, rates, fees, and charges and an actuary's signed opinion that the project as


436274

proposed is feasible and that the study has been prepared in accordance with Actuarial Standards of Practice No. 3 for Continuing Care Retirement Communities, Revised Edition, effective May 1, 2011.

(c) Documents evidencing that commitments have been secured for construction financing and long-term financing or that a documented plan acceptable to the office has been adopted by the applicant for long-term financing.

(d) Documents evidencing that all conditions of the lender have been satisfied to activate the commitment to disburse funds, other than the obtaining of the certificate of authority, the completion of construction, or the closing of the purchase of realty or buildings for the facility.

(e) Documents evidencing that the aggregate amount of entrance fees received by or pledged to the applicant, plus anticipated proceeds from any long-term financing commitment and funds from all other sources in the actual possession of the applicant, equal at least 100 percent of the aggregate cost of constructing or purchasing, equipping, and furnishing the facility plus 100 percent of the anticipated startup losses of the facility.

(f) A complete audited financial report of the applicant, prepared by an independent certified public accountant in accordance with generally accepted accounting principles, as of the date the applicant commenced business operations or for the fiscal year that ended immediately preceding the date of application, whichever is later; and complete unaudited quarterly financial statements attested to by the applicant after the date of the last audit.

436274

(g) Documents evidencing that the applicant will be able to comply with s. 651.035.

(h) Such other reasonable data, financial statements, and pertinent information as the commission or office may require with respect to the applicant or the facility to determine the financial status of the facility and the management capabilities of its managers and owners.

If any material change occurs in the facts set forth in an application filed with the office pursuant to this subsection, an amendment setting forth such change must be filed with the office within 10 business days after the applicant becomes aware of such change, and a copy of the amendment must be sent by registered mail to the principal office of the facility and to the principal office of the controlling company.

(3) If an applicant has or proposes to have more than one facility offering continuing care or continuing care at-home, a separate certificate of authority must be obtained for each facility.

(4) Within 45 days after receipt of the information required under subsection (2), the office shall examine the information and notify the applicant in writing, specifically requesting any additional information that the office is authorized to require. An application is deemed complete when the office receives all requested information and the applicant corrects any error or omission of which the applicant was timely notified or when the time for such notification has expired. Within 15 days after receipt of all of the requested additional information, the office shall notify the applicant in writing

that all of the requested information has been received and that the application is deemed complete as of the date of the notice. Failure to notify the applicant in writing within the 15-day period constitutes acknowledgment by the office that it has received all requested additional information, and the application is deemed complete for purposes of review on the date the applicant files all of the required additional information.

(5) Within 45 days after an application is deemed complete as set forth in subsection (4) and upon completion of the remaining requirements of this section, the office shall complete its review and issue or deny a certificate of authority to the applicant. If a certificate of authority is denied, the office shall notify the applicant in writing, citing the specific failures to satisfy this chapter, and the applicant is entitled to an administrative hearing pursuant to chapter 120.

(6) The office shall issue a certificate of authority upon determining that the applicant meets all of the requirements of law and has submitted all of the information required under this section, that all escrow requirements have been satisfied, and that the fees prescribed in s. 651.015(2) have been paid.

(7) The issuance of a certificate of authority entitles the applicant to begin construction and collect reservation deposits and entrance fees from prospective residents. The reservation contract must state the cancellation policy and the terms of the continuing care contract. All or any part of an entrance fee or reservation deposit collected must be placed in an escrow account or on deposit with the department pursuant to s. 651.033.


436274

(8) The provider is entitled to secure release of the moneys held in escrow within 7 days after the office receives an affidavit from the provider, along with appropriate documentation to verify, and notification is provided to the escrow agent by certified mail, that all of the following conditions have been satisfied:

(a) A certificate of occupancy has been issued.

(b) Payment in full has been received for at least 70 percent of the total units of a phase or of the total of the combined phases constructed. If a provider offering continuing care at-home is applying for a release of escrowed entrance fees, the same minimum requirement must be met for the continuing care contracts and for the continuing care at-home contracts independently of each other.

(c) The provider has evidence of sufficient funds to meet the requirements of s. 651.035, which may include funds deposited in the initial entrance fee account.

(d) Documents evidencing the intended application of the proceeds upon release and documents evidencing that the entrance fees, when released, will be applied as represented to the office.

(9) The office may not approve any application that includes in the plan of financing any encumbrance of the operating reserves or renewal and replacement reserves required by this chapter.

(10) The office may not issue a certificate of authority to a facility that does not have a component that is to be licensed pursuant to part II of chapter 400 or part I of chapter 429, or that does not offer personal services or nursing services

through written contractual agreement. A written contractual agreement must be disclosed in the contract for continuing care or continuing care at-home and is subject to s. 651.1151.

Section 7. Subsections (2), (3), (6), and (8) of section 651.022, Florida Statutes, are amended, and subsection (5) of that section is republished, to read:

651.022 Provisional certificate of authority; application.—

(2) The application for a provisional certificate of authority must ~~shall~~ be on a form prescribed by the commission and must ~~shall~~ contain the following information:

(a) If the applicant or provider is a corporation, a copy of the articles of incorporation and bylaws; if the applicant or provider is a partnership or other unincorporated association, a copy of the partnership agreement, articles of association, or other membership agreement; and, if the applicant or provider is a trust, a copy of the trust agreement or instrument.

(b) The full names, residences, and business addresses of:

1. The proprietor, if the applicant or provider is an individual.

2. Every partner or member, if the applicant or provider is a partnership or other unincorporated association, however organized, having fewer than 50 partners or members, together with the business name and address of the partnership or other organization.

3. The principal partners or members, if the applicant or provider is a partnership or other unincorporated association, however organized, having 50 or more partners or members, together with the business name and business address of the partnership or other organization. If such unincorporated

organization has officers and a board of directors, the full name and business address of each officer and director may be set forth in lieu of the full name and business address of its principal members.

4. The corporation and each officer and director thereof, if the applicant or provider is a corporation.

5. Every trustee and officer, if the applicant or provider is a trust.

6. The manager, whether an individual, corporation, partnership, or association.

7. Any stockholder holding at least a 10 percent interest in the operations of the facility in which the care is to be offered.

8. Any person whose name is required to be provided in the application under this paragraph and who owns any interest in or receives any remuneration from, directly or indirectly, any professional service firm, association, trust, partnership, or corporation providing goods, leases, or services to the facility for which the application is made, with a real or anticipated value of $10,000 or more, and the name and address of the professional service firm, association, trust, partnership, or corporation in which such interest is held. The applicant shall describe such goods, leases, or services and the probable cost to the facility or provider and shall describe why such goods, leases, or services should not be purchased from an independent entity.

9. Any person, corporation, partnership, association, or trust owning land or property leased to the facility, along with a copy of the lease agreement.


436274

10. Any affiliated parent or subsidiary corporation or partnership.

(c)1. Evidence that the applicant is reputable and of responsible character. If the applicant is a firm, association, organization, partnership, business trust, corporation, or company, the form must ~~shall~~ require evidence that the members or shareholders ~~are reputable and of responsible character,~~ and the person in charge of providing care under a certificate of authority are ~~shall likewise be required to produce evidence of being~~ reputable and of responsible character.

2. Evidence satisfactory to the office of the ability of the applicant to comply with ~~the provisions of~~ this chapter and with rules adopted by the commission pursuant to this chapter.

3. A statement of whether a person identified in the application for a provisional certificate of authority or the administrator or manager of the facility, if such person has been designated, or any such person living in the same location:

a. Has been convicted of a felony or has pleaded nolo contendere to a felony charge, or has been held liable or has been enjoined in a civil action by final judgment, if the felony or civil action involved fraud, embezzlement, fraudulent conversion, or misappropriation of property.

b. Is subject to a currently effective injunctive or restrictive order or federal or state administrative order relating to business activity or health care as a result of an action brought by a public agency or department, including, without limitation, an action affecting a license under chapter 400 or chapter 429.


436274

The statement must ~~shall~~ set forth the court or agency, the date of conviction or judgment, and the penalty imposed or damages assessed, or the date, nature, and issuer of the order. Before determining whether a provisional certificate of authority is to be issued, the office may make an inquiry to determine the accuracy of the information submitted pursuant to subparagraphs 1., 2., and 3. ~~1. and 2.~~

(d) The contracts for continuing care and continuing care at-home to be entered into between the provider and residents which meet the minimum requirements of s. 651.055 or s. 651.057 and which include a statement describing the procedures required by law relating to the release of escrowed entrance fees. Such statement may be furnished through an addendum.

(e) Any advertisement or other written material proposed to be used in the solicitation of residents.

(f) Such other reasonable data, financial statements, and pertinent information as the commission or office may reasonably require with respect to the provider or the facility, including the most recent audited financial report ~~statements~~ of comparable facilities currently or previously owned, managed, or developed by the applicant or its principal, to assist in determining the financial viability of the project and the management capabilities of its managers and owners.

(g) The forms of the residency contracts, reservation contracts, escrow agreements, and wait list contracts, if applicable, which are proposed to be used by the provider in the furnishing of care. The office shall approve contracts and escrow agreements that comply with ss. 651.023(1)(c), 651.033, 651.055, and 651.057. Thereafter, no other form of contract or

agreement may be used by the provider until it has been submitted to the office and approved.

If any material change occurs in the facts set forth in an application filed with the office pursuant to this subsection, an amendment setting forth such change must be filed with the office within 10 business days after the applicant becomes aware of such change, and a copy of the amendment must be sent by registered mail to the principal office of the facility and to the principal office of the controlling company.

(3) In addition to the information required in subsection (2), an applicant for a provisional certificate of authority shall submit a ~~market~~ feasibility study with appropriate financial, marketing, and actuarial assumptions for the first 5 years of operations. The ~~market~~ feasibility study must ~~shall~~ include at least the following information:

(a) A description of the proposed facility, including the location, size, anticipated completion date, and the proposed construction program.

(b) An identification and evaluation of the primary and, if appropriate, the secondary market areas of the facility and the projected unit sales per month.

(c) Projected revenues, including anticipated entrance fees; monthly service fees; nursing care revenues ~~rates~~, if applicable; and all other sources of revenue~~, including the total amount of debt financing required~~.

(d) Projected expenses, including staffing requirements and salaries; cost of property, plant, and equipment, including depreciation expense; interest expense; marketing expense; and

other operating expenses.

(e) A projected balance sheet ~~Current assets and liabilities of the applicant~~.

(f) Expectations of the financial condition of the project, including the projected cash flow, and ~~a projected balance sheet and~~ an estimate of the funds anticipated to be necessary to cover startup losses.

(g) The inflation factor, if any, assumed in the feasibility study for the proposed facility and how and where it is applied.

(h) Project costs and the total amount of debt financing required, marketing projections, resident fees and charges, the competition, resident contract provisions, and other factors that ~~which~~ affect the feasibility of the facility.

(i) Appropriate population projections, including morbidity and mortality assumptions.

(j) The name of the person who prepared the feasibility study and the experience of such person in preparing similar studies or otherwise consulting in the field of continuing care. The preparer of the feasibility study may be the provider or a contracted third party.

(k) Any other information that the applicant deems relevant and appropriate to enable the office to make a more informed determination.

(5)(a) Within 30 days after receipt of an application for a provisional certificate of authority, the office shall examine the application and shall notify the applicant in writing, specifically setting forth and specifically requesting any additional information the office is permitted by law to

require. If the application submitted is determined by the office to be substantially incomplete so as to require substantial additional information, including biographical information, the office may return the application to the applicant with a written notice that the application as received is substantially incomplete and, therefore, unacceptable for filing without further action required by the office. Any filing fee received shall be refunded to the applicant.

(b) Within 15 days after receipt of all of the requested additional information, the office shall notify the applicant in writing that all of the requested information has been received and the application is deemed to be complete as of the date of the notice. Failure to so notify the applicant in writing within the 15-day period shall constitute acknowledgment by the office that it has received all requested additional information, and the application shall be deemed to be complete for purposes of review upon the date of the filing of all of the requested additional information.

(6) Within 45 days after the date an application is deemed complete as set forth in paragraph (5)(b), the office shall complete its review and issue a provisional certificate of authority to the applicant based upon its review and a determination that the application meets all requirements of law, that the feasibility study was based on sufficient data and reasonable assumptions, and that the applicant will be able to provide continuing care or continuing care at-home as proposed and meet all financial and contractual obligations related to its operations, including the financial requirements of this chapter. If the application is denied, the office shall notify


436274

the applicant in writing, citing the specific failures to meet the provisions of this chapter. Such denial entitles the applicant to a hearing pursuant to chapter 120.

(8) The office may ~~shall~~ not approve any application that ~~which~~ includes in the plan of financing any encumbrance of the operating reserves or renewal and replacement reserves required by this chapter.

Section 8. Subsections (1) and (4) through (9) of section 651.023, Florida Statutes, are amended, and subsection (2) of that section is republished, to read:

651.023 Certificate of authority; application.—

(1) After issuance of a provisional certificate of authority, the office shall issue to the holder of such provisional certificate a certificate of authority if the holder of the provisional certificate provides the office with the following information:

(a) Any material change in status with respect to the information required to be filed under s. 651.022(2) in the application for the provisional certificate.

(b) A feasibility study prepared by an independent consultant which contains all of the information required by s. 651.022(3) and financial forecasts or projections prepared in accordance with standards adopted by the American Institute of Certified Public Accountants or in accordance with standards for feasibility studies or continuing care retirement communities adopted by the Actuarial Standards Board.

~~1. The study must also contain an independent evaluation and examination opinion, or a comparable opinion acceptable to the office, by the consultant who prepared the study, of the~~

~~underlying assumptions used as a basis for the forecasts or projections in the study and that the assumptions are reasonable and proper and the project as proposed is feasible.~~

1.~~2.~~ The study must take into account project costs, actual marketing results to date and marketing projections, resident fees and charges, competition, resident contract provisions, and any other factors which affect the feasibility of operating the facility.

2.~~3.~~ If the study is prepared by an independent certified public accountant, it must contain an examination opinion or a compilation report acceptable to the office containing a financial forecast or projections for the first 5 ~~3~~ years of operations which take into account an actuary's mortality and morbidity assumptions as the study relates to turnover, rates, fees, and charges ~~and financial projections having a compilation opinion for the next 3 years~~. If the study is prepared by an independent consulting actuary, it must contain mortality and morbidity assumptions as the study relates to turnover, rates, fees, and charges ~~data~~ and an actuary's signed opinion that the project as proposed is feasible and that the study has been prepared in accordance with standards adopted by the American Academy of Actuaries.

(c) Subject to subsection (4), a provider may submit an application for a certificate of authority and any required exhibits upon submission of documents evidencing ~~proof~~ that the project has a minimum of 30 percent of the units reserved for which the provider is charging an entrance fee. ~~This does not apply to an application for a certificate of authority for the acquisition of a facility for which a certificate of authority~~


436274

~~was issued before October 1, 1983, to a provider who subsequently becomes a debtor in a case under the United States Bankruptcy Code, 11 U.S.C. ss. 101 et seq., or to a provider for which the department has been appointed receiver pursuant to part II of chapter 631.~~

(d) Documents evidencing ~~Proof~~ that commitments have been secured for both construction financing and long-term financing or a documented plan acceptable to the office has been adopted by the applicant for long-term financing.

(e) Documents evidencing ~~Proof~~ that all conditions of the lender have been satisfied to activate the commitment to disburse funds other than the obtaining of the certificate of authority, the completion of construction, or the closing of the purchase of realty or buildings for the facility.

(f) Documents evidencing ~~Proof~~ that the aggregate amount of entrance fees received by or pledged to the applicant, plus anticipated proceeds from any long-term financing commitment, plus funds from all other sources in the actual possession of the applicant, equal at least 100 percent of the aggregate cost of constructing or purchasing, equipping, and furnishing the facility plus 100 percent of the anticipated startup losses of the facility.

(g) A complete audited financial report ~~statements~~ of the applicant, prepared by an independent certified public accountant in accordance with generally accepted accounting principles, as of the date the applicant commenced business operations or for the fiscal year that ended immediately preceding the date of application, whichever is later, and complete unaudited quarterly financial statements attested to by

the applicant after the date of the last audit.

(h) Documents evidencing ~~Proof~~ that the applicant has complied with the escrow requirements of subsection (5) or subsection (7) and will be able to comply with s. 651.035.

(i) Such other reasonable data, financial statements, and pertinent information as the commission or office may require with respect to the applicant or the facility, to determine the financial status of the facility and the management capabilities of its managers and owners.

If any material change occurs in the facts set forth in an application filed with the office pursuant to this subsection, an amendment setting forth such change must be filed with the office within 10 business days after the applicant becomes aware of such change, and a copy of the amendment must be sent by registered mail to the principal office of the facility and to the principal office of the controlling company.

(2) Within 30 days after receipt of the information required under subsection (1), the office shall examine such information and notify the provider in writing, specifically requesting any additional information the office is permitted by law to require. Within 15 days after receipt of all of the requested additional information, the office shall notify the provider in writing that all of the requested information has been received and the application is deemed to be complete as of the date of the notice. Failure to notify the applicant in writing within the 15-day period constitutes acknowledgment by the office that it has received all requested additional information, and the application shall be deemed complete for

purposes of review on the date of filing all of the required additional information.

(4) The office shall issue a certificate of authority upon determining that the applicant meets all requirements of law and has submitted all of the information required by this section, that all escrow requirements have been satisfied, and that the fees prescribed in s. 651.015(2) have been paid.

(a) A ~~Notwithstanding satisfaction of the 30-percent minimum reservation requirement of paragraph (1)(c), no~~ certificate of authority may not ~~shall~~ be issued until documentation evidencing that the project has a minimum of 50 percent of the units reserved for which the provider is charging an entrance fee~~, and proof~~ is provided to the office. If a provider offering continuing care at-home is applying for a certificate of authority ~~or approval of an expansion pursuant to s. 651.021(2)~~, the same minimum reservation requirements must be met for the continuing care and continuing care at-home contracts, independently of each other.

(b) In order for a unit to be considered reserved under this section, the provider must collect a minimum deposit of the lesser of $40,000 or 10 percent of the then-current entrance fee for that unit, and may assess a forfeiture penalty of 2 percent of the entrance fee due to termination of the reservation contract after 30 days for any reason other than the death or serious illness of the resident, the failure of the provider to meet its obligations under the reservation contract, or other circumstances beyond the control of the resident that equitably entitle the resident to a refund of the resident’s deposit. The reservation contract must state the cancellation policy and the

terms of the continuing care or continuing care at-home contract to be entered into.

(5) Up to 25 percent of the moneys paid for all or any part of an initial entrance fee may be included or pledged for the construction or purchase of the facility or as security for long-term financing. As used in this section, the term "initial entrance fee" means the total entrance fee charged by the facility to the first occupant of a unit.

~~(a)~~ A minimum of 75 percent of the moneys paid for all or any part of an initial entrance fee collected for continuing care or continuing care at-home must ~~shall~~ be placed in an escrow account or on deposit with the department as prescribed in s. 651.033.

~~(b) For an expansion as provided in s. 651.021(2), a minimum of 75 percent of the moneys paid for all or any part of an initial entrance fee collected for continuing care and 50 percent of the moneys paid for all or any part of an initial fee collected for continuing care at-home shall be placed in an escrow account or on deposit with the department as prescribed in s. 651.033.~~

(6) The provider is entitled to secure release of the moneys held in escrow within 7 days after receipt by the office of an affidavit from the provider, along with appropriate copies to verify, and notification to the escrow agent by certified mail, that the following conditions have been satisfied:

(a) A certificate of occupancy has been issued.

(b) Payment in full has been received for at least 70 percent of the total units of a phase or of the total of the combined phases constructed. If a provider offering continuing


436274

care at-home is applying for a release of escrowed entrance fees, the same minimum requirement must be met for the continuing care and continuing care at-home contracts, independently of each other.

~~(c) The consultant who prepared the feasibility study required by this section or a substitute approved by the office certifies within 12 months before the date of filing for office approval that there has been no material adverse change in status with regard to the feasibility study. If a material adverse change exists at the time of submission, sufficient information acceptable to the office and the feasibility consultant must be submitted which remedies the adverse condition.~~

(c) ~~(d)~~ Documents evidencing ~~Proof~~ that commitments have been secured or a documented plan adopted by the applicant has been approved by the office for long-term financing.

(d) ~~(e)~~ Documents evidencing ~~Proof~~ that the provider has sufficient funds to meet the requirements of s. 651.035, which may include funds deposited in the initial entrance fee account.

(e) ~~(f)~~ Documents evidencing ~~Proof as to~~ the intended application of the proceeds upon release and documentation ~~proof~~ that the entrance fees when released will be applied as represented to the office.

(f) If any material change occurred in the facts set forth in the application filed with the office pursuant to subsection (1), the applicant timely filed the amendment setting forth such change with the office and sent copies of the amendment to the principal office of the facility and to the principal office of the controlling company as required under that subsection.

Notwithstanding chapter 120, no person, other than the provider, the escrow agent, and the office, may have a substantial interest in any office decision regarding release of escrow funds in any proceedings under chapter 120 or this chapter regarding release of escrow funds.

(7) In lieu of the provider fulfilling the requirements in subsection (5) and paragraphs (6)(b) and (c) ~~(d)~~, the office may authorize the release of escrowed funds to retire all outstanding debts on the facility and equipment upon application of the provider and upon the provider's showing that the provider will grant to the residents a first mortgage on the land, buildings, and equipment that constitute the facility, and that the provider has satisfied paragraphs (6)(a)~~, (c),~~ and (d) ~~(e)~~. Such mortgage shall secure the refund of the entrance fee in the amount required by this chapter. The granting of such mortgage is subject to the following:

(a) The first mortgage is granted to an independent trust that is beneficially held by the residents. The document creating the trust must include a provision that agrees to an annual audit and will furnish to the office all information the office may reasonably require. The mortgage may secure payment on bonds issued to the residents or trustee. Such bonds are redeemable after termination of the residency contract in the amount and manner required by this chapter for the refund of an entrance fee.

(b) Before granting a first mortgage to the residents, all construction must be substantially completed and substantially all equipment must be purchased. No part of the entrance fees

436274

may be pledged as security for a construction loan or otherwise used for construction expenses before the completion of construction.

(c) If the provider is leasing the land or buildings used by the facility, the leasehold interest must be for a term of at least 30 years.

(8) ~~The timeframes provided under s. 651.022(5) and (6) apply to applications submitted under s. 651.021(2).~~ The office may not issue a certificate of authority to a facility that does not have a component that is to be licensed pursuant to part II of chapter 400 or to part I of chapter 429 or that does not offer personal services or nursing services through written contractual agreement. A written contractual agreement must be disclosed in the contract for continuing care or continuing care at-home and is subject to ~~the provisions of~~ s. 651.1151, relating to administrative, vendor, and management contracts.

(9) The office may not approve an application that includes in the plan of financing any encumbrance of the operating reserves or renewal and replacement reserves required by this chapter.

Section 9. Section 651.024, Florida Statutes, is amended to read:

651.024 Acquisition.—

(1) A person who seeks to assume the role of general partner of a provider or to otherwise assume ownership or possession of, or control over, 10 percent or more of a provider, a controlling company of the provider, or a provider's assets, based on the balance sheet from the most recent financial audit report filed with the office, is ~~issued a~~

436274

~~certificate of authority to operate a continuing care facility or a provisional certificate of authority shall be~~ subject to ~~the provisions of~~ s. 628.4615 and is not required to make filings pursuant to s. 651.022, s. 651.023, or s. 651.0245.

(2) A person who seeks to acquire and become the provider for a facility is subject to s. 651.0245 and is not required to make filings pursuant to ss. 628.4615, 651.022, and 651.023.

(3) A person may rebut a presumption of control by filing a disclaimer of control with the office on a form prescribed by the commission. The disclaimer must fully disclose all material relationships and bases for affiliation between the person and the provider or facility, as well as the basis for disclaiming the affiliation. In lieu of such form, a person or acquiring party may file with the office a copy of a Schedule 13G filed with the Securities and Exchange Commission pursuant to Rule 13d-1(b) or (c), 17 C.F.R. s. 240.13d-1, under the Securities Exchange Act of 1934, as amended. After a disclaimer has been filed, the provider or facility is relieved of any duty to register or report under this section which may arise out of the provider's or facility's relationship with the person, unless the office disallows the disclaimer.

(4) In addition to the provider, the facility, or the controlling company, the office has standing to petition a circuit court as described in s. 628.4615(9).

Section 10. Section 651.0245, Florida Statutes, is created to read:

651.0245 Application for the simultaneous acquisition of a facility and issuance of a certificate of authority.—

(1) Except with the prior written approval of the office, a


436274

person may not, individually or in conjunction with any affiliated person of such person, directly or indirectly acquire a facility operating under a subsisting certificate of authority and engage in the business of providing continuing care.

(2) An applicant seeking simultaneous acquisition of a facility and issuance of a certificate of authority must:

(a) Comply with the notice requirements of s. 628.4615(2)(a); and

(b) File an application in the form required by the office and cooperate with the office's review of the application.

(3) The commission shall adopt by rule application requirements equivalent to those described in ss. 628.4615(4) and (5), 651.022(2), and 651.023(1)(b). The office shall review the application and issue an approval or disapproval of the filing in accordance with ss. 628.4615(6)(a) and (c), (7)-(10), and (14); and 651.023(1)(b).

(4) In addition to the facility, the provider, or the controlling company, the office has standing to petition a circuit court as described in s. 628.4615(9).

(5) A person may rebut a presumption of control by filing a disclaimer of control with the office on a form prescribed by the commission. The disclaimer must fully disclose all material relationships and bases for affiliation between the person and the provider or facility, as well as the basis for disclaiming the affiliation. In lieu of such form, a person or acquiring party may file with the office a copy of a Schedule 13G filed with the Securities and Exchange Commission pursuant to Rule 13d-1(b) or (c), 17 C.F.R. s. 240.13d-1, under the Securities Exchange Act of 1934, as amended. After a disclaimer has been


436274

filed, the provider or facility is relieved of any duty to register or report under this section which may arise out of the provider's or facility's relationship with the person, unless the office disallows the disclaimer.

(6) The commission may adopt rules as necessary to administer this section.

Section 11. Section 651.0246, Florida Statutes, is created to read:

651.0246 Expansions.—

(1)(a) A provider must obtain written approval from the office before commencing construction or marketing for an expansion of a certificated facility equivalent to the addition of at least 20 percent of existing units or 20 percent or more of the number of continuing care at-home contracts. If the provider has exceeded the current statewide median for days cash on hand, debt service coverage ratio, and total facility occupancy for two consecutive annual reporting periods, the provider is automatically granted approval to expand the total number of existing units by up to 35 percent upon submitting a letter to the office indicating the total number of planned units in the expansion, the proposed sources and uses of funds, and an attestation that the provider understands and pledges to comply with all minimum liquid reserve and escrow account requirements. As used in this section, the term "existing units" means the sum of the total number of independent living units and assisted living units identified in the most recent annual report filed with the office pursuant to s. 651.026. For purposes of this section, the statewide median for days cash on hand, debt service coverage ratio, and total facility occupancy


436274

is the median calculated in the most recent annual report submitted by the office to the Continuing Care Advisory Council pursuant to s. 651.121(8). This section does not apply to construction for which a certificate of need from the Agency for Health Care Administration is required.

(b) The application for the approval of an addition consisting of 20 percent or more of existing units or continuing care at-home contracts must be on forms adopted by the commission and provided by the office. The application must include the feasibility study required by this section and such other information as reasonably requested by the office. If the expansion is only for continuing care at-home contracts, an actuarial study prepared by an independent actuary in accordance with standards adopted by the American Academy of Actuaries which presents the financial impact of the expansion may be substituted for the feasibility study.

(c) In determining whether an expansion should be approved, the office shall consider:

1. Whether the application meets all requirements of law;

2. Whether the feasibility study was based on sufficient data and reasonable assumptions; and

3. Whether the applicant will be able to provide continuing care or continuing care at-home as proposed and meet all financial obligations related to its operations, including the financial requirements of this chapter.

If the application is denied, the office must notify the applicant in writing, citing the specific failures to meet the provisions of this chapter. A denial entitles the applicant to a

436274

hearing pursuant to chapter 120.

(2) A provider applying for expansion of a certificated facility must submit all of the following:

(a) A feasibility study prepared by an independent certified public accountant. The feasibility study must include at least the following information:

1. A description of the facility and proposed expansion, including the location, the size, the anticipated completion date, and the proposed construction program.

2. An identification and evaluation of the primary and, if applicable, secondary market areas of the facility and the projected unit sales per month.

3. Projected revenues, including anticipated entrance fees; monthly service fees; nursing care revenues, if applicable; and all other sources of revenue.

4. Projected expenses, including for staffing requirements and salaries; the cost of property, plant, and equipment, including depreciation expense; interest expense; marketing expense; and other operating expenses.

5. A projected balance sheet of the applicant.

6. The expectations for the financial condition of the project, including the projected cash flow and an estimate of the funds anticipated to be necessary to cover startup losses.

7. The inflation factor, if any, assumed in the study for the proposed expansion and how and where it is applied.

8. Project costs; the total amount of debt financing required; marketing projections; resident rates, fees, and charges; the competition; resident contract provisions; and other factors that affect the feasibility of the facility.


436274

9. Appropriate population projections, including morbidity and mortality assumptions.

10. The name of the person who prepared the feasibility study and his or her experience in preparing similar studies or otherwise consulting in the field of continuing care.

11. Financial forecasts or projections prepared in accordance with standards adopted by the American Institute of Certified Public Accountants or in accordance with standards for feasibility studies for continuing care retirement communities adopted by the Actuarial Standards Board.

12. An independent evaluation and examination opinion for the first 5 years of operations, or a comparable opinion acceptable to the office, by the consultant who prepared the study, of the underlying assumptions used as a basis for the forecasts or projections in the study and that the assumptions are reasonable and proper and the project as proposed is feasible.

13. Any other information that the provider deems relevant and appropriate to provide to enable the office to make a more informed determination.

(b) Such other reasonable data, financial statements, and pertinent information as the commission or office may require with respect to the applicant or the facility to determine the financial status of the facility and the management capabilities of its managers and owners.

If any material change occurs in the facts set forth in an application filed with the office pursuant to this section, an amendment setting forth such change must be filed with the

436274

office within 10 business days after the applicant becomes aware of such change, and a copy of the amendment must be sent by registered mail to the principal office of the facility and to the principal office of the controlling company.

(3) A minimum of 75 percent of the moneys paid for all or any part of an initial entrance fee or reservation deposit collected for units in the expansion and 50 percent of the moneys paid for all or any part of an initial fee collected for continuing care at-home contracts in the expansion must be placed in an escrow account or on deposit with the department as prescribed in s. 651.033. Up to 25 percent of the moneys paid for all or any part of an initial entrance fee or reservation deposit may be included or pledged for the construction or purchase of the facility or as security for long-term financing. As used in this section, the term "initial entrance fee" means the total entrance fee charged by the facility to the first occupant of a unit.

(4) The provider is entitled to secure release of the moneys held in escrow within 7 days after receipt by the office of an affidavit from the provider, along with appropriate copies to verify, and notification to the escrow agent by certified mail that the following conditions have been satisfied:

(a) A certificate of occupancy has been issued.

(b) Payment in full has been received for at least 50 percent of the total units of a phase or of the total of the combined phases constructed. If a provider offering continuing care at-home is applying for a release of escrowed entrance fees, the same minimum requirement must be met for the continuing care and continuing care at-home contracts

436274

independently of each other.

(c) Documents evidencing that commitments have been secured or that a documented plan adopted by the applicant has been approved by the office for long-term financing.

(d) Documents evidencing that the provider has sufficient funds to meet the requirements of s. 651.035, which may include funds deposited in the initial entrance fee account.

(e) Documents evidencing the intended application of the proceeds upon release and documentation that the entrance fees, when released, will be applied as represented to the office.

Notwithstanding chapter 120, only the provider, the escrow agent, and the office have a substantial interest in any office decision regarding release of escrow funds in any proceedings under chapter 120 or this chapter.

(5)(a) Within 30 days after receipt of an application for expansion, the office shall examine the application and shall notify the applicant in writing, specifically requesting any additional information that the office is authorized to require. Within 15 days after the office receives all the requested additional information, the office shall notify the applicant in writing that the requested information has been received and that the application is deemed complete as of the date of the notice. If the office chooses not to notify the applicant within the 15-day period, the application is deemed complete for purposes of review on the date the applicant files the additional requested information. If the application submitted is determined by the office to be substantially incomplete so as to require substantial additional information, including


436274

biographical information, the office may return the application to the applicant with a written notice stating that the application as received is substantially incomplete and, therefore, is unacceptable for filing without further action required by the office. Any filing fee received must be refunded to the applicant.

(b) An application is deemed complete upon the office receiving all requested information and the applicant correcting any error or omission of which the applicant was timely notified or when the time for such notification has expired. The office shall notify the applicant in writing of the date on which the application was deemed complete.

(6) Within 45 days after the date on which an application is deemed complete as provided in paragraph (5)(b), the office shall complete its review and, based upon its review, approve an expansion by the applicant and issue a determination that the application meets all requirements of law, that the feasibility study was based on sufficient data and reasonable assumptions, and that the applicant will be able to provide continuing care or continuing care at-home as proposed and meet all financial and contractual obligations related to its operations, including the financial requirements of this chapter. If the office requests additional information and the applicant provides it within 5 business days after notification, the period for reviewing or approving an application may not be extended beyond the period specified in paragraph (5)(a). If the application is denied, the office must notify the applicant in writing, citing the specific failures to meet the requirements of this chapter. The denial entitles the applicant to a hearing pursuant to

chapter 120.

Section 12. Paragraphs (b) and (c) of subsection (2) and subsection (3) of section 651.026, Florida Statutes, are amended, subsection (10) is added to that section, and paragraph (a) of subsection (2) of that section is republished, to read:

651.026 Annual reports.—

(2) The annual report shall be in such form as the commission prescribes and shall contain at least the following:

(a) Any change in status with respect to the information required to be filed under s. 651.022(2).

(b) A financial report ~~statements~~ audited by an independent certified public accountant which must contain, for two or more periods if the facility has been in existence that long, all of the following:

1. An accountant's opinion and, in accordance with generally accepted accounting principles:

a. A balance sheet;

b. A statement of income and expenses;

c. A statement of equity or fund balances; and

d. A statement of changes in cash flows.

2. Notes to the financial report ~~statements~~ considered customary or necessary for full disclosure or adequate understanding of the financial report ~~statements~~, financial condition, and operation.

(c) The following financial information:

1. A detailed listing of the assets maintained in the liquid reserve as required under s. 651.035 and in accordance with part II of chapter 625;

2. A schedule giving additional information relating to


436274

property, plant, and equipment having an original cost of at least $25,000, so as to show in reasonable detail with respect to each separate facility original costs, accumulated depreciation, net book value, appraised value or insurable value and date thereof, insurance coverage, encumbrances, and net equity of appraised or insured value over encumbrances. Any property not used in continuing care must be shown separately from property used in continuing care;

3. The level of participation in Medicare or Medicaid programs, or both;

4. A statement of all fees required of residents, including, but not limited to, a statement of the entrance fee charged, the monthly service charges, the proposed application of the proceeds of the entrance fee by the provider, and the plan by which the amount of the entrance fee is determined if the entrance fee is not the same in all cases; ~~and~~

5. Any change or increase in fees if the provider changes the scope of, or the rates for, care or services, regardless of whether the change involves the basic rate or only those services available at additional costs to the resident;~~.~~

6. If the provider has more than one certificated facility, or has operations that are not licensed under this chapter, it shall submit a balance sheet, statement of income and expenses, statement of equity or fund balances, and statement of cash flows for each facility licensed under this chapter as supplemental information to the audited financial report ~~statements~~ required under paragraph (b); and~~.~~

7. The management's calculation of the provider's debt service coverage ratio, occupancy, and days cash on hand for the


436274

current reporting period.

(3) The commission shall adopt by rule additional ~~meaningful~~ measures of assessing the financial viability of a provider. ~~The rule may include the following factors:~~

~~(a) Debt service coverage ratios.~~

~~(b) Current ratios.~~

~~(c) Adjusted current ratios.~~

~~(d) Cash flows.~~

~~(e) Occupancy rates.~~

~~(f) Other measures, ratios, or trends.~~

~~(g) Other factors as may be appropriate.~~

(10) By August 1 annually, the office shall publish an industry benchmarking report for the preceding calendar year which contains all of the following:

(a) The median days cash on hand for all providers.

(b) The median debt service coverage ratio for all providers.

(c) The median occupancy rate for all providers by setting, including independent living, assisted living, skilled nursing, and the entire facility.

Section 13. Section 651.0261, Florida Statutes, is amended to read:

651.0261 Quarterly and monthly statements.—

(1) Within 45 days after the end of each fiscal quarter, each provider shall file a quarterly unaudited financial statement of the provider or of the facility in the form prescribed by commission rule and days cash on hand, occupancy, debt service coverage ratio, and a detailed listing of the assets maintained in the liquid reserve as required under s.


436274

651.035. This requirement may be waived by the office upon written request from a provider that is accredited without conditions or stipulations or that has obtained an investment grade credit rating from a United States credit rating agency as authorized under s. 651.028. The last quarterly statement for a fiscal year is not required if a provider does not have pending a regulatory action level event or a corrective action plan.

(2) If the office finds~~, pursuant to rules of the commission,~~ that such information is needed to properly monitor the financial condition of a provider or facility or is otherwise needed to protect the public interest, the office may require the provider to file:

(a) Within 25 days after the end of each month, a monthly unaudited financial statement of the provider or of the facility in the form prescribed by the commission by rule and a detailed listing of the assets maintained in the liquid reserve as required under s. 651.035~~, within 45 days after the end of each fiscal quarter, a quarterly unaudited financial statement of the provider or of the facility in the form prescribed by the commission by rule. The commission may by rule require all or part of the statements or filings required under this section to be submitted by electronic means in a computer-readable form compatible with the electronic data format specified by the commission~~.

(b) Such other data, financial statements, and pertinent information as the commission or office may reasonably require with respect to the provider or the facility, its directors or trustees, or, with respect to any parent, subsidiary, or affiliate, if the provider or facility relies on a contractual

or financial relationship with such parent, subsidiary, or affiliate in order to meet the financial requirements of this chapter, to determine the financial status of the provider or of the facility and the management capabilities of its managers and owners.

(3) A filing under subsection (2) may be required if any of the following applies:

(a) The provider is:

1. Subject to administrative supervision proceedings;

2. Subject to a corrective action plan resulting from a regulatory action level event for up to 2 years after the factors that caused the regulatory action level event have been corrected; or

3. Subject to delinquency or receivership proceedings or has filed for bankruptcy.

(b) The provider or facility displays a declining financial position.

(c) A change of ownership of the provider or facility has occurred within the previous 2 years.

(d) The facility is found to be impaired.

(4) The commission may by rule require all or part of the statements or filings required under this section to be submitted by electronic means in a computer-readable format compatible with an electronic data format specified by the commission.

Section 14. Section 651.028, Florida Statutes, is amended to read:

651.028 Accredited or certain credit-rated facilities.—If a provider or obligated group is accredited without stipulations


436274

or conditions by a process found by the office to be acceptable and substantially equivalent to the provisions of this chapter or has obtained an investment grade credit rating from a nationally recognized credit rating agency, as applicable, from Moody's Investors Service, Standard & Poor's, or Fitch Ratings, the office may, pursuant to rule of the commission, waive the quarterly filing ~~any~~ requirements under s. 651.0261 ~~of this chapter~~ with respect to the provider if the office finds that such waivers are not inconsistent with the security protections intended by this chapter. A provider or obligated group that is accredited without stipulations or conditions or that has obtained such an investment grade credit rating shall provide documentation substantiating such accreditation or investment grade rating in its request for the waiver. If the office grants a waiver to the provider or obligated group, the provider or obligated group must notify the office within 10 business days after any changes in the accreditation or investment grade rating.

Section 15. Subsections (1), (2), (3), and (5) of section 651.033, Florida Statutes, are amended, and subsection (6) is added to that section, to read:

651.033 Escrow accounts.—

(1) When funds are required to be deposited in an escrow account pursuant to s. 651.0215, s. 651.022, s. 651.023, s. 651.0246, s. 651.035, or s. 651.055:

(a) The escrow account must ~~shall~~ be established in a Florida bank, Florida savings and loan association, ~~or~~ Florida trust company, or a national bank that is chartered and supervised by the Office of the Comptroller of the Currency


436274

within the United States Department of the Treasury and that has either a branch or a license to operate in this state, which is acceptable to the office, or such funds must be deposited ~~on deposit~~ with the department~~;~~ and ~~the funds deposited therein shall~~ be kept and maintained in an account separate and apart from the provider's business accounts.

(b) An escrow agreement shall be entered into between the bank, savings and loan association, or trust company and the provider of the facility; the agreement shall state that its purpose is to protect the resident or the prospective resident; and, upon presentation of evidence of compliance with applicable portions of this chapter, or upon order of a court of competent jurisdiction, the escrow agent shall release and pay over the funds, or portions thereof, together with any interest accrued thereon or earned from investment of the funds, to the provider or resident as directed.

(c) Any agreement establishing an escrow account required under ~~the provisions of~~ this chapter is ~~shall be~~ subject to approval by the office. The agreement must ~~shall~~ be in writing and ~~shall~~ contain, in addition to any other provisions required by law, a provision whereby the escrow agent agrees to abide by the duties imposed by paragraphs (b) and (e), (3)(a), (3)(b), and (5)(a) and subsection (6) ~~under this section~~.

(d) All funds deposited in an escrow account, if invested, shall be invested as set forth in part II of chapter 625; however, such investment may not diminish the funds held in escrow below the amount required by this chapter. Funds deposited in an escrow account are not subject to charges by the escrow agent except escrow agent fees associated with


436274

administering the accounts, or subject to any liens, judgments, garnishments, creditor's claims, or other encumbrances against the provider or facility except as provided in s. 651.035(1).

(e) At the request of either the provider or the office, the escrow agent shall issue a statement indicating the status of the escrow account.

(2) Notwithstanding s. 651.035(7), ~~In addition, the escrow agreement shall provide that the escrow agent or another person designated to act in the escrow agent's place and the provider, except as otherwise provided in s. 651.035, shall notify the office in writing at least 10 days before the withdrawal of any portion of any funds required to be escrowed under the provisions of s. 651.035. However,~~ in the event of an emergency and upon petition by the provider, the office may ~~waive the 10-day notification period and~~ allow a withdrawal of up to 10 percent of the required minimum liquid reserve. The office shall have 3 working days to deny the petition for the emergency 10-percent withdrawal. If the office fails to deny the petition within 3 working days, the petition is ~~shall be~~ deemed to have been granted by the office. For purposes ~~the purpose~~ of this section, the term "working day" means each day that is not a Saturday, Sunday, or legal holiday as defined by Florida law. Also, for purposes ~~the purpose~~ of this section, the day the petition is received by the office is ~~shall~~ not ~~be~~ counted as one of the 3 days.

(3) ~~In addition,~~ When entrance fees are required to be deposited in an escrow account pursuant to s. 651.0215, s. 651.022, s. 651.023, s. 651.0246, or s. 651.055:

(a) The provider shall deliver to the resident a written

436274

receipt. The receipt must show the payor's name and address, the date, the price of the care contract, and the amount of money paid. A copy of each receipt, together with the funds, must ~~shall~~ be deposited with the escrow agent or as provided in paragraph (c). The escrow agent must ~~shall~~ release such funds to the provider 7 days after the date of receipt of the funds by the escrow agent if the provider, operating under a certificate of authority issued by the office, has met the requirements of s. 651.0215(8), s. 651.023(6), or s. 651.0246. However, if the resident rescinds the contract within the 7-day period, the escrow agent must ~~shall~~ release the escrowed fees to the resident.

(b) At the request of an individual resident of a facility, the escrow agent shall issue a statement indicating the status of the resident's portion of the escrow account.

(c) At the request of an individual resident of a facility, the provider may hold the check for the 7-day period and may ~~shall~~ not deposit it during this time period. If the resident rescinds the contract within the 7-day period, the check must ~~shall~~ be immediately returned to the resident. Upon the expiration of the 7 days, the provider shall deposit the check.

(d) A provider may assess a nonrefundable fee, which is separate from the entrance fee, for processing a prospective resident's application for continuing care or continuing care at-home.

(5) When funds are required to be deposited in an escrow account pursuant to s. 651.0215, s. 651.022, s. 651.023, s. 651.0246, or s. 651.035, the following ~~shall~~ apply:

(a) The escrow agreement must ~~shall~~ require that the escrow

agent furnish the provider with a quarterly statement indicating the amount of any disbursements from or deposits to the escrow account and the condition of the account during the period covered by the statement. The agreement must ~~shall~~ require that the statement be furnished to the provider by the escrow agent on or before the 10th day of the month following the end of the quarter for which the statement is due. If the escrow agent does not provide the quarterly statement to the provider on or before the 10th day of the month following the month for which the statement is due, the office may, in its discretion, levy against the escrow agent a fine not to exceed $25 a day for each day of noncompliance with the provisions of this subsection.

(b) If the escrow agent does not provide the quarterly statement to the provider on or before the 10th day of the month following the quarter for which the statement is due, the provider shall, on or before the 15th day of the month following the quarter for which the statement is due, send a written request for the statement to the escrow agent by certified mail return receipt requested.

(c) On or before the 20th day of the month following the quarter for which the statement is due, the provider shall file with the office a copy of the escrow agent’s statement or, if the provider has not received the escrow agent’s statement, a copy of the written request to the escrow agent for the statement.

(d) The office may, in its discretion, in addition to any other penalty that may be provided for under this chapter, levy a fine against the provider not to exceed $25 a day for each day the provider fails to comply with the provisions of this

subsection.

(e) Funds held on deposit with the department are exempt from the reporting requirements of this subsection.

(6) Except as described in paragraph (3)(a), the escrow agent may not release or otherwise allow the transfer of funds without the written approval of the office, unless the withdrawal is from funds in excess of the amounts required by ss. 651.0215, 651.022, 651.023, 651.0246, 651.035, and 651.055.

Section 16. Section 651.034, Florida Statutes, is created to read:

651.034 Financial and operating requirements for providers.—

(1)(a) If a regulatory action level event occurs, the office must:

1. Require the provider to prepare and submit a corrective action plan or, if applicable, a revised corrective action plan;

2. Perform an examination pursuant to s. 651.105 or an analysis, as the office considers necessary, of the assets, liabilities, and operations of the provider, including a review of the corrective action plan or the revised corrective action plan; and

3. After the examination or analysis, issue a corrective order, if necessary, specifying any corrective actions that the office determines are required.

(b) In determining corrective actions, the office shall consider any factor relevant to the provider based upon the office's examination or analysis of the assets, liabilities, and operations of the provider. The provider must submit the corrective action plan or the revised corrective action plan

436274

within 30 days after the occurrence of the regulatory action level event. The office shall review and approve or disapprove the corrective action plan within 45 business days.

(c) The office may use members of the Continuing Care Advisory Council, individually or as a group, or may retain actuaries, investment experts, and other consultants to review a provider's corrective action plan or revised corrective action plan, examine or analyze the assets, liabilities, and operations of a provider, and formulate the corrective order with respect to the provider. The costs and expenses relating to consultants must be borne by the affected provider.

(2) If an impairment occurs and except when s. 651.114(11)(a) applies, the office must take action necessary to place the provider under regulatory control, including any remedy available under part I of chapter 631. An impairment is sufficient grounds for the department to be appointed as receiver as provided in chapter 631. Except when s. 651.114(11)(a) is applicable, the department may appoint a receiver. If s. 651.114(11)(a) applies, the provider must make available to the office copies of any corrective action plan approved by the third-party lender or trustee to cure the impairment and any related required report. Notwithstanding s. 631.011, impairment of a provider, for purposes of s. 631.051, is defined according to the term "impaired" under s. 651.011. The office may forego taking action for up to 180 days after the impairment if the office finds there is a reasonable expectation that the impairment may be eliminated within the 180-day period.

(3) There is no liability on the part of, and a cause of action may not arise against, the commission, department, or

436274

office, or their employees or agents, for any action they take in the performance of their powers and duties under this section.

(4) The office shall transmit any notice that may result in regulatory action by registered mail, certified mail, or any other method of transmission which includes documentation of receipt by the provider. Notice is effective when the provider receives it.

(5) This section is supplemental to the other laws of this state and does not preclude or limit any power or duty of the department or office under those laws or under the rules adopted pursuant to those laws.

(6) The office may exempt a provider from subsection (1) or subsection (2) until stabilized occupancy is reached or until the time projected to achieve stabilized occupancy as reported in the last feasibility study required by the office as part of an application filing under s. 651.0215, s. 651.023, s. 651.024, or s. 651.0246 has elapsed, but for no longer than 5 years after the date of issuance of the certificate of occupancy.

(7) The commission may adopt rules to administer this section, including, but not limited to, rules regarding corrective action plans, revised corrective action plans, corrective orders, and procedures to be followed in the event of a regulatory action level event or an impairment.

Section 17. Paragraphs (a), (b), and (c) of subsection (1) of section 651.035, Florida Statutes, are amended, and subsections (7) through (10) are added to that section, to read:

651.035 Minimum liquid reserve requirements.—

(1) A provider shall maintain in escrow a minimum liquid


436274

reserve consisting of the following reserves, as applicable:

(a) Each provider shall maintain in escrow as a debt service reserve the aggregate amount of all principal and interest payments due during the fiscal year on any mortgage loan or other long-term financing of the facility, including property taxes as recorded in the audited financial report ~~statements~~ required under s. 651.026. The amount must include any leasehold payments and all costs related to such payments. If principal payments are not due during the fiscal year, the provider must ~~shall~~ maintain in escrow as a minimum liquid reserve an amount equal to interest payments due during the next 12 months on any mortgage loan or other long-term financing of the facility, including property taxes. If a provider does not have a mortgage loan or other financing on the facility, the provider must deposit monthly in escrow as a minimum liquid reserve an amount equal to one-twelfth of the annual property tax liability as indicated in the most recent tax notice provided pursuant to s. 197.322(3), and must annually pay property taxes out of such escrow.

(b) A provider that has outstanding indebtedness that requires a debt service reserve to be held in escrow pursuant to a trust indenture or mortgage lien on the facility and for which the debt service reserve may only be used to pay principal and interest payments on the debt that the debtor is obligated to pay, and which may include property taxes and insurance, may include such debt service reserve in computing the minimum liquid reserve needed to satisfy this subsection if the provider furnishes to the office a copy of the agreement under which such debt service is held, together with a statement of the amount


436274

being held in escrow for the debt service reserve, certified by the lender or trustee and the provider to be correct. The trustee shall provide the office with any information concerning the debt service reserve account upon request of the provider or the office. Any such separate debt service reserves are not subject to the transfer provisions set forth in subsection (8).

(c) Each provider shall maintain in escrow an operating reserve equal to 30 percent of the total operating expenses projected in the feasibility study required by s. 651.023 for the first 12 months of operation. Thereafter, each provider shall maintain in escrow an operating reserve equal to 15 percent of the total operating expenses in the annual report filed pursuant to s. 651.026. If a provider has been in operation for more than 12 months, the total annual operating expenses must ~~shall~~ be determined by averaging the total annual operating expenses reported to the office by the number of annual reports filed with the office within the preceding 3-year period subject to adjustment if there is a change in the number of facilities owned. For purposes of this subsection, total annual operating expenses include all expenses of the facility except~~:~~ depreciation and amortization; interest and property taxes included in paragraph (a); extraordinary expenses that are adequately explained and documented in accordance with generally accepted accounting principles; liability insurance premiums in excess of those paid in calendar year 1999; and changes in the obligation to provide future services to current residents. For providers initially licensed during or after calendar year 1999, liability insurance must ~~shall~~ be included in the total operating expenses in an amount not to exceed the premium paid


436274

during the first 12 months of facility operation. ~~Beginning January 1, 1993,~~ The operating reserves required under this subsection must ~~shall~~ be in an unencumbered account held in escrow for the benefit of the residents. Such funds may not be encumbered or subject to any liens or charges by the escrow agent or judgments, garnishments, or creditors' claims against the provider or facility. However, if a facility had a lien, mortgage, trust indenture, or similar debt instrument in place before January 1, 1993, which encumbered all or any part of the reserves required by this subsection and such funds were used to meet the requirements of this subsection, then such arrangement may be continued, unless a refinancing or acquisition has occurred, and the provider is ~~shall be~~ in compliance with this subsection.

(7)(a) A provider may withdraw funds held in escrow without the approval of the office if the amount held in escrow exceeds the requirements of this section and if the withdrawal will not affect compliance with this section.

(b)1. For all other proposed withdrawals, in order to receive the consent of the office, the provider must file documentation showing why the withdrawal is necessary for the continued operation of the facility and such additional information as the office reasonably requires.

2. The office shall notify the provider when the filing is deemed complete. If the provider has complied with all prior requests for information, the filing is deemed complete after 30 days without communication from the office.

3. Within 30 days after the date a file is deemed complete, the office shall provide the provider with written notice of its


436274

approval or disapproval of the request. The office may disapprove any request to withdraw such funds if it determines that the withdrawal is not in the best interest of the residents.

(8) The office may order the immediate transfer of up to 100 percent of the funds held in the minimum liquid reserve to the custody of the department pursuant to part III of chapter 625 if the office finds that the provider is impaired or insolvent. The office may order such a transfer regardless of whether the office has suspended or revoked, or intends to suspend or revoke, the certificate of authority of the provider.

(9) Each facility shall file with the office annually, together with the annual report required by s. 651.026, a calculation of its minimum liquid reserve determined in accordance with this section on a form prescribed by the commission.

(10) Any increase in the minimum liquid reserve must be funded not later than 61 days after the minimum liquid reserve calculation is due to be filed as provided in s. 651.026.

Section 18. Effective July 1, 2019, section 651.043, Florida Statutes, is created to read:

651.043 Approval of change in management.—

(1) A contract with a management company entered into after July 1, 2019, must be in writing and include a provision that the contract will be canceled upon issuance of an order by the office pursuant to this section and without the application of a cancellation fee or penalty. If a provider contracts with a management company, a separate written contract is not required for the individual manager employed by the management company to

oversee a facility. If a management company voluntarily executes a contract with a manager or contractor, the contract is not required to be submitted to the office unless requested by the office.

(2) A provider shall notify the office, in writing or electronically, of any change in management within 10 business days. For each new management company or manager not employed by a management company, the provider shall submit to the office the information required by s. 651.022(2) and a copy of the written management contract, if applicable.

(3) For a provider that is found to be impaired or that has a regulatory action level event pending, the office may disapprove new management and order the provider to remove the new management after reviewing the information required under subsection (2).

(4) For a provider other than that specified in subsection (3), the office may disapprove new management and order the provider to remove the new management after receiving the required information under subsection (2), if the office:

(a) Finds that the new management is incompetent or untrustworthy;

(b) Finds that the new management is so lacking in managerial experience as to make the proposed operation hazardous to the residents or potential residents;

(c) Finds that the new management is so lacking in experience, ability, and standing as to jeopardize the reasonable promise of successful operation; or

(d) Has good reason to believe that the new management is affiliated directly or indirectly through ownership, control, or

business relations with any person or persons whose business operations are or have been marked by manipulation of assets or accounts or by bad faith, to the detriment of residents, stockholders, investors, creditors, or the public.

The office shall complete its review as required under subsections (3) and (4) and, if applicable, issue notice of disapproval of the new management within 30 business days after the filing is deemed complete. A filing is deemed complete upon the office's receipt of all requested information and the provider's correction of any error or omission for which the provider was timely notified. If the office does not issue notice of disapproval of the new management within 15 business days after the filing is deemed complete, the new management is deemed approved.

(5) Management disapproved by the office must be removed within 30 days after receipt by the provider of notice of such disapproval.

(6) The office may revoke, suspend, or take other administrative action against the certificate of authority of the provider if the provider:

(a) Fails to timely remove management disapproved by the office;

(b) Fails to timely notify the office of a change in management;

(c) Appoints new management without a written contract when a written contract is required under this section; or

(d) Repeatedly appoints management that was previously disapproved by the office or that is not approvable under

436274

subsection (4).

(7) The provider shall remove any management immediately upon discovery of either of the following conditions, if the conditions were not disclosed in the notice to the office required under subsection (2):

(a) That a manager has been found guilty of, or has pled guilty or no contest to, a felony charge, or has been held liable or has been enjoined in a civil action by final judgment, if the felony or civil action involved fraud, embezzlement, fraudulent conversion, or misappropriation of property.

(b) That a manager is now, or was in the past, affiliated, directly or indirectly, through ownership interest of 10 percent or more in, or control of, any business, corporation, or other entity that has been found guilty of or has pled guilty or no contest to a felony charge, or has been held liable or has been enjoined in a civil action by final judgment, if the felony or civil action involved fraud, embezzlement, fraudulent conversion, or misappropriation of property.

The failure to remove such management is grounds for revocation or suspension of the provider's certificate of authority.

Section 19. Section 651.051, Florida Statutes, is amended to read:

651.051 Maintenance of assets and records in state.—All records and assets of a provider must be maintained or readily accessible in this state or, if the provider's corporate office is located in another state, such records must be electronically stored in a manner that will ensure that the records are readily accessible to the office. No records or assets may be removed


436274

from this state by a provider unless the office consents to such removal in writing before such removal. Such consent must ~~shall~~ be based upon the provider's submitting satisfactory evidence that the removal will facilitate and make more economical the operations of the provider and will not diminish the service or protection thereafter to be given the provider's residents in this state. Before ~~Prior to~~ such removal, the provider shall give notice to the president or chair of the facility's residents' council. If such removal is part of a cash management system which has been approved by the office, disclosure of the system must ~~shall~~ meet the notification requirements. The electronic storage of records on a web-based, secured storage platform by contract with a third party is acceptable if the records are readily accessible to the office.

Section 20. Subsection (3) of section 651.055, Florida Statutes, is amended to read:

651.055 Continuing care contracts; right to rescind.—

(3) The contract must include or be accompanied by a statement, printed in boldfaced type, which reads: "This facility and all other continuing care facilities (also known as life plan communities) in the State of Florida are regulated by chapter 651, Florida Statutes. A copy of the law is on file in this facility. The law gives you or your legal representative the right to inspect our most recent financial statement and inspection report before signing the contract."

Section 21. Subsection (2) of section 651.057, Florida Statutes, is amended to read:

651.057 Continuing care at-home contracts.—

(2) A provider that holds a certificate of authority and

wishes to offer continuing care at-home must also:

(a) Submit a business plan to the office with the following information:

1. A description of the continuing care at-home services that will be provided, the market to be served, and the fees to be charged;

2. A copy of the proposed continuing care at-home contract;

3. An actuarial study prepared by an independent actuary in accordance with the standards adopted by the American Academy of Actuaries which presents the impact of providing continuing care at-home on the overall operation of the facility; and

4. A ~~market~~ feasibility study that meets the requirements of s. 651.022(3) and documents that there is sufficient interest in continuing care at-home contracts to support such a program;

(b) Demonstrate to the office that the proposal to offer continuing care at-home contracts to individuals who do not immediately move into the facility will not place the provider in an unsound financial condition;

(c) Comply with the requirements of s. 651.0246(1) ~~s. 651.021(2)~~, except that an actuarial study may be substituted for the feasibility study; and

(d) Comply with the requirements of this chapter.

Section 22. Subsection (1) of section 651.071, Florida Statutes, is amended to read:

651.071 Contracts as preferred claims on liquidation or receivership.—

(1) In the event of receivership or liquidation proceedings against a provider, all continuing care and continuing care at-home contracts executed by a provider are ~~shall be~~ deemed

preferred claims or policyholder loss ~~preferred~~ claims pursuant to s. 631.271(1)(b) against all assets owned by the provider; however, such claims are subordinate to any secured claim.

Section 23. Subsection (2) and present paragraph (g) of subsection (3) of section 651.091, Florida Statutes, are amended, and a new paragraph (i) and paragraphs (j), (k), and (l) are added to that subsection, and paragraph (d) of subsection (3) and subsection (4) of that section are republished, to read:

651.091 Availability, distribution, and posting of reports and records; requirement of full disclosure.—

(2) Every continuing care facility shall:

(a) Display the certificate of authority in a conspicuous place inside the facility.

(b) Post in a prominent position in the facility which is accessible to all residents and the general public a concise summary of the last examination report issued by the office, with references to the page numbers of the full report noting any deficiencies found by the office, and the actions taken by the provider to rectify such deficiencies, indicating in such summary where the full report may be inspected in the facility.

(c) Post in a prominent position in the facility, accessible to all residents and the general public, a notice containing the contact information for the office and the Division of Consumer Services of the department and stating that the division or office may be contacted for the submission of inquiries and complaints with respect to potential violations of this chapter committed by a provider. Such contact information must include the division’s website and the toll-free consumer


436274

helpline and the office's website and telephone number.

(d) Provide notice to the president or chair of the residents' council within 10 business days after issuance of a final examination report or the initiation of any legal or administrative proceeding by the office or the department and include a copy of such document.

(e) ~~(c)~~ Post in a prominent position in the facility which is accessible to all residents and the general public a summary of the latest annual statement, indicating in the summary where the full annual statement may be inspected in the facility. A listing of any proposed changes in policies, programs, and services must also be posted.

(f) ~~(d)~~ Distribute a copy of the full annual statement and a copy of the most recent third-party ~~third party~~ financial audit filed with the annual report to the president or chair of the residents' council within 30 days after filing the annual report with the office, and designate a staff person to provide explanation thereof.

(g) ~~(e)~~ Deliver the information described in s. 651.085(4) in writing to the president or chair of the residents' council and make supporting documentation available upon request ~~Notify the residents' council of any plans filed with the office to obtain new financing, additional financing, or refinancing for the facility and of any applications to the office for any expansion of the facility~~.

(h) ~~(f)~~ Deliver to the president or chair of the residents' council a summary of entrance fees collected and refunds made during the time period covered in the annual report and the refund balances due at the end of the report period.

(i) ~~(g)~~ Deliver to the president or chair of the residents' council a copy of each quarterly statement within 30 days after the quarterly statement is filed with the office if the facility is required to file quarterly.

(j) ~~(h)~~ Upon request, deliver to the president or chair of the residents' council a copy of any newly approved continuing care or continuing care at-home contract within 30 days after approval by the office.

(k) Provide to the president or chair of the residents' council a copy of any notice filed with the office relating to any change in ownership within 10 business days after such filing by the provider.

(l) Make the information available to prospective residents pursuant to paragraph (3)(d) available to current residents and provide notice of changes to that information to the president or chair of the residents' council within 3 business days.

(3) Before entering into a contract to furnish continuing care or continuing care at-home, the provider undertaking to furnish the care, or the agent of the provider, shall make full disclosure, and provide copies of the disclosure documents to the prospective resident or his or her legal representative, of the following information:

(d) In keeping with the intent of this subsection relating to disclosure, the provider shall make available for review master plans approved by the provider's governing board and any plans for expansion or phased development, to the extent that the availability of such plans does not put at risk real estate, financing, acquisition, negotiations, or other implementation of operational plans and thus jeopardize the success of

negotiations, operations, and development.

~~(g) The amount and location of any reserve funds required by this chapter, and the name of the person or entity having a claim to such funds in the event of a bankruptcy, foreclosure, or rehabilitation proceeding.~~

(i) Notice of the issuance of a final examination report or the initiation of any legal or administrative proceeding by the office or the department, including where the report or filing may be inspected in the facility, and that, upon request, an electronic copy or specific website address will be provided from which the document can be downloaded at no cost.

(j) Notice that the entrance fee is the property of the provider after the expiration of the 7-day escrow requirement under s. 651.055(2).

(k) A statement that distribution of assets or income may occur or a statement that such distributions will not occur.

(l) Notice of any holding company system or obligated group of which the provider is a member.

(4) A true and complete copy of the full disclosure document to be used must be filed with the office before use. A resident or prospective resident or his or her legal representative may inspect the full reports referred to in paragraph (2)(b); the charter or other agreement or instrument required to be filed with the office pursuant to s. 651.022(2), together with all amendments thereto; and the bylaws of the corporation or association, if any. Upon request, copies of the reports and information shall be provided to the individual requesting them if the individual agrees to pay a reasonable charge to cover copying costs.

Section 24. Subsection (4) of section 651.095, Florida Statutes, is amended to read:

651.095 Advertisements; requirements; penalties.—

(4) It is unlawful for any person, other than a provider licensed pursuant to this chapter, to advertise or market to the general public any product similar to continuing care through the use of such terms as "life care," "life plan," "life plan at-home," "continuing care," or "guaranteed care for life," or similar terms, words, or phrases.

Section 25. Section 651.105, Florida Statutes, is amended to read:

651.105 Examination ~~and inspections~~.—

(1) The office may at any time, and shall at least once every 3 years, examine the business of any applicant for a certificate of authority and any provider engaged in the execution of care contracts or engaged in the performance of obligations under such contracts, in the same manner as is provided for the examination of insurance companies pursuant to ss. 624.316 and 624.318 ~~s. 624.316~~. For a provider as described ~~defined~~ in s. 651.028, such examinations must ~~shall~~ take place at least once every 5 years. Such examinations must ~~shall~~ be made by a representative or examiner designated by the office whose compensation will be fixed by the office pursuant to s. 624.320. Routine examinations may be made by having the necessary documents submitted to the office; and, for this purpose, financial documents and records conforming to commonly accepted accounting principles and practices, as required under s. 651.026, are deemed adequate. The final written report of each examination must be filed with the office and, when so

filed, constitutes a public record. Any provider being examined shall, upon request, give reasonable and timely access to all of its records. The representative or examiner designated by the office may at any time examine the records and affairs and inspect the physical property of any provider, whether in connection with a formal examination or not.

(2) Any duly authorized officer, employee, or agent of the office may, upon presentation of proper identification, have access to, and inspect, any records, with or without advance notice, to secure compliance with, or to prevent a violation of, any provision of this chapter.

(3) Reports of the results of such financial examinations must be kept on file by the office. Any investigatory records, reports, or documents held by the office are confidential and exempt from the provisions of s. 119.07(1), until the investigation is completed or ceases to be active. For the purpose of this section, an investigation is active while it is being conducted by the office with a reasonable, good faith belief that it could lead to the filing of administrative, civil, or criminal proceedings. An investigation does not cease to be active if the office is proceeding with reasonable dispatch and has a good faith belief that action could be initiated by the office or other administrative or law enforcement agency.

(4) The office shall notify the provider and the executive officer of the governing body of the provider in writing of all deficiencies in its compliance with the provisions of this chapter and the rules adopted pursuant to this chapter and shall set a reasonable length of time for compliance by the provider.

In addition, the office shall require corrective action or request a corrective action plan from the provider which plan demonstrates a good faith attempt to remedy the deficiencies by a specified date. If the provider fails to comply within the established length of time, the office may initiate action against the provider in accordance with the provisions of this chapter.

(5) A provider shall respond to written correspondence from the office and provide data, financial statements, and pertinent information as requested by the office or by the office's investigators, examiners, or inspectors. The office has standing to petition a circuit court for mandatory injunctive relief to compel access to and require the provider to produce the documents, data, records, and other information requested by the office or its investigators, examiners, or inspectors. The office may petition the circuit court in the county in which the facility is situated or the Circuit Court of Leon County to enforce this section ~~At the time of the routine examination, the office shall determine if all disclosures required under this chapter have been made to the president or chair of the residents' council and the executive officer of the governing body of the provider~~.

(6) A representative of the provider must give a copy of the final examination report and corrective action plan, if one is required by the office, to the executive officer of the governing body of the provider within 60 days after issuance of the report.

(7) Unless a provider or facility is impaired or subject to a regulatory action level event, any parent, subsidiary, or

436274

affiliate is not subject to examination by the office as part of a routine examination. However, if a provider or facility relies on a contractual or financial relationship with a parent, a subsidiary, or an affiliate in order to meet the financial requirements of this chapter, the office may examine any parent, subsidiary, or affiliate that has a contractual or financial relationship with the provider or facility to the extent necessary to ascertain the financial condition of the provider.

Section 26. Section 651.106, Florida Statutes, is amended to read:

651.106 Grounds for discretionary refusal, suspension, or revocation of certificate of authority.—The office may deny an application or~~,~~ suspend~~,~~ or revoke the provisional certificate of authority or the certificate of authority of any applicant or provider if it finds that any one or more of the following grounds applicable to the applicant or provider exist:

(1) Failure by the provider to continue to meet the requirements for the authority originally granted.

(2) Failure by the provider to meet one or more of the qualifications for the authority specified by this chapter.

(3) Material misstatement, misrepresentation, or fraud in obtaining the authority, or in attempting to obtain the same.

(4) Demonstrated lack of fitness or trustworthiness.

(5) Fraudulent or dishonest practices of management in the conduct of business.

(6) Misappropriation, conversion, or withholding of moneys.

(7) Failure to comply with, or violation of, any proper order or rule of the office or commission or violation of any provision of this chapter.

(8) The insolvent or impaired condition of the provider or the provider's being in such condition or using such methods and practices in the conduct of its business as to render its further transactions in this state hazardous or injurious to the public.

(9) Refusal by the provider to be examined or to produce its accounts, records, and files for examination, or refusal by any of its officers to give information with respect to its affairs or to perform any other legal obligation under this chapter when required by the office.

(10) Failure by the provider to comply with the requirements of s. 651.026 or s. 651.033.

(11) Failure by the provider to maintain escrow accounts or funds as required by this chapter.

(12) Failure by the provider to meet the requirements of this chapter for disclosure of information to residents concerning the facility, its ownership, its management, its development, or its financial condition or failure to honor its continuing care or continuing care at-home contracts.

(13) Any cause for which issuance of the license could have been refused had it then existed and been known to the office.

(14) Having been found guilty of, or having pleaded guilty or nolo contendere to, a felony in this state or any other state, without regard to whether a judgment or conviction has been entered by the court having jurisdiction of such cases.

(15) In the conduct of business under the license, engaging in unfair methods of competition or in unfair or deceptive acts or practices prohibited under part IX of chapter 626.

(16) A pattern of bankrupt enterprises.

(17) The ownership, control, or management of the organization includes any person:

(a) Who is not reputable and of responsible character;

(b) Who is so lacking in management expertise as to make the operation of the provider hazardous to potential and existing residents;

(c) Who is so lacking in management experience, ability, and standing as to jeopardize the reasonable promise of successful operation;

(d) Who is affiliated, directly or indirectly, through ownership or control, with any person or persons whose business operations are or have been marked by business practices or conduct that is detrimental to the public, contract holders, investors, or creditors by manipulation of assets, finances, or accounts or by bad faith; or

(e) Whose business operations are or have been marked by business practices or conduct that is detrimental to the public, contract holders, investors, or creditors by manipulation of assets, finances, or accounts or by bad faith.

(18) The provider has not filed a notice of change in management, fails to remove a disapproved manager, or persists in appointing disapproved managers.

Revocation of a certificate of authority under this section does not relieve a provider from the provider's obligation to residents under the terms and conditions of any continuing care or continuing care at-home contract between the provider and residents or the provisions of this chapter. The provider shall continue to file its annual statement and pay license fees to

436274

the office as required under this chapter as if the certificate of authority had continued in full force, but the provider shall not issue any new contracts. The office may seek an action in the Circuit Court of Leon County to enforce the office's order and the provisions of this section.

Section 27. Section 651.1065, Florida Statutes, is created to read:

651.1065 Soliciting or accepting new continuing care contracts by impaired or insolvent facilities or providers.—

(1) Regardless of whether delinquency proceedings as to a continuing care facility have been or are to be initiated, a proprietor, a general partner, a member, an officer, a director, a trustee, or a manager of a continuing care facility may not actively solicit, approve the solicitation or acceptance of, or accept new continuing care contracts in this state after the proprietor, general partner, member, officer, director, trustee, or manager knew, or reasonably should have known, that the continuing care facility was impaired or insolvent except with the written permission of the office. If the facility has declared bankruptcy, the bankruptcy court or trustee appointed by the court has jurisdiction over such matters. The office must approve or disapprove the continued marketing of new contracts within 15 days after receiving a request from a provider.

(2) A proprietor, a general partner, a member, an officer, a director, a trustee, or a manager who violates this section commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 28. Subsections (1) and (3) of section 651.111, Florida Statutes, are amended to read:

651.111 Requests for inspections.—

(1) Any interested party may request an inspection of the records and related financial affairs of a provider providing care in accordance with ~~the provisions of~~ this chapter by transmitting to the office notice of an alleged violation of applicable requirements prescribed by statute or by rule, specifying to a reasonable extent the details of the alleged violation, which notice must ~~shall~~ be signed by the complainant. As used in this section, the term "inspection" means an inquiry into a provider's compliance with this chapter.

(3) Upon receipt of a complaint, the office shall make a preliminary review to determine if the complaint alleges a violation of this chapter~~;~~ and, unless the office determines that the complaint does not allege a violation of this chapter or is without any reasonable basis, the office shall make an inspection. The office shall provide the complainant with a written acknowledgment of the complaint within 15 days after receipt by the office. The complainant shall be advised, within 30 days after the receipt of the complaint by the office, of the office's determination that the complaint does not allege a violation of this chapter, that the complaint is without any reasonable basis, or that the office will make an inspection. The notice must include an estimated timeframe for completing the inspection and a contact number. If the inspection is not completed within the estimated timeframe, the office must provide the complainant with a revised timeframe. Within 15 days after completing an inspection, the office shall provide the complainant and the provider a written statement specifying any violations of this chapter and any actions taken or that no such

436274

violation was found ~~proposed course of action of the office~~.

Section 29. Section 651.114, Florida Statutes, is amended to read:

651.114 Delinquency proceedings; remedial rights.—

(1) Upon determination by the office that a provider is not in compliance with this chapter, the office may notify the chair of the Continuing Care Advisory Council, who may assist the office in formulating a corrective action plan.

(2) Within 30 days after a request by either the advisory council or the office, a provider shall make a plan for obtaining compliance or solvency available to the advisory council and the office~~, within 30 days after being requested to do so by the council, a plan for obtaining compliance or solvency~~.

(3) Within 30 days after receipt of a plan for obtaining compliance or solvency, the office or, at the request of the office, ~~notification,~~ the advisory council shall:

(a) Consider and evaluate the plan submitted by the provider.

(b) Discuss the problem and solutions with the provider.

(c) Conduct such other business as is necessary.

(d) Report its findings and recommendations to the office, which may require additional modification of the plan.

This subsection may not be construed to delay or prevent the office from taking any regulatory measures it deems necessary regarding the provider that submitted the plan.

(4) If the financial condition of a continuing care facility or provider is impaired or is such that if not modified


436274

or corrected, its continued operation would result in insolvency, the office may direct the provider to formulate and file with the office a corrective action plan. If the provider fails to submit a plan within 30 days after the office's directive or submits a plan that is insufficient to correct the condition, the office may specify a plan and direct the provider to implement the plan. Before specifying a plan, the office may seek a recommended plan from the advisory council.

(5) ~~(4)~~ After receiving approval of a plan by the office, the provider shall submit a progress report monthly to the advisory council or the office, or both, in a manner prescribed by the office. After 3 months, or at any earlier time deemed necessary, the council shall evaluate the progress by the provider and shall advise the office of its findings.

(6) ~~(5)~~ If ~~Should~~ the office finds ~~find~~ that sufficient grounds exist for rehabilitation, liquidation, conservation, reorganization, seizure, or summary proceedings of an insurer as set forth in ss. 631.051, 631.061, and 631.071, the department ~~office~~ may petition for an appropriate court order or may pursue such other relief as is afforded in part I of chapter 631. Before invoking its powers under part I of chapter 631, the department ~~office~~ shall notify the chair of the advisory council.

(7) Notwithstanding s. 631.011, impairment of a provider, for purposes of s. 631.051, has the same meaning as the term "impaired" in s. 651.011.

(8) ~~(6)~~ In the event an order of conservation, rehabilitation, liquidation, or ~~conservation, reorganization,~~ seizure~~, or summary proceeding~~ has been entered against a


436274

provider, the department and office are vested with all of the powers and duties they have under ~~the provisions of~~ part I of chapter 631 in regard to delinquency proceedings of insurance companies. A provider shall give written notice of the proceeding to its residents within 3 business days after the initiation of a delinquency proceeding under chapter 631 and shall include a notice of the delinquency proceeding in any written materials provided to prospective residents

~~(7) If the financial condition of the continuing care facility or provider is such that, if not modified or corrected, its continued operation would result in insolvency, the office may direct the provider to formulate and file with the office a corrective action plan. If the provider fails to submit a plan within 30 days after the office's directive or submits a plan that is insufficient to correct the condition, the office may specify a plan and direct the provider to implement the plan~~.

(9) A provider subject to an order to show cause entered pursuant to chapter 631 must file its written response to the order, together with any defenses it may have to the department's allegations, not later than 20 days after service of the order to show cause, but not less than 15 days before the date of the hearing set by the order to show cause.

(10) A hearing held pursuant to chapter 631 to determine whether cause exists for the department to be appointed receiver must be commenced within 60 days after an order directing a provider to show cause.

(11)(a) ~~(8)(a)~~ The rights of the office described in this section are subordinate to the rights of a trustee or lender pursuant to the terms of a resolution, ordinance, loan


436274

agreement, indenture of trust, mortgage, lease, security agreement, or other instrument creating or securing bonds or notes issued to finance a facility, and the office, subject to ~~the provisions of~~ paragraph (c), may ~~shall~~ not exercise its remedial rights provided under this section and ss. 651.018, 651.106, 651.108, and 651.116 with respect to a facility that is subject to a lien, mortgage, lease, or other encumbrance or trust indenture securing bonds or notes issued in connection with the financing of the facility, if the trustee or lender, by inclusion or by amendment to the loan documents or by a separate contract with the office, agrees that the rights of residents under a continuing care or continuing care at-home contract will be honored and will not be disturbed by a foreclosure or conveyance in lieu thereof as long as the resident:

1. Is current in the payment of all monetary obligations required by the contract;

2. Is in compliance and continues to comply with all provisions of the contract; and

3. Has asserted no claim inconsistent with the rights of the trustee or lender.

(b) This subsection does not require a trustee or lender to:

1. Continue to engage in the marketing or resale of new continuing care or continuing care at-home contracts;

2. Pay any rebate of entrance fees as may be required by a resident’s continuing care or continuing care at-home contract as of the date of acquisition of the facility by the trustee or lender and until expiration of the period described in paragraph (d);

 436274

3. Be responsible for any act or omission of any owner or operator of the facility arising before the acquisition of the facility by the trustee or lender; or

4. Provide services to the residents to the extent that the trustee or lender would be required to advance or expend funds that have not been designated or set aside for such purposes.

(c) If ~~Should~~ the office determines ~~determine~~, at any time during the suspension of its remedial rights as provided in paragraph (a), that:

1. The trustee or lender is not in compliance with paragraph (a);~~, or that~~

2. A lender or trustee has assigned or has agreed to assign all or a portion of a delinquent or defaulted loan to a third party without the office's written consent;~~,~~

3. The provider engaged in the misappropriation, conversion, or illegal commitment or withdrawal of minimum liquid reserve or escrowed funds required under this chapter;

4. The provider refused to be examined by the office pursuant to s. 651.105(1); or

5. The provider refused to produce any relevant accounts, records, and files requested as part of an examination,

the office shall notify the trustee or lender in writing of its determination, setting forth the reasons giving rise to the determination and specifying those remedial rights afforded to the office which the office shall then reinstate.

(d) Upon acquisition of a facility by a trustee or lender and evidence satisfactory to the office that the requirements of paragraph (a) have been met, the office shall issue a 90-day

436274

temporary certificate of authority granting the trustee or lender the authority to engage in the business of providing continuing care or continuing care at-home and to issue continuing care or continuing care at-home contracts subject to the office's right to immediately suspend or revoke the temporary certificate of authority if the office determines that any of the grounds described in s. 651.106 apply to the trustee or lender or that the terms of the contract used as the basis for the issuance of the temporary certificate of authority by the office have not been or are not being met by the trustee or lender since the date of acquisition.

Section 30. Section 651.1141, Florida Statutes, is created to read:

651.1141 Immediate final orders.—

(1) The Legislature finds that the following actions constitute an imminent and immediate threat to the public health, safety, and welfare of the residents of this state:

(a) The installation of a general partner of a provider or assumption of ownership or possession or control of 10 percent or more of a provider's assets in violation of s. 651.024 or s. 651.0245;

(b) The removal or commitment of 10 percent or more of the required minimum liquid reserve funds in violation of s. 651.035; or

(c) The assumption of control over a facility's operations in violation of s. 651.043.

(2) If it finds that a person or entity is engaging or has engaged in one or more of the above activities, the office may, pursuant to s. 120.569, issue an immediate final order:


436274

(a) Directing that such person or entity cease and desist that activity; or

(b) Suspending the certificate of authority of the facility.

Section 31. Subsection (1) of section 651.121, Florida Statutes, is amended to read:

651.121 Continuing Care Advisory Council.—

(1) The Continuing Care Advisory Council to the office is created consisting of 10 members ~~who are residents of this state~~ appointed by the Governor and geographically representative of this state. Three members shall be representatives ~~administrators~~ of facilities that hold valid certificates of authority under this chapter and ~~shall~~ have been actively engaged in the offering of continuing care contracts in this state for 5 years before appointment. The remaining members include:

(a) A representative of the business community whose expertise is in the area of management.

(b) A representative of the financial community who is not a facility owner or administrator.

(c) A certified public accountant.

~~(d) An attorney.~~

(d)~~(c)~~ Four ~~Three~~ residents who hold continuing care or continuing care at-home contracts with a facility certified in this state.

Section 32. Subsections (1) and (4) of section 651.125, Florida Statutes, are amended to read:

651.125 Criminal penalties; injunctive relief.—

(1) Any person who maintains, enters into, or, as manager

436274

or officer or in any other administrative capacity, assists in entering into, maintaining, or performing any continuing care or continuing care at-home contract subject to this chapter without ~~doing so in pursuance of~~ a valid provisional certificate of authority or certificate of authority ~~or renewal thereof~~, as contemplated by or provided in this chapter, or who otherwise violates any provision of this chapter or rule adopted in pursuance of this chapter, commits a felony of the third degree, punishable as provided in s. 775.082 or s. 775.083. Each violation of this chapter constitutes a separate offense.

(4) Any action brought by the office against a provider shall not abate by reason of a sale or other transfer of ownership of the facility used to provide care, which provider is a party to the action, except with the express written consent of the ~~director of the~~ office.

Section 33. Except as otherwise expressly provided in this act and except for this section, which shall take effect July 1, 2019, this act shall take effect January 1, 2020.

================ T I T L E A M E N D M E N T ================

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to continuing care contracts; amending s. 651.011, F.S.; adding and revising definitions; amending s. 651.012, F.S.; conforming a cross-reference; deleting an obsolete date; amending s. 651.013, F.S.; adding certain Florida Insurance Code

provisions to the Office of Insurance Regulation's authority to regulate providers of continuing care and continuing care at-home; amending s. 651.019, F.S.; revising requirements for providers and facilities relating to financing and refinancing transactions; amending s. 651.021, F.S.; conforming provisions to changes made by the act; creating s. 651.0215, F.S.; specifying conditions, requirements, procedures, and prohibitions relating to consolidated applications for provisional certificates of authority and for certificates of authority and to the office's review of such applications; specifying conditions under which a provider is entitled to secure the release of certain escrowed funds; providing construction; amending s. 651.022, F.S.; revising and specifying requirements, procedures, and prohibitions relating to applications for provisional certificates of authority and to the office's review of such applications; amending s. 651.023, F.S.; revising and specifying requirements, procedures, and prohibitions relating to applications for certificates of authority and to the office's review of such applications; conforming provisions to changes made by the act; amending s. 651.024, F.S.; revising requirements for certain persons relating to provider acquisitions; specifying procedures for rebutting a presumption of control; providing standing to the office to petition a circuit court in certain proceedings; creating s. 651.0245, F.S.; specifying procedures, requirements, and a

prohibition relating to an application for the simultaneous acquisition of a facility and issuance of a certificate of authority and to the office's review of such application; specifying rulemaking requirements and authority of the Financial Services Commission; providing standing to the office to petition a circuit court in certain proceedings; specifying procedures for rebutting a presumption of control; creating s. 651.0246, F.S.; specifying requirements, conditions, procedures, and prohibitions relating to provider applications to commence construction or marketing for expansions of certificated facilities and to the office's review of such applications; defining the term "existing units"; specifying escrow requirements for certain moneys; specifying conditions under which providers are entitled to secure release of such moneys; providing applicability and construction; amending s. 651.026, F.S.; revising requirements for annual reports filed by providers with the office; revising the commission's rulemaking authority; requiring the office to annually publish a specified industry benchmarking report; amending s. 651.0261, F.S.; requiring providers to file quarterly unaudited financial statements; authorizing the office to waive such requirement under certain circumstances; providing an exception for filing a certain quarterly statement; revising information that the office may require providers to file and the circumstances under

which such information must be filed; revising the commission's rulemaking authority; amending s. 651.028, F.S.; revising requirements that the office may waive under certain circumstances; revising the entities that may qualify for such waiver; requiring such entities to provide certain information within a certain timeframe to the office under certain circumstances; amending s. 651.033, F.S.; revising applicability of escrow requirements; revising requirements for escrow accounts and agreements; revising the office's authority to allow a withdrawal of a specified percentage of the required minimum liquid reserve; revising applicability of requirements relating to the deposit of certain funds in escrow accounts; prohibiting an escrow agent, except under certain circumstances, from releasing or allowing the transfer of funds; creating s. 651.034, F.S.; specifying requirements for the office if a regulatory action level event occurs; specifying requirements for corrective action plans; authorizing the office to use members of the Continuing Care Advisory Council and to retain consultants for certain purposes; requiring affected providers to bear costs and expenses relating to such consultants; specifying requirements for, and authorized actions of, the office and the Department of Financial Services if an impairment occurs; providing construction; authorizing the office to exempt a provider from certain requirements for a certain timeframe; authorizing the commission to adopt

rules; amending s. 651.035, F.S.; revising minimum liquid reserve requirements for providers; specifying requirements, limitations, and procedures for a provider's withdrawal of funds held in escrow and the office's review of certain requests for withdrawal; authorizing the office to order certain transfers under certain circumstances; requiring facilities to annually file with the office a minimum liquid reserve calculation; requiring increases in the minimum liquid reserve to be funded within a certain timeframe; creating s. 651.043, F.S.; specifying requirements for certain management company contracts; specifying requirements, procedures, and authorized actions relating to changes in provider management and to the office's review of such changes; requiring that disapproved management be removed within a certain timeframe; authorizing the office to take certain disciplinary actions under certain circumstances; requiring providers to immediately remove management under certain circumstances; amending s. 651.051, F.S.; revising requirements for the maintenance of provider records and assets; amending s. 651.055, F.S.; revising a required statement in continuing care contracts; amending s. 651.057, F.S.; conforming provisions to changes made by the act; amending s. 651.071, F.S.; specifying the priority of continuing care contracts and continuing care at-home contracts in receivership or liquidation proceedings against a provider; amending s. 651.091, F.S.; revising

requirements for continuing care facilities relating to posting or providing notices; amending s. 651.095, F.S.; adding terms to a list of prohibited terms in certain advertisements; amending s. 651.105, F.S.; adding a certain Florida Insurance Code provision to the office's authority to examine certain providers and applicants; requiring providers to respond to the office's written correspondence and to provide certain information; providing standing to the office to petition certain circuit courts for certain relief; revising, and specifying limitations on, the office's examination authority; amending s. 651.106, F.S.; authorizing the office to deny applications on specified grounds; adding and revising grounds for suspension or revocation of provisional certificates of authority and certificates of authority; creating s. 651.1065, F.S.; prohibiting certain actions by certain persons of an impaired or insolvent continuing care facility; providing that bankruptcy courts or trustees have jurisdiction over certain matters; requiring the office to approve or disapprove the continued marketing of new contracts within a certain timeframe; providing a criminal penalty; amending s. 651.111, F.S.; defining the term "inspection"; revising procedures and requirements relating to requests for inspections to the office; amending s. 651.114, F.S.; revising and specifying requirements, procedures, and authorized actions relating to providers' corrective action plans; providing


436274

construction; revising and specifying requirements and procedures relating to delinquency proceedings against a provider; revising circumstances under which the office must provide a certain notice to trustees or lenders; creating s. 651.1141, F.S.; providing legislative findings; authorizing the office to issue certain immediate final orders under certain circumstances; amending s. 651.121, F.S.; revising the composition of the Continuing Care Advisory Council; amending s. 651.125, F.S.; revising a prohibition to include certain actions performed without a valid provisional certificate of authority; providing effective dates.

242422

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/11/2019	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Perry) recommended the following:

Senate Amendment to Amendment (436274)

Delete lines 187 - 188

and insert:

(25) "Regulatory action level event" means that any two of the following have occurred:

564702

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/11/2019	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Lee) recommended the following:

Senate Amendment to Amendment (436274)

Delete line 1293
and insert:
a regulatory action level event or a corrective action plan. The office may not waive the quarterly reporting requirement for a period of 12 months for any provider that is impaired, or does not comply with a requirement for debt service coverage ratio, days cash on hand, or average facility occupancy under s. 651.011(25).

738088

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/11/2019	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Perry) recommended the following:

Senate Amendment to Amendment (436274) (with directory and title amendments)

Between lines 1682 and 1683
insert:

(11) Notwithstanding subsection (6), if the market value of the minimum liquid reserve is less than the required minimum amount at the end of any fiscal quarter, the provider must fund the shortfall within 10 business days.

738088

====== D I R E C T O R Y C L A U S E A M E N D M E N T ======
And the directory clause is amended as follows:
Delete line 1574
and insert:
subsections (7) through (11) are added to that section, to read:

================ T I T L E A M E N D M E N T ================
And the title is amended as follows:
Between lines 2514 and 2515
insert:
requiring providers to fund shortfalls in minimum liquid reserves under certain circumstances within a certain timeframe;

By Senator Lee

20-00388A-19 20191070__

A bill to be entitled

An act relating to continuing care contracts; amending s. 651.011, F.S.; adding and revising definitions; amending s. 651.012, F.S.; conforming a cross-reference; deleting an obsolete date; amending s. 651.013, F.S.; adding certain Florida Insurance Code provisions to the Office of Insurance Regulation's authority to regulate providers of continuing care and continuing care at-home; amending s. 651.019, F.S.; revising requirements for providers and facilities relating to financing and refinancing transactions; amending s. 651.021, F.S.; conforming provisions to changes made by the act; creating s. 651.0215, F.S.; specifying conditions, requirements, procedures, and prohibitions relating to consolidated applications for provisional certificates of authority and for certificates of authority and to the office's review of such applications; specifying conditions under which a provider is entitled to secure the release of certain escrowed funds; providing construction; amending s. 651.022, F.S.; revising and specifying requirements, procedures, and prohibitions relating to applications for provisional certificates of authority and to the office's review of such applications; amending s. 651.023, F.S.; revising and specifying requirements, procedures, and prohibitions relating to applications for certificates of authority and to the office's review of such applications; conforming provisions to changes made by the act; amending s.

20-00388A-19 20191070__

651.024, F.S.; revising requirements for certain persons relating to provider acquisitions; specifying procedures for rebutting a presumption of control; providing standing to the office to petition a circuit court in certain proceedings; creating s. 651.0245, F.S.; specifying procedures, requirements, and a prohibition relating to an application for the simultaneous acquisition of a facility and issuance of a certificate of authority and to the office's review of such application; specifying rulemaking requirements and authority of the Financial Services Commission; providing standing to the office to petition a circuit court in certain proceedings; specifying procedures for rebutting a presumption of control; creating s. 651.0246, F.S.; specifying requirements, conditions, procedures, and prohibitions relating to provider applications to commence construction or marketing for expansions of certificated facilities and to the office's review of such applications; defining the term "existing units"; specifying escrow requirements for certain moneys; specifying conditions under which providers are entitled to secure release of such moneys; providing applicability and construction; amending s. 651.026, F.S.; revising requirements for annual reports filed by providers with the office; revising the commission's rulemaking authority; requiring the office to annually publish a specified industry benchmarking report; amending s. 651.0261, F.S.;

requiring providers to file quarterly unaudited financial statements; authorizing the office to waive such requirement under certain circumstances; providing an exception for filing a certain quarterly statement; revising information that the office may require providers to file and the circumstances under which such information must be filed; revising the commission's rulemaking authority; amending s. 651.028, F.S.; revising requirements that the office may waive under certain circumstances; revising the entities that may qualify for such waiver; requiring such entities to provide certain information to the office under certain circumstances; amending s. 651.033, F.S.; revising applicability of escrow requirements; revising requirements for escrow accounts and agreements; revising the office's authority to allow a withdrawal of a specified percentage of the required minimum liquid reserve; revising applicability of requirements relating to the deposit of certain funds in escrow accounts; prohibiting an escrow agent, except under certain circumstances, from releasing or allowing the transfer of funds; creating s. 651.034, F.S.; specifying requirements for the office if a regulatory action level event occurs; specifying requirements for corrective action plans; authorizing the office to use members of the Continuing Care Advisory Council and to retain consultants for certain purposes; requiring affected providers to bear the fees, costs, and

expenses of such consultants; specifying requirements for, and authorized actions of, the office and the Department of Financial Services if an impairment occurs; providing construction; authorizing the office to exempt a provider from certain requirements for a certain timeframe; authorizing the commission to adopt rules; amending s. 651.035, F.S.; revising minimum liquid reserve requirements for providers; specifying requirements, limitations, and procedures for a provider's withdrawal of funds held in escrow and the office's review of certain requests for withdrawal; authorizing the office to order certain transfers under certain circumstances; requiring facilities to annually file with the office a minimum liquid reserve calculation; providing construction; creating s. 651.043, F.S.; specifying requirements for certain management company contracts; specifying requirements, procedures, and authorized actions relating to changes in provider management and to the office's review of such changes; requiring that disapproved management be removed within a certain timeframe; authorizing the office to take certain disciplinary actions under certain circumstances; requiring providers to immediately remove management under certain circumstances; amending s. 651.051, F.S.; revising requirements for the maintenance of provider records and assets; amending s. 651.055, F.S.; revising a required statement in continuing care contracts; amending s. 651.057, F.S.; conforming provisions to

changes made by the act; amending s. 651.071, F.S.; specifying the priority of continuing care contracts and continuing care at-home contracts in receivership or liquidation proceedings against a provider; amending s. 651.091, F.S.; revising requirements for continuing care facilities relating to posting or providing notices; amending s. 651.095, F.S.; adding terms to a list of prohibited terms in certain advertisements; amending s. 651.105, F.S.; adding a certain Florida Insurance Code provision to the office's authority to examine certain providers and applicants; requiring providers to respond to the office's written correspondence and to provide certain information; providing standing to the office to petition certain circuit courts for certain relief; revising, and specifying limitations on, the office's examination authority; amending s. 651.106, F.S.; authorizing the office to deny applications on specified grounds; adding and revising grounds for suspension or revocation of provisional certificates of authority and certificates of authority; creating s. 651.1065, F.S.; prohibiting certain actions by certain persons of an impaired or insolvent continuing care facility; providing that bankruptcy courts or trustees have jurisdiction over certain matters; requiring the office to approve or disapprove the continued marketing of new contracts within a certain timeframe; providing a criminal penalty; amending s. 651.111, F.S.; defining the term "inspection";

revising procedures and requirements relating to requests for inspections to the office; amending s. 651.114, F.S.; revising and specifying requirements, procedures, and authorized actions relating to providers' corrective action plans; providing construction; revising and specifying requirements and procedures relating to delinquency proceedings against a provider; revising circumstances under which the office must provide a certain notice to trustees or lenders; creating s. 651.1141, F.S.; providing legislative findings; authorizing the office to issue certain immediate final orders under certain circumstances; amending s. 651.121, F.S.; revising the composition of the Continuing Care Advisory Council; amending s. 651.125, F.S.; revising a prohibition to include certain actions performed without a valid provisional certificate of authority; providing effective dates.

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

Section 1. Section 651.011, Florida Statutes, is amended to read:

651.011 Definitions.—As used in this chapter, the term:

(1) "Actuarial opinion" means an opinion issued by an actuary in accordance with Actuarial Standards of Practice No. 3 for Continuing Care Retirement Communities, Revised Edition, effective May 1, 2011.

(2) "Actuarial study" means an analysis prepared for an

individual facility, or consolidated for multiple facilities, for either a certified provider, as of a current valuation date or the most recent fiscal year, or for an applicant, as of a projected future valuation date, which includes an actuary's opinion as to whether such provider or applicant is in satisfactory actuarial balance in accordance with Actuarial Standards of Practice No. 3 for Continuing Care Retirement Communities, Revised Edition, effective May 1, 2011.

(3) "Actuary" means an individual who is qualified to sign an actuarial opinion in accordance with the American Academy of Actuaries' qualification standards and who is a member in good standing of the American Academy of Actuaries.

(4) ~~(1)~~ "Advertising" means the dissemination of written, visual, or electronic information by a provider, or any person affiliated with or controlled by a provider, to potential residents or their representatives for the purpose of inducing such persons to subscribe to or enter into a contract for continuing care or continuing care at-home.

(5) ~~(2)~~ "Continuing care" or "care" means, pursuant to a contract, furnishing shelter and nursing care or personal services to a resident who resides in a facility, whether such nursing care or personal services are provided in the facility or in another setting designated in the contract for continuing care, by an individual not related by consanguinity or affinity to the resident, upon payment of an entrance fee.

(6) ~~(3)~~ "Continuing Care Advisory Council" or "advisory council" means the council established in s. 651.121.

(7) ~~(4)~~ "Continuing care at-home" means, pursuant to a contract other than a contract described in subsection (5) ~~(2)~~,

furnishing to a resident who resides outside the facility the right to future access to shelter and nursing care or personal services, whether such services are provided in the facility or in another setting designated in the contract, by an individual not related by consanguinity or affinity to the resident, upon payment of an entrance fee.

(8) "Controlling company" means any corporation, trust, or association that directly or indirectly owns 25 percent or more of:

(a) The voting securities of one or more providers or facilities that are stock corporations; or

(b) The ownership interest of one or more providers or facilities that are not stock corporations.

(9) "Corrective order" means an order issued by the office which specifies corrective actions that the office determines are required in accordance with this chapter or commission rule.

(10) "Days cash on hand" means the quotient obtained by dividing the value of paragraph (a) by the value of paragraph (b).

(a) The sum of unrestricted cash, unrestricted short-term and long-term investments, provider restricted funds, and the minimum liquid reserve as of the reporting date.

(b) Operating expenses less depreciation, amortization, and other noncash expenses and nonoperating losses, divided by 365. Operating expenses, depreciation, amortization, and other noncash expenses and nonoperating losses are each the sum of their respective values over the 12-month period ending on the reporting date.

With prior written approval of the office, a demand note or other parental guarantee may be considered a short-term or long-term investment for the purposes of paragraph (a). However, the total of all demand notes issued by the parent may not, at any time, be more than the sum of unrestricted cash and unrestricted short-term and long-term investments held by the parent.

(11) "Debt service coverage ratio" means the quotient obtained by dividing the value of paragraph (a) by the value of paragraph (b).

(a) The sum of total expenses less interest expense on the debt facility, depreciation, amortization, and other noncash expense and nonoperating losses, subtracted from the sum of total revenues, excluding noncash revenues and nonoperating gains, and gross entrance fees received less earned entrance fees and refunds paid. Expenses, interest expense on the debt facility, depreciation, amortization, and other noncash expense and nonoperating losses, revenues, noncash revenues, nonoperating gains, gross entrance fees, earned entrance fees, and refunds are each the sum of their respective values over the 12-month period ending on the reporting date.

(b) Total annual principal and interest expense due on the debt facility over the 12-month period ending on the reporting date. For the purposes of this paragraph, principal excludes any balloon principal payment amounts, and interest expense due is the sum of the interest over the 12-month period immediately preceding the reporting date.

(12) "Department" means the Department of Financial Services.

(13)~~(5)~~ "Entrance fee" means an initial or deferred payment

of a sum of money or property made as full or partial payment for continuing care or continuing care at-home. An accommodation fee, admission fee, member fee, or other fee of similar form and application are considered to be an entrance fee.

(14)~~(6)~~ "Facility" means a place where continuing care is furnished and may include one or more physical plants on a primary or contiguous site or an immediately accessible site. As used in this subsection, the term "immediately accessible site" means a parcel of real property separated by a reasonable distance from the facility as measured along public thoroughfares, and the term "primary or contiguous site" means the real property contemplated in the feasibility study required by this chapter.

~~(7) "Generally accepted accounting principles" means those accounting principles and practices adopted by the Financial Accounting Standards Board and the American Institute of Certified Public Accountants, including Statement of Position 90-8 with respect to any full year to which the statement applies.~~

(15) "Impaired" or "impairment" means that either of the following has occurred:

(a) A provider has failed to maintain its minimum liquid reserve as required under s. 651.035, unless the provider has received prior written approval from the office for a withdrawal pursuant to s. 651.035(6) and is compliant with the approved payment schedule.

(b) Beginning January 1, 2021:

1. For a provider with mortgage financing from a third-party lender or a public bond issue, the provider's debt service

coverage ratio is less than 1.00:1 and the provider's days cash on hand is less than 90; or

2. For a provider without mortgage financing from a third-party lender or public bond issue, the provider's days cash on hand is less than 90.

If the provider is a member of an obligated group having cross-collateralized debt, the obligated group's debt service coverage ratio and days cash on hand must be used to determine if the provider is impaired.

(16) ~~(8)~~ "Insolvency" means the condition in which a ~~the~~ provider is unable to pay its obligations as they come due in the normal course of business.

(17) ~~(9)~~ "Licensed" means that a ~~the~~ provider has obtained a certificate of authority from the office ~~department~~.

(18) "Manager", "management," or "management company" means a person who administers the day-to-day business operations of a facility for a provider, subject to the policies, directives, and oversight of the provider.

(19) ~~(10)~~ "Nursing care" means those services or acts rendered to a resident by an individual licensed or certified pursuant to chapter 464.

(20) "Obligated group" means one or more entities that jointly agree to be bound by a financing structure containing security provisions and covenants applicable to the group. For the purposes of this subsection, debt issued under such a financing structure must be a joint and several obligation of each member of the group.

(21) "Occupancy" means the total number of occupied

independent living units, assisted living units, and skilled nursing beds in a facility divided by the total number of units and beds in that facility, excluding units and beds that are unavailable to market or that are reserved by prospective residents.

(22) ~~(11)~~ "Personal services" has the same meaning as in s. 429.02.

(23) ~~(12)~~ "Provider" means the owner or operator, whether a natural person, partnership or other unincorporated association, however organized, trust, or corporation, of an institution, building, residence, or other place, whether operated for profit or not, which owner or operator provides continuing care or continuing care at-home for a fixed or variable fee, or for any other remuneration of any type, whether fixed or variable, for the period of care, payable in a lump sum or lump sum and monthly maintenance charges or in installments. The term does not apply to an entity that has existed and continuously operated a facility located on at least 63 acres in this state providing residential lodging to members and their spouses for at least 66 years on or before July 1, 1989, and has the residential capacity of 500 persons, is directly or indirectly owned or operated by a nationally recognized fraternal organization, is not open to the public, and accepts only its members and their spouses as residents.

(24) ~~(13)~~ "Records" means all documents, correspondence, and ~~the permanent~~ financial, directory, and personnel information and data maintained by a provider pursuant to this chapter, regardless of the physical form, characteristics, or means of transmission.

(25) "Regulatory action level event" means that any of the following has occurred:

(a) The provider's debt service coverage ratio is less than the minimum ratio specified in the provider's bond covenants or lending agreement for long-term financing, or, if the provider does not have a debt service coverage ratio required by its lending institution, the provider's debt service coverage ratio is less than 1.20:1 as of the most recent annual report filed with the office. If the provider is a member of an obligated group having cross-collateralized debt, the obligated group's debt service coverage ratio must be used as the provider's debt service coverage ratio.

(b) The provider's days cash on hand is less than the minimum number of days cash on hand specified in the provider's bond covenants or lending agreement for long-term financing. If the provider does not have a days cash on hand required by its lending institution, the days cash on hand may not be less than 100 as of the most recent annual report filed with the office. If the provider is a member of an obligated group having cross-collateralized debt, the days cash on hand of the obligated group must be used as the provider's days cash on hand.

(c) The average occupancy of the provider's facility over the 12-month period ending on the reporting date is less than 80 percent.

(26)~~(14)~~ "Resident" means a purchaser of, a nominee of, or a subscriber to a continuing care or continuing care at-home contract. Such contract does not give the resident a part ownership of the facility in which the resident is to reside, unless expressly provided in the contract.

(27)~~(15)~~ "Shelter" means an independent living unit, room, apartment, cottage, villa, personal care unit, nursing bed, or other living area within a facility set aside for the exclusive use of one or more identified residents.

Section 2. Section 651.012, Florida Statutes, is amended to read:

651.012 Exempted facility; written disclosure of exemption.—Any facility exempted under ss. 632.637(1)(e) and 651.011(23) ~~651.011(12)~~ must provide written disclosure of such exemption to each person admitted to the facility ~~after October 1, 1996~~. This disclosure must be written using language likely to be understood by the person and must briefly explain the exemption.

Section 3. Subsection (2) of section 651.013, Florida Statutes, is amended to read:

651.013 Chapter exclusive; applicability of other laws.—

(2) In addition to other applicable provisions cited in this chapter, the office has the authority granted under ss. 624.302 and 624.303, 624.307-624.312, 624.318 ~~624.308-624.312~~, 624.319(1)-(3), 624.320-624.321, 624.324, ~~and~~ 624.34, and 624.422 of the Florida Insurance Code to regulate providers of continuing care and continuing care at-home.

Section 4. Section 651.019, Florida Statutes, is amended to read:

651.019 New financing, additional financing, or refinancing.—

(1)(a) A provider shall provide a written general outline of the amount and the anticipated terms of any new financing or refinancing, and the intended use of proceeds, to the residents'

council at least 30 days before the closing date of the financing or refinancing transaction. If there is a material change in the noticed information, a provider shall provide an updated notice to the residents' council within 10 business days after the provider becomes aware of such change.

(b) If the facility does not have a residents' council, the facility must make available, in the same manner as other community notices, the information required under paragraph (a) ~~After issuance of a certificate of authority, the provider shall submit to the office a general outline, including intended use of proceeds, with respect to any new financing, additional financing, or refinancing at least 30 days before the closing date of such financing transaction~~.

(2) Within 30 days after the closing date of such financing or refinancing transaction, ~~The provider shall furnish any information the office may reasonably request in connection with any new financing, additional financing, or refinancing, including, but not limited to, the financing agreements and any related documents, escrow or trust agreements, and statistical or financial data.~~ the provider shall ~~also~~ submit to the office copies of executed financing documents, escrow or trust agreements prepared in support of such financing or refinancing transaction, and a copy of all documents required to be submitted to the residents' council under paragraph (1)(a) ~~within 30 days after the closing date~~.

Section 5. Section 651.021, Florida Statutes, is amended to read:

651.021 Certificate of authority required.—

~~(1)~~ A ~~No~~ person may not engage in the business of providing

continuing care, issuing contracts for continuing care or continuing care at-home, or constructing a facility for the purpose of providing continuing care in this state without a certificate of authority obtained from the office as provided in this chapter. This section ~~subsection~~ does not prohibit the preparation of a construction site or construction of a model residence unit for marketing purposes, or both. The office may allow the purchase of an existing building for the purpose of providing continuing care if the office determines that the purchase is not being made to circumvent the prohibitions in this section.

~~(2) Written approval must be obtained from the office before commencing construction or marketing for an expansion of a certificated facility equivalent to the addition of at least 20 percent of existing units or 20 percent or more in the number of continuing care at-home contracts. This provision does not apply to construction for which a certificate of need from the Agency for Health Care Administration is required.~~

~~(a) For providers that offer both continuing care and continuing care at-home, the 20 percent is based on the total of both existing units and existing contracts for continuing care at-home. For purposes of this subsection, an expansion includes increases in the number of constructed units or continuing care at-home contracts or a combination of both.~~

~~(b) The application for such approval shall be on forms adopted by the commission and provided by the office. The application must include the feasibility study required by s. 651.022(3) or s. 651.023(1)(b) and such other information as required by s. 651.023. If the expansion is only for continuing~~

~~care-at-home contracts, an actuarial study prepared by an independent actuary in accordance with standards adopted by the American Academy of Actuaries which presents the financial impact of the expansion may be substituted for the feasibility study.~~

~~(c) In determining whether an expansion should be approved, the office shall use the criteria provided in ss. 651.022(6) and 651.023(4).~~

Section 6. Section 651.0215, Florida Statutes, is created to read:

651.0215 Consolidated application for a provisional certificate of authority and a certificate of authority; required restrictions on use of entrance fees.—

(1) For an applicant to qualify for a certificate of authority without first obtaining a provisional certificate of authority, all of the following conditions must be met:

(a) All reservation deposits and entrance fees must be placed in escrow in accordance with s. 651.033. The applicant may not use or pledge any part of an initial entrance fee for the construction or purchase of the facility or as security for long-term financing.

(b) The reservation deposit may not exceed the lesser of $40,000 or 10 percent of the then-current fee for the unit selected by a resident and must be refundable at any time before the resident takes occupancy of the selected unit.

(c) The resident contract must state that collection of the balance of the entrance fee is to occur after the resident is notified that his or her selected unit is available for occupancy and on or before the occupancy date.

(2) The consolidated application must be on a form prescribed by the commission and must contain all of the following information:

(a) All of the information required under s. 651.022(2).

(b) A feasibility study prepared by an independent consultant which contains all of the information required by s. 651.022(3) and financial forecasts or projections prepared in accordance with standards adopted by the American Institute of Certified Public Accountants or in accordance with standards for feasibility studies for continuing care retirement communities adopted by the Actuarial Standards Board.

1. The feasibility study must take into account project costs, actual marketing results to date and marketing projections, resident fees and charges, competition, resident contract provisions, and other factors that affect the feasibility of operating the facility.

2. If the feasibility study is prepared by an independent certified public accountant, it must contain an examination report, or a compilation report acceptable to the office, containing a financial forecast or projections for the first 5 years of operations which take into account an actuary's mortality and morbidity assumptions as the study relates to turnover, rates, fees, and charges. If the study is prepared by an independent consulting actuary, it must contain mortality and morbidity assumptions as it relates to turnover, rates, fees, and charges and an actuary's signed opinion that the project as proposed is feasible and that the study has been prepared in accordance with Actuarial Standards of Practice No. 3 for Continuing Care Retirement Communities, Revised Edition,

effective May 1, 2011.

(c) Documents evidencing that commitments have been secured for construction financing and long-term financing or that a documented plan acceptable to the office has been adopted by the applicant for long-term financing.

(d) Documents evidencing that all conditions of the lender have been satisfied to activate the commitment to disburse funds, other than the obtaining of the certificate of authority, the completion of construction, or the closing of the purchase of realty or buildings for the facility.

(e) Documents evidencing that the aggregate amount of entrance fees received by or pledged to the applicant, plus anticipated proceeds from any long-term financing commitment and funds from all other sources in the actual possession of the applicant, equal at least 100 percent of the aggregate cost of constructing or purchasing, equipping, and furnishing the facility plus 100 percent of the anticipated startup losses of the facility.

(f) A complete audited financial report of the applicant, prepared by an independent certified public accountant in accordance with generally accepted accounting principles, as of the date the applicant commenced business operations or for the fiscal year that ended immediately preceding the date of application, whichever is later; and complete unaudited quarterly financial statements attested to by the applicant after the date of the last audit.

(g) Documents evidencing that the applicant will be able to comply with s. 651.035.

(h) Such other reasonable data, financial statements, and

pertinent information as the commission or office may require with respect to the applicant or the facility to determine the financial status of the facility and the management capabilities of its managers and owners.

If any material change occurs in the facts set forth in an application filed with the office pursuant to this subsection, an amendment setting forth such change must be filed with the office within 10 business days after the applicant becomes aware of such change, and a copy of the amendment must be sent by registered mail to the principal office of the facility and to the principal office of the controlling company.

(3) If an applicant has or proposes to have more than one facility offering continuing care or continuing care at-home, a separate certificate of authority must be obtained for each facility.

(4) Within 45 days after receipt of the information required under subsection (2), the office shall examine the information and notify the applicant in writing, specifically requesting any additional information that the office is authorized to require. An application is deemed complete when the office receives all requested information and the applicant corrects any error or omission of which the applicant was timely notified or when the time for such notification has expired. Within 15 days after receipt of all of the requested additional information, the office shall notify the applicant in writing that all of the requested information has been received and that the application is deemed complete as of the date of the notice. Failure to notify the applicant in writing within the 15-day

period constitutes acknowledgment by the office that it has received all requested additional information, and the application is deemed complete for purposes of review on the date the applicant files all of the required additional information.

(5) Within 45 days after an application is deemed complete as set forth in subsection (4) and upon completion of the remaining requirements of this section, the office shall complete its review and issue or deny a certificate of authority to the applicant. If the office requests additional information and the applicant provides it within 5 business days after notification, the period for reviewing or approving an application may not be extended beyond the period specified in subsection (4). If a certificate of authority is denied, the office shall notify the applicant in writing, citing the specific failures to satisfy this chapter, and the applicant is entitled to an administrative hearing pursuant to chapter 120.

(6) The office shall issue a certificate of authority upon determining that the applicant meets all of the requirements of law and has submitted all of the information required under this section, that all escrow requirements have been satisfied, and that the fees prescribed in s. 651.015(2) have been paid.

(7) The issuance of a certificate of authority entitles the applicant to begin construction and collect reservation deposits and entrance fees from prospective residents. The reservation contract must state the cancellation policy and the terms of the continuing care contract. All or any part of an entrance fee or reservation deposit collected must be placed in an escrow account or on deposit with the department pursuant to s.

651.033.

(8) The provider is entitled to secure release of the moneys held in escrow within 7 days after the office receives an affidavit from the provider, along with appropriate documentation to verify, and notification is provided to the escrow agent by certified mail, that all of the following conditions have been satisfied:

(a) A certificate of occupancy has been issued.

(b) Payment in full has been received for at least 70 percent of the total units of a phase or of the total of the combined phases constructed. If a provider offering continuing care at-home is applying for a release of escrowed entrance fees, the same minimum requirement must be met for the continuing care contracts and for the continuing care at-home contracts independently of each other.

(c) The provider has evidence of sufficient funds to meet the requirements of s. 651.035, which may include funds deposited in the initial entrance fee account.

(d) Documents evidencing the intended application of the proceeds upon release and documents evidencing that the entrance fees, when released, will be applied as represented to the office.

Notwithstanding chapter 120, a person, other than the provider, the escrow agent, and the office, may not have a substantial interest in any decision by the office regarding the release of escrow funds in any proceeding under chapter 120 or this chapter.

(9) The office may not approve any application that

includes in the plan of financing any encumbrance of the operating reserves or renewal and replacement reserves required by this chapter.

(10) The office may not issue a certificate of authority to a facility that does not have a component that is to be licensed pursuant to part II of chapter 400 or part I of chapter 429, or that does not offer personal services or nursing services through written contractual agreement. A written contractual agreement must be disclosed in the contract for continuing care or continuing care at-home and is subject to s. 651.1151.

Section 7. Subsections (2), (3), (6), and (8) of section 651.022, Florida Statutes, are amended, and subsection (5) of that section is republished, to read:

651.022 Provisional certificate of authority; application.—

(2) The application for a provisional certificate of authority must ~~shall~~ be on a form prescribed by the commission and must ~~shall~~ contain the following information:

(a) If the applicant or provider is a corporation, a copy of the articles of incorporation and bylaws; if the applicant or provider is a partnership or other unincorporated association, a copy of the partnership agreement, articles of association, or other membership agreement; and, if the applicant or provider is a trust, a copy of the trust agreement or instrument.

(b) The full names, residences, and business addresses of:

1. The proprietor, if the applicant or provider is an individual.

2. Every partner or member, if the applicant or provider is a partnership or other unincorporated association, however organized, having fewer than 50 partners or members, together

with the business name and address of the partnership or other organization.

3. The principal partners or members, if the applicant or provider is a partnership or other unincorporated association, however organized, having 50 or more partners or members, together with the business name and business address of the partnership or other organization. If such unincorporated organization has officers and a board of directors, the full name and business address of each officer and director may be set forth in lieu of the full name and business address of its principal members.

4. The corporation and each officer and director thereof, if the applicant or provider is a corporation.

5. Every trustee and officer, if the applicant or provider is a trust.

6. The manager, whether an individual, corporation, partnership, or association.

7. Any stockholder holding at least a 10 percent interest in the operations of the facility in which the care is to be offered.

8. Any person whose name is required to be provided in the application under this paragraph and who owns any interest in or receives any remuneration from, directly or indirectly, any professional service firm, association, trust, partnership, or corporation providing goods, leases, or services to the facility for which the application is made, with a real or anticipated value of $10,000 or more, and the name and address of the professional service firm, association, trust, partnership, or corporation in which such interest is held. The applicant shall

describe such goods, leases, or services and the probable cost to the facility or provider and shall describe why such goods, leases, or services should not be purchased from an independent entity.

9. Any person, corporation, partnership, association, or trust owning land or property leased to the facility, along with a copy of the lease agreement.

10. Any affiliated parent or subsidiary corporation or partnership.

(c)1. Evidence that the applicant is reputable and of responsible character. If the applicant is a firm, association, organization, partnership, business trust, corporation, or company, the form must ~~shall~~ require evidence that the members or shareholders ~~are reputable and of responsible character,~~ and the person in charge of providing care under a certificate of authority are ~~shall likewise be required to produce evidence of being~~ reputable and of responsible character.

2. Evidence satisfactory to the office of the ability of the applicant to comply with ~~the provisions of~~ this chapter and with rules adopted by the commission pursuant to this chapter.

3. A statement of whether a person identified in the application for a provisional certificate of authority or the administrator or manager of the facility, if such person has been designated, or any such person living in the same location:

a. Has been convicted of a felony or has pleaded nolo contendere to a felony charge, or has been held liable or has been enjoined in a civil action by final judgment, if the felony or civil action involved fraud, embezzlement, fraudulent conversion, or misappropriation of property.

b. Is subject to a currently effective injunctive or restrictive order or federal or state administrative order relating to business activity or health care as a result of an action brought by a public agency or department, including, without limitation, an action affecting a license under chapter 400 or chapter 429.

The statement must ~~shall~~ set forth the court or agency, the date of conviction or judgment, and the penalty imposed or damages assessed, or the date, nature, and issuer of the order. Before determining whether a provisional certificate of authority is to be issued, the office may make an inquiry to determine the accuracy of the information submitted pursuant to subparagraphs 1., 2., and 3. ~~1. and 2.~~

(d) The contracts for continuing care and continuing care at-home to be entered into between the provider and residents which meet the minimum requirements of s. 651.055 or s. 651.057 and which include a statement describing the procedures required by law relating to the release of escrowed entrance fees. Such statement may be furnished through an addendum.

(e) Any advertisement or other written material proposed to be used in the solicitation of residents.

(f) Such other reasonable data, financial statements, and pertinent information as the commission or office may reasonably require with respect to the provider or the facility, including the most recent audited financial report ~~statements~~ of comparable facilities currently or previously owned, managed, or developed by the applicant or its principal, to assist in determining the financial viability of the project and the

management capabilities of its managers and owners.

(g) The forms of the residency contracts, reservation contracts, escrow agreements, and wait list contracts, if applicable, which are proposed to be used by the provider in the furnishing of care. The office shall approve contracts and escrow agreements that comply with ss. 651.023(1)(c), 651.033, 651.055, and 651.057. Thereafter, no other form of contract or agreement may be used by the provider until it has been submitted to the office and approved.

If any material change occurs in the facts set forth in an application filed with the office pursuant to this subsection, an amendment setting forth such change must be filed with the office within 10 business days after the applicant becomes aware of such change, and a copy of the amendment must be sent by registered mail to the principal office of the facility and to the principal office of the controlling company.

(3) In addition to the information required in subsection (2), an applicant for a provisional certificate of authority shall submit a ~~market~~ feasibility study with appropriate financial, marketing, and actuarial assumptions for the first 5 years of operations. The ~~market~~ feasibility study must ~~shall~~ include at least the following information:

(a) A description of the proposed facility, including the location, size, anticipated completion date, and the proposed construction program.

(b) An identification and evaluation of the primary and, if appropriate, the secondary market areas of the facility and the projected unit sales per month.

(c) Projected revenues, including anticipated entrance fees; monthly service fees; nursing care revenues ~~rates~~, if applicable; and all other sources of revenue~~, including the total amount of debt financing required~~.

(d) Projected expenses, including staffing requirements and salaries; cost of property, plant, and equipment, including depreciation expense; interest expense; marketing expense; and other operating expenses.

(e) A projected balance sheet ~~Current assets and liabilities of the applicant~~.

(f) Expectations of the financial condition of the project, including the projected cash flow, and ~~a projected balance sheet and~~ an estimate of the funds anticipated to be necessary to cover startup losses.

(g) The inflation factor, if any, assumed in the feasibility study for the proposed facility and how and where it is applied.

(h) Project costs and the total amount of debt financing required, marketing projections, resident fees and charges, the competition, resident contract provisions, and other factors that ~~which~~ affect the feasibility of the facility.

(i) Appropriate population projections, including morbidity and mortality assumptions.

(j) The name of the person who prepared the feasibility study and the experience of such person in preparing similar studies or otherwise consulting in the field of continuing care. The preparer of the feasibility study may be the provider or a contracted third party.

(k) Any other information that the applicant deems relevant

and appropriate to enable the office to make a more informed determination.

(5)(a) Within 30 days after receipt of an application for a provisional certificate of authority, the office shall examine the application and shall notify the applicant in writing, specifically setting forth and specifically requesting any additional information the office is permitted by law to require. If the application submitted is determined by the office to be substantially incomplete so as to require substantial additional information, including biographical information, the office may return the application to the applicant with a written notice that the application as received is substantially incomplete and, therefore, unacceptable for filing without further action required by the office. Any filing fee received shall be refunded to the applicant.

(b) Within 15 days after receipt of all of the requested additional information, the office shall notify the applicant in writing that all of the requested information has been received and the application is deemed to be complete as of the date of the notice. Failure to so notify the applicant in writing within the 15-day period shall constitute acknowledgment by the office that it has received all requested additional information, and the application shall be deemed to be complete for purposes of review upon the date of the filing of all of the requested additional information.

(6) Within 45 days after the date an application is deemed complete as set forth in paragraph (5)(b), the office shall complete its review and issue a provisional certificate of authority to the applicant based upon its review and a

determination that the application meets all requirements of law, that the feasibility study was based on sufficient data and reasonable assumptions, and that the applicant will be able to provide continuing care or continuing care at-home as proposed and meet all financial and contractual obligations related to its operations, including the financial requirements of this chapter. If the office requests additional information and the applicant provides it within 5 business days after notification, the period for reviewing or approving the application may not be extended beyond the period specified in subsection (5). If the application is denied, the office shall notify the applicant in writing, citing the specific failures to meet the provisions of this chapter. Such denial entitles the applicant to a hearing pursuant to chapter 120.

(8) The office may ~~shall~~ not approve any application that ~~which~~ includes in the plan of financing any encumbrance of the operating reserves or renewal and replacement reserves required by this chapter.

Section 8. Subsections (1), (3), and (4), paragraph (b) of subsection (5), and subsections (6) through (9) of section 651.023, Florida Statutes, are amended, and subsection (2) of that section is republished, to read:

651.023 Certificate of authority; application.—

(1) After issuance of a provisional certificate of authority, the office shall issue to the holder of such provisional certificate a certificate of authority if the holder of the provisional certificate provides the office with the following information:

(a) Any material change in status with respect to the

information required to be filed under s. 651.022(2) in the application for the provisional certificate.

(b) A feasibility study prepared by an independent consultant which contains all of the information required by s. 651.022(3) and financial forecasts or projections prepared in accordance with standards adopted by the American Institute of Certified Public Accountants or in accordance with standards for feasibility studies or continuing care retirement communities adopted by the Actuarial Standards Board.

~~1. The study must also contain an independent evaluation and examination opinion, or a comparable opinion acceptable to the office, by the consultant who prepared the study, of the underlying assumptions used as a basis for the forecasts or projections in the study and that the assumptions are reasonable and proper and the project as proposed is feasible.~~

1.~~2.~~ The study must take into account project costs, actual marketing results to date and marketing projections, resident fees and charges, competition, resident contract provisions, and any other factors which affect the feasibility of operating the facility.

2.~~3.~~ If the study is prepared by an independent certified public accountant, it must contain an examination opinion or a compilation report acceptable to the office containing a financial forecast or projections for the first 5 ~~3~~ years of operations which take into account an actuary's mortality and morbidity assumptions as the study relates to turnover, rates, fees, and charges ~~and financial projections having a compilation opinion for the next 3 years~~. If the study is prepared by an independent consulting actuary, it must contain mortality and

morbidity assumptions as the study relates to turnover, rates, fees, and charges ~~data~~ and an actuary's signed opinion that the project as proposed is feasible and that the study has been prepared in accordance with standards adopted by the American Academy of Actuaries.

(c) Subject to subsection (4), a provider may submit an application for a certificate of authority and any required exhibits upon submission of documents evidencing ~~proof~~ that the project has a minimum of 30 percent of the units reserved for which the provider is charging an entrance fee. ~~This does not apply to an application for a certificate of authority for the acquisition of a facility for which a certificate of authority was issued before October 1, 1983, to a provider who subsequently becomes a debtor in a case under the United States Bankruptcy Code, 11 U.S.C. ss. 101 et seq., or to a provider for which the department has been appointed receiver pursuant to part II of chapter 631.~~

(d) Documents evidencing ~~Proof~~ that commitments have been secured for both construction financing and long-term financing or a documented plan acceptable to the office has been adopted by the applicant for long-term financing.

(e) Documents evidencing ~~Proof~~ that all conditions of the lender have been satisfied to activate the commitment to disburse funds other than the obtaining of the certificate of authority, the completion of construction, or the closing of the purchase of realty or buildings for the facility.

(f) Documents evidencing ~~Proof~~ that the aggregate amount of entrance fees received by or pledged to the applicant, plus anticipated proceeds from any long-term financing commitment,

plus funds from all other sources in the actual possession of the applicant, equal at least 100 percent of the aggregate cost of constructing or purchasing, equipping, and furnishing the facility plus 100 percent of the anticipated startup losses of the facility.

(g) A complete audited financial report ~~statements~~ of the applicant, prepared by an independent certified public accountant in accordance with generally accepted accounting principles, as of the date the applicant commenced business operations or for the fiscal year that ended immediately preceding the date of application, whichever is later, and complete unaudited quarterly financial statements attested to by the applicant after the date of the last audit.

(h) Documents evidencing ~~Proof~~ that the applicant has complied with the escrow requirements of subsection (5) or subsection (7) and will be able to comply with s. 651.035.

(i) Such other reasonable data, financial statements, and pertinent information as the commission or office may require with respect to the applicant or the facility, to determine the financial status of the facility and the management capabilities of its managers and owners.

If any material change occurs in the facts set forth in an application filed with the office pursuant to this subsection, an amendment setting forth such change must be filed with the office within 10 business days after the applicant becomes aware of such change, and a copy of the amendment must be sent by registered mail to the principal office of the facility and to the principal office of the controlling company.

(2) Within 30 days after receipt of the information required under subsection (1), the office shall examine such information and notify the provider in writing, specifically requesting any additional information the office is permitted by law to require. Within 15 days after receipt of all of the requested additional information, the office shall notify the provider in writing that all of the requested information has been received and the application is deemed to be complete as of the date of the notice. Failure to notify the applicant in writing within the 15-day period constitutes acknowledgment by the office that it has received all requested additional information, and the application shall be deemed complete for purposes of review on the date of filing all of the required additional information.

(3) Within 45 days after an application is deemed complete as set forth in subsection (2), and upon completion of the remaining requirements of this section, the office shall complete its review and issue or deny a certificate of authority to the holder of a provisional certificate of authority. If a certificate of authority is denied, the office must notify the holder of the provisional certificate in writing, citing the specific failures to satisfy the provisions of this chapter. If the office requests additional information and the applicant provides it within 5 business days after notification, the period for reviewing or approving an application may not be extended beyond the period specified in subsection (2). If denied, the holder of the provisional certificate is entitled to an administrative hearing pursuant to chapter 120.

(4) The office shall issue a certificate of authority upon

determining that the applicant meets all requirements of law and has submitted all of the information required by this section, that all escrow requirements have been satisfied, and that the fees prescribed in s. 651.015(2) have been paid.

(a) A ~~Notwithstanding satisfaction of the 30 percent minimum reservation requirement of paragraph (1)(c), no~~ certificate of authority may not ~~shall~~ be issued until documentation evidencing that the project has a minimum of 50 percent of the units reserved for which the provider is charging an entrance fee~~, and proof~~ is provided to the office. If a provider offering continuing care at-home is applying for a certificate of authority ~~or approval of an expansion pursuant to s. 651.021(2)~~, the same minimum reservation requirements must be met for the continuing care and continuing care at-home contracts, independently of each other.

(b) In order for a unit to be considered reserved under this section, the provider must collect a minimum deposit of the lesser of $40,000 or 10 percent of the then-current entrance fee for that unit, and may assess a forfeiture penalty of 2 percent of the entrance fee due to termination of the reservation contract after 30 days for any reason other than the death or serious illness of the resident, the failure of the provider to meet its obligations under the reservation contract, or other circumstances beyond the control of the resident that equitably entitle the resident to a refund of the resident's deposit. The reservation contract must state the cancellation policy and the terms of the continuing care or continuing care at-home contract to be entered into.

(5) Up to 25 percent of the moneys paid for all or any part

of an initial entrance fee may be included or pledged for the construction or purchase of the facility or as security for long-term financing. The term "initial entrance fee" means the total entrance fee charged by the facility to the first occupant of a unit.

(b) For an expansion as provided in s. 651.0246 ~~s. 651.021(2)~~, a minimum of 75 percent of the moneys paid for all or any part of an initial entrance fee collected for continuing care and 50 percent of the moneys paid for all or any part of an initial fee collected for continuing care at-home shall be placed in an escrow account or on deposit with the department as prescribed in s. 651.033.

(6) The provider is entitled to secure release of the moneys held in escrow within 7 days after receipt by the office of an affidavit from the provider, along with appropriate copies to verify, and notification to the escrow agent by certified mail, that the following conditions have been satisfied:

(a) A certificate of occupancy has been issued.

(b) Payment in full has been received for at least 70 percent of the total units of a phase or of the total of the combined phases constructed. If a provider offering continuing care at-home is applying for a release of escrowed entrance fees, the same minimum requirement must be met for the continuing care and continuing care at-home contracts, independently of each other.

~~(c) The consultant who prepared the feasibility study required by this section or a substitute approved by the office certifies within 12 months before the date of filing for office approval that there has been no material adverse change in~~

~~status with regard to the feasibility study. If a material adverse change exists at the time of submission, sufficient information acceptable to the office and the feasibility consultant must be submitted which remedies the adverse condition.~~

(c) ~~(d)~~ Documents evidencing ~~Proof~~ that commitments have been secured or a documented plan adopted by the applicant has been approved by the office for long-term financing.

(d) ~~(c)~~ Documents evidencing ~~Proof~~ that the provider has sufficient funds to meet the requirements of s. 651.035, which may include funds deposited in the initial entrance fee account.

(e) ~~(f)~~ Documents evidencing ~~Proof as to~~ the intended application of the proceeds upon release and documentation ~~proof~~ that the entrance fees when released will be applied as represented to the office.

(f) If any material change occurred in the facts set forth in the application filed with the office pursuant to subsection (1), the applicant timely filed the amendment setting forth such change with the office and sent copies of the amendment to the principal office of the facility and to the principal office of the controlling company as required under that subsection.

Notwithstanding chapter 120, no person, other than the provider, the escrow agent, and the office, may have a substantial interest in any office decision regarding release of escrow funds in any proceedings under chapter 120 or this chapter regarding release of escrow funds.

(7) In lieu of the provider fulfilling the requirements in subsection (5) and paragraphs (6)(b) and (c) ~~(d)~~, the office may

authorize the release of escrowed funds to retire all outstanding debts on the facility and equipment upon application of the provider and upon the provider's showing that the provider will grant to the residents a first mortgage on the land, buildings, and equipment that constitute the facility, and that the provider has satisfied paragraphs (6)(a) ~~, (c),~~ and (d) ~~(c)~~. Such mortgage shall secure the refund of the entrance fee in the amount required by this chapter. The granting of such mortgage is subject to the following:

(a) The first mortgage is granted to an independent trust that is beneficially held by the residents. The document creating the trust must include a provision that agrees to an annual audit and will furnish to the office all information the office may reasonably require. The mortgage may secure payment on bonds issued to the residents or trustee. Such bonds are redeemable after termination of the residency contract in the amount and manner required by this chapter for the refund of an entrance fee.

(b) Before granting a first mortgage to the residents, all construction must be substantially completed and substantially all equipment must be purchased. No part of the entrance fees may be pledged as security for a construction loan or otherwise used for construction expenses before the completion of construction.

(c) If the provider is leasing the land or buildings used by the facility, the leasehold interest must be for a term of at least 30 years.

(8) ~~The timeframes provided under s. 651.022(5) and (6) apply to applications submitted under s. 651.021(2).~~ The office

may not issue a certificate of authority to a facility that does not have a component that is to be licensed pursuant to part II of chapter 400 or to part I of chapter 429 or that does not offer personal services or nursing services through written contractual agreement. A written contractual agreement must be disclosed in the contract for continuing care or continuing care at-home and is subject to ~~the provisions of~~ s. 651.1151, relating to administrative, vendor, and management contracts.

(9) The office may not approve an application that includes in the plan of financing any encumbrance of the operating reserves or renewal and replacement reserves required by this chapter.

Section 9. Section 651.024, Florida Statutes, is amended to read:

651.024 Acquisition.—

(1) A person who seeks to assume the role of general partner of a provider or to otherwise assume ownership or possession of, or control over, 10 percent or more of a provider's assets, based on the balance sheet from the most recent financial audit report filed with the office, is ~~issued a certificate of authority to operate a continuing care facility or a provisional certificate of authority shall be~~ subject to ~~the provisions of~~ s. 628.4615 and is not required to make filings pursuant to s. 651.022, s. 651.023, or s. 651.0245.

(2) A person who seeks to acquire and become the provider for a facility is subject to s. 651.0245 and is not required to make filings pursuant to ss. 628.4615, 651.022, and 651.023.

(3) A person may rebut a presumption of control by filing a disclaimer of control with the office on a form prescribed by

the commission. The disclaimer must fully disclose all material relationships and bases for affiliation between the person and the provider or facility, as well as the basis for disclaiming the affiliation. In lieu of such form, a person or acquiring party may file with the office a copy of a Schedule 13G filed with the Securities and Exchange Commission pursuant to Rule 13d-1(b) or (c), 17 C.F.R. s. 240.13d-1, under the Securities Exchange Act of 1934, as amended. After a disclaimer has been filed, the provider or facility is relieved of any duty to register or report under this section which may arise out of the provider's or facility's relationship with the person, unless the office disallows the disclaimer.

(4) In addition to the provider, the facility, or the controlling company, the office has standing to petition a circuit court as described in s. 628.4615(9).

Section 10. Section 651.0245, Florida Statutes, is created to read:

651.0245 Application for the simultaneous acquisition of a facility and issuance of a certificate of authority.—

(1) Except with the prior written approval of the office, a person may not, individually or in conjunction with any affiliated person of such person, directly or indirectly acquire a facility operating under a subsisting certificate of authority and engage in the business of providing continuing care.

(2) An applicant seeking simultaneous acquisition of a facility and issuance of a certificate of authority must:

(a) Comply with the notice requirements of s. 628.4615(2)(a); and

(b) File an application in the form required by the office

and cooperate with the office's review of the application.

(3) The commission shall adopt by rule application requirements equivalent to those described in ss. 628.4615(4) and (5), 651.022(2), and 651.023(1)(b). The office shall review the application and issue an approval or disapproval of the filing in accordance with ss. 628.4615(6)(a) and (c), (7)-(10), and (14); and 651.023(1)(b).

(4) In addition to the facility, the provider, or the controlling company, the office has standing to petition a circuit court as described in s. 628.4615(9).

(5) A person may rebut a presumption of control by filing a disclaimer of control with the office on a form prescribed by the commission. The disclaimer must fully disclose all material relationships and bases for affiliation between the person and the provider or facility, as well as the basis for disclaiming the affiliation. In lieu of such form, a person or acquiring party may file with the office a copy of a Schedule 13G filed with the Securities and Exchange Commission pursuant to Rule 13d-1(b) or (c), 17 C.F.R. s. 240.13d-1, under the Securities Exchange Act of 1934, as amended. After a disclaimer has been filed, the provider or facility is relieved of any duty to register or report under this section which may arise out of the provider's or facility's relationship with the person, unless the office disallows the disclaimer.

(6) The commission may adopt rules as necessary to administer this section.

Section 11. Section 651.0246, Florida Statutes, is created to read:

651.0246 Expansions.—

(1)(a) A provider must obtain written approval from the office before commencing construction or marketing for an expansion of a certificated facility equivalent to the addition of at least 20 percent of existing units or 20 percent or more of the number of continuing care at-home contracts. If the provider has exceeded the current statewide median for days cash on hand, debt service coverage ratio, and total campus occupancy for two consecutive annual reporting periods, the provider is automatically granted approval to expand the total number of existing units by up to 35 percent upon submitting a letter to the office indicating the total number of planned units in the expansion, the proposed sources and uses of funds, and an attestation that the provider understands and pledges to comply with all minimum liquid reserve and escrow account requirements. As used in this section, the term "existing units" means the sum of the total number of independent living units and assisted living units identified in the most recent annual report filed with the office pursuant to s. 651.026. For purposes of this section, the statewide median for days cash on hand, debt service coverage ratio, and total campus occupancy is the median calculated in the most recent annual report submitted by the office to the Continuing Care Advisory Council pursuant to s. 651.121(8). This section does not apply to construction for which a certificate of need from the Agency for Health Care Administration is required.

(b) The application for the approval of an addition consisting of 20 percent or more of existing units or continuing care at-home contracts must be on forms adopted by the commission and provided by the office. The application must

include the feasibility study required by this section and such other information as reasonably requested by the office. If the expansion is only for continuing care at-home contracts, an actuarial study prepared by an independent actuary in accordance with standards adopted by the American Academy of Actuaries which presents the financial impact of the expansion may be substituted for the feasibility study.

(c) In determining whether an expansion should be approved, the office shall consider:

1. Whether the application meets all requirements of law;

2. Whether the feasibility study was based on sufficient data and reasonable assumptions; and

3. Whether the applicant will be able to provide continuing care or continuing care at-home as proposed and meet all financial obligations related to its operations, including the financial requirements of this chapter.

If the application is denied, the office must notify the applicant in writing, citing the specific failures to meet the provisions of this chapter. A denial entitles the applicant to a hearing pursuant to chapter 120.

(2) A provider applying for expansion of a certificated facility must submit all of the following:

(a) A feasibility study prepared by an independent certified public accountant. The feasibility study must include at least the following information:

1. A description of the facility and proposed expansion, including the location, the size, the anticipated completion date, and the proposed construction program.

2. An identification and evaluation of the primary and, if applicable, secondary market areas of the facility and the projected unit sales per month.

3. Projected revenues, including anticipated entrance fees; monthly service fees; nursing care revenues, if applicable; and all other sources of revenue.

4. Projected expenses, including for staffing requirements and salaries; the cost of property, plant, and equipment, including depreciation expense; interest expense; marketing expense; and other operating expenses.

5. A projected balance sheet of the applicant.

6. The expectations for the financial condition of the project, including the projected cash flow and an estimate of the funds anticipated to be necessary to cover startup losses.

7. The inflation factor, if any, assumed in the study for the proposed expansion and how and where it is applied.

8. Project costs; the total amount of debt financing required; marketing projections; resident rates, fees, and charges; the competition; resident contract provisions; and other factors that affect the feasibility of the facility.

9. Appropriate population projections, including morbidity and mortality assumptions.

10. The name of the person who prepared the feasibility study and his or her experience in preparing similar studies or otherwise consulting in the field of continuing care.

11. Financial forecasts or projections prepared in accordance with standards adopted by the American Institute of Certified Public Accountants or in accordance with standards for feasibility studies for continuing care retirement communities

adopted by the Actuarial Standards Board.

12. An independent evaluation and examination opinion for the first 5 years of operations, or a comparable opinion acceptable to the office, by the consultant who prepared the study, of the underlying assumptions used as a basis for the forecasts or projections in the study and that the assumptions are reasonable and proper and the project as proposed is feasible.

13. Any other information that the provider deems relevant and appropriate to provide to enable the office to make a more informed determination.

(b) Such other reasonable data, financial statements, and pertinent information as the commission or office may require with respect to the applicant or the facility to determine the financial status of the facility and the management capabilities of its managers and owners.

(3) A minimum of 75 percent of the moneys paid for all or any part of an initial entrance fee or reservation deposit collected for units in the expansion and 50 percent of the moneys paid for all or any part of an initial fee collected for continuing care at-home contracts in the expansion must be placed in an escrow account or on deposit with the department as prescribed in s. 651.033. Up to 25 percent of the moneys paid for all or any part of an initial entrance fee or reservation deposit may be included or pledged for the construction or purchase of the facility or as security for long-term financing. As used in this section, the term "initial entrance fee" means the total entrance fee charged by the facility to the first occupant of a unit.

(4) The provider is entitled to secure release of the moneys held in escrow within 7 days after receipt by the office of an affidavit from the provider, along with appropriate copies to verify, and notification to the escrow agent by certified mail that the following conditions have been satisfied:

(a) A certificate of occupancy has been issued.

(b) Payment in full has been received for at least 50 percent of the total units of a phase or of the total of the combined phases constructed. If a provider offering continuing care at-home is applying for a release of escrowed entrance fees, the same minimum requirement must be met for the continuing care and continuing care at-home contracts independently of each other.

(c) Documents evidencing that commitments have been secured or that a documented plan adopted by the applicant has been approved by the office for long-term financing.

(d) Documents evidencing that the provider has sufficient funds to meet the requirements of s. 651.035, which may include funds deposited in the initial entrance fee account.

(e) Documents evidencing the intended application of the proceeds upon release and documentation that the entrance fees, when released, will be applied as represented to the office.

Notwithstanding chapter 120, only the provider, the escrow agent, and the office have a substantial interest in any office decision regarding release of escrow funds in any proceedings under chapter 120 or this chapter.

(5)(a) Within 30 days after receipt of an application for expansion, the office shall examine the application and shall

notify the applicant in writing, specifically requesting any additional information that the office is authorized to require. Within 15 days after the office receives all the requested additional information, the office shall notify the applicant in writing that the requested information has been received and that the application is deemed complete as of the date of the notice. If the office chooses not to notify the applicant within the 15-day period, the application is deemed complete for purposes of review on the date the applicant files the additional requested information. If the application submitted is determined by the office to be substantially incomplete so as to require substantial additional information, including biographical information, the office may return the application to the applicant with a written notice stating that the application as received is substantially incomplete and, therefore, is unacceptable for filing without further action required by the office. Any filing fee received must be refunded to the applicant.

(b) An application is deemed complete upon the office receiving all requested information and the applicant correcting any error or omission of which the applicant was timely notified or when the time for such notification has expired. The office shall notify the applicant in writing of the date on which the application was deemed complete.

(6) Within 45 days after the date on which an application is deemed complete as provided in paragraph (5)(b), the office shall complete its review and, based upon its review, approve an expansion by the applicant and issue a determination that the application meets all requirements of law, that the feasibility

study was based on sufficient data and reasonable assumptions, and that the applicant will be able to provide continuing care or continuing care at-home as proposed and meet all financial and contractual obligations related to its operations, including the financial requirements of this chapter. If the office requests additional information and the applicant provides it within 5 business days after notification, the period for reviewing or approving an application may not be extended beyond the period specified in paragraph (5)(a). If the application is denied, the office must notify the applicant in writing, citing the specific failures to meet the requirements of this chapter. The denial entitles the applicant to a hearing pursuant to chapter 120.

Section 12. Paragraphs (b) and (c) of subsection (2) and subsection (3) of section 651.026, Florida Statutes, are amended, subsection (10) is added to that section, and paragraph (a) of subsection (2) of that section is republished, to read:

651.026 Annual reports.—

(2) The annual report shall be in such form as the commission prescribes and shall contain at least the following:

(a) Any change in status with respect to the information required to be filed under s. 651.022(2).

(b) A financial report ~~statements~~ audited by an independent certified public accountant which must contain, for two or more periods if the facility has been in existence that long, all of the following:

1. An accountant's opinion and, in accordance with generally accepted accounting principles:

a. A balance sheet;

b. A statement of income and expenses;

c. A statement of equity or fund balances; and

d. A statement of changes in cash flows.

2. Notes to the financial report ~~statements~~ considered customary or necessary for full disclosure or adequate understanding of the financial report ~~statements~~, financial condition, and operation.

(c) The following financial information:

1. A detailed listing of the assets maintained in the liquid reserve as required under s. 651.035 and in accordance with part II of chapter 625;

2. A schedule giving additional information relating to property, plant, and equipment having an original cost of at least $25,000, so as to show in reasonable detail with respect to each separate facility original costs, accumulated depreciation, net book value, appraised value or insurable value and date thereof, insurance coverage, encumbrances, and net equity of appraised or insured value over encumbrances. Any property not used in continuing care must be shown separately from property used in continuing care;

3. The level of participation in Medicare or Medicaid programs, or both;

4. A statement of all fees required of residents, including, but not limited to, a statement of the entrance fee charged, the monthly service charges, the proposed application of the proceeds of the entrance fee by the provider, and the plan by which the amount of the entrance fee is determined if the entrance fee is not the same in all cases; ~~and~~

5. Any change or increase in fees if the provider changes

the scope of, or the rates for, care or services, regardless of whether the change involves the basic rate or only those services available at additional costs to the resident;~~.~~

6. If the provider has more than one certificated facility, or has operations that are not licensed under this chapter, it shall submit a balance sheet, statement of income and expenses, statement of equity or fund balances, and statement of cash flows for each facility licensed under this chapter as supplemental information to the audited financial report ~~statements~~ required under paragraph (b); and~~.~~

7. The management's calculation of the provider's debt service coverage ratio, occupancy, and days cash on hand for the current reporting period.

(3) The commission shall adopt by rule additional ~~meaningful~~ measures of assessing the financial viability of a provider. ~~The rule may include the following factors:~~

~~(a) Debt service coverage ratios.~~

~~(b) Current ratios.~~

~~(c) Adjusted current ratios.~~

~~(d) Cash flows.~~

~~(e) Occupancy rates.~~

~~(f) Other measures, ratios, or trends.~~

~~(g) Other factors as may be appropriate.~~

(10) Within 90 days after the conclusion of each annual reporting period, the office shall publish an industry benchmarking report that contains all of the following:

(a) The median days cash on hand for all providers.

(b) The median debt service coverage ratio for all providers.

(c) The median occupancy rate for all providers by setting, including independent living, assisted living, skilled nursing, and the entire campus.

Section 13. Section 651.0261, Florida Statutes, is amended to read:

651.0261 Quarterly and monthly statements.—

(1) Within 45 days after the end of each fiscal quarter, each provider shall file a quarterly unaudited financial statement of the provider or of the facility in the form prescribed by commission rule and days cash on hand, occupancy, debt service coverage ratio, and a detailed listing of the assets maintained in the liquid reserve as required under s. 651.035. This requirement may be waived by the office upon written request from a provider that is accredited without conditions or stipulations or that has obtained an investment grade credit rating from a United States credit rating agency as authorized under s. 651.028. The last quarterly statement for a fiscal year is not required if a provider does not have pending a regulatory action level event or a corrective action plan.

(2) If the office finds~~, pursuant to rules of the commission,~~ that such information is needed to properly monitor the financial condition of a provider or facility or is otherwise needed to protect the public interest, the office may require the provider to file:

(a) Within 25 days after the end of each month, a monthly unaudited financial statement of the provider or of the facility in the form prescribed by the commission by rule and a detailed listing of the assets maintained in the liquid reserve as required under s. 651.035~~, within 45 days after the end of each~~

~~fiscal quarter, a quarterly unaudited financial statement of the provider or of the facility in the form prescribed by the commission by rule. The commission may by rule require all or part of the statements or filings required under this section to be submitted by electronic means in a computer-readable form compatible with the electronic data format specified by the commission~~.

(b) Such other data, financial statements, and pertinent information as the commission or office may reasonably require with respect to the provider or the facility, its directors or trustees, or, with respect to any parent, subsidiary, or affiliate, if the provider or facility relies on a contractual or financial relationship with such parent, subsidiary, or affiliate in order to meet the financial requirements of this chapter, to determine the financial status of the provider or of the facility and the management capabilities of its managers and owners.

(3) A filing under subsection (2) may be required if any of the following applies:

(a) The provider is:

1. Subject to administrative supervision proceedings;

2. Subject to a corrective action plan resulting from a regulatory action level event for up to 2 years after the factors that caused the regulatory action level event have been corrected; or

3. Subject to delinquency or receivership proceedings or has filed for bankruptcy.

(b) The provider or facility displays a declining financial position.

(c) A change of ownership of the provider or facility has occurred within the previous 2 years.

(d) The facility is found to be impaired.

(4) The commission may by rule require all or part of the statements or filings required under this section to be submitted by electronic means in a computer-readable format compatible with an electronic data format specified by the commission.

Section 14. Section 651.028, Florida Statutes, is amended to read:

651.028 Accredited or certain credit-rated facilities.—If a provider or obligated group is accredited without stipulations or conditions by a process found by the office to be acceptable and substantially equivalent to the provisions of this chapter or has obtained an investment grade credit rating from a nationally recognized credit rating agency, as applicable, from Moody's Investors Service, Standard & Poor's, or Fitch Ratings, the office may, pursuant to rule of the commission, waive the quarterly filing ~~any~~ requirements under s. 651.0261 ~~of this chapter~~ with respect to the provider if the office finds that such waivers are not inconsistent with the security protections intended by this chapter. A provider or obligated group that is accredited without stipulations or conditions or that has obtained such an investment grade credit rating shall provide documentation substantiating such accreditation or investment grade rating in its request for the waiver. If the office grants a waiver to the provider or obligated group, the provider or obligated group must notify the office of any changes in the accreditation or investment grade rating.

Section 15. Subsections (1), (2), (3), and (5) of section 651.033, Florida Statutes, are amended, and subsection (6) is added to that section, to read:

651.033 Escrow accounts.—

(1) When funds are required to be deposited in an escrow account pursuant to s. 651.0215, s. 651.022, s. 651.023, s. 651.0246, s. 651.035, or s. 651.055:

(a) The escrow account must ~~shall~~ be established in a Florida bank, Florida savings and loan association, ~~or~~ Florida trust company, or a national bank that is chartered and supervised by the Office of the Comptroller of the Currency within the United States Department of the Treasury and that has either a branch or a license to operate in this state, which is acceptable to the office, or such funds must be deposited ~~on deposit~~ with the department~~;~~ and ~~the funds deposited therein shall~~ be kept and maintained in an account separate and apart from the provider's business accounts.

(b) An escrow agreement shall be entered into between the bank, savings and loan association, or trust company and the provider of the facility; the agreement shall state that its purpose is to protect the resident or the prospective resident; and, upon presentation of evidence of compliance with applicable portions of this chapter, or upon order of a court of competent jurisdiction, the escrow agent shall release and pay over the funds, or portions thereof, together with any interest accrued thereon or earned from investment of the funds, to the provider or resident as directed.

(c) Any agreement establishing an escrow account required under ~~the provisions of~~ this chapter is ~~shall be~~ subject to

approval by the office. The agreement must ~~shall~~ be in writing and ~~shall~~ contain, in addition to any other provisions required by law, a provision whereby the escrow agent agrees to abide by the duties imposed by paragraphs (b) and (e), (3)(a), (3)(b), and (5)(a) and subsection (6) ~~under this section~~.

(d) All funds deposited in an escrow account, if invested, shall be invested as set forth in part II of chapter 625; however, such investment may not diminish the funds held in escrow below the amount required by this chapter. Funds deposited in an escrow account are not subject to charges by the escrow agent except escrow agent fees associated with administering the accounts, or subject to any liens, judgments, garnishments, creditor's claims, or other encumbrances against the provider or facility except as provided in s. 651.035(1).

(e) At the request of either the provider or the office, the escrow agent shall issue a statement indicating the status of the escrow account.

(2) Notwithstanding s. 651.035(7), ~~In addition, the escrow agreement shall provide that the escrow agent or another person designated to act in the escrow agent's place and the provider, except as otherwise provided in s. 651.035, shall notify the office in writing at least 10 days before the withdrawal of any portion of any funds required to be escrowed under the provisions of s. 651.035. However,~~ in the event of an emergency and upon petition by the provider, the office may ~~waive the 10-day notification period and~~ allow a withdrawal of up to 10 percent of the required minimum liquid reserve. The office shall have 3 working days to deny the petition for the emergency 10-percent withdrawal. If the office fails to deny the petition

within 3 working days, the petition is ~~shall be~~ deemed to have been granted by the office. For purposes ~~the purpose~~ of this section, the term "working day" means each day that is not a Saturday, Sunday, or legal holiday as defined by Florida law. Also, for purposes ~~the purpose~~ of this section, the day the petition is received by the office is ~~shall~~ not ~~be~~ counted as one of the 3 days.

(3) ~~In addition,~~ When entrance fees are required to be deposited in an escrow account pursuant to s. 651.0215, s. 651.022, s. 651.023, s. 651.0246, or s. 651.055:

(a) The provider shall deliver to the resident a written receipt. The receipt must show the payor's name and address, the date, the price of the care contract, and the amount of money paid. A copy of each receipt, together with the funds, must ~~shall~~ be deposited with the escrow agent or as provided in paragraph (c). The escrow agent must ~~shall~~ release such funds to the provider 7 days after the date of receipt of the funds by the escrow agent if the provider, operating under a certificate of authority issued by the office, has met the requirements of s. 651.0215(8), s. 651.023(6), or s. 651.0246. However, if the resident rescinds the contract within the 7-day period, the escrow agent must ~~shall~~ release the escrowed fees to the resident.

(b) At the request of an individual resident of a facility, the escrow agent shall issue a statement indicating the status of the resident's portion of the escrow account.

(c) At the request of an individual resident of a facility, the provider may hold the check for the 7-day period and may ~~shall~~ not deposit it during this time period. If the resident

rescinds the contract within the 7-day period, the check must ~~shall~~ be immediately returned to the resident. Upon the expiration of the 7 days, the provider shall deposit the check.

(d) A provider may assess a nonrefundable fee, which is separate from the entrance fee, for processing a prospective resident's application for continuing care or continuing care at-home.

(5) When funds are required to be deposited in an escrow account pursuant to s. 651.0215, s. 651.022, s. 651.023, s. 651.0246, or s. 651.035, the following ~~shall~~ apply:

(a) The escrow agreement must ~~shall~~ require that the escrow agent furnish the provider with a quarterly statement indicating the amount of any disbursements from or deposits to the escrow account and the condition of the account during the period covered by the statement. The agreement must ~~shall~~ require that the statement be furnished to the provider by the escrow agent on or before the 10th day of the month following the end of the quarter for which the statement is due. If the escrow agent does not provide the quarterly statement to the provider on or before the 10th day of the month following the month for which the statement is due, the office may, in its discretion, levy against the escrow agent a fine not to exceed $25 a day for each day of noncompliance with the provisions of this subsection.

(b) If the escrow agent does not provide the quarterly statement to the provider on or before the 10th day of the month following the quarter for which the statement is due, the provider shall, on or before the 15th day of the month following the quarter for which the statement is due, send a written request for the statement to the escrow agent by certified mail

return receipt requested.

(c) On or before the 20th day of the month following the quarter for which the statement is due, the provider shall file with the office a copy of the escrow agent's statement or, if the provider has not received the escrow agent's statement, a copy of the written request to the escrow agent for the statement.

(d) The office may, in its discretion, in addition to any other penalty that may be provided for under this chapter, levy a fine against the provider not to exceed $25 a day for each day the provider fails to comply with the provisions of this subsection.

(e) Funds held on deposit with the department are exempt from the reporting requirements of this subsection.

(6) Except as described in paragraph (3)(a), the escrow agent may not release or otherwise allow the transfer of funds without the written approval of the office, unless the withdrawal is from funds in excess of the amounts required by ss. 651.0215, 651.022, 651.023, 651.0246, 651.035, and 651.055.

Section 16. Section 651.034, Florida Statutes, is created to read:

651.034 Financial and operating requirements for providers.—

(1)(a) If a regulatory action level event occurs, the office must:

1. Require the provider to prepare and submit a corrective action plan or, if applicable, a revised corrective action plan;

2. Perform an examination pursuant to s. 651.105 or an analysis, as the office considers necessary, of the assets,

liabilities, and operations of the provider, including a review of the corrective action plan or the revised corrective action plan; and

3. After the examination or analysis, issue a corrective order, if necessary, specifying any corrective actions that the office determines are required.

(b) In determining corrective actions, the office shall consider any factor relevant to the provider based upon the office's examination or analysis of the assets, liabilities, and operations of the provider. The provider must submit the corrective action plan or the revised corrective action plan within 30 days after the occurrence of the regulatory action level event. The office shall review and approve or disapprove the corrective action plan within 15 business days.

(c) The office may use members of the Continuing Care Advisory Council, individually or as a group, or may retain actuaries, investment experts, and other consultants to review a provider's corrective action plan or revised corrective action plan, examine or analyze the assets, liabilities, and operations of a provider, and formulate the corrective order with respect to the provider. The fees, costs, and expenses relating to consultants must be borne by the affected provider.

(2) If an impairment occurs and except when s. 651.114(11)(a) applies, the office must take action necessary to place the provider under regulatory control, including any remedy available under part I of chapter 631. An impairment is sufficient grounds for the department to be appointed as receiver as provided in chapter 631. Except when s. 651.114(11)(a) is applicable, the department may appoint a

receiver. If s. 651.114(11)(a) applies, the provider must make available to the office copies of any corrective action plan approved by the third-party lender or trustee to cure the impairment and any related required report. Notwithstanding s. 631.011, impairment of a provider, for purposes of s. 631.051, is defined according to the term "impaired" under s. 651.011. The office may forego taking action for up to 180 days after the impairment if the office finds there is a reasonable expectation that the impairment may be eliminated within the 180-day period.

(3) There is no liability on the part of, and a cause of action may not arise against, the commission, department, or office, or their employees or agents, for any action they take in the performance of their powers and duties under this section.

(4) The office shall transmit any notice that may result in regulatory action by registered mail, certified mail, or any other method of transmission which includes documentation of receipt by the provider. Notice is effective when the provider receives it.

(5) This section is supplemental to the other laws of this state and does not preclude or limit any power or duty of the department or office under those laws or under the rules adopted pursuant to those laws.

(6) The office may exempt a provider from subsection (1) or subsection (2) until stabilized occupancy is reached or until the time projected to achieve stabilized occupancy as reported in the last feasibility study required by the office as part of an application filing under s. 651.0215, s. 651.023, s. 651.024, or s. 651.0246 has elapsed, but for no longer than 5 years after

the date of issuance of the certificate of occupancy.

(7) The commission may adopt rules to administer this section, including, but not limited to, rules regarding corrective action plans, revised corrective action plans, corrective orders, and procedures to be followed in the event of a regulatory action level event or an impairment.

Section 17. Paragraphs (a), (b), and (c) of subsection (1) of section 651.035, Florida Statutes, are amended, and subsections (7) through (10) are added to that section, to read:

651.035 Minimum liquid reserve requirements.—

(1) A provider shall maintain in escrow a minimum liquid reserve consisting of the following reserves, as applicable:

(a) Each provider shall maintain in escrow as a debt service reserve the aggregate amount of all principal and interest payments due during the fiscal year on any mortgage loan or other long-term financing of the facility, including property taxes as recorded in the audited financial report ~~statements~~ required under s. 651.026. The amount must include any leasehold payments and all costs related to such payments. If principal payments are not due during the fiscal year, the provider must ~~shall~~ maintain in escrow as a minimum liquid reserve an amount equal to interest payments due during the next 12 months on any mortgage loan or other long-term financing of the facility, including property taxes. If a provider does not have a mortgage loan or other financing on the facility, the provider must deposit monthly in escrow as a minimum liquid reserve an amount equal to one-twelfth of the annual property tax liability as indicated in the most recent tax notice provided pursuant to s. 197.322(3), and must annually pay

property taxes out of such escrow.

(b) A provider that has outstanding indebtedness that requires a debt service reserve to be held in escrow pursuant to a trust indenture or mortgage lien on the facility and for which the debt service reserve may only be used to pay principal and interest payments on the debt that the debtor is obligated to pay, and which may include property taxes and insurance, may include such debt service reserve in computing the minimum liquid reserve needed to satisfy this subsection if the provider furnishes to the office a copy of the agreement under which such debt service is held, together with a statement of the amount being held in escrow for the debt service reserve, certified by the lender or trustee and the provider to be correct. The trustee shall provide the office with any information concerning the debt service reserve account upon request of the provider or the office. Any such separate debt service reserves are not subject to the transfer provisions set forth in subsection (8).

(c) Each provider shall maintain in escrow an operating reserve equal to 30 percent of the total operating expenses projected in the feasibility study required by s. 651.023 for the first 12 months of operation. Thereafter, each provider shall maintain in escrow an operating reserve equal to 15 percent of the total operating expenses in the annual report filed pursuant to s. 651.026. If a provider has been in operation for more than 12 months, the total annual operating expenses must ~~shall~~ be determined by averaging the total annual operating expenses reported to the office by the number of annual reports filed with the office within the preceding 3-year period subject to adjustment if there is a change in the number

of facilities owned. For purposes of this subsection, total annual operating expenses include all expenses of the facility except~~:~~ depreciation and amortization; interest and property taxes included in paragraph (a); extraordinary expenses that are adequately explained and documented in accordance with generally accepted accounting principles; liability insurance premiums in excess of those paid in calendar year 1999; and changes in the obligation to provide future services to current residents. For providers initially licensed during or after calendar year 1999, liability insurance must ~~shall~~ be included in the total operating expenses in an amount not to exceed the premium paid during the first 12 months of facility operation. ~~Beginning January 1, 1993,~~ The operating reserves required under this subsection must ~~shall~~ be in an unencumbered account held in escrow for the benefit of the residents. Such funds may not be encumbered or subject to any liens or charges by the escrow agent or judgments, garnishments, or creditors' claims against the provider or facility. However, if a facility had a lien, mortgage, trust indenture, or similar debt instrument in place before January 1, 1993, which encumbered all or any part of the reserves required by this subsection and such funds were used to meet the requirements of this subsection, then such arrangement may be continued, unless a refinancing or acquisition has occurred, and the provider is ~~shall be~~ in compliance with this subsection.

(7)(a) A provider may withdraw funds held in escrow without the approval of the office if the amount held in escrow exceeds the requirements of this section and if the withdrawal will not affect compliance with this section.

(b)1. For all other proposed withdrawals, in order to receive the consent of the office, the provider must file documentation showing why the withdrawal is necessary for the continued operation of the facility and such additional information as the office reasonably requires.

2. The office shall notify the provider when the filing is deemed complete. If the provider has complied with all prior requests for information, the filing is deemed complete after 30 days without communication from the office.

3. Within 30 days after the date a file is deemed complete, the office shall provide the provider with written notice of its approval or disapproval of the request. The office may disapprove any request to withdraw such funds if it determines that the withdrawal is not in the best interest of the residents.

(8) The office may order the immediate transfer of up to 100 percent of the funds held in the minimum liquid reserve to the custody of the department pursuant to part III of chapter 625 if the office finds that the provider is impaired or insolvent. The office may order such a transfer regardless of whether the office has suspended or revoked, or intends to suspend or revoke, the certificate of authority of the provider.

(9) Each facility shall file with the office annually, together with the annual report required by s. 651.026, a calculation of its minimum liquid reserve determined in accordance with this section on a form prescribed by the commission.

(10) If the balance of the minimum liquid reserve is below the required amount, the provider must be deemed out of

compliance with this section.

Section 18. Effective July 1, 2019, section 651.043, Florida Statutes, is created to read:

651.043 Approval of change in management.—

(1) A contract with a management company entered into after July 1, 2019, must be in writing and include a provision that the contract will be canceled upon issuance of an order by the office pursuant to this section and without the application of a cancellation fee or penalty. If a provider contracts with a management company, a separate written contract is not required for the individual manager employed by the management company to oversee a facility. If a management company voluntarily executes a contract with a manager or contractor, the contract is not required to be submitted to the office unless requested by the office.

(2) A provider shall notify the office, in writing or electronically, of any change in management within 10 business days. For each new management company or manager not employed by a management company, the provider shall submit to the office the information required by s. 651.022(2) and a copy of the written management contract, if applicable.

(3) For a provider that is found to be impaired or that has a regulatory action level event pending, the office may disapprove new management and order the provider to remove the new management after reviewing the information required under subsection (2).

(4) For a provider other than that specified in subsection (3), the office may disapprove new management and order the provider to remove the new management after receiving the

required information under subsection (2), if the office:

(a) Finds that the new management is incompetent or untrustworthy;

(b) Finds that the new management is so lacking in managerial experience as to make the proposed operation hazardous to the residents or potential residents;

(c) Finds that the new management is so lacking in experience, ability, and standing as to jeopardize the reasonable promise of successful operation; or

(d) Has good reason to believe that the new management is affiliated directly or indirectly through ownership, control, or business relations with any person or persons whose business operations are or have been marked by manipulation of assets or accounts or by bad faith, to the detriment of residents, stockholders, investors, creditors, or the public.

The office shall complete its review as required under subsections (3) and (4) and, if applicable, issue notice of disapproval of the new management within 15 business days after the filing is deemed complete. A filing is deemed complete upon the office's receipt of all requested information and the provider's correction of any error or omission for which the provider was timely notified. If the office does not issue notice of disapproval of the new management within 15 business days after the filing is deemed complete, the new management is deemed approved.

(5) Management disapproved by the office must be removed within 30 days after receipt by the provider of notice of such disapproval.

(6) The office may revoke, suspend, or take other administrative action against the certificate of authority of the provider if the provider:

(a) Fails to timely remove management disapproved by the office;

(b) Fails to timely notify the office of a change in management;

(c) Appoints new management without a written contract when a written contract is required under this section; or

(d) Repeatedly appoints management that was previously disapproved by the office or that is not approvable under subsection (4).

(7) The provider shall remove any management immediately upon discovery of either of the following conditions, if the conditions were not disclosed in the notice to the office required under subsection (2):

(a) That a manager has been found guilty of, or has pled guilty or no contest to, a felony charge, or has been held liable or has been enjoined in a civil action by final judgment, if the felony or civil action involved fraud, embezzlement, fraudulent conversion, or misappropriation of property.

(b) That a manager is now, or was in the past, affiliated, directly or indirectly, through ownership interest of 10 percent or more in, or control of, any business, corporation, or other entity that has been found guilty of or has pled guilty or no contest to a felony charge, or has been held liable or has been enjoined in a civil action by final judgment, if the felony or civil action involved fraud, embezzlement, fraudulent conversion, or misappropriation of property.

The failure to remove such management is grounds for revocation or suspension of the provider's certificate of authority.

Section 19. Section 651.051, Florida Statutes, is amended to read:

651.051 Maintenance of assets and records in state.—All records and assets of a provider must be maintained or readily accessible in this state or, if the provider's corporate office is located in another state, such records must be electronically stored in a manner that will ensure that the records are readily accessible to the office. No records or assets may be removed from this state by a provider unless the office consents to such removal in writing before such removal. Such consent must ~~shall~~ be based upon the provider's submitting satisfactory evidence that the removal will facilitate and make more economical the operations of the provider and will not diminish the service or protection thereafter to be given the provider's residents in this state. Before ~~Prior to~~ such removal, the provider shall give notice to the president or chair of the facility's residents' council. If such removal is part of a cash management system which has been approved by the office, disclosure of the system must ~~shall~~ meet the notification requirements. The electronic storage of records on a web-based, secured storage platform by contract with a third party is acceptable if the records are readily accessible to the office.

Section 20. Subsection (3) of section 651.055, Florida Statutes, is amended to read:

651.055 Continuing care contracts; right to rescind.—

(3) The contract must include or be accompanied by a

statement, printed in boldfaced type, which reads: "This facility and all other continuing care facilities (also known as life plan communities) in the State of Florida are regulated by chapter 651, Florida Statutes. A copy of the law is on file in this facility. The law gives you or your legal representative the right to inspect our most recent financial statement and inspection report before signing the contract."

Section 21. Subsection (2) of section 651.057, Florida Statutes, is amended to read:

651.057 Continuing care at-home contracts.—

(2) A provider that holds a certificate of authority and wishes to offer continuing care at-home must also:

(a) Submit a business plan to the office with the following information:

1. A description of the continuing care at-home services that will be provided, the market to be served, and the fees to be charged;

2. A copy of the proposed continuing care at-home contract;

3. An actuarial study prepared by an independent actuary in accordance with the standards adopted by the American Academy of Actuaries which presents the impact of providing continuing care at-home on the overall operation of the facility; and

4. A ~~market~~ feasibility study that meets the requirements of s. 651.022(3) and documents that there is sufficient interest in continuing care at-home contracts to support such a program;

(b) Demonstrate to the office that the proposal to offer continuing care at-home contracts to individuals who do not immediately move into the facility will not place the provider in an unsound financial condition;

(c) Comply with the requirements of s. 651.0246(1) ~~s. 651.021(2)~~, except that an actuarial study may be substituted for the feasibility study; and

(d) Comply with the requirements of this chapter.

Section 22. Subsection (1) of section 651.071, Florida Statutes, is amended to read:

651.071 Contracts as preferred claims on liquidation or receivership.—

(1) In the event of receivership or liquidation proceedings against a provider, all continuing care and continuing care at-home contracts executed by a provider are ~~shall be~~ deemed preferred claims or policyholder loss ~~preferred~~ claims pursuant to s. 631.271(1)(b) against all assets owned by the provider; however, such claims are subordinate to any secured claim.

Section 23. Subsection (2) and present paragraph (g) of subsection (3) of section 651.091, Florida Statutes, are amended, and a new paragraph (i) and paragraphs (j), (k), and (l) are added to that subsection, and paragraph (d) of subsection (3) and subsection (4) of that section are republished, to read:

651.091 Availability, distribution, and posting of reports and records; requirement of full disclosure.—

(2) Every continuing care facility shall:

(a) Display the certificate of authority in a conspicuous place inside the facility.

(b) Post in a prominent position in the facility which is accessible to all residents and the general public a concise summary of the last examination report issued by the office, with references to the page numbers of the full report noting

any deficiencies found by the office, and the actions taken by the provider to rectify such deficiencies, indicating in such summary where the full report may be inspected in the facility.

(c) Post in a prominent position in the facility, accessible to all residents and the general public, a notice containing the contact information for the office and the Division of Consumer Services of the department and stating that the division or office may be contacted for the submission of inquiries and complaints with respect to potential violations of this chapter committed by a provider. Such contact information must include the division's website and the toll-free consumer helpline and the office's website and telephone number.

(d) Provide notice to the president or chair of the residents' council within 10 business days after issuance of a final examination report or the initiation of any legal or administrative proceeding by the office or the department and include a copy of such document.

(e) ~~(c)~~ Post in a prominent position in the facility which is accessible to all residents and the general public a summary of the latest annual statement, indicating in the summary where the full annual statement may be inspected in the facility. A listing of any proposed changes in policies, programs, and services must also be posted.

(f) ~~(d)~~ Distribute a copy of the full annual statement and a copy of the most recent third-party ~~third party~~ financial audit filed with the annual report to the president or chair of the residents' council within 30 days after filing the annual report with the office, and designate a staff person to provide explanation thereof.

(g) ~~(e)~~ Deliver the information described in s. 651.085(4) in writing to the president or chair of the residents' council and make supporting documentation available upon request ~~Notify the residents' council of any plans filed with the office to obtain new financing, additional financing, or refinancing for the facility and of any applications to the office for any expansion of the facility~~.

(h) ~~(f)~~ Deliver to the president or chair of the residents' council a summary of entrance fees collected and refunds made during the time period covered in the annual report and the refund balances due at the end of the report period.

(i) ~~(g)~~ Deliver to the president or chair of the residents' council a copy of each quarterly statement within 30 days after the quarterly statement is filed with the office if the facility is required to file quarterly.

(j) ~~(h)~~ Upon request, deliver to the president or chair of the residents' council a copy of any newly approved continuing care or continuing care at-home contract within 30 days after approval by the office.

(k) Provide to the president or chair of the residents' council a copy of any notice filed with the office relating to any change in ownership within 10 business days after such filing by the provider.

(l) Make the information available to prospective residents pursuant to paragraph (3)(d) available to current residents and provide notice of changes to that information to the president or chair of the residents' council within 3 business days.

(3) Before entering into a contract to furnish continuing care or continuing care at-home, the provider undertaking to

furnish the care, or the agent of the provider, shall make full disclosure, and provide copies of the disclosure documents to the prospective resident or his or her legal representative, of the following information:

(d) In keeping with the intent of this subsection relating to disclosure, the provider shall make available for review master plans approved by the provider's governing board and any plans for expansion or phased development, to the extent that the availability of such plans does not put at risk real estate, financing, acquisition, negotiations, or other implementation of operational plans and thus jeopardize the success of negotiations, operations, and development.

~~(g) The amount and location of any reserve funds required by this chapter, and the name of the person or entity having a claim to such funds in the event of a bankruptcy, foreclosure, or rehabilitation proceeding.~~

(i) Notice of the issuance of a final examination report or the initiation of any legal or administrative proceeding by the office or the department, including where the report or filing may be inspected in the facility, and that, upon request, an electronic copy or specific website address will be provided from which the document can be downloaded at no cost.

(j) Notice that the entrance fee is the property of the provider after the expiration of the 7-day escrow requirement under s. 651.055(2).

(k) A statement that distribution of assets or income may occur or a statement that such distributions will not occur.

(l) Notice of any holding company system or obligated group of which the provider is a member.

(4) A true and complete copy of the full disclosure document to be used must be filed with the office before use. A resident or prospective resident or his or her legal representative may inspect the full reports referred to in paragraph (2)(b); the charter or other agreement or instrument required to be filed with the office pursuant to s. 651.022(2), together with all amendments thereto; and the bylaws of the corporation or association, if any. Upon request, copies of the reports and information shall be provided to the individual requesting them if the individual agrees to pay a reasonable charge to cover copying costs.

Section 24. Subsection (4) of section 651.095, Florida Statutes, is amended to read:

651.095 Advertisements; requirements; penalties.—

(4) It is unlawful for any person, other than a provider licensed pursuant to this chapter, to advertise or market to the general public any product similar to continuing care through the use of such terms as "life care," "life plan," "life plan at-home," "continuing care," or "guaranteed care for life," or similar terms, words, or phrases.

Section 25. Section 651.105, Florida Statutes, is amended to read:

651.105 Examination ~~and inspections~~.—

(1) The office may at any time, and shall at least once every 3 years, examine the business of any applicant for a certificate of authority and any provider engaged in the execution of care contracts or engaged in the performance of obligations under such contracts, in the same manner as is provided for the examination of insurance companies pursuant to

ss. 624.316 and 624.318 ~~s. 624.316~~. For a provider as described ~~defined~~ in s. 651.028, such examinations must ~~shall~~ take place at least once every 5 years. Such examinations must ~~shall~~ be made by a representative or examiner designated by the office whose compensation will be fixed by the office pursuant to s. 624.320. Routine examinations may be made by having the necessary documents submitted to the office; and, for this purpose, financial documents and records conforming to commonly accepted accounting principles and practices, as required under s. 651.026, are deemed adequate. The final written report of each examination must be filed with the office and, when so filed, constitutes a public record. Any provider being examined shall, upon request, give reasonable and timely access to all of its records. The representative or examiner designated by the office may at any time examine the records and affairs and inspect the physical property of any provider, whether in connection with a formal examination or not.

(2) Any duly authorized officer, employee, or agent of the office may, upon presentation of proper identification, have access to, and inspect, any records, with or without advance notice, to secure compliance with, or to prevent a violation of, any provision of this chapter.

(3) Reports of the results of such financial examinations must be kept on file by the office. Any investigatory records, reports, or documents held by the office are confidential and exempt from the provisions of s. 119.07(1), until the investigation is completed or ceases to be active. For the purpose of this section, an investigation is active while it is being conducted by the office with a reasonable, good faith

belief that it could lead to the filing of administrative, civil, or criminal proceedings. An investigation does not cease to be active if the office is proceeding with reasonable dispatch and has a good faith belief that action could be initiated by the office or other administrative or law enforcement agency.

(4) The office shall notify the provider and the executive officer of the governing body of the provider in writing of all deficiencies in its compliance with the provisions of this chapter and the rules adopted pursuant to this chapter and shall set a reasonable length of time for compliance by the provider. In addition, the office shall require corrective action or request a corrective action plan from the provider which plan demonstrates a good faith attempt to remedy the deficiencies by a specified date. If the provider fails to comply within the established length of time, the office may initiate action against the provider in accordance with the provisions of this chapter.

(5) A provider shall respond to written correspondence from the office and provide data, financial statements, and pertinent information as requested by the office or by the office's investigators, examiners, or inspectors. The office has standing to petition a circuit court for mandatory injunctive relief to compel access to and require the provider to produce the documents, data, records, and other information requested by the office or its investigators, examiners, or inspectors. The office may petition the circuit court in the county in which the facility is situated or the Circuit Court of Leon County to enforce this section ~~At the time of the routine examination, the~~

~~office shall determine if all disclosures required under this chapter have been made to the president or chair of the residents' council and the executive officer of the governing body of the provider~~.

(6) A representative of the provider must give a copy of the final examination report and corrective action plan, if one is required by the office, to the executive officer of the governing body of the provider within 60 days after issuance of the report.

(7) Unless a provider or facility is impaired or subject to a regulatory action level event, any parent, subsidiary, or affiliate is not subject to examination by the office as part of a routine examination. However, if a provider or facility relies on a contractual or financial relationship with a parent, a subsidiary, or an affiliate in order to meet the financial requirements of this chapter, the office may examine any parent, subsidiary, or affiliate that has a contractual or financial relationship with the provider or facility to the extent necessary to ascertain the financial condition of the provider.

(8) If a provider voluntarily contracts with an actuary for an actuarial study or review at regular intervals, the office may not use any recommendations made by the actuary as a measure of performance when conducting an examination or inspection. The office may not request, as part of the examination or inspection, documents associated with an actuarial study or review marked "restricted distribution" if the study or review is not required by this chapter.

Section 26. Section 651.106, Florida Statutes, is amended to read:

651.106 Grounds for discretionary refusal, suspension, or revocation of certificate of authority.—The office may deny an application or~~,~~ suspend~~,~~ or revoke the provisional certificate of authority or the certificate of authority of any applicant or provider if it finds that any one or more of the following grounds applicable to the applicant or provider exist:

(1) Failure by the provider to continue to meet the requirements for the authority originally granted.

(2) Failure by the provider to meet one or more of the qualifications for the authority specified by this chapter.

(3) Material misstatement, misrepresentation, or fraud in obtaining the authority, or in attempting to obtain the same.

(4) Demonstrated lack of fitness or trustworthiness.

(5) Fraudulent or dishonest practices of management in the conduct of business.

(6) Misappropriation, conversion, or withholding of moneys.

(7) Failure to comply with, or violation of, any proper order or rule of the office or commission or violation of any provision of this chapter.

(8) The insolvent or impaired condition of the provider or the provider's being in such condition or using such methods and practices in the conduct of its business as to render its further transactions in this state hazardous or injurious to the public.

(9) Refusal by the provider to be examined or to produce its accounts, records, and files for examination, or refusal by any of its officers to give information with respect to its affairs or to perform any other legal obligation under this chapter when required by the office.

(10) Failure by the provider to comply with the requirements of s. 651.026 or s. 651.033.

(11) Failure by the provider to maintain escrow accounts or funds as required by this chapter.

(12) Failure by the provider to meet the requirements of this chapter for disclosure of information to residents concerning the facility, its ownership, its management, its development, or its financial condition or failure to honor its continuing care or continuing care at-home contracts.

(13) Any cause for which issuance of the license could have been refused had it then existed and been known to the office.

(14) Having been found guilty of, or having pleaded guilty or nolo contendere to, a felony in this state or any other state, without regard to whether a judgment or conviction has been entered by the court having jurisdiction of such cases.

(15) In the conduct of business under the license, engaging in unfair methods of competition or in unfair or deceptive acts or practices prohibited under part IX of chapter 626.

(16) A pattern of bankrupt enterprises.

(17) The ownership, control, or management of the organization includes any person:

(a) Who is not reputable and of responsible character;

(b) Who is so lacking in management expertise as to make the operation of the provider hazardous to potential and existing residents;

(c) Who is so lacking in management experience, ability, and standing as to jeopardize the reasonable promise of successful operation;

(d) Who is affiliated, directly or indirectly, through

ownership or control, with any person or persons whose business operations are or have been marked by business practices or conduct that is detrimental to the public, contract holders, investors, or creditors by manipulation of assets, finances, or accounts or by bad faith; or

(e) Whose business operations are or have been marked by business practices or conduct that is detrimental to the public, contract holders, investors, or creditors by manipulation of assets, finances, or accounts or by bad faith.

(18) The provider has not filed a notice of change in management, fails to remove a disapproved manager, or persists in appointing disapproved managers.

Revocation of a certificate of authority under this section does not relieve a provider from the provider's obligation to residents under the terms and conditions of any continuing care or continuing care at-home contract between the provider and residents or the provisions of this chapter. The provider shall continue to file its annual statement and pay license fees to the office as required under this chapter as if the certificate of authority had continued in full force, but the provider shall not issue any new contracts. The office may seek an action in the Circuit Court of Leon County to enforce the office's order and the provisions of this section.

Section 27. Section 651.1065, Florida Statutes, is created to read:

651.1065 Soliciting or accepting new continuing care contracts by impaired or insolvent facilities or providers.—

(1) Regardless of whether delinquency proceedings as to a

continuing care facility have been or are to be initiated, a proprietor, a general partner, a member, an officer, a director, a trustee, or a manager of a continuing care facility may not actively solicit, approve the solicitation or acceptance of, or accept new continuing care contracts in this state after the proprietor, general partner, member, officer, director, trustee, or manager knew, or reasonably should have known, that the continuing care facility was impaired or insolvent except with the written permission of the office. If the facility has declared bankruptcy, the bankruptcy court or trustee appointed by the court has jurisdiction over such matters. The office must approve or disapprove the continued marketing of new contracts within 15 days after receiving a request from a provider.

(2) A proprietor, a general partner, a member, an officer, a director, a trustee, or a manager who violates this section commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 28. Subsections (1) and (3) of section 651.111, Florida Statutes, are amended to read:

651.111 Requests for inspections.—

(1) Any interested party may request an inspection of the records and related financial affairs of a provider providing care in accordance with ~~the provisions of~~ this chapter by transmitting to the office notice of an alleged violation of applicable requirements prescribed by statute or by rule, specifying to a reasonable extent the details of the alleged violation, which notice must ~~shall~~ be signed by the complainant. As used in this section, the term "inspection" means an inquiry into a provider's compliance with this chapter.

(3) Upon receipt of a complaint, the office shall make a preliminary review to determine if the complaint alleges a violation of this chapter~~.~~ and, unless the office determines that the complaint does not allege a violation of this chapter or is without any reasonable basis, the office shall make an inspection. The office shall provide the complainant with a written acknowledgment of the complaint within 15 days after receipt by the office. The complainant shall be advised, within 30 days after the receipt of the complaint by the office, of the office's determination that the complaint does not allege a violation of this chapter, that the complaint is without any reasonable basis, or that the office will make an inspection. The notice must include an estimated timeframe for completing the inspection and a contact number. If the inspection is not completed within the estimated timeframe, the office must provide the complainant with a revised timeframe. Within 15 days after completing an inspection, the office shall provide the complainant and the provider a written statement specifying any violations of this chapter and any actions taken or that no such violation was found ~~proposed course of action of the office~~.

Section 29. Section 651.114, Florida Statutes, is amended to read:

651.114 Delinquency proceedings; remedial rights.—

(1) Upon determination by the office that a provider is not in compliance with this chapter, the office may notify the chair of the Continuing Care Advisory Council, who may assist the office in formulating a corrective action plan.

(2) Within 30 days after a request by either the advisory council or the office, a provider shall make a plan for

obtaining compliance or solvency available to the advisory council and the office~~, within 30 days after being requested to do so by the council, a plan for obtaining compliance or solvency~~.

(3) Within 30 days after receipt of a plan for obtaining compliance or solvency, the office or, at the request of the office, ~~notification,~~ the advisory council shall:

(a) Consider and evaluate the plan submitted by the provider.

(b) Discuss the problem and solutions with the provider.

(c) Conduct such other business as is necessary.

(d) Report its findings and recommendations to the office, which may require additional modification of the plan.

This subsection may not be construed to delay or prevent the office from taking any regulatory measures it deems necessary regarding the provider that submitted the plan.

(4) If the financial condition of a continuing care facility or provider is impaired or is such that if not modified or corrected, its continued operation would result in insolvency, the office may direct the provider to formulate and file with the office a corrective action plan. If the provider fails to submit a plan within 30 days after the office's directive or submits a plan that is insufficient to correct the condition, the office may specify a plan and direct the provider to implement the plan. Before specifying a plan, the office may seek a recommended plan from the advisory council.

(5)~~(4)~~ After receiving approval of a plan by the office, the provider shall submit a progress report monthly to the

advisory council or the office, or both, in a manner prescribed by the office. After 3 months, or at any earlier time deemed necessary, the council shall evaluate the progress by the provider and shall advise the office of its findings.

(6)~~(5)~~ If ~~Should~~ the office finds ~~find~~ that sufficient grounds exist for rehabilitation, liquidation, conservation, reorganization, seizure, or summary proceedings of an insurer as set forth in ss. 631.051, 631.061, and 631.071, the department ~~office~~ may petition for an appropriate court order or may pursue such other relief as is afforded in part I of chapter 631. Before invoking its powers under part I of chapter 631, the department ~~office~~ shall notify the chair of the advisory council.

(7) Notwithstanding s. 631.011, impairment of a provider, for purposes of s. 631.051, has the same meaning as the term "impaired" in s. 651.011.

(8)~~(6)~~ In the event an order of conservation, rehabilitation, liquidation, or ~~conservation, reorganization,~~ seizure~~, or summary proceeding~~ has been entered against a provider, the department and office are vested with all of the powers and duties they have under ~~the provisions of~~ part I of chapter 631 in regard to delinquency proceedings of insurance companies. A provider shall give written notice of the proceeding to its residents within 3 business days after the initiation of a delinquency proceeding under chapter 631 and shall include a notice of the delinquency proceeding in any written materials provided to prospective residents

~~(7) If the financial condition of the continuing care facility or provider is such that, if not modified or corrected,~~

~~its continued operation would result in insolvency, the office may direct the provider to formulate and file with the office a corrective action plan. If the provider fails to submit a plan within 30 days after the office's directive or submits a plan that is insufficient to correct the condition, the office may specify a plan and direct the provider to implement the plan~~.

(9) A provider subject to an order to show cause entered pursuant to chapter 631 must file its written response to the order, together with any defenses it may have to the department's allegations, not later than 20 days after service of the order to show cause, but not less than 15 days before the date of the hearing set by the order to show cause.

(10) A hearing held pursuant to chapter 631 to determine whether cause exists for the department to be appointed receiver must be commenced within 60 days after an order directing a provider to show cause.

(11)(a) ~~(8)(a)~~ The rights of the office described in this section are subordinate to the rights of a trustee or lender pursuant to the terms of a resolution, ordinance, loan agreement, indenture of trust, mortgage, lease, security agreement, or other instrument creating or securing bonds or notes issued to finance a facility, and the office, subject to ~~the provisions of~~ paragraph (c), may ~~shall~~ not exercise its remedial rights provided under this section and ss. 651.018, 651.106, 651.108, and 651.116 with respect to a facility that is subject to a lien, mortgage, lease, or other encumbrance or trust indenture securing bonds or notes issued in connection with the financing of the facility, if the trustee or lender, by inclusion or by amendment to the loan documents or by a separate

contract with the office, agrees that the rights of residents under a continuing care or continuing care at-home contract will be honored and will not be disturbed by a foreclosure or conveyance in lieu thereof as long as the resident:

1. Is current in the payment of all monetary obligations required by the contract;

2. Is in compliance and continues to comply with all provisions of the contract; and

3. Has asserted no claim inconsistent with the rights of the trustee or lender.

(b) This subsection does not require a trustee or lender to:

1. Continue to engage in the marketing or resale of new continuing care or continuing care at-home contracts;

2. Pay any rebate of entrance fees as may be required by a resident's continuing care or continuing care at-home contract as of the date of acquisition of the facility by the trustee or lender and until expiration of the period described in paragraph (d);

3. Be responsible for any act or omission of any owner or operator of the facility arising before the acquisition of the facility by the trustee or lender; or

4. Provide services to the residents to the extent that the trustee or lender would be required to advance or expend funds that have not been designated or set aside for such purposes.

(c) If ~~Should~~ the office determines ~~determine~~, at any time during the suspension of its remedial rights as provided in paragraph (a), that:

1. The trustee or lender is not in compliance with

paragraph (a)~~;, or that~~

2. A lender or trustee has assigned or has agreed to assign all or a portion of a delinquent or defaulted loan to a third party without the office's written consent~~;~~

3. The provider engaged in the misappropriation, conversion, or illegal commitment or withdrawal of minimum liquid reserve or escrowed funds required under this chapter;

4. The provider refused to be examined by the office pursuant to s. 651.105(1); or

5. The provider refused to produce any relevant accounts, records, and files requested as part of an examination,

the office shall notify the trustee or lender in writing of its determination, setting forth the reasons giving rise to the determination and specifying those remedial rights afforded to the office which the office shall then reinstate.

(d) Upon acquisition of a facility by a trustee or lender and evidence satisfactory to the office that the requirements of paragraph (a) have been met, the office shall issue a 90-day temporary certificate of authority granting the trustee or lender the authority to engage in the business of providing continuing care or continuing care at-home and to issue continuing care or continuing care at-home contracts subject to the office's right to immediately suspend or revoke the temporary certificate of authority if the office determines that any of the grounds described in s. 651.106 apply to the trustee or lender or that the terms of the contract used as the basis for the issuance of the temporary certificate of authority by the office have not been or are not being met by the trustee or

lender since the date of acquisition.

Section 30. Section 651.1141, Florida Statutes, is created to read:

651.1141 Immediate final orders.—

(1) The Legislature finds that the following actions constitute an imminent and immediate threat to the public health, safety, and welfare of the residents of this state:

(a) The installation of a general partner of a provider or assumption of ownership or possession or control of 10 percent or more of a provider's assets in violation of s. 651.024 or s. 651.0245;

(b) The removal or commitment of 10 percent or more of the required minimum liquid reserve funds in violation of s. 651.035; or

(c) The assumption of control over a facility's operations in violation of s. 651.043.

(2) If it finds that a person or entity is engaging or has engaged in one or more of the above activities, the office may, pursuant to s. 120.569, issue an immediate final order:

(a) Directing that such person or entity cease and desist that activity; or

(b) Suspending the certificate of authority of the facility.

Section 31. Subsection (1) of section 651.121, Florida Statutes, is amended to read:

651.121 Continuing Care Advisory Council.—

(1) The Continuing Care Advisory Council to the office is created consisting of 10 members ~~who are residents of this state~~ appointed by the Governor and geographically representative of

this state. Three members shall be representatives ~~administrators~~ of facilities that hold valid certificates of authority under this chapter and ~~shall~~ have been actively engaged in the offering of continuing care contracts in this state for 5 years before appointment. The remaining members include:

(a) A representative of the business community whose expertise is in the area of management.

(b) A representative of the financial community who is not a facility owner or administrator.

(c) A certified public accountant.

~~(d) An attorney.~~

(d) ~~(e)~~ Four ~~Three~~ residents who hold continuing care or continuing care at-home contracts with a facility certified in this state.

Section 32. Subsections (1) and (4) of section 651.125, Florida Statutes, are amended to read:

651.125 Criminal penalties; injunctive relief.—

(1) Any person who maintains, enters into, or, as manager or officer or in any other administrative capacity, assists in entering into, maintaining, or performing any continuing care or continuing care at-home contract subject to this chapter without ~~doing so in pursuance of~~ a valid provisional certificate of authority or certificate of authority ~~or renewal thereof~~, as contemplated by or provided in this chapter, or who otherwise violates any provision of this chapter or rule adopted in pursuance of this chapter, commits a felony of the third degree, punishable as provided in s. 775.082 or s. 775.083. Each violation of this chapter constitutes a separate offense.

(4) Any action brought by the office against a provider shall not abate by reason of a sale or other transfer of ownership of the facility used to provide care, which provider is a party to the action, except with the express written consent of the ~~director of the~~ office.

Section 33. Except as otherwise expressly provided in this act and except for this section, which shall take effect July 1, 2019, this act shall take effect January 1, 2020.

The Florida Senate

Committee Agenda Request

To: Senator Doug Broxson, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: February 25, 2019

I respectfully request that **Senate Bill #1070**, relating to Continuing Care Contracts, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Tom Lee
Florida Senate, District 20

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

1070
Bill Number (if applicable)

Topic SB1070 - Regulating CERCs

Amendment Barcode (if applicable)

Name Joel Anderson

Job Title CEO

Address 8501 Eagle Preserve Way
Street

Phone 239-281-3505

Sarasota FL 34241
City State Zip

Email

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Village On The Isle

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/19
Meeting Date

SB 1070
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Kip Corrivean

Job Title Dir. of Mission

Address 10300 4th St North
Street

St. Petersburg FL 33716
City *State* *Zip*

Phone 7275681042

Email Kip_Corrivean@bshs.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Bon Secours St. Petersburg Health System

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/19
Meeting Date

1070
Bill Number (if applicable)

Topic CCRCs

Amendment Barcode (if applicable)

Name Bruce Jones

Job Title CEO - Vicar's Landing

Address 1000 Vicar's Landing Way
Street

Ponte Vedra Beach FL 32082
City *State* *Zip*

Phone 904-273-1701

Email bjones@vicarslanding.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

March 11/2019
Meeting Date

1070
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Tim Meenan

Job Title _____

Address 400 S. Duval St.
Street

Tallahassee FL 32302
City *State* *Zip*

Phone (850) 425-4000

Email Tim@meenanlawfirm.com

Speaking: ☒ For ☐ Against ☒ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Argentum

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/19
Meeting Date

1070
Bill Number (if applicable)

Topic Continuing Care Retirement Communities

Amendment Barcode (if applicable)

Name Karen Kugell

Job Title Chair Legislative Committee FLiCRA Board West-minster Oaks

Address 4425 Meandering Way Apt 515 Phone 207 776 9671
Street

Tallahassee, FL 32308 Email KKugel102@gmail.com
City *State* *Zip*

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FL Life Care Residents Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/19
Meeting Date

SB 1070
Bill Number (if applicable)

Topic Continuing Care Contracts

Amendment Barcode (if applicable)

Name Steve Bahmer

Job Title President / CEO

Address 1812 Riggins Rd
Street

Tallahassee FL 32308
City *State* *Zip*

Phone 850/671-3900

Email Sbahmer@leadingagefl
orida.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing LeadingAge Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/19
Meeting Date

SB 1070
Bill Number (if applicable)

436274
Amendment Barcode (if applicable)

Topic Continuing Care Contracts

Name Steve Bahmer

Job Title President/CEO

Address 1812 Riggins Rd
Street
Tallahassee FL 32308
City *State* *Zip*

Phone 850/671-3700

Email Sbahmer@leadingagefloride.org

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Leading Age Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/19
Meeting Date

SB 1070
Bill Number (if applicable)

738088
Amendment Barcode (if applicable)

Topic Continuing Care Contracts

Name Steve Bahmer

Job Title President / CEO

Address 1812 Riggins Rd
Street

Tallahassee FL 32308
City *State* *Zip*

Phone 850/371.3700

Email Sbahmer@leadingagefloride.org

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Leading Age Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	CS/SB 1184
INTRODUCER:	Banking and Insurance Committee and Senator Baxley
SUBJECT:	Payments to Surviving Successors
DATE:	March 12, 2019 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Billmeier	Knudson	BI	**Fav/CS**
2.			JU	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1184 allows a financial institution to pay the authorized family member of a decedent, without any court proceedings, order, or judgment authorizing the payment, the funds on deposit in all qualified accounts of the decedent at the financial institution if the total amount of such funds does not exceed $10,000. The financial institution may make such payment not earlier than 2 years after the date of the decedent's death. Currently, an authorized family member can make a claim for the funds in the account only after the financial institution reports the funds to the Department of Financial Services pursuant to the Unclaimed Property Law.

The bill requires an authorized family member to provide an affidavit to the financial institution containing:

- A statement attesting that the authorized family member is the surviving spouse, adult child, adult descendant, or parent of the decedent;
- A statement to demonstrate that the authorized family member is the appropriate person to receive the funds, e.g. an adult child of the decedent must attest there is no surviving spouse or a parent of the decedent must attest there is no surviving spouse, no surviving adult children, and no surviving adult descendants;
- The date of death of the decedent and the address of the last residence of the decedent;
- A statement attesting that the total amount of all qualified accounts held by the decedent with any financial institution does not exceed $10,000;

- A statement acknowledging that a personal representative has not been appointed to administer the estate of the decedent, that no probate or summary administration procedures have been commenced with respect to the estate of the decedent;
- A statement identifying the name of each family member of the decedent and the notarized written consent of each other family member of the decedent;
- A statement acknowledging that the affiant has no knowledge of the existence of a will or other document or agreement relating to the distribution of the decedent's estate;
- A statement acknowledging that the payment of the funds constitutes a full release and discharge of the financial institution's obligation regarding the amount paid;
- A statement acknowledging that the affiant understands that he or she is personally liable to the persons rightfully entitled to the funds under the Florida Probate Code, to the extent that the amount paid exceeds the amount properly attributable to the affiant's share; and
- A statement acknowledging that the affiant understands that making a false statement in the affidavit may be punishable as a criminal offense.

The bill does not require the financial institution to determine whether the contents of the sworn affidavit are truthful and the bill provides that a person does not have a right or cause of action against a financial institution because of payment of the funds.

The bill provides that the authorized family member who withdraws the funds is personally liable to any persons rightfully entitled to the funds under the Florida Probate Code, to the extent that the amount paid exceeds the amount properly attributable to the authorized family member's share.

The bill allows a financial institution to release the existence of and amounts contained in any qualified account of the decedent at the financial institution to a surviving spouse who presents a copy of a marriage certificate evidencing the spouse's marriage to the decedent or an adult child of the decedent who presents a copy of a birth certificate evidencing that the decedent is the parent of the adult child.

The bill takes effect July 1, 2019.

II. Present Situation:

Florida Probate Law

The Florida Probate Code provides the statutory mechanism for the transfer of property from a decedent to persons or entities named in a decedent's will (often called beneficiaries) or to the decedent's heirs, if there is no will. The property transferred via the probate process is called the "estate." In addition, the code provides a statutory mechanism to wind up the decedent's financial affairs and ensure that the decedent's creditors are paid.

If the decedent had a will, the property is transferred as directed by the will. If a person dies without a will, the person is considered to have died "intestate" and the person's property is transferred to heirs according to the laws of intestate succession. Section 732.102, F.S., provides that a surviving spouse takes the entire intestate estate if there is no surviving descendant of the decedent. If the decedent is survived by one or more descendants, all of whom are also

descendants of the surviving spouse, and the surviving spouse has no other descendants, the surviving spouse takes the entire intestate estate.[1] If there are one or more surviving descendants of the decedent who are not lineal descendants of the surviving spouse, the surviving spouse takes one-half of the intestate estate.[2] If there are one or more surviving descendants of the decedent, all of whom are also descendants of the surviving spouse, and the surviving spouse has one or more descendants who are not descendants of the decedent, the surviving spouse takes one-half of the intestate estate.[3]

The part of the intestate estate not passing to the surviving spouse, or the entire intestate estate if there is no surviving spouse, transfers to the descendants of the decedent.[4] If the descendant has no descendants, the descendant's parents take the intestate estate.[5]

In order for the decedent's estate to be transferred to heirs or to the beneficiaries of the will, a petition for administration must be filed with the circuit court.[6] The personal representative, a person designated by the will or the circuit court to serve in that role, must provide a notice of administration to various persons, such as family members and beneficiaries, and other entities.[7] Those persons must act to contest the will or take other actions within statutory time limits.[8] The personal representative must search for and provide notice, by publication in a newspaper, to creditors of the decedent.[9] Creditors must generally make claims against the estate within 3 months of notice.[10] In order for personal representatives to claim monies from bank accounts on for the estate, the court must issue letters of administration granting the personal representative the authority to act on behalf of the estate. The letters give the personal representative the power to gather assets, pay creditors, and pay the heirs or beneficiaries. Even a simple probate estate can take 5 or 6 months to administer and close.[11] For small estates, ch. 735, F.S., provides for summary administration or disposition without administration.

Florida Unclaimed Property Law

Chapter 717, F.S., is Florida's law dealing with the disposition of unclaimed property. The most common types of unclaimed property are dormant bank accounts, unclaimed insurance proceeds, stocks, dividends, uncashed checks, deposits, credit balances and refunds. Unclaimed property assets are held by businesses for a set period of time, usually 5 years. Businesses (holders of unclaimed property) are required to try to locate the owner, but when their attempts fail, they report the property and the owner's name, last known address and other information to the Department of Financial Services. The Department acts as custodian for the State of Florida, but never takes legal ownership of the property. The State uses various methods, including database

[1] *See* s. 732.102(2), F.S.
[2] *See* s. 732.102(3), F.S.
[3] *See* s. 732.102(4), F.S.
[4] *See* s. 732.103(1), F.S.
[5] *See* s. 732.103(2), F.S.
[6] *See* s. 733.202, F.S.
[7] *See* s. 733.212, F.S.
[8] *See* s. 733.212, F.S.
[9] *See* s. 733.2121, F.S.
[10] *See* s. 733.702, F.S.
[11] *See* https://www.floridabar.org/public/consumer/pamphlet026/ (last visited March 6, 2019).

searches, in an effort to notify owners of their property. Citizens have the right to claim their property, at no cost, any time, regardless of the amount.[12]

Funds Held by Financial Institutions

Funds held by a financial institution may be transferred to a person who survives a decedent in different ways. If an account is in two or more names, it vests in the surviving person or persons if one of the account holders dies.[13] An account holder may elect to designate a beneficiary or beneficiaries through a "pay-on-death designation."[14] Upon the death of the account holder, the amount on deposit in the account belong to the surviving beneficiaries.[15] Not all account holders elect a "pay on death" designation.[16]

Section 735.301, F.S., allows for a disposition of small estates without administration. This type of proceeding is used to request release of assets of the deceased to reimburse the person who paid the final expenses, such as funeral or medical bills, for the last 60 days.

III. Effect of Proposed Changes:

This bill allows a financial institution to pay the authorized family member[17] of a decedent, without any court proceedings, order, or judgment authorizing the payment, the funds on deposit in all qualified accounts[18] of the decedent at the financial institution if the total amount of such funds does not exceed $10,000. The financial institution may make such payment not earlier than 2 years after the date of the decedent's death.[19]

In order to obtain payment from a financial institution, the authorized family member must provide the financial institution with a certified copy of the decedent's death certificate and a sworn affidavit that includes all of the following:

- A statement attesting that the authorized family member is the surviving spouse, adult child, adult descendant, or parent of the decedent;
- A statement to demonstrate that the authorized family member is the appropriate person to receive the funds, e.g. an adult child of the decedent must attest there is no surviving spouse or a parent of the decedent must attest there is no surviving spouse, no surviving adult children, and no surviving adult descendants;
- The date of death of the decedent and the address of the last residence of the decedent;

[12] *See* https://www.fltreasurehunt.gov/UP-Web/sitePages/FAQs.jsp (last visited March 6, 2019).
[13] *See* s. 655.79, F.S.
[14] *See* s. 655.82, F.S.
[15] *See* s. 655.82, F.S.
[16] Information Sheet provided by the Florida Bankers Association (on file with the Committee on Banking and Insurance).
[17] The bill defines "authorized family member" as (1) the surviving spouse of the decedent; (2) if the decedent did not leave a surviving spouse, an adult child of the decedent; (3) if the decedent did not leave a surviving spouse or an adult child, an adult descendant of the decedent, or (4) the parent of the decedent.
[18] The bill defines "qualified account" as a depository account or a certificate of deposit held in the sole name of the decedent with no pay on death or other survivor designation.
[19] Allowing a surviving successor to claim the funds 45 days after the date of the decedent's death would be a change from the current method under the Florida Probate Code. Under the Probate Code, the estate must go through either formal or summary administration. Those procedures provide an opportunity, usually three months, to make claims against the estate.

- A statement attesting that the total amount of all qualified accounts held by the decedent with any financial institution does not exceed $10,000;
- A statement acknowledging that a personal representative has not been appointed to administer the estate of the decedent and that no probate or summary administration procedures have been commenced with respect to the estate of the decedent;
- A statement identifying the name of each family member[20] of the decedent and the notarized written consent of each other family member of the decedent;
- A statement acknowledging that the affiant has no knowledge of the existence of a will or other document or agreement relating to the distribution of the decedent's estate;
- A statement acknowledging that the payment of the funds constitutes a full release and discharge of the financial institution's obligation regarding the amount paid;
- A statement acknowledging that the affiant understands that he or she is personally liable to the persons rightfully entitled to the funds under the Florida Probate Code, to the extent that the amount paid exceeds the amount properly attributable to the affiant's share; and
- A statement acknowledging that the affiant understands that making a false statement in the affidavit may be punishable as a criminal offense.

Heirs other than a surviving spouse, an adult child, and adult descendant, or a parent may not make a claim to the financial institution and would have to make a claim under the Probate Code.

The bill requires the financial institution to maintain a copy or an image of the affidavit for a period of 7 years after releasing the funds. If a family member of the decedent requests a copy of the affidavit during such time, the financial institution may provide a copy of the affidavit to the requesting family member of the decedent.

The bill does not require the financial institution to determine whether the contents of the sworn affidavit are truthful. The payment of funds by the financial institution to the surviving successor constitutes a full release and discharge of the financial institution for the amount paid. The bill provides that a person does not have a right or cause of action against a financial institution because of such payment.

The bill provides that the authorized family member who withdraws the funds is personally liable to any persons rightfully entitled to the funds under the Florida Probate Code, to the extent that the amount paid exceeds the amount properly attributable to the authorized family member's share.

The bill allows a financial institution to release, upon presentation of a decedent's death certificate to a financial institution not less than 2 years after the date of death of the decedent, the existence of and amounts contained in any qualified account of the decedent at the financial institution to a surviving spouse who presents a copy of a marriage certificate evidencing the spouse's marriage to the decedent or an adult child of the decedent who presents a copy of a birth certificate evidencing that the decedent is the parent of the adult child. The bill also makes a

[20] The bill defines "family member" as "1. the surviving spouse of the decedent; 2. If there is no surviving spouse, or if any of the children of the decedent are not also children of the surviving spouse, the living children of the decedent, and the living descendants of any deceased child of the decedent; or 3. If there is no surviving spouse or living descendants of the decedent, the living parents of the decedent."

conforming change by amending s. 655.059, F.S., to allow a financial institution to disclose the existence of and amounts on deposit in any qualified accounts of a decedent, and to provide a copy of any affidavit delivered to the financial institution pursuant s. 655.795, F.S., to persons authorized to receive such information under s. 655.795, F.S.

The bill makes knowingly making a false statement in a sworn affidavit provided to a financial institution is punishable as theft, punishable as provided in s. 812.014, F.S.

The bill provides a form affidavit for use by surviving successors to make claims with financial institutions.

The bill takes effect July 1, 2019.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

On lines the bill allows the bank to "release the existence of and amounts contained in any qualified account" to specified persons. It is unclear whether "release…the amounts contained in any qualified account" refers to providing information regarding the amount in the account or paying the funds in the account to specified persons. Striking "release" and inserting "disclose" would resolve this ambiguity.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 655.795 of the Florida Statutes.

This bill amends section 655.059 of the Florida Statutes.

IX. Additional Information:

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

CS by Banking and Insurance on March 11, 2019:
The CS:

- Replaces the term "surviving successor" with "authorized family member;"
- Allows adult descendants of the decedent to claim funds in specified circumstances;
- Provides that an authorized family member cannot claim the funds in the account until at least 2 years have elapsed since the decedent's death;
- Removes provisions of the bill requiring the authorized family member to indemnify the financial institution against claims brought against financial institutions relating to payments made pursuant to the bill; and
- Allows the financial institution to disclose to the authorized family member the existence of and amounts on deposit in a decedent's account.

B. Amendments:

None.

176592

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/11/2019	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Baxley) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Paragraph (b) of subsection (2) of section 655.059, Florida Statutes, is amended to read:

655.059 Access to books and records; confidentiality; penalty for disclosure.—

(2)

(b) The books and records pertaining to trust accounts and

the deposit accounts and loans of depositors, borrowers, members, and stockholders of any financial institution shall be kept confidential by the financial institution and its directors, officers, and employees and may not be released except upon express authorization of the account holder as to her or his own accounts, loans, or voting rights. However, information relating to any loan made by a financial institution may be released without the borrower's authorization in a manner prescribed by the board of directors for the purpose of meeting the needs of commerce and for fair and accurate credit information. Information may also be released, without the authorization of a member or depositor but in a manner prescribed by the board of directors, to verify or corroborate the existence or amount of a customer's or member's account when such information is reasonably provided to meet the needs of commerce and to ensure accurate credit information. In addition, a financial institution, affiliate, and its subsidiaries, and any holding company of the financial institution or subsidiary of such holding company, may furnish to one another information relating to their customers or members, subject to the requirement that each corporation receiving information that is confidential maintain the confidentiality of such information and not provide or disclose such information to any unaffiliated person or entity. Notwithstanding this paragraph, this subsection does not prohibit:

1. A financial institution from disclosing financial information as referenced in this subsection as authorized by Pub. L. No. 106-102 (1999), as set forth in 15 U.S.C.A. s. 6802, as amended.

2. The Florida office of the international banking corporation or international trust entity from sharing books and records under this subsection with the home-country supervisor in accordance with subsection (1).

3. A financial institution from disclosing, pursuant to s. 655.795, the existence of and amounts on deposit in any qualified accounts of a decedent, and providing a copy of any affidavit delivered to the financial institution pursuant thereto, to persons authorized to receive such information under s. 655.795.

Section 2. Section 655.795, Florida Statutes, is created to read:

655.795 Payment to successor without court proceedings.—

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

(a) "Authorized family member" means:

1. The surviving spouse of the decedent;

2. If the decedent did not leave a surviving spouse, an adult child of the decedent;

3. If the decedent did not leave a surviving spouse or a surviving adult child, an adult descendant of the decedent; or

4. If the decedent did not leave a surviving spouse, an adult child, or an adult descendant, the parent of the decedent.

(b) "Family members of the decedent" means:

1. The surviving spouse of the decedent;

2. If there is no surviving spouse, or if any of the children of the decedent are not also children of the surviving spouse, the living children of the decedent, and the living descendants of any deceased child of the decedent; or

3. If there is no surviving spouse or living descendants of

the decedent, the living parents of the decedent.

(c) "Qualified account" means a depository account or certificate of deposit held in the sole name of the decedent without a pay-on-death or any other survivor designation.

(2) A financial institution in this state may pay to the authorized family member of a decedent, without any court proceeding, order, or judgment, the funds on deposit in all qualified accounts of the decedent at the financial institution if the total amount of the combined funds in the qualified accounts at that financial institution do not exceed $10,000. The financial institution may not make such payment earlier than 2 years after the date of the decedent's death.

(3) In order to receive the funds, the authorized family member must provide the financial institution with a certified copy of the decedent's death certificate and a sworn affidavit that includes all of the following:

(a) A statement attesting that the affiant is the surviving spouse, adult child, adult descendant, or parent of the decedent.

1. If the affiant is an adult child of the decedent, the affidavit must attest that the decedent left no surviving spouse.

2. If the affiant is an adult descendant of the decedent, the affidavit must attest that the decedent left no surviving spouse or adult children.

3. If the affiant is a parent of the decedent, the affidavit must attest that the decedent left no surviving spouse, adult children, or adult descendants.

(b) The date of death and the address of the last residence

of the decedent.

(c) A statement attesting that the total amount in all qualified accounts held by the decedent with any financial institution known to the affiant does not exceed $10,000.

(d) A statement acknowledging that a personal representative has not been appointed to administer the decedent's estate and stating that no probate proceeding or summary administration procedure has been commenced with respect to the estate.

(e) A statement identifying the name of each of the family members of the decedent and that the notarized written consent of each other family member of the decedent is attached. The natural parent or guardian of any person who is a minor may give consent on behalf of such person.

(f) A statement acknowledging that the affiant has no knowledge of the existence of any last will and testament or other document or agreement relating to the distribution of the estate of the decedent.

(g) A statement acknowledging that the payment of the funds constitutes a full release and discharge of the financial institution's obligation regarding the amount paid.

(h) A statement acknowledging that the affiant understands that he or she is personally liable to the persons rightfully entitled to the funds under the Florida Probate Code, to the extent that the amount paid exceeds the amount properly attributable to the affiant's share.

(i) A statement acknowledging that the affiant understands that making a false statement in the affidavit may be punishable as a criminal offense.

(4) The authorized family member may use an affidavit in substantially the following form to fulfill the requirements of subsection (3):

AFFIDAVIT UNDER SECTION 655.795, FLORIDA STATUTES, TO OBTAIN BANK PROPERTY OF DECEASED ACCOUNTHOLDER: ...(Name of decedent)...

State of ....
County of ....

Before the undersigned authority personally appeared ...(name of affiant)..., of ...(residential address of affiant)..., who has been sworn and says the following statements are true:

(a) The affiant is (initial one of the following responses):

.... The surviving spouse of the decedent.

.... A surviving adult child of the decedent, and the decedent left no surviving spouse.

.... A surviving adult descendent of the decedent, and the decedent left no surviving spouse and no surviving adult children.

.... A surviving parent of the decedent, and the decedent left no surviving spouse, no surviving adult children, and no surviving adult descendant.

(b) As shown in the certified death certificate, the date of death of the decedent was ...(date of death)..., and the address of the decedent’s last residence was ...(address of last residence)....

(c) The affiant is entitled to payment of the funds in the

176592

decedent's depository accounts and certificates of deposit held by the financial institution ...(name of financial institution).... The total of qualified accounts held by the decedent in all financial institutions known to the affiant does not exceed an aggregate total of $10,000. The affiant requests full payment from the financial institution.

(d) A personal representative has not been appointed to administer the decedent's estate and no probate proceeding or summary administration procedure has been commenced with respect to the estate.

(e) The affiant has been provided with and has read the provisions s. 655.795, Florida Statutes, and (initial one of the following responses):

.... There are no family members of the decedent other than affiant.

.... The family members of the decedent are ...(identify by name).... Notarized letters from all of the family members of the decedent other than the affiant consenting to the affiant's funds withdrawal are attached.

(f) The affiant has no knowledge of any last will and testament or other document or agreement relating to the distribution of decedent's estate.

(g) The payment of the funds constitutes a full release and discharge of the financial institution for the amount paid.

(h) The affiant understands that he or she is personally liable to the persons rightfully entitled to the funds under the Florida Probate Code, to the extent that the amount paid exceeds the amount properly attributable to the affiant's share.

(i) The affiant understands that making a false statement

176592

in this affidavit may be punishable as a criminal offense.

By ...(signature of Affiant)...

Sworn to and subscribed before me this .... day of .... by ...(name of Affiant)..., who is personally known to me or produced .... as identification, and did take an oath.

...(Signature of Notary Public - State of Florida)...
...(Print, Type, or Stamp Commissioned Name of Notary Public)...
My commission expires: ...(date of expiration of commission)...

(5) The financial institution is not required to determine whether the contents of the sworn affidavit are truthful. The payment of the funds by the financial institution to the affiant constitutes the financial institution's full release and discharge for the amount paid. A person does not have a right or cause of action against the financial institution for taking any action, or for failing to take an action, in connection with the affidavit or the payment of the funds.

(6) The authorized family member who withdraws the funds under this section is personally liable to any persons rightfully entitled to the funds under the Florida Probate Code, to the extent that the amount paid exceeds the amount properly attributable to the authorized family member's share.

(7) The financial institution shall maintain a copy or an image of the affidavit for a period of 7 years after releasing

the funds. If a family member of the decedent requests a copy of the affidavit during such time, the financial institution may provide a copy of the affidavit to the requesting family member of the decedent.

(8) Upon presentation of a decedent's death certificate to a financial institution not less than 2 years after the date of death of the decedent, the financial institution may release the existence of and amounts contained in any qualified account of the decedent at the financial institution to the following persons:

1. A surviving spouse who presents a copy of a marriage certificate evidencing the spouse's marriage to the decedent; or

2. An adult child of the decedent who presents a copy of a birth certificate evidencing that the decedent is the parent of the adult child.

(9) In addition to any other penalty provided by law, a person who knowingly makes a false statement in a sworn affidavit given to a financial institution to receive a decedent's funds under this section commits theft, punishable as provided in s. 812.014.

Section 3. This act shall take effect July 1, 2019.

================ T I T L E A M E N D M E N T ================

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to bank property of deceased accountholders; amending s. 655.059, F.S.; specifying

that a financial institution is not prohibited from disclosing specified information to certain persons relating to deceased account holders; creating s. 655.795, F.S.; defining terms; authorizing a financial institution to pay to the authorized family member of a decedent depositor, without any court proceeding, order, or judgment authorizing the payment and not earlier than a specified time, the funds in the decedent's qualified accounts if the sum does not exceed a specified amount; requiring the authorized family member to provide the financial institution a certified copy of the decedent's death certificate and a specified affidavit in order to receive the funds; providing an affidavit form the authorized family member may use; providing that the financial institution has no duty to make certain determinations; specifying a person does not have a right or cause of action against a financial institution for certain actions or for failing to take certain actions; providing liability for authorized family members; requiring a financial institution to maintain a copy or image of the affidavit for a specified time; authorizing the financial institution to provide copies of the affidavit to certain persons; authorizing a financial institution to release certain information bank accounts under certain circumstances; providing a criminal penalty; providing an effective date.

By Senator Baxley

12-00570A-19 20191184__

A bill to be entitled

An act relating to payments to surviving successors; creating s. 655.795, F.S.; defining the terms "qualified account" and "surviving successor"; authorizing a financial institution to pay to the surviving successor of a decedent depositor, without any court proceeding, order, or judgment authorizing the payment and not earlier than a specified time, the funds in the decedent's qualified accounts if the sum does not exceed a specified amount; requiring the surviving successor to provide a certified copy of the decedent's death certificate and a specified affidavit to the financial institution; providing that the financial institution has no duty to make certain determinations; providing construction relating to liability and indemnification; providing a criminal penalty; providing an affidavit form the surviving successor may use; providing construction relating to any conflict with the Florida Probate Code; providing an effective date.

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

Section 1. Section 655.795, Florida Statutes, is created to read:

655.795 Payment to successor without court proceedings.—

(1) For purposes of this section, the term:

(a) "Qualified account" means a depository account or a certificate of deposit held in the sole name of the decedent

12-00570A-19 20191184__

with no pay on death or other survivor designation.

(b) "Surviving successor" means:

1. The surviving spouse of the decedent;

2. If the decedent did not leave a surviving spouse, an adult child of the decedent; or

3. If the decedent did not leave a surviving spouse or an adult child, the parent of the decedent.

(2)(a) A financial institution in this state may pay to the surviving successor of a decedent, without any court proceedings, order, or judgment authorizing the payment, the funds on deposit in all qualified accounts of the decedent at the financial institution if the total amount of such funds does not exceed $10,000. The financial institution may make such payment not earlier than 45 days after the date of the decedent's death.

(b) The surviving successor must provide the financial institution with a certified copy of the decedent's death certificate and a sworn affidavit that includes all of the following:

1. A statement attesting that the surviving successor is the surviving spouse, adult child, or parent of the decedent.

a. If the surviving successor is the surviving spouse, a statement that either all of the decedent's children are also the children of the surviving spouse, or a statement identifying the children of the decedent who are not also children of the surviving spouse and that the written consent of each of those children to the withdrawal of funds in the qualified account by the surviving spouse is attached. The natural parent or the guardian of any such child who is a minor may give consent on

behalf of the child.

b. If the surviving successor is an adult child, the affidavit must attest that the decedent left no surviving spouse. The affidavit must also indicate that there are no other surviving adult children of the decedent, or must include a statement identifying the other surviving adult children of the decedent and stating that that the written consent of the other surviving children to the withdrawal of funds from the qualified account by the affiant adult child is attached. If any such child is a minor, the natural parent or the guardian of such child may give consent on behalf of the child.

c. If the surviving successor is a parent, the affidavit must attest that the decedent left no surviving spouse or adult child. The affidavit must also indicate that there is no other surviving parent of the decedent, or must include a statement identifying the other surviving parent and stating that the written consent of the other surviving parent to the withdrawal of funds from the qualified account by the affiant parent is attached.

2. The date of death of the decedent and the address of the last residence of the decedent.

3. A statement attesting that the total amount of all qualified accounts held by the decedent with any financial institution does not exceed an aggregate total of $10,000.

4. A statement acknowledging that a personal representative has not been appointed to administer the estate of the decedent, that no probate or summary administration procedures have been commenced with respect to the estate of the decedent, and that after diligent inquiry, the surviving successor believes in good

faith that no last will and testament of the decedent will be presented to any court for administration.

5. A statement attesting either that the affiant has made a diligent search for creditors of the decedent, and that after the search, has no knowledge of the existence of any unpaid creditor of the decedent, or that the written consent of all known creditors of the decedent to the withdrawal by the surviving successor is attached.

6. A statement acknowledging that the payment of the funds constitutes a full release and discharge of the financial institution for the amount paid and that the surviving successor indemnifies the financial institution against claims; demands; expenses, including attorney fees and court costs; losses; or damages incurred by the financial institution for taking any action, or failing to take an action, in connection with the payment of the funds.

(c) The financial institution is not required to determine whether the contents of the sworn affidavit are truthful. The payment of funds by the financial institution to the surviving successor constitutes a full release and discharge of the financial institution for the amount paid. A person does not have a right or cause of action against a financial institution because of such payment, and the surviving successor must indemnify and hold harmless the financial institution against claims; demands; expenses, including attorney fees and court costs; losses; or damages incurred by the financial institution for taking any action, or failing to take an action, in connection with the affidavit or the payment.

(d) The surviving successor who withdraws funds is

personally liable:

1. To the creditors of the decedent to the extent of the amount paid;

2. To the personal representative of the decedent to the extent of the amount paid;

3. If a personal representative has not been appointed, to the other intestate heirs of the decedent, to the extent of excess of the amount paid over the amount that is properly attributable to the intestate share of the surviving successor; and

4. If the personal representative has been discharged, to the devisees of the estate to the extent of excess of the amount paid over the amount that would have been devised to the surviving successor.

(e) Personal liability of the surviving successor under this section is not barred by s. 733.702 or s. 733.710 unless the surviving successor publishes a notice to creditors which complies with s. 733.2121, except that the notice must state that the creditors must notify the surviving successor of the claim within the time limits set forth in s. 733.702 or be forever barred, in which case the claim must be barred as provided in s. 733.702.

(f) In addition to any other penalty provided by law, a person who knowingly makes a false statement in a sworn affidavit provided to a financial institution pursuant to this section commits theft, punishable as provided in s. 812.014.

(2) The surviving successor may use the following affidavit form to fulfill the requirements of paragraph (2)(b):

AFFIDAVIT UNDER SECTION 655.795, FLORIDA STATUTES, TO OBTAIN BANK PROPERTY OF DECEASED ACCOUNTHOLDER: ...(Name of deceased)...

State of ....

County of ....

Before me, the undersigned authority, personally appeared Affiant ...(name of Affiant)... of ...(residential address of Affiant)..., who has been sworn and says the following statements are true:

1. Affiant is (initial one response):

.... The surviving spouse of the deceased and the decedent had no children who are not also children of the Affiant.

.... The surviving spouse of the deceased. The children of the decedent who are not also children of the Affiant are identified as ...(names of children)..., and the written consent of each such child to the withdrawal of funds in the qualified account by the Affiant is attached.

.... A surviving adult child of the deceased, and the deceased left no surviving spouse and no other surviving children.

.... A surviving adult child of the deceased, and the deceased left no surviving spouse. The other surviving children of the decedent are identified as ...(names of children)... and the written consent of each such child to the withdrawal of funds in the qualified account by the Affiant is attached.

.... A surviving parent of the deceased, and the deceased left no surviving spouse, no surviving adult children, and no

other surviving parent.

.... A surviving parent of the deceased, and the deceased left no surviving spouse and no surviving adult children. The other surviving parent of the decedent is identified as ...(name of other parent)... and the written consent of such other parent of the decedent to the withdrawal of funds in the qualified account by the Affiant is attached.

2. As shown in the certified death certificate, the date of death was ...(date of death)... and the last address of the deceased was ...(last address)....

3. Total amount of all accounts held in the sole name of the decedent with any financial institution does not exceed an aggregate total of $10,000.

4. A personal representative has not been appointed to administer the estate of the deceased and no probate or summary administration procedures have been commenced with respect to the estate of the decedent. After diligent inquiry, the Affiant believes in good faith that no last will and testament of the decedent will be presented to any court for administration.

5. Affiant has (initial one response):

.... Made a diligent search for creditors of the decedent and has no knowledge of the existence of any unpaid creditor of the decedent.

.... Made a diligent search for creditors of the decedent and written consent of all creditors of the decedent known by the Affiant to the withdrawal of funds from the qualified account by Affiant is attached.

6. Affiant is entitled to payment of the deceased's deposit accounts ("Funds") held by ...(name of financial institution)...

("Financial Institution"). Affiant requests full payment from the Financial Institution.

7. The payment of the Funds constitutes a full release and discharge of the Financial Institution for the amount paid.

8. Individually and as the Affiant, the Affiant agrees to indemnify the Financial Institution and hold it free and harmless from any and all claims; demands; expenses, including attorney fees and court costs; losses; or damages incurred by the Financial Institution for any action taken, or failure to take an action, in connection with this Affidavit and the payment of the Funds to Affiant or as instructed by Affiant.

By ...(signature of Affiant)...

Sworn to and subscribed before me this .... day of .... by ...(name of Affiant)..., who is personally known to me or produced .... as identification, and did take an oath.

...(name of notary public)...
Notary Public
My Commission Expires:
...(date of expiration of commission)...

(3) In the event of a conflict between this section and the Florida Probate Code, this section supersedes the conflicting provision of the Florida Probate Code.

Section 2. This act shall take effect July 1, 2019.

FLORIDA BANKERS ASSOCIATION

Payments to Surviving Successors

Current Situation: While financial institutions often encourage depositors to decide, there are times when clients either refuse or fail to provide instructions on who should receive funds at their death. Financial institutions must then notify surviving spouses or children that they cannot pay out funds that should rightfully go to these successors. Whenever the amounts do not exceed $10,000, going through a probate to receive these funds may significantly reduce or even extinguish the small amount available. Successors often leave the money in the financial institution for 5 years, until it escheats to the state and can be claimed via affidavit. However, the affidavit process with the state still requires a summary administration court order, in at least some cases.

Proposed Law: The new law would provide an affidavit process to be completed 2 years after the decedent has passed for accounts that are less than $10,000. Affiants would be required to attest to the fact that there are no other creditors, no other probate open and that the spouse or children are the sole rightful heirs. Fraudulently submitted affidavits carry a misdemeanor charge and a criminal penalty of up to one year in jail and a $1,000 criminal penalty. The new law also contains indemnification of financial institutions after distributions to these heirs.

Rationale: Successors should not have to wait five years to receive these monies. For persons who only had these smaller accounts but left no pay on death instructions, financial institutions should be allowed to disperse this money to those heirs via affidavit. This also allows financial institutions the ability to move many small, inactive accounts off of their books and help their customers to expenses of the diseased.

Status: SB 1184 has been filed by Senator Dennis Baxley (R-Ocala) and HB 837 has been filed by Rep. Colleen Burton (R-Lakeland) and FBA has already begun pushing these bills to be heard.

Recommended by the GRC and approved by the Board in 2018.

2019 AGENCY LEGISLATIVE BILL ANALYSIS
Florida Office of Financial Regulation

BILL INFORMATION	
BILL NUMBER:	SB 1184
BILL TITLE:	Payments to Surviving Successors
BILL SPONSOR:	Senator Baxley
EFFECTIVE DATE:	07/01/2019

COMMITTEES OF REFERENCE
1) Banking and Insurance
2) Judiciary
3) Rules
4)
5)

CURRENT COMMITTEE

SIMILAR BILLS	
BILL NUMBER:	HB 837
SPONSOR:	Rep. Burton

PREVIOUS LEGISLATION	
BILL NUMBER:	SB 892
SPONSOR:	Senator Garcia
YEAR:	2018
LAST ACTION:	Died in Banking and Insurance

IDENTICAL BILLS	
BILL NUMBER:	
SPONSOR:	

Is this bill part of an agency package?
No

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	March 4, 2019
LEAD AGENCY ANALYST:	Alexander J. Anderson, Director of Legislative Affairs (850) 410-9601
ADDITIONAL ANALYST(S):	Jeremy Smith, Director, Division of Financial Institutions (850) 410-9601
LEGAL ANALYST:	Tony Cammarata, General Counsel (850) 410-9601
FISCAL ANALYST:	Mark Hammett, Budget Director (850) 410-9601

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

The proposed legislation creates a new section within Chapter 655, F.S., relating to Financial Institutions. The bill creates s. 655.795, F.S., to authorize a financial institution[1] to pay to the surviving successor of a decedent, without any court proceedings, order, or judgment authorizing the payment, the funds on deposit in all qualified accounts of the decedent if the total amount of such funds does not exceed $10,000. The funds would be payable upon the surviving successor's presentation of the death certificate and a sworn affidavit attesting to the information specified in new s. 655.795, F.S., including that the surviving successor is the spouse, child, or parent of the decedent and is entitled to the funds. Under the proposed legislation, a financial institution is not required to determine whether the contents of the affidavit are truthful and the payment of the funds constitutes the financial institution's full release and discharge for the amount paid. The surviving successor must also indemnify and hold harmless the financial institution against any claims, demands, or expenses including attorney fees and court costs, losses or damages in connection with the payment.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

Currently, the Florida Financial Institutions Codes[2] contemplate two ways in which a decedent's funds on deposit with an authorized financial institution may be automatically transferred to a person who survives the decedent.

First, any deposit account or certificate of deposit, regardless of amount, in two or more names is presumed to vest in the surviving person should one of the account holders die, unless another outcome is expressly provided for in a contract, agreement, or signature card executed in connection with the opening or maintenance of the account.[3] This presumption may be rebutted by proof of fraud, undue influence, or clear and convincing proof of contrary intent.[4] In the case of a credit union, the surviving person may hold and be paid the deposits, but may not vote, obtain a loan, hold office, or be required to pay an entrance or membership fee unless they are a member in their own right.[5]

Second, an account holder may elect to designate a beneficiary or beneficiaries through a "pay-on-death designation."[6] An account holder may make this designation regardless of the amount of funds on deposit. If the account holder makes such an election, the account is called a "pay-on-death account" and will be administered pursuant to the provisions of s. 655.82, F.S. Until his or her death, the account holder[7] will have a present right to payment from the account.[8] Upon the death of a sole account holder or all account holder(s), the sums on deposit in the account belong to the surviving beneficiaries, and the financial institution may pay sums on deposit in the account to the beneficiaries if proof of death is presented to the institution showing that the beneficiaries survived the account holder.[9] If two or more beneficiaries survive, then each has an equal and undivided share of the sums on deposit in the account, unless otherwise provided.[10]

---

[1] Pursuant to s. 655.005(1)(i), F.S. (2018), a "financial institution" is "a state or federal savings or thrift association, bank, savings bank, trust company, international bank agency, international banking corporation, international branch, international representative office, international administrative office, international trust entity, international trust company representative office, qualified limited service affiliate, credit union, or an agreement corporation operating pursuant to s. 25 of the Federal Reserve Act, 12 U.S.C. ss. 601 et seq. or Edge Act corporation organized pursuant to s. 25(a) of the Federal Reserve Act, 12 U.S.C. ss. 611 et seq."

[2] Chapters 655-667, F.S. (2018).

[3] § 655.79(1), Fla. Stat.

[4] § 655.79(2), Fla. Stat.

[5] § 655.78(2), Fla. Stat.

[6] § 655.82, Fla. Stat.

[7] An account holder who has a present right, subject to request, to payment from the account other than as a beneficiary is referred to as a "party" in the statute. § 655.82(1)(f), Fla. Stat. The term "account holder" is used here for ease of reference.

[8] § 655.82(3)(a), Fla. Stat.

[9] § 655.82(3)(b) and 655.82(6)(b), Fla. Stat.

[10] § 655.82(3)(b), Fla. Stat.

A financial institution may also pay the sums on deposit to the personal representative or devisees[11] of the account holder, if any, provided that proof of death is presented showing that the decedent was the survivor of all persons named on the account as either an account holder or beneficiary.[12]

Currently, the Financial Institutions Codes contemplate one way for an authorized financial institution to automatically transfer ownership of a decedent's funds on deposit to an unnamed or undesignated surviving person. If there is no personal representative of the deceased account holder, and the deceased account holder survived each other person named as an account holder or beneficiary of the account, then a financial institution may pay the sums on deposit to the heirs of the deceased account holder upon presentation of proof of death showing the same.[13] For the purposes of this section, an "heir" is defined as "those persons, including a surviving spouse, who are entitled, under the laws of this state regarding intestate succession, to the property of a decedent."[14]

2. EFFECT OF THE BILL:

Section 1 creates s. 655.795, F.S., to authorize a financial institution to pay to the surviving successor of a decedent, without any court proceedings, order, or judgment authorizing the payment, the funds on deposit in all qualified accounts of the decedent if the total amount of such funds does not exceed $10,000.

Subsection (1), paragraph (a) of subsection 655.795, F.S., defines a qualified account as a depository account or a certificate of deposit held in the sole name of the decedent with no pay on death or other survivor designation.

Subsection (1), paragraph (b), defines a surviving successor as the surviving spouse of the decedent, an adult child of the decedent if the decedent did not leave a surviving spouse, or the parent of the decedent if the decedent did not leave a surviving spouse or an adult child.

Subsection (2), paragraph (a) provides that a financial institution in this state may pay to the surviving successor of a decedent, without any court proceedings, order, or judgment authorizing the payment, the funds on deposit in all qualified accounts of the decedent at the financial institution if the total amount of such funds does not exceed $10,000. The financial institution may make such payment not earlier than 45 days after the date of the decedent's death.

Subsection (2), paragraph (b) requires that a surviving successor must provide the financial institution with a certified copy of the decedent's death certificate, and a sworn affidavit that includes all of the following (set forth in subparagraphs 1 through 6 of subparagraph (b)):

- A statement attesting that the surviving successor is the surviving spouse, adult child, or parent of the decedent. Furthermore:
    - If the surviving successor is the surviving spouse, a statement that either all of the decedent's children are also the children of the surviving spouse, or a statement identifying the children of the decedent who are not also children of the surviving spouse and that the written consent of each of those children to the withdrawal of funds in the qualified account by the surviving spouse is attached. The natural parent or the guardian of any such child who is a minor may give consent on behalf of the child.
    - If the surviving successor is an adult child, the affidavit must attest that the decedent left no surviving spouse. The affidavit must also indicate that there are no other surviving adult children of the decedent or must include a statement identifying the other surviving adult children of the decedent and stating that the written consent of the other surviving children to the withdrawal of funds from the qualified account by the affiant adult child is attached. If any such child is a minor, the natural parent or the guardian of such child may give consent on behalf of the child.
    - If the surviving successor is a parent, the affidavit must attest that the decedent left no surviving spouse or adult child. The affidavit must also indicate that there is no other surviving parent of the decedent or must include a statement identifying the other surviving parent and stating that the written consent of the

[11] A "devisee" is "any person designated in a will to receive a testamentary disposition of real or personal property." § 655.82(1)(c), Fla. Stat.
[12] § 655.82(6)(c), Fla. Stat.
[13] § 655.82(6)(c), Fla. Stat.
[14] § 655.82(1)(d), Fla. Stat.

other surviving parent to the withdrawal of funds from the qualified account by the affiant parent is attached.

- The date of death and address of the last residence of the decedent.
- A statement attesting that the total amount of all qualified accounts held by the decedent with any[15] financial institution does not exceed an aggregate total of $10,000.
- A statement acknowledging that a personal representative has not been appointed to administer the decedent's estate, that no probate proceeding, or summary administration procedures have been commenced with respect to the estate, and that after diligent inquiry, the surviving successor believes in good faith that no last will and testament of the decedent will be presented to any court for administration.
- A statement attesting either that the affiant has made a diligent search for creditors of the decedent, and that after the search, has no knowledge of the existence of any unpaid creditor of the decedent, or that the written consent of all known creditors of the decedent to the withdrawal by the surviving successor is attached.
- A statement acknowledging that the payment of the funds constitutes a full release and discharge of the financial institution for the amount paid and that the surviving successor indemnifies the financial institution against claims; demands; expenses, including attorney fees and court costs; losses; or damages incurred by the financial institution for taking any action, or failing to take an action, in connection with the payment of the funds.

Subsection (2), paragraph (c) provides certain protections for the financial institution. The financial institution is not required to determine whether the contents of the affidavit are truthful. Additionally, paragraph (c) provides that the financial institution's payment of funds to the surviving successor constitutes a full release and discharge of the financial institution for the amount paid. Paragraph (c) further provides that a person does not have a right or cause of action against a financial institution because of such payment, and the surviving successor must indemnify and hold harmless the financial institution against claims; demands; expenses, including attorney fees and court costs; losses; or damages incurred by the financial institution for taking any action, or failing to take an action, in connection with the affidavit or the payment.

Subsection (2), paragraph (d) (and as further set forth in subparagraphs 1 through 4) lists various persons to whom the surviving successor who withdraws funds is personally liable. The surviving successor is personally liable, to the extent of the amount paid, to the creditors and personal representative of the decedent. If a personal representative has not been appointed, the surviving successor who withdraws funds is personally liable to the other intestate heirs of the decedent, to the extent of excess of the amount paid over the amount that is properly attributable to the intestate share of the surviving successor. If the personal representative has been discharged, the surviving successor who withdraws funds is personally liable to the devisees of the estate to the extent of excess of the amount paid over the amount that would have been devised to the surviving successor.

Subsection (2), paragraph (e) provides that personal liability of the surviving successor under this section is not barred by s. 733.702 or s. 733.710 unless the surviving successor publishes a notice to creditors which complies with s. 733.2121, except that the notice must state that the creditors must notify the surviving successor of the claim within the time limits set forth in s. 733.702 or be forever barred, in which case the claim must be barred as provided in s. 733.702.

Subsection (2), paragraph (f) provides that a person who knowingly makes a false statement in a sworn affidavit provided to a financial institution commits theft, punishable as provided in s. 812.014, F.S.

Subsection (3)[16] provides a template affidavit for use in providing the information required by subsection (2).

Subsection (4)[17] provides that s. 655.795, F.S., supersedes any conflict provision of the Florida Probate Code.

Section 2 provides an effective date of July 1, 2019.

[15] See general comment below.
[16] This subsection is numbered (2) in the bill, but presumably was intended to be subsection (3).
[17] This subsection is numbered (3) in the bill, but presumably was intended to be subsection (4).

3. DOES THE LEGISLATION DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES? Y☐ N☒

If yes, explain:	
Is the change consistent with the agency's core mission?	Y☐N☐
Rule(s) impacted (provide references to F.A.C., etc.):	N/A

4. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?

Proponents and summary of position:	N/A
Opponents and summary of position:	N/A

5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL? Y☐ N☒

If yes, provide a description:	N/A
Date Due:	N/A
Bill Section Number(s):	N/A

6. ARE THERE ANY NEW GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSIONS, ETC. REQUIRED BY THIS BILL? Y☐ N☒

Board:	N/A
Board Purpose:	N/A
Who Appoints:	N/A
Changes:	N/A
Bill Section Number(s):	N/A

FISCAL ANALYSIS

1. FISCAL IMPACT TO LOCAL GOVERNMENT Y☐ N☒

Revenues:	N/A
Expenditures:	N/A
Does the legislation increase local taxes or fees? If yes, explain.	N/A

If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	N/A

2. FISCAL IMPACT TO STATE GOVERNMENT Y☐ N☒

Revenues:	N/A
Expenditures:	N/A
Does the legislation contain a State Government appropriation?	N/A
If yes, was this appropriated last year?	N/A

3. FISCAL IMPACT TO THE PRIVATE SECTOR Y☐ N☒

Revenues:	N/A
Expenditures:	N/A
Other:	N/A

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES? Y☐ N☒

If yes, explain impact.	N/A
Bill Section Number:	N/A

TECHNOLOGY IMPACT

1. DOES THE BILL IMPACT THE AGENCY'S TECHNOLOGY SYSTEMS (I.E. IT SUPPORT, LICENSING SOFTWARE, DATA STORAGE, ETC.)? Y☐ N☒

If yes, describe the anticipated impact to the agency including any fiscal impact.	N/A

FEDERAL IMPACT

1. DOES THE BILL HAVE A FEDERAL IMPACT (I.E. FEDERAL COMPLIANCE, FEDERAL FUNDING, FEDERAL AGENCY INVOLVEMENT, ETC.)? Y☐ N☒

If yes, describe the anticipated impact including any fiscal impact.	N/A

ADDITIONAL COMMENTS

The bill requires a surviving successor to attest that the total amount of all qualified accounts held by the decedent with "any" financial institution does not exceed an aggregate total of $10,000. A similar bill, HB 837, requires a surviving successor to attest that the funds in the decedent's qualified accounts held by "the" financial institution does not cumulatively exceed $10,000. If the decedent held qualified accounts at more than one institution, the end result under a bill referring to "any" institution may be different than the end result under a bill referring to "the" institution.

Pursuant to s. 655.059(2)(b), F.S., the books and records pertaining to the accounts of depositors shall be kept confidential by the financial institution and may not be released except upon express authorization of the account holder. A willful, unlawful disclosure of such confidential information is a felony of the third degree. *See* § 655.059(2)(c), Fla. Stat. To receive payment, the bill requires a surviving successor to attest that the total amount of all accounts held in the sole name of the decedent with any financial institution does not exceed an aggregate total of $10,000. Thus, given the inability of a financial institution to provide a surviving successor information regarding the amount of funds a decedent had on deposit, it may be difficult or impossible for a surviving successor to provide a sufficient affidavit, if the surviving successor did not have previous access to the account information.

LEGAL - GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments:	The General Counsel has reviewed the agency's bill analysis concerning SB 1184, and the analysis sufficiently details the bill's effect and areas of impact. The General Counsel has no issues, concerns or further comments regarding the bill.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3.11.19
Meeting Date

1184
Bill Number (if applicable)

Topic Payroll to surviving spouse

Amendment Barcode (if applicable)

Name Ashley Kalifeh

Job Title Lobbyist

Address 101 E Colly #502
Street
Tallahassee FL
City *State* *Zip*

Phone 222-9075

Email akalifeh@capitalcounsel.com

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing League of Southeastern Credit Unions

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/19
Meeting Date

SB 1184
Bill Number (if applicable)

176592
Amendment Barcode (if applicable)

Topic Payments to Surviving Successors

Name Kenneth Pratt

Job Title SVP of Governmental Affairs

Address 1001 Thomasville Rd Ste 201
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850-509-8020

Email Kpratt@floridabankers.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Bankers Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/11/19
Meeting Date

SB 1184
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Payments to Surviving Successors

Name Kenneth Pratt

Job Title SVP of Governmental Affairs

Address 1001 Thomasville Rd, Ste 201
Street

Phone 850-509-8020

Tallahassee FL 32301
City *State* *Zip*

Email kpratt@floridabankers.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Bankers Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

CourtSmart Tag Report

Room: KN 412 **Case No.:** **Type:**
Caption: Senate Banking and Insurance Committee **Judge:**

Started: 3/11/2019 4:01:42 PM
Ends: 3/11/2019 5:59:47 PM Length: 01:58:06

4:01:41 PM Meeting called to order.
4:01:58 PM Roll Call - quorum present
4:04:01 PM Senator Stewart recognized to present bill.
4:09:10 PM Ashley Kalfer - Attorney
4:10:10 PM Senator Sttewart recognized to close on bill.
4:10:24 PM Roll call vote - Favorable
4:11:01 PM TAB 4 - by Sen. Diaz - Health Ins. Savings Programs
4:11:51 PM Senator Diaz recognized to present the bill.
4:15:02 PM Amd. 441564 by Sen. Diaz - Favorable
4:16:02 PM Roll call vote on SB 524 - Favorable
4:16:47 PM TAB 9 by Sen. Baxley - Payments to Surviving Successors
4:19:02 PM Delete all Amend. 176594 by Sen. Baxley
4:20:03 PM Kenneth Pratt, Sup. of Governmental Afairs
4:20:49 PM Amendment Adopted
4:21:20 PM Senator Baxley recognized to close.
4:21:34 PM Roll call vote on SB 1184 - Favorable
4:22:22 PM TAB 2 - SB 264 by Sen. Gruters - FL Workers' Comp JUA
4:22:58 PM Senator Gruters presents bill.
4:23:10 PM Amd. 124924 - explanation of amendment by Sen. Gruters
4:24:13 PM Amend. adopted on voice vote.
4:26:23 PM Sen.. waives close.
4:26:32 PM roll call on SB 264 - Favorable
4:27:32 PM TAB 8 - Senator Lee - Continuing Care Contracts
4:27:46 PM Senator Lee reconized to present the bill.
4:32:47 PM Delete all Amd. 436274 - technical amendment
4:33:47 PM Amd. to Amd. by Senator Perry - 242422
4:34:07 PM Senator Perry recognized to explain amendment.
4:35:05 PM
4:35:08 PM Amendment adopted on voice vote
4:35:14 PM Late Amd. to Amd. 564702 by Sen. Lee.
4:36:36 PM Sen. Lee recognized to explain the amd. -adopted
4:38:01 PM Amd. 738088 - adopted by voice vote
4:38:44 PM Back on Delete all amend - as amended
4:39:14 PM Steve Bahmer, Pres./CEO - Leading Age Florida
4:41:25 PM Senator Lee recognized to close on delete all amendment
4:43:13 PM Amendment adopted
4:43:29 PM Karen Kugell, Chair - FL Life Care Residents Assoc.
4:46:25 PM Roll call on SB 1070 - Favorable
4:47:20 PM TAB 1 - by Sen. Bean - Genetic Information Used for Ins. Purposes
4:47:47 PM Senator Bean recognized to explain the bill.
4:55:11 PM Dr. Robert Gleeson, M.D. - ACLI Consultant
5:09:08 PM Professor Patricia Born - Am Council of Life Insurers
5:14:37 PM Paul Sanford - American Council of Life Insurers and FL Insur. Council
5:24:03 PM Sen. Bean recognized to closed on bill.
5:25:34 PM Roll call vote on SB 258 - Favorable
5:26:53 PM TAB 5 - Sen. Brandes - Nonadmitted Ins. Market Reform
5:27:09 PM Sen. Brandes recognized to explain Amd. 207744 - Voice Vote - Favorable
5:29:24 PM Sen. Brandes waives close.
5:29:42 PM Roll call vaote on SB 538 - Favorable
5:30:43 PM TAB 3 - Senator Brandes - Nonemergency Medical Transp. Servs.
5:31:15 PM Senator Brandes explains the bill
5:31:37 PM Late amd. 529474 (Rouson) ---Amendment withdrawn

5:32:30 PM Audrey Brown - FL Assoc. of Health Plans
5:36:15 PM Cari Roth --Lobbyist for FL Ambulance Assoc.
5:37:43 PM Meeting called to order
5:39:11 PM Roll call vote on SB 302 - Favorable
5:39:39 PM TAB 7 - Senator Brandes - Nonadmitted Insr. Market Reform
5:41:34 PM Amd. 917258 - explanation of amd. by Sen. Brandes-fav. on voice vote
5:42:53 PM Amd. 474272 by Sen. Perry - Voice Vote - Fav.
5:43:41 PM Sub. Amend. 548022
5:44:22 PM Johanne Clark - FL Justice Reform Ins.
5:51:58 PM Chip Merlin representing self
5:55:52 PM Amd. 548022 - Favorable - voice vote
5:57:17 PM Time cetain vote by Sen. Brandes @ 5:59
5:58:32 PM Tanya Hanks -Pastor
5:58:48 PM Sen. Brandes waives close on bill
5:58:58 PM roll call on S 714 - Favorable
5:59:34 PM meeting adjourned