Tab 1	**SB 46** by **Wright (CO-INTRODUCERS) Harrell, Osgood, Jones**; (Identical to H 01063) Health Insurance Cost Sharing

Tab 2	**SB 622** by **Yarborough**; (Similar to CS/H 01573) Continuing Care Contracts

528586	D	S	RS	BI, Yarborough	Delete everything after	04/07 11:26 AM
140214	SD	S	RCS	BI, Yarborough	Delete everything after	04/07 11:26 AM

Tab 3	**SB 1344** by **Bradley**; (Compare to CS/H 01299) Medical Treatment Under the Workers' Compensation Law

Tab 4	**SB 1614** by **Rodriguez**; (Identical to H 01575) Public Safety Emergency Communications Systems

376650	D	S	RCS	BI, Rodriguez	Delete everything after	04/07 10:04 AM
525110	AA	S	RCS	BI, Rodriguez	btw L.118 - 119:	04/07 10:04 AM

Tab 5	**SPB 7052** by **BI**; Insurer Accountability

Tab 6	**SPB 7054** by **BI**; Central Bank Digital Currency

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

BANKING AND INSURANCE
Senator Boyd, Chair
Senator DiCeglie, Vice Chair

MEETING DATE: Wednesday, April 5, 2023
TIME: 8:30—10:30 a.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Boyd, Chair; Senator DiCeglie, Vice Chair; Senators Broxson, Burgess, Burton, Hutson, Ingoglia, Mayfield, Powell, Thompson, Torres, and Trumbull

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 46** Wright (Identical H 1063)	Health Insurance Cost Sharing; Requiring specified individual health insurers and their pharmacy benefit managers to apply payments by or on behalf of insureds toward the total contributions of the insureds' cost-sharing requirements; requiring specified contracts to require pharmacy benefit managers to apply payments by or on behalf of insureds toward the insureds' total contributions to cost-sharing requirements; requiring specified group health insurers and their pharmacy benefit managers to apply payments by or on behalf of insureds toward the total contributions of the insureds' cost-sharing requirements; requiring specified contracts to require pharmacy benefit managers to apply payments by or on behalf of insureds toward the insureds' total contributions to cost-sharing requirements, etc. BI 04/05/2023 Favorable HP FP	Favorable Yeas 8 Nays 0
2	**SB 622** Yarborough (Similar CS/H 1573)	Continuing Care Contracts; Revising requirements for feasibility studies submitted by providers applying for expansions of certificated continuing care facilities; revising information required to be contained in certain providers' financial reports in their annual reports; authorizing the office, upon a provider's written request, to temporarily suspend financial and operating requirements under ch. 651, F.S., for specified reasons; specifying the authority of residents' councils and the eligibility of persons to participate in residents' council matters; revising applicability of a specified time limit on the use of sheltered nursing home beds for certain persons, etc. BI 04/05/2023 Fav/CS AEG FP	Fav/CS Yeas 9 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
3	**SB 1344** Bradley (Compare CS/H 1299)	Medical Treatment Under the Workers' Compensation Law; Increasing limits on witness fees charged by certain witnesses; increasing maximum reimbursement allowances for physicians and surgical procedures, etc. BI 04/05/2023 Favorable HP FP	Favorable Yeas 9 Nays 0
4	**SB 1614** Rodriguez (Identical H 1575)	Public Safety Emergency Communications Systems; Requiring a qualified third party to make a specified certification before a local authority having jurisdiction may require an assessment of the need for or the installation of a two-way radio communications enhancement system in certain buildings; specifying the length of time such certification is valid; prohibiting the local authority having jurisdiction from withholding a certificate of occupancy under certain circumstances and from requiring the installation of a specified system within a certain time period after completion of a specified report, etc. CA 03/22/2023 Favorable BI 04/05/2023 Fav/CS RC	Fav/CS Yeas 10 Nays 0
	Consideration of proposed bill:		
5	**SPB 7052** **(Preliminary Draft Available - final draft will be made available at least 24 hours prior to the meeting)**	Insurer Accountability; Authorizing electronic responses to certain requests from the Division of Consumer Services of the Department of Financial Services concerning consumer complaints; specifying reporting requirements for the Office of Insurance Regulation's internal auditor in the office's annual report relating to the enforcement of insurer compliance; specifying requirements for the office to report quarterly to the Legislature relating to the enforcement of insurer compliance; providing that authorized property insurers must, rather than may, be subject to an additional market conduct examination after a hurricane if specified conditions are met, etc.	Submitted and Reported Favorably as Committee Bill Yeas 8 Nays 0
	Consideration of proposed bill:		
6	**SPB 7054**	Central Bank Digital Currency; Defining the term "central bank digital currency" and revising the definition of the term "money" for purposes of the Uniform Commercial Code, etc.	Submitted and Reported Favorably as Committee Bill Yeas 7 Nays 1

TAB	OFFICE and APPOINTMENT (HOME CITY)	FOR TERM ENDING	COMMITTEE ACTION
	Senate Confirmation Hearing: A public hearing will be held for consideration of the below-named executive appointment to the office indicated.		
	Executive Director, Citizens Property Insurance Corporation		
7	Cerio, Timothy M. (Tallahassee)	Pleasure of the Board	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
	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 46
INTRODUCER:	Senator Wright and others
SUBJECT:	Health Insurance Cost Sharing
DATE:	April 5, 2023
REVISED:	

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

I. Summary:

SB 46 creates provisions relating to prescription drug cost-sharing requirements for individual health insurers, group health insurers, and health maintenance organizations. The bill applies to any health insurance policy or health maintenance contract or certificate issued, delivered, or renewed on or after January 1, 2024.

The bill provides that each individual health insurer, group health insurer, or health maintenance organization providing prescription drug coverage, or any pharmacy benefit manager on behalf of such insurer or organization, must apply any amount paid by an insured or subscriber, or by another person on behalf of the insured or subscriber, toward the insured's or subscriber's total contribution to any cost-sharing requirement. The amount paid by, or on behalf of, the insured or subscriber which is applied toward the insured's or subscriber's total contribution to any cost-sharing requirement includes, but is not limited to:

- Any payment with or any discount through financial assistance;
- A manufacturer copay card;
- A product voucher; or
- Any other reduction in out-of-pocket expenses made by or on behalf of the insured for a prescription drug.

The bill requires each such insurer or organization providing prescription drug coverage to disclose that any amount paid by a policyholder or subscriber, or by another person on behalf of the policyholder or subscriber, must be applied toward the policyholder's or subscriber's total contribution to any cost-sharing requirement.

The bill requires that contracts between such insurers or health maintenance organization and a pharmacy benefit manager must require that the pharmacy benefit manager apply any amount paid by an insured or subscriber, or by another person on behalf of the insured or subscriber, toward the insured's or subscriber's total contribution to any cost-sharing requirement.

The bill's fiscal impact on state and local government is unknown, but the bill may lead to increased costs for health care coverage.

The bill becomes effective on July 1, 2023.

II. Present Situation:

Prescription drugs are a vitally important part of a person's health regimen, however, the cost of these drugs keep them out of reach for some. Data from a 2019 poll shows 25 percent of Americans reporting difficulty affording their medicine.[1]

Many chronic conditions are treated with biologics[2], brand-name or "specialty" drugs, which can be particularly costly. Researchers studied prices of six specialty drugs between 2014 and 2018 and found that prices rose on average 57 percent, while prices for generics decreased 35 percent.[3] Other research found specialty drugs make up almost 38 percent of personal prescription drug spending, even though they account for a small portion of all prescriptions.[4]

Manufacturers sometimes offer copay assistance coupons to help patients offset the cost of their prescriptions. This assistance is intended to help limit patients' out-of-pocket costs by reducing the amount a patient pays and also may be applied to a patient's annual cost-sharing requirement (such as deductibles).[5]

In order to encourage patients to choose lower cost drug options, some health plans restrict the use of copay coupons toward deductibles by implementing copay adjustment programs. When a patient's health plan uses a copay adjustment program, also known as a copay accumulator or maximizer program, it restricts a manufacturer's coupon from counting toward a patient's annual out-of-pocket maximums. When the value of the coupon is exhausted at the pharmacy counter, the patient must cover the full amount of his or her annual cost-sharing requirement before plan benefits kick in.[6] A recent report shows that nine out of 12 health plans in Florida have copay accumulator adjustment policies.[7]

Although copay adjustment programs might encourage patients to look for cheaper therapeutic alternatives before turning to a more expensive treatment, they can be problematic for

---

[1] Kaiser Family Foundation (conducted February 14 - 24, 2019), press-release/poll (last accessed March 30, 2023).
[2] A substance that is made from a living organism or its products and is used in the prevention, diagnosis, or treatment of cancer and other diseases. Biological drugs include antibodies, interleukins, and vaccines. Also called biologic agent and biological agent. National Cancer Institute, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/biological-drug (last accessed March 30, 2023).
[3] Peterson-KFF, Health System Tracker, *What are the recent and forecasted trends in prescription drug spending?*, healthsystemtracker.org/chart (last accessed March 30, 2023).
[4] *Net Spending On Retail Specialty Drugs Grew Rapidly, Especially For Private Insurance And Medicare Part D*, Hill, Miller, and Ding, November 2020, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.01830 (last accessed March 30, 2023).
[5] National Conference of State Legislatures, *Copayment Adjustment Programs, February 23, 2023*, https://www.ncsl.org/health/copayment-adjustment-programs (last accessed March 30, 2023).
[6] *Id.*
[7] The Aids Institute, *Discriminatory Copay Policies Undermine Coverage for People with Chronic Illness*, February 2023, p. 33, Report-Copay-Accumulator-Adjustment-Programs (last accessed March 30, 2023).

individuals whose plans involve high cost-sharing or co-insurance—where a patient pays a percentage of the cost rather than a flat amount. Moreover, people with complex conditions, such as cancer, rheumatoid arthritis, and diabetes that must be treated with expensive prescription drugs cannot choose a less expensive drug.[8]

As of February 2023, laws in 16 states[9] and Puerto Rico address the use of copay adjustment programs by insurers or PBMs by requiring any payment or discount made by or on behalf of the patient be applied to a consumer's annual out-of-pocket cost-sharing requirement.[10]

Health Insurance Policies

Florida law requires a contract for the purchase of individual health insurance to contain certain provisions, for instance, provisions on the notice of claim, claim forms, proof of loss, and time for the payment of claims.[11] Health insurance policies must provide for certain mandated coverage,[12] and must contain certain information, such as the consideration for the policy, the time when the insurance takes effect and terminates, and reductions in indemnity.[13]

Group health insurance is health insurance that covers group of persons under a master group plan health insurance policy[14] issued to a group specified under certain Florida provisions.[15] Group health insurance policies must comply with provisions of the Florida Insurance Code relating to the rights of individuals to specified benefits and coverages.[16] Section 641.312, F.S., relating to the Office of Insurance Regulation adopting rules to administer the National Association of Insurance Commissioners' Uniform Health Carrier External Review Model Act, and the provisions of the Employee Retirement Income Security Act of 1974,[17] relating to internal grievances, apply to all group health insurance policies issued under the Florida Insurance Code except for certain specified policies.[18]

Health Maintenance Organization

A health maintenance organization is any organization authorized under the Florida Insurance Code which:

- Provides, through arrangements with other persons, emergency care, inpatient hospital services, and physician care.

[8] *Id.*
[9] Arizona, Arkansas, Connecticut, Delaware, Georgia, Illinois, Kentucky, Louisiana, Maine, New York, North Carolina, Oklahoma, Tennessee, Virginia, Washington, and West Virginia.
[10] *Id.*
[11] *See* ss. 627.610 to 627.613, F.S.
[12] Section 627.6011, F.S., provides that "mandatory health benefits" means those benefits in ss. 627.6401-627.64193, F.S. which, for example, includes coverage relating to maternity care, diabetes, osteoporosis, newborn children, mammograms, and breast cancer.
[13] Section 627.602(1), F.S.
[14] Section 627.652(2)(a), F.S., provides group health insurance policies include plans of self-insurance providing health insurance benefits.
[15] Section 627.652(1), F.S.
[16] Section 627.651(1), F.S.
[17] 29 C.F.R. s. 2560.503-1.
[18] Section 627.6513, F.S.

- Provides, either directly or through arrangements with other persons, health care services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis.
- Provides, either directly or through arrangements with other persons, comprehensive health care services which subscribers are entitled to receive pursuant to a contract.
- Provides physician services, by physicians licensed under chs. 458, 459, 460, and 461, F.S., directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians.
- If offering services through a managed care system, has a system in which a primary physician licensed under chs. 458, 459, 460, or 461, F.S., is designated for each subscriber upon request of a subscriber requesting service by a physician licensed under any of those chapters and is responsible for coordinating the health care of the subscriber of the respectively requested service and for referring the subscriber to other providers of the same discipline when necessary.[19]

A health maintenance organization must apply for and obtain a certificate of authority to operate in Florida.[20] Florida law requires health maintenance organizations to afford certain subscriber protections, including, in part:

- Ensuring that the health care services provided to its subscribers are rendered under reasonable standards of quality care;
- Making sure that subscribers receive quality care from a broad panel of providers; and
- Providing assurance that the health maintenance organization has been independently accredited by a national review organization.

Pharmacy Benefit Managers

A "pharmacy benefit manager" is a person or entity doing business in Florida which contracts to administer or manage prescription drug benefits on behalf of a health insurer to residents in Florida.[21] An individual and group health insurer and a health maintain organization's contract with a pharmacy benefit manager for individual and group plans must require the pharmacy benefit manager to do certain tasks, including:

- Update maximum allowable cost pricing information at least every 7 calendar days; and
- Maintain a process that will timely eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.[22]

Such contracts must prohibit the pharmacy benefit manager from limiting a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug and the availability of a more affordable alternative drug.[23] Finally, the contracts must prohibit a pharmacy benefit manager from requiring an insured to pay an amount for a

[19] Section 641.19(12), F.S.
[20] Section 641.21(1), F.S.
[21] Sections 627.64741(1)(b), 627.6572(1)(b), and 641.314(1)(b), F.S.
[22] Sections 627.64741(2), 627.6572(2), and 641.314(2) F.S.
[23] Sections 627.64741(3), 627.6572(3), and 641.314(3), F.S.

prescription drug at the point of sale that exceeds the lesser of the applicable cost-sharing amount or the retail price of the drug in the absence of prescription drug coverage.[24]

Prescription Drugs

Any health insurer or health maintenance organization that agrees to provide coverage for prescription drugs on an outpatient basis must provide a benefits-identification card which contains specified information, such as the name of the claim processor, the insured's name, and the claims submission name and address.[25] A health insurer or health maintenance organization that provides individual and group health insurance in the state that includes prescription drug coverage must offer medication synchronization and must implement a process for dispensing prescription drugs for the purpose of aligning the refill dates.[26]

III. Effect of Proposed Changes:

Section 1 creates s. 627.6383, F.S., relating to cost-sharing requirements for individual health insurers. The bill defines "cost-sharing requirement" to mean "a dollar limit, a deductible, a copayment, coinsurance, or any other out-of-pocket expense imposed on an insured, including, but not limited to, the annual limitation on cost sharing subject to 42 U.S.C. s. 18022."

The bill requires, for any health insurance policy issued, delivered, or renewed on or after January 1, 2024, that each individual health insurer providing prescription drug coverage, or any pharmacy benefit manager on behalf of such insurer, must apply any amount paid by an insured, or by another person on behalf of the insured, toward the insured's total contribution to any cost-sharing requirement. The amount paid by, or on behalf of, the insured which is applied toward the insured's total contribution to any cost-sharing requirement includes, but is not limited to:

- Any payment with or any discount through financial assistance;
- A manufacturer copay card;
- A product voucher; or
- Any other reduction in out-of-pocket expenses made by or on behalf of the insured for a prescription drug.

Section 2 amends s. 627.6385, F.S., to provide that, for any health insurance policy issued, delivered, or renewed on or after January 1, 2024, a health insurer providing prescription drug coverage, whether or not the prescription drug benefits are administered or managed by the health insurer or by a pharmacy benefit manager on behalf of the health insurer, must disclose on its website that any amount paid by a policyholder, or by another person on behalf of the policyholder, must be applied toward the policyholder's total contribution to any cost-sharing requirement.

Section 3 amends s. 627.64741, F.S., relating to pharmacy benefit manager contracts, that, for any insured whose insurance policy is issued, delivered, or renewed on or after January 1, 2024, a contract between an individual health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager apply any amount paid by an insured, or by another person on

[24] Sections 627.64741(4), 627.6572(4), and 641.314(4), F.S.
[25] Section 627.4302(2), F.S.
[26] Sections 627.64196(1) and 641.31(44), F.S.

behalf of the insured, toward the insured's total contribution to any cost-sharing requirement. The pharmacy benefit manager must disclose to every insured whose insurance policy is issued, delivered, or renewed on or after January 1, 2024, that the pharmacy benefit manager will apply any amount paid by the insured, or by another person on behalf of the insured, toward the insured's total contribution to any cost-sharing requirement.

Section 4 creates s. 627.65715, F.S., relating to cost-sharing requirements for group health insurers. The bill defines "cost-sharing requirement" to mean "a dollar limit, a deductible, a copayment, coinsurance, or any other out-of-pocket expense imposed on an insured, including, but not limited to, the annual limitation on cost sharing subject to 42 U.S.C. s. 18022."

The bill requires, for any health insurance policy issued, delivered, or renewed on or after January 1, 2024, that each group health insurer providing prescription drug coverage, or any pharmacy benefit manager on behalf of such insurer, must apply any amount paid by an insured, or by another person on behalf of the insured, toward the insured's total contribution to any cost-sharing requirement. The amount paid by, or on behalf of, the insured which is applied toward the insured's total contribution to any cost-sharing requirement includes, but is not limited to:

- Any payment with or any discount through financial assistance;
- A manufacturer copay card;
- A product voucher; or
- Any other reduction in out-of-pocket expenses made by or on behalf of the insured for a prescription drug.

Section 5 amends s. 627.6572, F.S., relating to pharmacy benefit manager contracts, that, for any insured whose insurance policy is issued, delivered, or renewed on or after January 1, 2024, a contract between a group health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager apply any amount paid by an insured, or by another person on behalf of the insured, toward the insured's total contribution to any cost-sharing requirement. The pharmacy benefit manager must disclose to every insured whose insurance policy is issued, delivered, or renewed on or after January 1, 2024, that the pharmacy benefit manager will apply any amount paid by the insured or by another person on behalf of the insured toward the insured's total contribution to any cost-sharing requirement.

Section 6 amends s. 627.6699, F.S., relating to the Employee Health Care Access Act, to require small employer carriers to comply with the group health insurer cost-sharing requirements provided in s. 627.65715, F.S., created in section 4 of the bill.

Section 7 amends s. 641.31, F.S.; relating to health maintenance contracts. The bill defines "cost-sharing requirement" to mean "a dollar limit, a deductible, a copayment, coinsurance, or any other out-of-pocket expense imposed on an insured, including, but not limited to, the annual limitation on cost sharing subject to 42 U.S.C. s. 18022."

The bill requires, for any health maintenance contract or certificate issued, delivered, or renewed on or after January 1, 2024, that each health maintenance organization providing prescription drug coverage, or any pharmacy benefit manager on behalf of such health maintenance organization, must apply any amount paid by a subscriber, or by another person on behalf of the subscriber, toward the subscriber's total contribution to any cost-sharing requirement. The

amount paid by, or on behalf of, the subscriber which is applied toward the subscriber's total contribution to any cost-sharing requirement includes, but is not limited to:

- Any payment with or any discount through financial assistance;
- A manufacturer copay card;
- A product voucher; or
- Any other reduction in out-of-pocket expenses made by or on behalf of the subscriber for a prescription drug.

The bill provides that, for any health maintenance contract issued, delivered, or renewed on or after January 1, 2024, a health maintenance organization providing prescription drug coverage, whether or not the prescription drug benefits are administered or managed by the health maintenance organization or by a pharmacy benefit manager on behalf of the health maintenance organization, must disclose on its website and in every subscriber's health maintenance contract, certificate, or member handbook, that any amount paid by a subscriber, or by another person on behalf of the subscriber, must be applied toward the subscriber's total contribution to any cost-sharing requirement.

Section 8 amends s. 641.314, F.S., relating to pharmacy benefit manager contracts, that, for any subscriber whose health maintenance contract or certificate is issued, delivered, or renewed on or after January 1, 2024, a contract between a health maintenance organization and a pharmacy benefit manager must require that the pharmacy benefit manager apply any amount paid by a subscriber, or by another person on behalf of the subscriber, toward the subscriber's total contribution to any cost-sharing requirement. The pharmacy benefit manager must disclose to every subscriber whose health maintenance contract or certificate is issued, delivered, or renewed on or after January 1, 2024, that the pharmacy benefit manager will apply any amount paid by the subscriber or by another person on behalf of the subscriber toward the subscriber's total contribution to any cost-sharing requirement.

Sections 9 and 10 amend ss. 409.967 and 641.185, F.S., to make conforming changes made necessary by the bill.

Section 11 provides a Legislative declaration that the bill fulfills an important state interest.

Section 12 provides an effective date of July 1, 2023.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill's fiscal impact is unknown, but the bill may lead to increased costs for health care coverage. The bill is expected to lead to savings for those able to avoid copay adjustment programs and use copay assistance coupons from drug manufacturers.

C. Government Sector Impact:

The bill's fiscal impact on state and local government is unknown, but the bill may lead to increased costs for health care coverage.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 627.6385, 627.64741, 627.6572, 627.6699, 641.31, 641.314, 409.967, and 641.185.

This bill creates the following sections of the Florida Statutes: 627.6383 and 627.65715.

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 Wright

8-00117-23 202346__

A bill to be entitled

An act relating to health insurance cost sharing; creating s. 627.6383, F.S.; defining the term "cost-sharing requirement"; requiring specified individual health insurers and their pharmacy benefit managers to apply payments by or on behalf of insureds toward the total contributions of the insureds' cost-sharing requirements; providing construction; providing applicability; amending s. 627.6385, F.S.; providing disclosure requirements; providing applicability; amending s. 627.64741, F.S.; requiring specified contracts to require pharmacy benefit managers to apply payments by or on behalf of insureds toward the insureds' total contributions to cost-sharing requirements; providing applicability; providing disclosure requirements; creating s. 627.65715, F.S.; defining the term "cost-sharing requirement"; requiring specified group health insurers and their pharmacy benefit managers to apply payments by or on behalf of insureds toward the total contributions of the insureds' cost-sharing requirements; providing construction; providing disclosure requirements; providing applicability; amending s. 627.6572, F.S.; requiring specified contracts to require pharmacy benefit managers to apply payments by or on behalf of insureds toward the insureds' total contributions to cost-sharing requirements; providing applicability; providing disclosure requirements; amending s. 627.6699, F.S.; requiring small employer carriers to

8-00117-23 202346__

comply with certain cost-sharing requirements; making technical changes; amending s. 641.31, F.S.; defining the term "cost-sharing requirement"; requiring specified health maintenance organizations and their pharmacy benefit managers to apply payments by or on behalf of subscribers toward the total contributions of the subscribers' cost-sharing requirements; providing construction; providing disclosure requirements; providing applicability; amending s. 641.314, F.S.; requiring specified contracts to require pharmacy benefit managers to apply payments by or on behalf of subscribers toward the subscribers' total contributions to cost-sharing requirements; providing applicability; providing disclosure requirements; amending s. 409.967, F.S.; conforming a cross-reference; amending s. 641.185, F.S.; conforming a provision to changes made by the act; providing a declaration of important state interest; providing an effective date.

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

Section 1. Section 627.6383, Florida Statutes, is created to read:

627.6383 Cost-sharing requirements.—

(1) As used in this section, the term "cost-sharing requirement" means a dollar limit, a deductible, a copayment, coinsurance, or any other out-of-pocket expense imposed on an insured, including, but not limited to, the annual limitation on

cost sharing subject to 42 U.S.C. s. 18022.

(2)(a) Each health insurer issuing, delivering, or renewing a policy in this state which provides prescription drug coverage, or each pharmacy benefit manager on behalf of such health insurer, shall apply any amount paid by an insured or by another person on behalf of the insured toward the insured's total contribution to any cost-sharing requirement.

(b) The amount paid by or on behalf of the insured which is applied toward the insured's total contribution to any cost-sharing requirement under paragraph (a) includes, but is not limited to, any payment with or any discount through financial assistance, a manufacturer copay card, a product voucher, or any other reduction in out-of-pocket expenses made by or on behalf of the insured for a prescription drug.

(3) This section applies to any health insurance policy issued, delivered, or renewed in this state on or after January 1, 2024.

Section 2. Present subsections (2) and (3) of section 627.6385, Florida Statutes, are redesignated as subsections (3) and (4), respectively, a new subsection (2) is added to that section, and present subsection (2) of that section is amended, to read:

627.6385 Disclosures to policyholders; calculations of cost sharing.—

(2) Each health insurer issuing, delivering, or renewing a policy in this state which provides prescription drug coverage, regardless of whether the prescription drug benefits are administered or managed by the health insurer or by a pharmacy benefit manager on behalf of the health insurer, shall disclose

on its website that any amount paid by a policyholder or by another person on behalf of the policyholder must be applied toward the policyholder's total contribution to any cost-sharing requirement pursuant to s. 627.6383. This subsection applies to any policy issued, delivered, or renewed in this state on or after January 1, 2024.

(3)~~(2)~~ Each health insurer shall include in every policy delivered or issued for delivery to any person in this ~~the~~ state or in materials provided as required by s. 627.64725 a notice that the information required by this section is available electronically and the website address ~~of the website~~ where the information can be accessed. In addition, each health insurer issuing, delivering, or renewing a policy in this state which provides prescription drug coverage, regardless of whether the prescription drug benefits are administered or managed by the health insurer or by a pharmacy benefit manager on behalf of the health insurer, shall include in every policy that is issued, delivered, or renewed to any person in this state on or after January 1, 2024, the disclosure that any amount paid by a policyholder or by another person on behalf of the policyholder must be applied toward the policyholder's total contribution to any cost-sharing requirement pursuant to s. 627.6383.

Section 3. Paragraph (c) is added to subsection (2) of section 627.64741, Florida Statutes, to read:

627.64741 Pharmacy benefit manager contracts.—

(2) A contract between a health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager:

(c)1. Apply any amount paid by an insured or by another person on behalf of the insured toward the insured's total

contribution to any cost-sharing requirement pursuant to s. 627.6383. This subparagraph applies to any insured whose insurance policy is issued, delivered, or renewed in this state on or after January 1, 2024.

2. Disclose to every insured whose insurance policy is issued, delivered, or renewed in this state on or after January 1, 2024, that the pharmacy benefit manager shall apply any amount paid by the insured or by another person on behalf of the insured toward the insured's total contribution to any cost-sharing requirement pursuant to s. 627.6383.

Section 4. Section 627.65715, Florida Statutes, is created to read:

627.65715 Cost-sharing requirements.—

(1) As used in this section, the term "cost-sharing requirement" means a dollar limit, a deductible, a copayment, coinsurance, or any other out-of-pocket expense imposed on an insured, including, but not limited to, the annual limitation on cost sharing subject to 42 U.S.C. s. 18022.

(2)(a) Each insurer issuing, delivering, or renewing a policy in this state which provides prescription drug coverage, or each pharmacy benefit manager on behalf of such insurer, shall apply any amount paid by an insured or by another person on behalf of the insured toward the insured's total contribution to any cost-sharing requirement.

(b) The amount paid by or on behalf of the insured which is applied toward the insured's total contribution to any cost-sharing requirement under paragraph (a) includes, but is not limited to, any payment with or any discount through financial assistance, a manufacturer copay card, a product voucher, or any

other reduction in out-of-pocket expenses made by or on behalf of the insured for a prescription drug.

(3) Each insurer issuing, delivering, or renewing a policy in this state which provides prescription drug coverage, regardless of whether the prescription drug benefits are administered or managed by the insurer or by a pharmacy benefit manager on behalf of the insurer, shall disclose on its website and in every policy issued, delivered, or renewed in this state on or after January 1, 2024, that any amount paid by an insured or by another person on behalf of the insured must be applied toward the insured's total contribution to any cost-sharing requirement.

(4) This section applies to any group health insurance policy issued, delivered, or renewed in this state on or after January 1, 2024.

Section 5. Paragraph (c) is added to subsection (2) of section 627.6572, Florida Statutes, to read:

627.6572 Pharmacy benefit manager contracts.—

(2) A contract between a health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager:

(c)1. Apply any amount paid by an insured or by another person on behalf of the insured toward the insured's total contribution to any cost-sharing requirement pursuant to s. 627.65715. This subparagraph applies to any insured whose insurance policy is issued, delivered, or renewed in this state on or after January 1, 2024.

2. Disclose to every insured whose insurance policy is issued, delivered, or renewed in this state on or after January 1, 2024, that the pharmacy benefit manager shall apply any

amount paid by the insured or by another person on behalf of the insured toward the insured's total contribution to any cost-sharing requirement pursuant to s. 627.65715.

Section 6. Paragraph (e) of subsection (5) of section 627.6699, Florida Statutes, is amended to read:

627.6699 Employee Health Care Access Act.—

(5) AVAILABILITY OF COVERAGE.—

(e) All health benefit plans issued under this section must comply with the following conditions:

1. For employers who have fewer than two employees, a late enrollee may be excluded from coverage for no longer than 24 months if he or she was not covered by creditable coverage continually to a date not more than 63 days before the effective date of his or her new coverage.

2. Any requirement used by a small employer carrier in determining whether to provide coverage to a small employer group, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employer groups having the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier, except that a small employer carrier that participates in, administers, or issues health benefits pursuant to s. 381.0406 which do not include a preexisting condition exclusion may require as a condition of offering such benefits that the employer has had no health insurance coverage for its employees for a period of at least 6 months. A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer

group.

3. In applying minimum participation requirements with respect to a small employer, a small employer carrier may ~~shall~~ not consider as an eligible employee employees or dependents who have qualifying existing coverage in an employer-based group insurance plan or an ERISA qualified self-insurance plan in determining whether the applicable percentage of participation is met. However, a small employer carrier may count eligible employees and dependents who have coverage under another health plan that is sponsored by that employer.

4. A small employer carrier may ~~shall~~ not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage, unless the employer size has changed, in which case the small employer carrier may apply the requirements that are applicable to the new group size.

5. If a small employer carrier offers coverage to a small employer, it must offer coverage to all the small employer's eligible employees and their dependents. A small employer carrier may not offer coverage limited to certain persons in a group or to part of a group, except with respect to late enrollees.

6. A small employer carrier may not modify any health benefit plan issued to a small employer with respect to a small employer or any eligible employee or dependent through riders, endorsements, or otherwise to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

7. An initial enrollment period of at least 30 days must be provided. An annual 30-day open enrollment period must be offered to each small employer's eligible employees and their dependents. A small employer carrier must provide special enrollment periods as required by s. 627.65615.

8. A small employer carrier shall comply with s. 627.65715 with respect to contribution to cost-sharing requirements, as defined in that section.

Section 7. Subsection (48) is added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.—

(48)(a) As used in this subsection, the term "cost-sharing requirement" means a dollar limit, a deductible, a copayment, coinsurance, or any other out-of-pocket expense imposed on a subscriber, including, but not limited to, the annual limitation on cost sharing subject to 42 U.S.C. s. 18022.

(b)1. Each health maintenance organization issuing, delivering, or renewing a health maintenance contract or certificate in this state which provides prescription drug coverage, or each pharmacy benefit manager on behalf of such health maintenance organization, shall apply any amount paid by a subscriber or by another person on behalf of the subscriber toward the subscriber's total contribution to any cost-sharing requirement.

2. The amount paid by or on behalf of the subscriber which is applied toward the subscriber's total contribution to any cost-sharing requirement under subparagraph 1. includes, but is not limited to, any payment with or any discount through financial assistance, a manufacturer copay card, a product

voucher, or any other reduction in out-of-pocket expenses made by or on behalf of the subscriber for a prescription drug.

(c) Each health maintenance organization issuing, delivering, or renewing a health maintenance contract or certificate in this state which provides prescription drug coverage, regardless of whether the prescription drug benefits are administered or managed by the health maintenance organization or by a pharmacy benefit manager on behalf of the health maintenance organization, shall disclose on its website and in every subscriber's health maintenance contract, certificate, or member handbook issued, delivered, or renewed in this state on or after January 1, 2024, that any amount paid by a subscriber or by another person on behalf of the subscriber must be applied toward the subscriber's total contribution to any cost-sharing requirement.

(d) This subsection applies to any health maintenance contract or certificate issued, delivered, or renewed in this state on or after January 1, 2024.

Section 8. Paragraph (c) is added to subsection (2) of section 641.314, Florida Statutes, to read:

641.314 Pharmacy benefit manager contracts.—

(2) A contract between a health maintenance organization and a pharmacy benefit manager must require that the pharmacy benefit manager:

(c)1. Apply any amount paid by a subscriber or by another person on behalf of the subscriber toward the subscriber's total contribution to any cost-sharing requirement pursuant to s. 641.31(48). This subparagraph applies to any subscriber whose health maintenance contract or certificate is issued, delivered,

or renewed in this state on or after January 1, 2024.

2. Disclose to every subscriber whose health maintenance contract or certificate is issued, delivered, or renewed in this state on or after January 1, 2024, that the pharmacy benefit manager shall apply any amount paid by the subscriber or by another person on behalf of the subscriber toward the subscriber's total contribution to any cost-sharing requirement pursuant to s. 641.31(48).

Section 9. Paragraph (o) of subsection (2) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(o) *Transparency.*—Managed care plans shall comply with ss. 627.6385(4) and 641.54(7) ~~ss. 627.6385(3) and 641.54(7)~~.

Section 10. Paragraph (k) of subsection (1) of section 641.185, Florida Statutes, is amended to read:

641.185 Health maintenance organization subscriber protections.—

(1) With respect to the provisions of this part and part III, the principles expressed in the following statements serve as standards to be followed by the commission, the office, the department, and the Agency for Health Care Administration in exercising their powers and duties, in exercising administrative discretion, in administrative interpretations of the law, in enforcing its provisions, and in adopting rules:

(k) A health maintenance organization subscriber shall be

given a copy of the applicable health maintenance contract, certificate, or member handbook specifying: all the provisions, disclosure, and limitations required pursuant to s. 641.31(1), ~~and~~ (4), and (48); the covered services, including those services, medical conditions, and provider types specified in ss. 641.31, 641.31094, 641.31095, 641.31096, 641.51(11), and 641.513; and where and in what manner services may be obtained pursuant to s. 641.31(4).

Section 11. The Legislature finds that this act fulfills an important state interest.

Section 12. This act shall take effect July 1, 2023.

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

4/5/23
Meeting Date

Fins. & Banking
Committee

SB 46
Bill Number or Topic

Amendment Barcode (if applicable)

Name Deborah Adamkin

Phone

Address 4983 Shaker Hts Ct.
Street

Email deborahadamkin@gmail.com

Naples, FL 34112
City State Zip

Speaking: ☑ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

Florida Hemophilia Association

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

5 April 2023
Meeting Date

Banking & Ins
Committee

46
Bill Number or Topic

Amendment Barcode (if applicable)

Name Barney Bishop III

Phone 850.510.9922

Address 1454 Vieux Carre Dr
Street

Email Barney@BarneyBishop.com

Tall FL 32308
City State Zip

Speaking: ☑ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Small Business Pharmacy

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

4/5/23	46
Meeting Date	Bill Number or Topic
B+I	
Committee	Amendment Barcode (if applicable)

Name Audrey Brown Phone (850) 559-3905

Address 200 W. College Ave. Email audrey@fahp.net
Street

Tall FL 32301
City *State* *Zip*

Speaking: ☐ For ☑ Against ☐ Information **OR** **Waive Speaking:** ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

4/5/23
Meeting Date

BI
Committee

SB 46
Bill Number or Topic

Amendment Barcode (if applicable)

Name Donna Sabatino

Phone 954-734-5901

Address 431 N. 10th St
Street

Email dsabatino@taimail.org

Flagler Beach FL 32136
City State Zip

Speaking: ☒ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☒ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

4/5/2023
Meeting Date

Banking & Insurance
Committee

0046
Bill Number or Topic

Amendment Barcode (if applicable)

Name David Poole

Phone (850) 766-3323

Address 1825 Country Club Dr
Street

Email david.poole@ahf.org

Tallahassee FL 32301
City *State* *Zip*

Reset Form

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
AHF (AIDS Healthcare Foundation)

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

4.5.23
Meeting Date

Banking & Insurance
Committee

46
Bill Number or Topic

Amendment Barcode (if applicable)

Name Greg Black

Phone 8505098022

Address PO Box 838
Street

Email Greg@WaypointStrat.com

Tallahassee FL 32302
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information **OR** **Waive Speaking:** ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:

Florida Breast Cancer Foundation

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

4/5/23
Meeting Date

B & I
Committee

46
Bill Number or Topic

Amendment Barcode (if applicable)

Name Toni Large

Phone (850) 556-1461

Address 1100 Brookwood Dr
Street

Email toni@sulaw.net

Tallahassee, FL 32308
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:

Florida Society of Rheumatology

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

4/5/23
Meeting Date

BANKING AND INSURANCE
Committee

SB 46
Bill Number or Topic

Amendment Barcode (if applicable)

Name TASHA CARTER

Phone 850-413-2868

Address 200 E. GAINES STREET
Street

Email TASHA.CARTER@MYFLORIDACFO.COM

TALLAHASSEE, FL 32399
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
OFFICE OF THE INSURANCE CONSUMER ADVOCATE

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

4-5-23
Meeting Date

Banking & Insurance
Committee

46
Bill Number or Topic

Amendment Barcode (if applicable)

Name Jarrod Fowler

Phone 850-224-6496

Address 1430 Piedmont Dr. E
Street

Email Jfowler@flmedical.org

Tallahassee FL 32308
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing: Florida Medical Association

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

April 5, 2023
Meeting Date

Banking and Insurance
Committee

46
Bill Number or Topic

Amendment Barcode (if applicable)

Name Chris Lyon

Phone 222-5702

Address 106 E. College Avenue, Suite 1500
Street

Email clyon@llw-law.com

Tallahassee FL 32301
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Florida Osteopathic Medical Association

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

4/5/23	46
Meeting Date	Bill Number or Topic
Banking and Insurance	
Committee	Amendment Barcode (if applicable)

Name Nancy Bryan, Bio Florida Phone 561-254-4946

Address 901 NW 35th Street Email nbryan@bioflorida.com
Street

Boca Raton FL 33431
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

Bio Florida,

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

4/5/23
Meeting Date

B & I
Committee

46
Bill Number or Topic

Amendment Barcode (if applicable)

Name Susan Harbin

Phone 770-546-8845

Address 1450 Lee Ave
Street

Tallahassee FL 32303
City State Zip

Email Susan.harbin@cancer.org

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
American Cancer Society Cancer Action Network

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

4/5/23
Meeting Date

Banking + Insurance
Committee

SB 46
Bill Number or Topic

Amendment Barcode (if applicable)

Name Amanda Fraser

Phone 850-556-1401

Address
Street

Email

Tallahassee
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information **OR** **Waive Speaking:** ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:
American Diabetes Association

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

4/5/23
Meeting Date

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

46
Bill Number or Topic

Committee

Amendment Barcode (if applicable)

Name Jared Willis

Phone

Address
Street

Email jared@willisga.com

City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:
Alliance for Patient Access

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

Committee Agenda Request

To: Senator Jim Boyd, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: December 28, 2022

I respectfully request that **Senate Bill 46**, relating to Health Insurance Cost Sharing, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Tom A. Wright
Florida Senate, District 8

File signed original with committee office

S-020 (03/2004)

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Banking and Insurance
ITEM: SB 46
FINAL ACTION: Favorable
MEETING DATE: Wednesday, April 5, 2023
TIME: 8:30—10:30 a.m.
PLACE: 412 Knott Building

FINAL VOTE								
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
		Broxson						
X		Burgess						
X		Burton						
X		Hutson						
		Ingoglia						
X		Mayfield						
X		Powell						
X		Thompson						
		Torres						
		Trumbull						
X		DiCeglie, VICE CHAIR						
X		Boyd, CHAIR						
8	0	**TOTALS**						
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

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 622
INTRODUCER:	Banking and Insurance Committee and Senator Yarborough
SUBJECT:	Continuing Care Contracts
DATE:	April 5, 2023
REVISED:	

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 622 revises many provisions of ch. 651, F.S., of the Insurance Code governing continuing care retirement communities (CCRC), 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. A CCRC can include an independent living apartment or house, 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. 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

- Makes it easier for a provider to access escrowed resident fees as part of an expansion, allowing access to the escrowed funds once 75 percent of the proposed units have been reserved rather than once payment in full has been received for 50 percent of the units.
- Reduces the time for OIR to approve or deny an expansion application from 45 days to 30 days from the date the application is deemed complete.
- Specifies that when a provider is using an escrow account held pursuant to a trust indenture or mortgage lien to meet its minimum liquid reserve requirement, the trust indenture, loan agreement, or escrow agreement must require that the provider, trustee, lender, escrow agent, or another person designated to act in their place notify OIR in writing at least 10 days before

the withdrawal of any portion of the debt service reserve funds required to meet the provider's minimum liquid reserve requirement. Further, the notice must include an affidavit sworn to by the provider, the trustee, or a person designated to act in their place which includes the amount of the scheduled debt service payment, the payment due date, the amount of the withdrawal, the accounts from which the withdrawal will be made, and a plan with a schedule for replenishing the withdrawn funds.

- Removes the requirement for a provider to obtain prior approval from OIR to withdraw funds from a debt service reserve required to be escrowed pursuant to a trust indenture of mortgage lien if the funds will be used to pay principal and interest payments.
- Expands the types of financial institutions that can provide a letter of credit to a provider to satisfy its minimum liquid reserve requirements by adding state-chartered financial institutions as well as federally-chartered financial institutions.
- Allows a provider to assess a cancellation penalty against a person who signs residency contract and rescinds it within seven days if the person had previously signed a reservation agreement and did not cancel it within 30 days.
- Requires OIR examinations of CCRCs to be commenced within 12 months after the end of the most recent fiscal year covered by the examination. Further, the scope of the examination may include events subsequent to the end of the most recent fiscal year and the events of any prior period, which affects the present financial condition of the provider.

Transparency for Residents

- Clarifies that a resident is eligible to participate in residents' council matter, including elections, if the person meets the definition of a resident, as provided in s. 651.011, F.S.
- Requires a provider that owns or operates more than one facility in Florida to have a designated resident representative at each facility.
- Requires that the designated resident representative be notified by the provider at least 14 days in advance of any meeting of the full governing body at which the annual budget and proposed changes in resident fees or services are on the agenda or will be discussed so that the resident can attend and participate in that portion of the meeting.
- Requires each facility to provide written notice to the president or chair of the residents' council within 10 business days after a change in management.
- Requires each facility to provide a copy of the OIR final examination report and corrective action plan, if applicable, to the president or chair of the residents' council within 60 days after issuance of the report.

II. Present Situation:

Continuing Care Retirement Communities (CCRC)

A provider[1] or a CCRC offers shelter and nursing care or personal services upon the payment of an entrance fee.[2] The CCRCs offer a transitional approach to the aging process, accommodating residents' changing level of care. A CCRC can include an independent living apartment or a house, as well as an assisted living facility or a nursing home. The CCRCs may also offer at-

[1] Section 651.011(23), F.S., defines a provider as an owner or operator that provides continuing care.
[2] Section 651.011(13), F.S.

home programs that provide residents CCRC services while continuing to live in their own homes until they are ready to move to the CCRC.[3] 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.[4]

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).[5] The OIR regulates CCRC providers[6] 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.[7] There are currently 70 licensed continuing care retirement communities in Florida.[8]

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.[9] Continuing care services are governed by a contract between the facility and the resident of a CCRC, which is subject to approval by the OIR.[10] As part of the regulation of CCRCs, OIR reviews applications for licensure, reviews expansion applications, conducts solvency monitoring through the review of financial statements and other documents, monitors minimum liquid reserve levels, and conducts examinations of each facility every three to five years. It is a felony of the third degree for any person to maintain, enter into, or perform any continuing care or continuing care at-home contract without actually having a valid provisional COA (Certificate of Authority) or COA. One may not avoid such criminal liability by simply being in pursuance of a COA.[11]

In order to operate a CCRC in Florida, a provider must generally obtain from the OIR a certificate of authority predicated upon first receiving a provisional certificate of authority.[12] A provisional certificate of authority is issued once a provider meets the requirements prescribed in s. 651.023, F.S. The application process for a provisional certificate of authority and a certificate of authority involves submitting audited financial reports, feasibility studies, copies of contracts,

[3] Sections 651.057 and 651.118, F.S.
[4] Office of Insurance Regulation, Analysis of SB 622 (Feb. 15, 2023).
[5] Chapter 651, F.S., and s. 20.121, F.S.
[6] Section 651.011(12), F.S., a provider means an owner or operator.
[7] Agency for Health Care Administration available at Consumer Guides | FloridaHealthFinder.gov (last viewed Mar. 21, 2023) and s. 651.118, F.S.
[8] Office of Insurance Regulation, Summary and Comparison of CCRC Data (2022) Re-Open Florida Task Force Meeting: Insurance (floir.com) last visited (Mar. 23, 2023).
[9] See ss. 651.021, 651.22, and 651.023, F.S.
[10] Sections 651.055 and 651.057, F.S.
[11] Section 651.125, F.S,
[12] Section 651.022, F.S.

and other information.[13] Further, the applicant must provide evidence that the applicant is reputable and of responsible character.[14]

The issuance of a provisional COA allows the applicant to collect entrance fees and reservation deposits from prospective residents. All entrance fees and reservation deposits must be placed in an escrow account or on deposit with Department of Financial Services (DFS).[15] The requirements for a provisional COA application and a COA application[16] require that the feasibility study must show projections for the first five years of operations. For a provisional COA, the preparer of the feasibility study may be the provider or a contracted third party.[17] Like the provisional COA application, an application for a COA requires the submission of various information, such as an audited financial report. For a COA application, a feasibility study must be prepared by an independent consultant. If the feasibility study is prepared by an independent certified public accountant (CPA), it must contain an examination opinion[18] or a compilation report[19] containing financial forecasts and projections.

A COA may not 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 is provided to the OIR. For a COA application, 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 entrance fee.[20]

Consolidated Application for a Provisional Certificate of Authority and a Certificate of Authority Applications – Section 651.0215, F.S., provides a consolidated application process, including requirements for handling escrowed funds, in order for an applicant to obtain a COA without first obtaining a provisional COA. The applicant must provide a feasibility study prepared by an independent consultant[21] as well as audited financial statements,[22] and other specified information to the OIR. If the feasibility study is conducted by an independent certified public accountant, it must contain an examination report, or a compilation report[23] acceptable to the OIR.

[13] See ss. 651.021-651.023, F.S.
[14] Section 651.022(2)(c), F.S.
[15] Section 651.023(5), F.S.
[16] Section 651.023, F.S.
[17] Section 651.022 (3)(j), F.S., provides that the preparer of the feasibility study for a provisional COA may be the provider or a contracted third party.
[18] This is undefined term in ch. 651, F.S.
[19] An audit is the highest level of assurance service that a CPA performs and is intended to provide a user comfort on the accuracy of the financial statements. The CPA performs procedures in order to obtain "reasonable assurance" (defined as a high but not absolute level of assurance) about whether the financial statements are free from material misstatement. In contrast, the CPA does not obtain any assurance for a compilation because the CPA is not required to verify the accuracy or completeness of the information provided or otherwise gather evidence for the purposes of expressing an audit opinion or a review conclusion. The compilation report states that the CPA did not audit or review the financial statements and accordingly does not express an opinion, a conclusion or provide any assurance on them. See American Institute of Certified Public Accountants financial-statement-services-guide.pdf (aicpa.org) (last visited Mar. 18, 2023)
[20] Section 651.023(4)(b), F.S.
[21] Section 651.0215(2)(b), F.S.
[22] Section 651.0215(2)(f), F.S.
[23] *Supra* FN 19.

Expansion Applications – Section 651.0246, F.S., specifies the application process and information required to obtain approval from OIR for expansion. This section also provides that automatic approval is granted for expansions up to 35 percent of the existing units if the provider exceeds the statewide median for days cash on hand, debt service coverage ratio, and total facility occupancy for the most recent two consecutive reporting periods. In order to obtain this automatic approval, the provider must submit a letter to the OIR indicating the planned number of units, the proposed sources and uses of funds, and an attestation that they understand and will comply with all minimum liquid reserve and escrow account requirements.

A feasibility study, prepared by an independent certified public accountant, is required to be submitted as part of an expansion application. The study includes an independent evaluation and examination opinion as to whether the assumptions contained in the study are reasonable and that the project is feasible.[24] 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 DFS, as prescribed in s. 651.033, F.S.[25]

The provider may secure release of the moneys held in escrow within 7 days after the receipt by the OIR of an affidavit by the provider that the following conditions have been satisfied:

- A certificate of occupancy has been issued.
- The provider has received payment in full for at least 50 percent of the total units of a phase or of the total of the combined phases constructed.
- Documents evidencing that commitments have been secured or that the provider's long-term financing has been approved by the OIR.
- Documents evidencing that the provider has sufficient funds to meet the minimum liquid reserve requirements of s. 651.035, F.S., which may include funds deposited in the initial entrance fee account.[26]

Within 30 days after receipt of an application for expansion, the OIR must examine the application and notify the applicant in writing, requesting any additional information.[27] Within 15 days after the OIR receives all the requested information, the OIR must notify the applicant in writing that the requested information has been received.[28] If the OIR fails to notify the applicant within the 15-day period, the application is deemed complete for purposes of the review.[29] Within 45 days of the OIR deeming the application complete, the OIR must complete its review and approve or deny an expansion.[30]

[24] Section 651.0246(2)(a), F.S.
[25] Section 651.0246(3), F.S.
[26] Section 651.0246((4), F.S.
[27] Section 651.0246(5)(a), F.S.
[28] *Id*.
[29] *Id*.
[30] Section 651.0246(6), 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.[31] 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.[32] The CCRC may assess a forfeiture fee equal to 2 percent of the entrance fee if the resident cancels his or her reservation after 30 days for reasons that are within the control of the resident.[33]

Reserving and Escrow Requirements

Section 651.035, F.S., which contains minimum liquid reserve requirements, requires providers that do not have a mortgage loan or other financing on the facility to deposit monthly in escrow one-twelfth of their annual property tax liability and to pay property taxes out of such escrow. Each facility is required to maintain a minimum liquid reserve for operations, debt service, and facility upkeep based on the facility's expenses and debt service obligations. OIR approval is required to be obtained prior to withdrawing all or a portion of the funds used to satisfy a facility's minimum liquid reserve requirement. Facilities who want to use a letter of credit to fund their minimum liquid reserve are limited to those institutions that participate in the State of Florida Treasury Certificate of Deposit Program.[34]

A provider may withdraw funds held in escrow without the approval of the OIR if the amount held in escrow exceeds the requirements of s. 651.035, F.S., and if the withdrawal will not affect compliance with this section.[35] Any other proposed withdrawals are subject to approval by the OIR. Within 30 days after a filing for such a request for withdrawal is deemed complete, the OIR must notify the provider of its approval or disapproval of the request.[36]

Any increase in the minimum liquid reserve must be funded no later than 61 days after the minimum liquid reserve calculation is due to be filed.[37] If the minimum liquid reserve is less than the required minimum amount at the end of any fiscal quarter due to a change in the market value of the invested funds, the provider must fund the shortfall within 10 business days.[38] Further, the section authorizes OIR authority to require the transfer of reserve funds into the custody of the DFS Bureau of Collateral Management if OIR finds that the provider is impaired or insolvent in order to ensure the safety of those assets.[39]

Section 651.033, F.S., contains requirements for a provider’s escrow account and the duties that apply to escrow agents, including the prohibition that an escrow agent may not release or

[31] Section 651.055, F.S.
[32] Supra FN 4.
[33] *Id.*
[34] Section 651.035(5), F.S.
[35] Section 651.035(7)(a), F.S.
[36] Section 651.035(7)(b), F.S.
[37] Section 651.035(10), F.S.
[38] Section 651.035(11), F.S.
[39] Section 651.035(8), F.S.

otherwise allow the transfer of funds without the written approval of the OIR, unless the withdrawal is from funds in excess of specified statutory requirements.

Financial Reporting

Section 651.026, F.S., requires the provider to submit annually the management's calculation of the provider's debt service coverage ratio, occupancy, and days cash on hand. The OIR is required to publish on its website by August 1 of each year an industry report for the preceding calendar year that contains the median days cash on hand for all providers, median debt service coverage ratio for all providers, and median occupancy rate for all providers by setting (independent living, assisted living, skilled nursing, and the entire facility).

Section 651.0261, F.S., requires that each provider must submit a quarterly unaudited financial statement of the provider or of the facility, days cash on hand, occupancy, debt service coverage ratio, and a detailed listing of the assets maintained in the liquid reserves within 45 days after the end of each fiscal quarter.[40] This information is intended for the OIR to use for monitoring the financial condition of a provider or facility on an ongoing basis. If a CCRC falls below the thresholds set for two or more of the key indicators (days cash on hand, debt service coverage ratio, or occupancy) at the time of the quarterly report, the CCRC must submit to the OIR an explanation of the circumstances and a description of the actions the CCRC will take to meet the requirements. The last quarterly statement for a fiscal year is not required if a provider does not have pending a regulatory action level event, an impairment, or a corrective action plan.

Section 651.0261, F.S., authorizes the OIR to require monthly reporting of certain information if it finds 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.[41] The section also specifies certain circumstances under which monthly filings may be required, such as a provider being subject to delinquency, receivership, or bankruptcy proceedings.[42]

Financial Indicators and Solvency Framework

Regulatory Action Level Event[43] – Section 651.034, F.S., provides a framework of required actions if a provider falls below specified levels of three key indicators at the time of the annual report: occupancy, days cash on hand, and the debt service coverage ratio. The key indicators were selected based on their tendency to highlight problematic financial developments. If the provider's performance falls below the specified levels on two of the following three key indicators at the time of the annual report, it is considered a "regulatory action level event":

- The provider's debt service coverage ratio is less than the greater of the minimum ratio specified in the provider's bond covenants or lending agreement for long-term financing or 1.20:1 as of the most recent annual report filed with the OIR; 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 OIR;
- The provider's days cash on hand is less than the greater of the minimum number of days cash on hand specified in the provider's bond covenants or lending agreement for long-term

[40] Section 651.0261(1), F.S.
[41] Section 651.0261(2), F.S.
[42] Section 651.0261(3), F.S.
[43] Section 651.011(25), F.S., defines "regulatory action level event."

financing or 100 days. 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 OIR; or,

- The occupancy of the provider's facility is less than 80 percent averaged over the 12-month period immediately preceding the annual 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 and days cash on hand must be used to determine if a regulatory action level event has occurred. In the event that a regulatory action level event occurs, the provider is required to submit a corrective action plan; the OIR is required to perform an examination or analysis of the provider; and the OIR is required to issue a corrective order specifying any corrective actions that the OIR determines are required. For new CCRCs, the OIR may exempt a provider from the consequences of a regulatory action level event or impairment until the earlier of the CCRC reaching stabilized occupancy, the time projected to achieve stabilized occupancy, or five years from the date of issuance of the COA.

Impairment – The bill creates a definition for "impaired" or impairment" to allow for earlier intervention by the OIR in an effort to prevent harm to Florida consumers. The impairment framework has been an effective tool in preventing, or minimizing the impact of, insurer insolvencies. 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. The establishment of the impairment framework will allow the OIR to begin partnering with a provider much sooner in order to mitigate or resolve any potential issues that would put resident interests in jeopardy. A provider is considered impaired if it fails to hold the minimum liquid reserve.[44] Additionally, a provider without mortgage or bond financing would be considered impaired if it does not maintain the specified level of days cash on hand, and a provider with mortgage or bond financing would be considered impaired if it does not maintain specified levels of days cash on hand and debt service coverage ratio.[45] 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.[46] The OIR may forego taking action for up to 180 days after an impairment occurs if the OIR finds there is a reasonable expectation that the impairment may be eliminated within the 180-day period.

Sections 651.022 and 651.023, F.S., prohibit the OIR from approving an application for a provisional COA or COA if it includes in the financing plan any encumbrance on renewal or replacement reserves required by ch. 651, F.S.

Section 651.114, F.S., requires that a provider, determined by the OIR to not be in compliance with ch. 651, F.S., must submit to the OIR and the Continuing Care Advisory Council a plan for obtaining compliance with ch. 651, F.S., and solvency. The OIR is not prohibited from taking other regulatory action while a plan for obtaining compliance or solvency is under review.

[44] Section 651.011(15)(a), F.S.
[45] Section 651.011(15)(b), F.S.
[46] Section 651.011(15), F.S.

Section 651.114, F.S., provides circumstances under which OIR's remedial rights are not subordinate to the rights of a trustee or lender. Those circumstances include the following:

- The provider engaged in the misappropriation, conversion, or illegal commitment or withdrawal of minimum liquid reserve or required escrowed funds;
- The provider refused to be examined by the OIR; or
- The provider refused to produce any relevant accounts, records, and files requested as part of an examination.

Even if the OIR's remedial rights are suspended, an impaired provider must make available to the OIR copies of any corrective action plan approved by the trustee or lender to cure the impairment.

Section 651.1065, F.S., requires an impaired or insolvent provider to receive prior approval of the OIR before writing new contracts if its proprietor, general partner, member, officer, director, trustee, or manager knows, or reasonably should know, that the CCRC is impaired or insolvent, even if the provider's COA has not been formally suspended. This is intended to help protect potential residents who may be considering investing substantial funds to enter into a CCRC contract. The OIR will have discretion to allow the issuance of new contracts where safeguards are adequate. Violating this section is a felony of the third degree.

Examinations of Providers

Section 651.105, F.S., requires OIR to examine at least once every 3 years any applicant for a COA and any provider engaged in the execution of care contracts or engaged in the performance of obligations under such contracts. If a provider is accredited under s. 651.028, F.S., such examinations must occur at least once every 5 years. Further, any duly authorized officer, employee, or agent of the office may have access to, and examine any records, with or without advance notice, to secure compliance with, or to prevent a violation of, any provision of this chapter.[47]

Rights of Residents; Transparency

Rights of Residents – The OIR is also authorized to discipline a facility for violations of residents' rights.[48] 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 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.[49]

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.[50] CCRCs are required

[47] Section 651.105(2), F.S.
[48] Section 651.083, F.S.
[49] *Id*.
[50] Section 651.081, F.S.

to maintain and make available certain public information and records, such as records of all cost and inspection reports pertaining to that facility, a concise summary of the last examination report issued by the OIR, and a summary of the most recent annual statement.[51]

Disclosures and Notices – Chapter 651 requires provider to give many types of notices to the residents or residents' council. These assists residents and prospective residents to remain apprised of the status and stability of the provider and to take action to protect their interests.

A provider is required to furnish the following information to the chair of the residents' council: 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, a notice of any change in ownership filing submitted to the OIR, and any master plans approved by the provider's governing board and any plans for expansion or phased development.[52] Additionally, a provider must post in a prominent place in the facility a notice that contains the OIR's website and phone number and the website and toll-free consumer helpline for the DFS Division of Consumer Services.[53] The notice must also state that either the OIR or DFS Division of Consumer Services may be contacted for the submission of inquiries and complaints with respect to potential violations of law.

Section 651.091(3), F.S., requires the following disclosures to prospective residents: 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; notice that, if the resident does not exercise the right to rescind a continuing care contract within seven days after executing the contract, the resident's funds held in escrow will be released to the provider; a statement that distribution of the provider's assets or income may occur or a statement that such distribution will not occur; and a disclosure of any holding company system or obligated group of which the provider is a member. Additionally, the provider must obtain written acknowledgment that the prospective resident or his or her legal representative received the disclosures required by s. 651.091(3), F.S.

Section 651.055(3), F.S., requires that contracts with a resident disclose that CCRC facilities in Florida are regulated by the OIR. Additionally, the contract disclosure must state that "[t]he financial structure of a continuing care provider can be complex, and the decision to enter into a contract for continuing care is a long-term commitment between a resident and the continuing care provider. You may wish to consult an attorney or financial advisor before entering into such contract."

Section 651.111, F.S., provides for the handling of resident complaints against providers, including a requirement that the OIR provide a written acknowledgement of any complaint within 15 days of receipt of the complaint and a written statement to the complainant specifying any violations of law and any actions taken. Such additional procedures will keep residents better informed as to the status and outcome of a complaint.

[51] Section 651.091, F.S.
[52] Section 651.091(2), F.S.
[53] Section 651.091, F.S.

Continuing Care Advisory Council

Section 651.121, F.S., creates the council and provides membership and duties of the ten members comprising the council is an advisory contains requirements for membership of the Continuing Care Advisory Council. The members include three members representing facilities with active COAs, one representative of the business community, one representative of the financial community, a certified public accountant, and four residents who hold continuing care contracts with a facility certified in Florida.

Department of Financial Services' Oversight of CCRCs

The DFS may become involved with a resident after a CCRC contractual agreement has been signed by both parties or during a mediation or arbitration process.[54] Typically, residents will contact the DFS Division of Consumer Services, which receives and resolves complaints involving products and persons regulated by the OIR or the DFS.[55]

Chapter 631, F.S., governs the rehabilitation and liquidation process for insurers in Florida. Federal law provides that insurance companies are not eligible to be a debtor in federal bankruptcy proceedings and are instead subject to state laws regarding receivership.[56] In Florida, the Division of Rehabilitation and Liquidation within the DFS is responsible for managing insurance companies placed into receivership. The goal of rehabilitation is to return the insurer to solvency. The goal of liquidation, however, is to liquidate the business of the insurer and use the proceeds to pay claims, including those of policyholders, creditors, and employees.

III. Effect of Proposed Changes:

Section 1 amends s. 651.011, F.S., to create definitions for the following terms:

- "Designated resident representative" means a resident elected by the residents' council to represent residents on matters related to changes in fees or services as specified in s. 651.085(2) and (3).
- "Residents' council" means an organized body representing the resident population of a certified facility. A residents' council shall serve as a liaison between residents and the appropriate representative of the provider.

Section 2 amends s. 651.0246, F.S., relating to expansions. Subsection (2)(a) is amended to clarify that the certified public accountant is responsible for preparing an independent evaluation and examination opinion for the first 5 years.
Subsection (4) is revised to allow a provider to have access to escrowed resident fees when the provider has collected a reservation deposit for at least 75 percent of the proposed units for which an entrance fee is to be charged. Further, a provider must use the funds for the sole purpose of paying secured indebtedness as specified in the feasibility study. The minimum reservation deposit must be the lessor of $40,000 or 10 percent of the then-current entrance fee

[54] Rules 69O-193.062 and 69O-193.063, F.A.C.
[55] Section 624.307, F.S.
[56] 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. s. 1012 (McCarran-Ferguson Act).

for the unit being reserved. If the expansion is to be completed in multiple phases, the 75 percent reservation requirement applies separately to each phase of the expansion.

Currently the provider may have access to the escrowed funds if payment in full has been received for 50 percent of the units of a phase or of the total of the combined phases constructed. Subsection (6) is revised to reduce the time for OIR to approve or deny an expansion application from 45 days to 30 days from the date the application is deemed complete.

Section 3 amends s. 651.026, F.S., relating to annual reports, to clarify that if a provider's financial statements are consolidated or combined with the financial statements of additional entities owned or controlled by the provider, the financial report must include as supplemental information a separate balance sheet, statement of income and expenses, statement of equity or fund balance, and statement of changes in cash flow for the individual provider and each additional entity comprising the consolidated or combined financial report. A similar supplemental presentation and reporting requirement is created for a provider that is a member of an obligated group.

Section 4 amends s. 651.033, F.S., relating to escrow accounts, to expand the number of eligible escrow agents by removing the requirement that a federal financial institution must have a branch in Florida. The section also provides technical changes. The section also authorizes a provider to hold a resident's check for a 7-day rescission period without receiving a request from the resident.

Section 5 amends s. 651.034, F.S., relating to financial and operating requirements. Subsection (6) extends the time OIR may exempt a provider from certain regulatory actions, such as the submission of a corrective action plan, when the provider's financial results, do not meet certain levels. The change in time frame is extended from 5 years from the date the provider received its certificate of occupancy to 5 years after the end of the provider's fiscal year in which the certificate of occupancy was issued.

Section 6 amends s. 651. 035, F.S., relating to minimum liquid reserves. The section eliminates the requirement for a provider to obtain prior approval from OIR to withdraw funds from a debt service reserve that required to be escrowed pursuant to a trust indenture of mortgage lien if the funds will be used to pay principal and interest payments.

Subsection (1) requires that when a provider is using an escrow account held pursuant to a trust indenture or mortgage lien to meet its minimum liquid reserve requirement, the trust indenture, loan agreement, or escrow agreement must require that the provider, trustee, lender, escrow agent, or another person designated to act in their place must notify OIR in writing at least 10 days before the withdrawal of any portion of the debt service reserve funds required to meet the provider's minimum liquid reserve requirement. The notice must include an affidavit sworn to by the provider, the trustee, or a person designated to act in their place which includes the amount of the scheduled debt service payment, the payment due date, the amount of the withdrawal, the accounts from which the withdrawal will be made, and a plan with a schedule for replenishing the withdrawn funds. If the plan is revised by a consultant that is retained as prescribed in the provider's financing documents, the revised plan must be submitted to OIR within 10 days after approval by the lender or trustee.

Subsection (5) also expands the types of financial institutions that can provide a letter of credit to a provider, and can be used to satisfy its minimum liquid reserve requirement by adding Florida state-chartered financial institutions and specified federal financial institutions

Section 7 amends s. 651.055, F.S., relating to continuing care contracts; right to rescind. The section is amended to authorize a provider to assess a cancellation penalty against a person who signs residency contract and rescinds it within 7 days, if the person had previously signed a reservation agreement and did not cancel it within 30 days. A prospective resident who has signed a reservation agreement and cancels their agreement after 30 days is generally subject to a cancelation penalty. Currently, a person who rescinds a residency contract receives a full refund. As a result, a resident who wants to avoid the reservation agreement cancellation penalty may sign a residency contract and then rescind the contract within 7 days, and receive a full refund. The change in this section would not allow this type of transaction to avoid the cancellation penalty.

Section 8 amends s. 651.081, relating to residents' council, to clarify that a residents' council can establish and maintain its own governance documents, such as bylaws or operating agreements, policies, and operating procedures, which may include establishment of committees. It also gives a resident the right to participate in residents' council matters including elections. The section removes the provision that the residents must allow for open meetings when appropriate.

Section 9 amends s. 651.083, F.S., relating to residents' rights, to clarify that residents have access to ombudsman staff.

Section 10 amends s. 651.085, F.S., relating to quarterly meetings between residents and the governing body of the provider, to require that each CCRC have its own designated resident representative and to clarify that the designated resident representative must be a resident and is to be nominated and elected by the residents' council. This section also clarifies that a representative of a provider must notify the designated resident representative at least 14 days in advance of any meeting of the full governing body at which the annual budget and proposed changes in resident fees or services are on the agenda or will be discussed so that the resident can attend and participate in that portion of the meeting. The section also requires that any resident who serves as a member of a board or governing body of the facility perform their duties in a fiduciary manner, including the duty of confidentiality, duty of care, duty of loyalty, and duty of obedience, as required of any individual serving on the board or governing body.

Section 11 amends s. 651.091, F.S., relating to availability of reports and records, to require each facility to provide a copy of the final examination report and corrective action plans, if applicable, to the executive officer of the governing body of the provider and the president or chair of the residents' council within 60 days after issuance of the report. It also requires the CCRC to notify the president or chair of the residents' council in writing of a change in management within 10 business days after the change, and to disclose to prospective residents whether the provider has one or more residents serving on its board or governing body and whether that individual has a vote or is serving in a nonvoting, ex officio capacity.

Section 12 amends s. 651.105, F.S, relating to examinations, to require the OIR that each examination must cover the preceding 3 or 5 years of the provider, whichever is applicable, and must be commenced with 12 months after the end of the most fiscal year covered by the examination. The section provides that the scope of OIR's examination may include events subsequent to the end of the most recent fiscal year and the events of any prior period which relate to possible violations of this chapter or which affect the present financial condition of the provider. Further, the OIR is required to conduct an interview with the current president or chair of the residents' council or their designee, as part of the examination.

Sections 13 and 14 (ss. 651.012 and 651.0261, F.S.) provide conforming changes.

Section 15 provides this act takes effect July 1, 2023.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Providers will have access to escrowed resident fees as part of expansion sooner since the provider can access the escrowed funds once 75 percent of the proposed units have been reserved rather than only allowing access if payment in full has been received for 50 percent of the units.

The bill expands the number of eligible escrow agents by removing the requirement that the financial institution must have a branch in Florida.

The bill expands the types of financial institutions that can provide a letter of credit to a provider to use to satisfy its minimum liquid reserve requirement by adding Florida state-chartered financial institutions and specified federal, financial institutions..

C. Government Sector Impact:

The OIR will need one additional Financial Control Analyst for CCRC examinations and investigations of consumer inquiries and complaints. For this position, OIR will require an additional $90,000 in salaries and benefits ($60,000 in rate) as well as $11,051 in expense with $4,682 nonrecurring to fill this new position. OIR needs an additional $15,000 in salaries and benefits ($10,000 in rate) to address vacancies, retain current employees, and reduce attrition.[57]

VI. Related Issues:

The term, "office," refers to the Office of Financial Regulation. However, the term, "office," is not defined in ch. 651.011, F.S. The term is used throughout ch. 651, F.S.

The term, "examination opinion," is not defined in ch. 651, F.S. The term is used in sections 651.023 and 651.0246, F.S.

VII. Statutes Affected:

This bill amends sections 651.011, 651.0246, 651.026, 651.033, 651.034, 651.035, 651.055, 651.081, 651.083, 651.085, 651.091, 651.105, 651.012, and 651.0261 of the Florida Statutes.

VIII. Additional Information:

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

CS by Banking and Insurance on April 5, 2023:
The CS:

- Removes provisions allowing the Office of Insurance Regulation to waive financial reporting requirements under specified circumstances.
- Removes provision revising criteria for conducting feasibility study required as part of an expansion application.
- Revises financial reporting requirements as it related to consolidated or combined financial statements and an obligated group.
- Provides technical, conforming changes.

[57] Office of Insurance Regulation, email from Kevin Jacobs (Apr. 4, 2023) On file with Banking and Insurance Committee.

B. Amendments:

None.

528586

LEGISLATIVE ACTION

Senate	.	House
Comm: RS	.	
04/07/2023	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Present subsections (13) through (26) and (27) of section 651.011, Florida Statutes, are redesignated as subsections (14) through (27) and (29), respectively, and new subsection (13) and subsection (28) are added to that section,

528586

to read:

651.011 Definitions.—As used in this chapter, the term:

(13) "Designated resident representative" means a resident elected by the residents' council to represent residents on matters related to changes in fees or services as specified in s. 651.085(2) and (3).

(28) "Residents' council" means an organized body representing the resident population of a certified facility. A residents' council shall serve as a liaison between residents and the appropriate representative of the provider.

Section 2. Paragraph (b) of subsection (4) and subsection (6) of section 651.0246, Florida Statutes, are amended to read:

651.0246 Expansions.—

(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:

(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; or a provider has collected a reservation deposit for at least 75 percent of the proposed units for which an entrance fee is to be charged and the escrowed funds will be used for the sole purpose of paying secured indebtedness as specified in the feasibility study submitted pursuant to paragraph (2)(a). The minimum reservation deposit must be the lesser of $40,000 or 10 percent of the then-current entrance fee for the unit being reserved. If the expansion is to be completed in multiple phases, the 75 percent

528586

reservation requirement applies separately to each phase of the expansion. 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.

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.

(6) Within 30 ~~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 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 3. Paragraph (b) of subsection (2) of section 651.026, Florida Statutes, is amended 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:

(b) A financial report 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 considered customary or necessary for full disclosure or adequate understanding of the financial report, financial condition, and operation.

3. If the provider's financial statements are consolidated or combined in accordance with generally accepted accounting principles with the financial statements of additional entities owned or controlled by the provider, the financial report must include as supplemental information a separate balance sheet, statement of income and expenses, statement of equity or fund balances, and statement of changes in cash flows for the individual provider and each additional entity comprising the consolidated or combined financial report.

4. If the provider is a member of an obligated group, the provider may use the obligated group's audited financial statements if they contain as supplemental information a separate balance sheet, statement of income and expenses, statement of equity or fund balances, and statement of changes in cash flows for the individual provider and other members of the obligated group.

528586

Section 4. Paragraph (a) of subsection (1) and paragraph (c) of subsection (3) of section 651.033, Florida Statutes, are amended, and paragraph (a) of subsection (3) of that section is republished, 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 be established in a Florida bank, Florida savings and loan association, 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 a branch in this state~~, which is acceptable to the office, or such funds must be deposited with the department and be kept and maintained in an account separate and apart from the provider's business accounts.

(3) 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 be deposited with the escrow agent or as provided in paragraph (c). The escrow agent must 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.


528586

651.023(6), or s. 651.0246. However, if the resident rescinds the contract within the 7-day period, the escrow agent must release the escrowed fees to the resident.

(c) As an alternative to paragraph (a) ~~At the request of an individual resident of a facility~~, the provider may hold the check for the 7-day period and may not deposit it during this time period. If the resident rescinds the contract within the 7-day period, the check must be immediately returned to the resident. Upon the expiration of the 7 days, the provider shall deposit the check.

Section 5. Subsection (6) of section 651.034, Florida Statutes, is amended to read:

651.034 Financial and operating requirements for providers.—

(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 end of the provider's fiscal year in which the certificate of occupancy was issued ~~date of issuance of the certificate of occupancy~~.

Section 6. Paragraph (b) of subsection (1), paragraph (a) of subsection (2), subsection (5), and paragraph (a) of subsection (7) of section 651.035, Florida Statutes, are amended 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:

(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 reserve 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. In addition, the trust indenture, loan agreement, or escrow agreement must provide that the provider, trustee, lender, escrow agent, or another person designated to act in their place shall notify the office in writing at least 10 days before the withdrawal of any portion of the debt service reserve funds required to be held in escrow as described in this paragraph. The notice must include an affidavit sworn to by the provider, the trustee, or a person designated to act in their place which includes the amount of the scheduled debt service payment, the payment due date, the amount of the withdrawal, the accounts from which the withdrawal will be made, and a plan with a schedule for replenishing the withdrawn funds. If the plan is revised by a consultant that is retained as prescribed in the provider’s financing documents,

528586

the revised plan must be submitted to the office within 10 days after approval by the lender or trustee. Any such separate debt service reserves are not subject to the transfer provisions set forth in subsection (8).

(2)(a) In facilities where not all residents are under continuing care or continuing care at-home contracts, the reserve requirements of subsection (1) shall be computed only with respect to the proportional share of operating expenses that are applicable to residents. For purposes of this calculation, the proportional share shall be based upon the ratio of residents under continuing care or continuing care at-home contracts to the total of all residents, including those residents who do not hold such contracts.

(5) A provider may satisfy the minimum liquid reserve requirements of this section by acquiring from a financial institution, as specified in paragraph (b), a clean, unconditional irrevocable letter of credit equal to the requirements of this section, less the amount of escrowed operating cash required by paragraph (d).

(a) The letter of credit must be issued by a financial institution participating in the State of Florida Treasury Certificate of Deposit Program or a Florida bank, a Florida savings and loan association, a 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 must be approved by the office before issuance and before any renewal or modification thereof. At a minimum, the letter of credit must provide for:

1. Ninety days' prior written notice to both the provider

and the office of the financial institution's determination not to renew or extend the term of the letter of credit.

2. Unless otherwise arranged by the provider to the satisfaction of the office, deposit by the financial institution of letter of credit funds in an account designated by the office no later than 30 days before the expiration of the letter of credit.

3. Deposit by the financial institution of letter of credit funds in an account designated by the office within 4 business days following written instructions from the office that, in the sole judgment of the office, funding of the minimum liquid reserve is required.

(b) The terms of the letter of credit must be approved by the office and the long-term debt of the financial institution providing such letter of credit must be rated in one of their top three long-term debt rating categories by either Moody's Investors Service, Standard & Poor's Corporation, or a recognized securities rating agency acceptable to the office.

(c) The letter of credit must name the office as beneficiary.

(d) Notwithstanding any other provision of this section, a provider using a letter of credit pursuant to this subsection shall, at all times, have and maintain in escrow an operating cash reserve equal to 2 months' operating expenses as determined pursuant to s. 651.026.

(e) If the issuing financial institution no longer participates in the State of Florida Treasury Certificate of Deposit Program, such financial institution shall deposit as collateral with the department eligible securities, as


528586

prescribed by s. 625.52, having a market value equal to or greater than 100 percent of the stated amount of the letter of credit.

(7)(a) A provider may withdraw funds held in escrow without the approval of the office if:

1. The amount held in escrow exceeds the requirements of this section and if the withdrawal will not affect compliance with this section; or

2. The withdrawal is from a debt service reserve required to be held in escrow pursuant to a trust indenture or mortgage lien on the facility as described in paragraph (1)(b) and will be used to pay principal or interest payments, which may include property taxes and insurance, the debtor is obligated to pay when sufficient funds are not available on the next principal or interest payment due date.

The notice specified in paragraph (1)(b) must be sent to the office at least 10 days before debt service reserve funds may be withdrawn without prior approval.

Section 7. Subsection (2) of section 651.055, Florida Statutes, is amended to read:

651.055 Continuing care contracts; right to rescind.—

(2) A resident has the right to rescind a continuing care contract and receive a full refund of any funds paid, without penalty or forfeiture, within 7 days after executing the contract. However, if an individual signs a reservation agreement pursuant to s. 651.023(4) and fails to cancel such agreement within 30 days after executing the agreement and subsequently signs a residency contract pursuant to this section


528586

and rescinds the contract within 7 days, the forfeiture penalty authorized under s. 651.023(4)(b) may be deducted from the refund unless the individual can demonstrate extenuating circumstances, such as, but not limited to, the death or illness of a spouse or partner, a diagnosis of a chronic or terminal illness of the individual, or a change in financial or asset position which warrants cancellation of the contract. A resident may not be required to move into the facility designated in the contract before the expiration of the 7-day period. During the 7-day period, the resident's funds must be held in an escrow account or the provider may hold the check until the 7-day period expires ~~unless otherwise requested by the resident~~ pursuant to s. 651.033(3)(c).

Section 8. Paragraphs (a) and (d) of subsection (2) of section 651.081, Florida Statutes, are amended to read:

651.081 Residents' council.—

(2)(a) Each facility shall establish a residents' council created for the purpose of representing residents on matters set forth in s. 651.085. A residents' council has authority to establish and maintain its own governance documents, such as bylaws or operating agreements, policies, and operating procedures, which may include establishment of committees. A person is eligible to participate in residents' council matters, including elections, if the person meets the definition of a resident under s. 651.011. The residents' council shall be established through an election in which the residents, as defined in s. 651.011, vote by ballot, physically or by proxy. If the election is to be held during a meeting, a notice of the organizational meeting must be provided to all residents of the


528586

community at least 10 business days before the meeting. Notice may be given through internal mailboxes, communitywide newsletters, bulletin boards, in-house television stations, and other similar means of communication. An election creating a residents' council is valid if at least 40 percent of the total resident population participates in the election and a majority of the participants vote affirmatively for the council. The initial residents' council created under this section is valid for at least 12 months. A residents' organization formalized by bylaws and elected officials must be recognized as the residents' council under this section and s. 651.085. Within 30 days after the election of a newly elected president or chair of the residents' council, the provider shall give the president or chair a copy of this chapter and rules adopted thereunder, or direct him or her to the appropriate public website to obtain this information. Only one residents' council may represent residents before the governing body of the provider as described in s. 651.085(2).

(d) ~~A residents' council shall adopt its own bylaws and governance documents subject to the vote and approval of the residents. The residents' council shall provide for open meetings when appropriate.~~ The residents' council governing documents shall define the manner in which residents may submit an issue to the council and define a reasonable timeframe in which the residents' council shall respond to a resident submission or inquiry. A residents' council may include term limits in its governing documents to ensure consistent integration of new leaders. If a licensed facility files for bankruptcy under chapter 11 of the United States Bankruptcy

Code, 11 U.S.C. chapter 11, the facility, in its required filing of the 20 largest unsecured creditors with the United States Trustee, shall include the name and contact information of a designated resident selected by the residents' council, and a statement explaining that the designated resident was chosen by the residents' council to serve as a representative of the residents' interest on the creditors' committee, if appropriate.

Section 9. Paragraph (f) of subsection (1) of section 651.083, Florida Statutes, is amended to read:

651.083 Residents' rights.—

(1) No resident of any facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, by the State Constitution, or by the United States Constitution solely by reason of status as a resident of a facility. Each resident of a facility has the right to:

(f) 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. This right includes access to ombudsman volunteers or staff and advocates and the right to be a member of, and active in, and to associate with, advocacy or special interest groups or associations.

Section 10. Subsections (2), (3), and (5) of section 651.085, Florida Statutes, are amended to read:

651.085 Quarterly meetings between residents and the governing body of the provider; resident representation before the governing body of the provider.—

(2) A residents' council formed pursuant to s. 651.081, members of which are elected by the residents, shall nominate

528586

and elect ~~designate~~ a designated resident representative to represent them on matters specified in subsection (3) before the governing body of the provider. The initial designated resident representative elected under this section shall be elected to serve at least 12 months. The designated resident representative need not be a current member of the residents' council; however, such individual must meet the definition of a resident under s. 651.011.

(3) The designated resident representative shall be notified by a representative of the provider at least 14 days in advance of any meeting of the full governing body at which the annual budget and proposed changes or increases in resident fees or services are on the agenda or will be discussed. The designated resident representative shall be invited to attend and participate in that portion of the meeting designated for the discussion of such changes. A designated resident representative shall perform his or her duties in good faith. For a provider that owns or operates more than one facility in this state, each facility must have its own designated resident representative.

(5) The board of directors or governing board of a licensed provider may at its sole discretion allow a resident of the facility to be a voting member of the board or governing body of the facility. The board of directors or governing board of a licensed provider may establish specific criteria for the nomination, selection, and term of a resident as a member of the board or governing body. If the board or governing body of a licensed provider operates more than one licensed facility, regardless of whether the facility is in-state or out-of-state,

528586

the board or governing body may select at its sole discretion one resident from among its facilities to serve on the board of directors or governing body on a rotating basis. A resident who serves as a member of a board or governing body of the facility shall perform his or her duties in a fiduciary manner, including the duty of confidentiality, duty of care, duty of loyalty, and duty of obedience, as required of any individual serving on the board or governing body.

Section 11. Present paragraphs (e) through (k) and (l) of subsection (2) of section 651.091, Florida Statutes, are redesignated as paragraphs (f) through (l) and (n), respectively, new paragraph (e) and paragraph (m) are added to that subsection, and paragraph (m) is added to subsection (3) of that section, to read:

651.091 Availability, distribution, and posting of reports and records; requirement of full disclosure.—

(2) Every continuing care facility shall:

(e) Provide 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 and the president or chair of the residents' council within 60 days after issuance of the report.

(m) Notify the president or chair of the residents' council in writing of a change in management within 10 business days after the change.

(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, obtain written acknowledgment of receipt, and

528586

provide copies of the disclosure documents to the prospective resident or his or her legal representative, of the following information:

(m) Disclosure of whether the provider has one or more residents serving on its board or governing body and whether that individual has a vote or is serving in a nonvoting, ex officio capacity.

Section 12. Subsections (1) and (6) of section 651.105, Florida Statutes, are amended to read:

651.105 Examination.—

(1)(a) 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. For a provider as deemed accredited under s. 651.028, such examinations must take place at least once every 5 years. An examination covering the preceding 3 or 5 fiscal years of the provider, as applicable, must be commenced within 12 months after the end of the most recent fiscal year covered by the examination. Such examination may include events subsequent to the end of the most recent fiscal year and the events of any prior period which relate to possible violations of this chapter or which affect the present financial condition of the provider. At least once every 3 or 5 fiscal years, as applicable, the office shall conduct an interview in person, telephonically, or through electronic communication with the current president or chair of the residents' council, or another


528586

designated officer of the council if the president or chair is not available, as part of the examination process.

(b) Such examinations must 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.

~~(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.~~

Section 13. 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(24) ~~ss. 632.637(1)(e) and 651.011(23)~~ must provide written disclosure of such exemption to each person admitted to the facility. This disclosure must be written using language

528586

likely to be understood by the person and must briefly explain the exemption.

Section 14. Subsection (1) of 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. The last quarterly statement for a fiscal year is not required if a provider does not have pending a regulatory action level event, impairment, or a corrective action plan. If a provider falls below two or more of the thresholds set forth in s. 651.011(26) ~~s. 651.011(25)~~ at the end of any fiscal quarter, the provider shall submit to the office, at the same time as the quarterly statement, an explanation of the circumstances and a description of the actions it will take to meet the requirements.

Section 15. This act shall take effect July 1, 2023.

================ 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.; defining the terms “designated

528586

resident representative" and "residents' council"; amending s. 651.0246, F.S.; revising a condition for the release of certain escrowed funds to providers applying for expansions of certificated continuing care facilities; revising the timeframe in which the Office of Insurance Regulation must complete its review of an application for expansion; amending s. 651.026, F.S.; revising information required to be contained in certain providers' financial reports in their annual reports; amending s. 651.033, F.S.; revising a requirement for national banks in which escrow accounts are established; revising a condition under which a provider may hold and not deposit a resident's check for a specified period; amending s. 651.034, F.S.; revising the timeframe during which the office may exempt certain providers from certain regulatory actions; amending s. 651.035, F.S.; providing that certain documents relating to a provider's debt service reserve must require certain notice to the office before the withdrawal of debt service reserve funds; specifying requirements for the notice and for certain plans to replenish withdrawn funds; revising the calculation of minimum liquid reserve requirements for certain facilities; revising requirements for letters of credit which satisfy minimum liquid reserve requirements; revising circumstances under which a provider may withdraw funds held in escrow without the office's approval; making a technical change; amending s. 651.055, F.S.;

528586

specifying that a forfeiture penalty may be deducted from certain resident refunds except under certain circumstances; conforming a provision to changes made by the act; amending s. 651.081, F.S.; specifying the authority of residents' councils and the eligibility of persons to participate in residents' council matters; deleting a requirement for open meetings of residents' councils; amending s. 651.083, F.S.; specifying that a resident has the right to access ombudsman staff; amending s. 651.085, F.S.; requiring residents' councils to nominate and elect a designated resident representative to represent them on specified matters; providing requirements for designated resident representatives; revising meetings of the full governing body for which the designated resident representative must be notified; requiring each facility of certain providers to have its own designated resident representative; providing a requirement for certain designated resident representatives; amending s. 651.091, F.S.; adding reporting and notice requirements for continuing care facilities; adding a disclosure requirement for providers to prospective residents or their legal representatives; amending s. 651.105, F.S.; specifying requirements for the office's examination of providers and applicants for certificates of authority; deleting a requirement for a provider's representative to give examination reports and corrective action plans to the governing body's executive officer within a certain

528586

timeframe; amending ss. 651.012 and 651.0261, F.S.; conforming cross-references; providing an effective date.

140214

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/07/2023	.	
	.	
	.	
	.	

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

Senate Substitute for Amendment (528586) (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Present subsections (13) through (26) and (27) of section 651.011, Florida Statutes, are redesignated as subsections (14) through (27) and (29), respectively, and new subsection (13) and subsection (28) are added to that section,

140214

to read:

651.011 Definitions.—As used in this chapter, the term:

(13) "Designated resident representative" means a resident elected by the residents' council to represent residents on matters related to changes in fees or services as specified in s. 651.085(2) and (3).

(28) "Residents' council" means an organized body representing the resident population of a certified facility. A residents' council shall serve as a liaison between residents and the appropriate representative of the provider.

Section 2. Paragraph (a) of subsection (2), paragraph (b) of subsection (4), and subsection (6) of section 651.0246, Florida Statutes, are amended to read:

651.0246 Expansions.—

(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 certified public accountant ~~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.

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 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.

(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:

(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; or a provider has collected a reservation deposit for at least 75 percent of the proposed units for which an entrance fee is to be charged and the escrowed funds will be used for the sole purpose of paying secured indebtedness as specified in the feasibility study submitted pursuant to paragraph (2)(a). The minimum reservation deposit must be the lesser of $40,000 or 10 percent of the then-current entrance fee for the unit being reserved. If the expansion is to be completed in multiple phases, the 75 percent reservation requirement applies separately to each phase of the

expansion. 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.

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.

(6) Within 30 ~~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 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 3. Paragraph (b) of subsection (2) of section 651.026, Florida Statutes, is amended 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:

(b) A financial report 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 considered customary or necessary for full disclosure or adequate understanding of the financial report, financial condition, and operation.

3. If the provider's financial statements are consolidated or combined in accordance with generally accepted accounting principles with the financial statements of additional entities owned or controlled by the provider, the financial report must include as supplemental information a separate balance sheet, statement of income and expenses, statement of equity or fund balances, and statement of changes in cash flows for the individual provider and each additional entity comprising the consolidated or combined financial report.

4. If the provider is a member of an obligated group, the provider may use the obligated group's audited financial statements if they contain as supplemental information a separate balance sheet, statement of income and expenses, statement of equity or fund balances, and statement of changes in cash flows for the individual provider and other members of the obligated group.

Section 4. Paragraph (a) of subsection (1) and paragraph

(c) of subsection (3) of section 651.033, Florida Statutes, are amended, and paragraph (a) of subsection (3) of that section is republished, 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 be established in a Florida state-chartered bank, ~~Florida~~ savings bank ~~and loan association~~, or ~~Florida~~ trust company, or a federal savings or thrift association, bank, savings bank, or trust company ~~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 a branch in this state~~, which is acceptable to the office, or such funds must be deposited with the department and be kept and maintained in an account separate and apart from the provider’s business accounts.

(3) 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 be deposited with the escrow agent or as provided in paragraph (c). The escrow agent must 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 release the escrowed fees to the resident.

(c) As an alternative to paragraph (a) ~~At the request of an individual resident of a facility~~, the provider may hold the check for the 7-day period and may not deposit it during this time period. If the resident rescinds the contract within the 7-day period, the check must be immediately returned to the resident. Upon the expiration of the 7 days, the provider shall deposit the check.

Section 5. Subsection (6) of section 651.034, Florida Statutes, is amended to read:

651.034 Financial and operating requirements for providers.—

(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 end of the provider's fiscal year in which the certificate of occupancy was issued ~~date of issuance of the certificate of occupancy~~.

Section 6. Paragraph (b) of subsection (1), paragraph (a) of subsection (2), subsection (5), and paragraph (a) of subsection (7) of section 651.035, Florida Statutes, are amended 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:

(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 reserve 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. In addition, the trust indenture, loan agreement, or escrow agreement must provide that the provider, trustee, lender, escrow agent, or another person designated to act in their place shall notify the office in writing at least 10 days before the withdrawal of any portion of the debt service reserve funds required to be held in escrow as described in this paragraph. The notice must include an affidavit sworn to by the provider, the trustee, or a person designated to act in their place which includes the amount of the scheduled debt service payment, the payment due date, the amount of the withdrawal, the accounts from which the withdrawal will be made, and a plan with a schedule for replenishing the withdrawn funds. If the plan is revised by a consultant that is retained as prescribed in the provider's financing documents,

the revised plan must be submitted to the office within 10 days after approval by the lender or trustee. Any such separate debt service reserves are not subject to the transfer provisions set forth in subsection (8).

(2)(a) In facilities where not all residents are under continuing care or continuing care at-home contracts, the reserve requirements of subsection (1) shall be computed only with respect to the proportional share of operating expenses that are applicable to residents. For purposes of this calculation, the proportional share shall be based upon the ratio of residents under continuing care or continuing care at-home contracts to the total of all residents, including those residents who do not hold such contracts.

(5) A provider may satisfy the minimum liquid reserve requirements of this section by acquiring from a financial institution, as specified in paragraph (b), a clean, unconditional irrevocable letter of credit equal to the requirements of this section, less the amount of escrowed operating cash required by paragraph (d).

(a) The letter of credit must be issued by a financial institution participating in the State of Florida Treasury Certificate of Deposit Program; a Florida state-chartered bank, savings bank, or trust company; or a federal savings or thrift association, bank, savings bank, or trust company, and must be approved by the office before issuance and before any renewal or modification thereof. At a minimum, the letter of credit must provide for:

1. Ninety days’ prior written notice to both the provider and the office of the financial institution’s determination not

to renew or extend the term of the letter of credit.

2. Unless otherwise arranged by the provider to the satisfaction of the office, deposit by the financial institution of letter of credit funds in an account designated by the office no later than 30 days before the expiration of the letter of credit.

3. Deposit by the financial institution of letter of credit funds in an account designated by the office within 4 business days following written instructions from the office that, in the sole judgment of the office, funding of the minimum liquid reserve is required.

(b) The terms of the letter of credit must be approved by the office and the long-term debt of the financial institution providing such letter of credit must be rated in one of their top three long-term debt rating categories by either Moody’s Investors Service, Standard & Poor’s Corporation, or a recognized securities rating agency acceptable to the office.

(c) The letter of credit must name the office as beneficiary.

(d) Notwithstanding any other provision of this section, a provider using a letter of credit pursuant to this subsection shall, at all times, have and maintain in escrow an operating cash reserve equal to 2 months’ operating expenses as determined pursuant to s. 651.026.

(e) If the issuing financial institution no longer participates in the State of Florida Treasury Certificate of Deposit Program, such financial institution shall deposit as collateral with the department eligible securities, as prescribed by s. 625.52, having a market value equal to or

greater than 100 percent of the stated amount of the letter of credit.

(7)(a) A provider may withdraw funds held in escrow without the approval of the office if:

1. The amount held in escrow exceeds the requirements of this section and if the withdrawal will not affect compliance with this section; or

2. The withdrawal is from a debt service reserve required to be held in escrow pursuant to a trust indenture or mortgage lien on the facility as described in paragraph (1)(b) and will be used to pay principal or interest payments, which may include property taxes and insurance, the debtor is obligated to pay when sufficient funds are not available on the next principal or interest payment due date.

The notice specified in paragraph (1)(b) must be sent to the office at least 10 days before debt service reserve funds may be withdrawn without prior approval.

Section 7. Subsection (2) of section 651.055, Florida Statutes, is amended to read:

651.055 Continuing care contracts; right to rescind.—

(2) A resident has the right to rescind a continuing care contract and receive a full refund of any funds paid, without penalty or forfeiture, within 7 days after executing the contract. However, if an individual signs a reservation agreement pursuant to s. 651.023(4) and fails to cancel such agreement within 30 days after executing the agreement and subsequently signs a residency contract pursuant to this section and rescinds the contract within 7 days, the forfeiture penalty

authorized under s. 651.023(4)(b) may be deducted from the refund unless the individual can demonstrate extenuating circumstances, such as, but not limited to, the death or illness of a spouse or partner, a diagnosis of a chronic or terminal illness of the individual, or a change in financial or asset position which warrants cancellation of the contract. A resident may not be required to move into the facility designated in the contract before the expiration of the 7-day period. During the 7-day period, the resident's funds must be held in an escrow account or the provider may hold the check until the 7-day period expires ~~unless otherwise requested by the resident~~ pursuant to s. 651.033(3)(c).

Section 8. Paragraphs (a) and (d) of subsection (2) of section 651.081, Florida Statutes, are amended to read:

651.081 Residents' council.—

(2)(a) Each facility shall establish a residents' council created for the purpose of representing residents on matters set forth in s. 651.085. A residents' council has authority to establish and maintain its own governance documents, such as bylaws or operating agreements, policies, and operating procedures, which may include establishment of committees. A person is eligible to participate in residents' council matters, including elections, if the person meets the definition of a resident under s. 651.011. The residents' council shall be established through an election in which the residents, as defined in s. 651.011, vote by ballot, physically or by proxy. If the election is to be held during a meeting, a notice of the organizational meeting must be provided to all residents of the community at least 10 business days before the meeting. Notice

140214

may be given through internal mailboxes, communitywide newsletters, bulletin boards, in-house television stations, and other similar means of communication. An election creating a residents' council is valid if at least 40 percent of the total resident population participates in the election and a majority of the participants vote affirmatively for the council. The initial residents' council created under this section is valid for at least 12 months. A residents' organization formalized by bylaws and elected officials must be recognized as the residents' council under this section and s. 651.085. Within 30 days after the election of a newly elected president or chair of the residents' council, the provider shall give the president or chair a copy of this chapter and rules adopted thereunder, or direct him or her to the appropriate public website to obtain this information. Only one residents' council may represent residents before the governing body of the provider as described in s. 651.085(2).

(d) ~~A residents' council shall adopt its own bylaws and governance documents subject to the vote and approval of the residents. The residents' council shall provide for open meetings when appropriate.~~ The residents' council governing documents shall define the manner in which residents may submit an issue to the council and define a reasonable timeframe in which the residents' council shall respond to a resident submission or inquiry. A residents' council may include term limits in its governing documents to ensure consistent integration of new leaders. If a licensed facility files for bankruptcy under chapter 11 of the United States Bankruptcy Code, 11 U.S.C. chapter 11, the facility, in its required filing

140214

of the 20 largest unsecured creditors with the United States Trustee, shall include the name and contact information of a designated resident selected by the residents' council, and a statement explaining that the designated resident was chosen by the residents' council to serve as a representative of the residents' interest on the creditors' committee, if appropriate.

Section 9. Paragraph (f) of subsection (1) of section 651.083, Florida Statutes, is amended to read:

651.083 Residents' rights.—

(1) No resident of any facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, by the State Constitution, or by the United States Constitution solely by reason of status as a resident of a facility. Each resident of a facility has the right to:

(f) 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. This right includes access to ombudsman volunteers or staff and advocates and the right to be a member of, and active in, and to associate with, advocacy or special interest groups or associations.

Section 10. Subsections (2), (3), and (5) of section 651.085, Florida Statutes, are amended to read:

651.085 Quarterly meetings between residents and the governing body of the provider; resident representation before the governing body of the provider.—

(2) A residents' council formed pursuant to s. 651.081, members of which are elected by the residents, shall nominate and elect ~~designate~~ a designated resident representative to

140214

represent them on matters specified in subsection (3) before the governing body of the provider. The initial designated resident representative elected under this section shall be elected to serve at least 12 months. The designated resident representative need not be a current member of the residents' council; however, such individual must meet the definition of a resident under s. 651.011.

(3) The designated resident representative shall be notified by a representative of the provider at least 14 days in advance of any meeting of the full governing body at which the annual budget and proposed changes or increases in resident fees or services are on the agenda or will be discussed. The designated resident representative shall be invited to attend and participate in that portion of the meeting designated for the discussion of such changes. A designated resident representative shall perform his or her duties in good faith. For a provider that owns or operates more than one facility in this state, each facility must have its own designated resident representative.

(5) The board of directors or governing board of a licensed provider may at its sole discretion allow a resident of the facility to be a voting member of the board or governing body of the facility. The board of directors or governing board of a licensed provider may establish specific criteria for the nomination, selection, and term of a resident as a member of the board or governing body. If the board or governing body of a licensed provider operates more than one licensed facility, regardless of whether the facility is in-state or out-of-state, the board or governing body may select at its sole discretion

140214

one resident from among its facilities to serve on the board of directors or governing body on a rotating basis. A resident who serves as a member of a board or governing body of the facility shall perform his or her duties in a fiduciary manner, including the duty of confidentiality, duty of care, duty of loyalty, and duty of obedience, as required of any individual serving on the board or governing body.

Section 11. Present paragraphs (e) through (k) and (l) of subsection (2) of section 651.091, Florida Statutes, are redesignated as paragraphs (f) through (l) and (n), respectively, new paragraph (e) and paragraph (m) are added to that subsection, and paragraph (m) is added to subsection (3) of that section, to read:

651.091 Availability, distribution, and posting of reports and records; requirement of full disclosure.—

(2) Every continuing care facility shall:

(e) Provide 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 and the president or chair of the residents' council within 60 days after issuance of the report.

(m) Notify the president or chair of the residents' council in writing of a change in management within 10 business days after the change.

(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, obtain written acknowledgment of receipt, and provide copies of the disclosure documents to the prospective

resident or his or her legal representative, of the following information:

(m) Disclosure of whether the provider has one or more residents serving on its board or governing body and whether that individual has a vote or is serving in a nonvoting, ex officio capacity.

Section 12. Subsections (1) and (6) of section 651.105, Florida Statutes, are amended to read:

651.105 Examination.—

(1)(a) 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. For a provider as deemed accredited under s. 651.028, such examinations must take place at least once every 5 years. An examination covering the preceding 3 or 5 fiscal years of the provider, as applicable, must be commenced within 12 months after the end of the most recent fiscal year covered by the examination. Such examination may include events subsequent to the end of the most recent fiscal year and the events of any prior period which relate to possible violations of this chapter or which affect the present financial condition of the provider. At least once every 3 or 5 fiscal years, as applicable, the office shall conduct an interview in person, telephonically, or through electronic communication with the current president or chair of the residents' council, or another designated officer of the council if the president or chair is

not available, as part of the examination process.

(b) Such examinations must 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.

~~(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.~~

Section 13. 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(24) ~~ss. 632.637(1)(e) and 651.011(23)~~ must provide written disclosure of such exemption to each person admitted to the facility. This disclosure must be written using language likely to be understood by the person and must briefly explain

the exemption.

Section 14. Subsection (1) of 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. The last quarterly statement for a fiscal year is not required if a provider does not have pending a regulatory action level event, impairment, or a corrective action plan. If a provider falls below two or more of the thresholds set forth in s. 651.011(26) ~~s. 651.011(25)~~ at the end of any fiscal quarter, the provider shall submit to the office, at the same time as the quarterly statement, an explanation of the circumstances and a description of the actions it will take to meet the requirements.

Section 15. This act shall take effect July 1, 2023.

================ 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.; defining the terms "designated resident representative" and "residents' council";

140214

amending s. 651.0246, F.S.; revising a requirement for specified information that must be submitted by a provider applying for expansion of a certificated continuing care facility; revising a condition for the release of certain escrowed funds to providers; revising the timeframe in which the Office of Insurance Regulation must complete its review of an application for expansion; amending s. 651.026, F.S.; revising information required to be contained in certain providers' financial reports in their annual reports; amending s. 651.033, F.S.; revising financial institutions in which escrow accounts must be established; revising a condition under which a provider may hold and not deposit a resident's check for a specified period; amending s. 651.034, F.S.; revising the timeframe during which the office may exempt certain providers from certain regulatory actions; amending s. 651.035, F.S.; providing that certain documents relating to a provider's debt service reserve must require certain notice to the office before the withdrawal of debt service reserve funds; specifying requirements for the notice and for certain plans to replenish withdrawn funds; revising the calculation of minimum liquid reserve requirements for certain facilities; revising requirements for letters of credit which satisfy minimum liquid reserve requirements; revising circumstances under which a provider may withdraw funds held in escrow without the office's approval; making a technical change; amending

s. 651.055, F.S.; specifying that a forfeiture penalty may be deducted from certain resident refunds except under certain circumstances; conforming a provision to changes made by the act; amending s. 651.081, F.S.; specifying the authority of residents' councils and the eligibility of persons to participate in residents' council matters; deleting a requirement for open meetings of residents' councils; amending s. 651.083, F.S.; specifying that a resident has the right to access ombudsman staff; amending s. 651.085, F.S.; requiring residents' councils to nominate and elect a designated resident representative to represent them on specified matters; providing requirements for designated resident representatives; revising meetings of the full governing body for which the designated resident representative must be notified; requiring each facility of certain providers to have its own designated resident representative; providing a requirement for certain designated resident representatives; amending s. 651.091, F.S.; adding reporting and notice requirements for continuing care facilities; adding a disclosure requirement for providers to prospective residents or their legal representatives; amending s. 651.105, F.S.; specifying requirements for the office's examination of providers and applicants for certificates of authority; deleting a requirement for a provider's representative to give examination reports and corrective action plans to the governing

body’s executive officer within a certain timeframe; amending ss. 651.012 and 651.0261, F.S.; conforming cross-references; providing an effective date.

By Senator Yarborough

4-00524A-23 2023622__

A bill to be entitled

An act relating to continuing care contracts; amending s. 651.011, F.S.; defining the terms "designated resident representative" and "residents' council"; amending s. 651.0246, F.S.; revising requirements for feasibility studies submitted by providers applying for expansions of certificated continuing care facilities; revising a condition for the release of certain escrowed funds to a provider; revising the timeframe in which the Office of Insurance Regulation must complete its review of an application for expansion; amending s. 651.026, F.S.; revising information required to be contained in certain providers' financial reports in their annual reports; amending s. 651.033, F.S.; revising a requirement for national banks in which escrow accounts are established; revising a condition under which a provider may hold and not deposit a resident's check for a specified period; amending s. 651.034, F.S.; revising the timeframe during which the office may exempt certain providers from certain regulatory actions; authorizing the office, upon a provider's written request, to temporarily suspend financial and operating requirements under ch. 651, F.S., for specified reasons; specifying conditions and requirements for such temporary suspensions; amending s. 651.035, F.S.; providing that certain documents relating to a provider's debt service reserve must require certain notice to the office before the

4-00524A-23 2023622__

withdrawal of debt service reserve funds; specifying requirements for the notice and for certain plans to replenish withdrawn funds; revising the calculation of minimum liquid reserve requirements for certain facilities; revising requirements for letters of credit which satisfy minimum liquid reserve requirements; revising circumstances under which a provider may withdraw funds held in escrow without the office's approval; making a technical change; amending s. 651.055, F.S.; specifying that a forfeiture penalty may be deducted from certain resident refunds except under certain circumstances; conforming a provision to changes made by the act; amending s. 651.081, F.S.; specifying the authority of residents' councils and the eligibility of persons to participate in residents' council matters; deleting a requirement for open meetings of residents' councils; amending s. 651.083, F.S.; specifying that a resident has the right to access ombudsman staff; amending s. 651.085, F.S.; requiring residents' councils to nominate and elect a designated resident representative to represent them on specified matters; providing requirements for designated resident representatives; revising meetings of the full governing body for which the designated resident representative must be notified; requiring each facility of certain providers to have its own designated resident representative; providing a requirement for certain designated resident representatives; amending s. 651.091, F.S.;

adding reporting and notice requirements for continuing care facilities; adding a disclosure requirement for providers to prospective residents or their legal representatives; amending s. 651.105, F.S.; specifying requirements for the office's examination of providers and applicants for certificates of authority; deleting a requirement for a provider's representative to give examination reports and corrective action plans to the governing body's executive officer within a certain timeframe; amending s. 651.118, F.S.; revising applicability of a specified time limit on the use of sheltered nursing home beds for certain persons; amending ss. 651.012 and 651.0261, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Present subsections (13) through (26) and (27) of section 651.011, Florida Statutes, are redesignated as subsections (14) through (27) and (29), respectively, and new subsection (13) and subsection (28) are added to that section, to read:

651.011 Definitions.—As used in this chapter, the term:

(13) "Designated resident representative" means a resident elected by the residents' council to represent residents on matters related to changes in fees or services as specified in s. 651.085(2) and (3).

(28) "Residents' council" means an organized body

representing the resident population of a certified facility. A residents' council shall serve as a liaison between residents and the appropriate representative of the provider.

Section 2. Paragraph (a) of subsection (2), paragraph (b) of subsection (4), and subsection (6) of section 651.0246, Florida Statutes, are amended to read:

651.0246 Expansions.—

(2) A provider applying for expansion of a certificated facility must submit all of the following:

(a) A feasibility study prepared by an independent consultant which includes an independent evaluation and examination opinion or compilation report for the first 5 years of operations, or a comparable opinion acceptable to the office, of the underlying assumptions used as a basis for the forecasts or projections in the study prepared in accordance with applicable professional standards adopted by the American Institute of Certified Public Accountants or standards for feasibility studies for continuing care retirement communities adopted by the Actuarial Standards Board ~~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.

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 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.

(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:

(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; or at least 75 percent of the proposed units for which an entrance fee is charged for a phase or a total of the combined phases are reserved and the provider submits an attestation to the office to use the entrance fees collected and held in escrow for the sole purpose of paying secured indebtedness as specified in the feasibility study submitted to the office pursuant to paragraph (2)(a). If the expansion is to be completed in multiple phases, the 75 percent

reservation requirement applies separately to each phase of the expansion. 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.

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.

(6) Within 30 ~~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 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 3. Paragraph (b) of subsection (2) of section 651.026, Florida Statutes, is amended 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:

(b) A financial report 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 considered customary or necessary for full disclosure or adequate understanding of the financial report, financial condition, and operation.

3. If the provider's financial statements are consolidated or combined in accordance with generally accepted accounting principles with the financial statements of additional entities owned or controlled by the provider, the financial report must provide as supplemental information the financial statements of the provider with the items in subparagraph 1. for the individual facility shown separately and its consolidated or combined entities comprising the financial report.

4. If the facility is a member of an obligated group, the facility may use the obligated group's audited financial statements if they contain the items in subparagraph 1. for the individual facility shown separately from other members of the obligated group.

Section 4. Paragraph (a) of subsection (1) and paragraph (c) of subsection (3) of section 651.033, Florida Statutes, are amended, and paragraph (a) of subsection (3) of that section is

republished, 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 be established in a Florida bank, Florida savings and loan association, 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 a branch in this state~~, which is acceptable to the office, or such funds must be deposited with the department and be kept and maintained in an account separate and apart from the provider's business accounts.

(3) 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 be deposited with the escrow agent or as provided in paragraph (c). The escrow agent must 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 release the escrowed fees to the resident.

(c) As an alternative to paragraph (a) ~~At the request of an individual resident of a facility~~, the provider may hold the check for the 7-day period and may not deposit it during this time period. If the resident rescinds the contract within the 7-day period, the check must be immediately returned to the resident. Upon the expiration of the 7 days, the provider shall deposit the check.

Section 5. Present subsection (7) of section 651.034, Florida Statutes, is redesignated as subsection (8), a new subsection (7) is added to that section, and subsection (6) of that section is amended, to read:

651.034 Financial and operating requirements for providers.—

(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 end of the provider's fiscal year in which the certificate of occupancy was issued ~~date of issuance of the certificate of occupancy~~.

(7) Upon written request of a provider, the office may temporarily suspend all or a portion of financial and operating requirements under this chapter due to an extraordinary event rendering the provider incapable of continuing normal operations such as, but not limited to, a pandemic, a fire, or a federal or state executive order declaring a natural disaster which forces the provider to evacuate, curtail operations, restrict

admissions, or suspend marketing for lifesafety reasons or repairs related to the event. Such temporary suspension may be granted by the office if the provider maintains compliance with ss. 651.026, 651.0261, and 651.035 and the provider is not insolvent or impaired. The provider shall comply with required reporting requested by the office, including the estimated time for completing repairs or remediating problems related to restrictions on admissions or marketing. When determining whether to grant a suspension of specific regulatory requirements, the office shall consider any formal action or amendments approved by a lender or trustee to the provider's lending agreements or bond covenants as a result of the event.

Section 6. Paragraph (b) of subsection (1), paragraph (a) of subsection (2), subsection (5), and paragraph (a) of subsection (7) of section 651.035, Florida Statutes, are amended 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:

(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 reserve 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. In addition, the trust indenture, loan agreement, or escrow agreement must provide that the provider, trustee, lender, escrow agent, or another person designated to act in their place shall notify the office in writing at least 10 days before the withdrawal of any portion of the debt service reserve funds required to be held in escrow as described in this paragraph. The notice must include an affidavit sworn to by the provider, the trustee, or a person designated to act in their place which includes the amount of the scheduled debt service payment, the payment due date, the amount of the withdrawal, the accounts from which the withdrawal will be made, and a plan with a schedule for replenishing the withdrawn funds. If the plan is revised by a consultant that is retained as prescribed in the provider's financing documents, the revised plan must be submitted to the office within 10 days after approval by the lender or trustee. Any such separate debt service reserves are not subject to the transfer provisions set forth in subsection (8).

(2)(a) In facilities where not all residents are under continuing care or continuing care at-home contracts, the reserve requirements of subsection (1) shall be computed only with respect to the proportional share of operating expenses that are applicable to residents. For purposes of this calculation, the proportional share shall be based upon the ratio of residents under continuing care or continuing care at-

home contracts to the total of all residents, including those residents who do not hold such contracts.

(5) A provider may satisfy the minimum liquid reserve requirements of this section by acquiring from a financial institution, as specified in paragraph (b), a clean, unconditional irrevocable letter of credit equal to the requirements of this section, less the amount of escrowed operating cash required by paragraph (d).

(a) The letter of credit must be issued by a financial institution participating in the State of Florida Treasury Certificate of Deposit Program or a Florida bank, a Florida savings and loan association, a 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 must be approved by the office before issuance and before any renewal or modification thereof. At a minimum, the letter of credit must provide for:

1. Ninety days' prior written notice to both the provider and the office of the financial institution's determination not to renew or extend the term of the letter of credit.

2. Unless otherwise arranged by the provider to the satisfaction of the office, deposit by the financial institution of letter of credit funds in an account designated by the office no later than 30 days before the expiration of the letter of credit.

3. Deposit by the financial institution of letter of credit funds in an account designated by the office within 4 business days following written instructions from the office that, in the sole judgment of the office, funding of the minimum liquid

reserve is required.

(b) The terms of the letter of credit must be approved by the office and the long-term debt of the financial institution providing such letter of credit must be rated in one of their top three long-term debt rating categories by either Moody's Investors Service, Standard & Poor's Corporation, or a recognized securities rating agency acceptable to the office.

(c) The letter of credit must name the office as beneficiary.

(d) Notwithstanding any other provision of this section, a provider using a letter of credit pursuant to this subsection shall, at all times, have and maintain in escrow an operating cash reserve equal to 2 months' operating expenses as determined pursuant to s. 651.026.

(e) If the issuing financial institution no longer participates in the State of Florida Treasury Certificate of Deposit Program, such financial institution shall deposit as collateral with the department eligible securities, as prescribed by s. 625.52, having a market value equal to or greater than 100 percent of the stated amount of the letter of credit.

(7)(a) A provider may withdraw funds held in escrow without the approval of the office if:

1. The amount held in escrow exceeds the requirements of this section and if the withdrawal will not affect compliance with this section; or

2. The withdrawal is from a debt service reserve required to be held in escrow pursuant to a trust indenture or mortgage lien on the facility as described in paragraph (1)(b) and will

be used to pay delinquent principal and interest payments the debtor is obligated to pay on the facility.

Section 7. Subsection (2) of section 651.055, Florida Statutes, is amended to read:

651.055 Continuing care contracts; right to rescind.—

(2) A resident has the right to rescind a continuing care contract and receive a full refund of any funds paid, without penalty or forfeiture, within 7 days after executing the contract. However, if an individual signs a reservation agreement pursuant to s. 651.023(4) and fails to cancel such agreement within 30 days after executing the agreement and subsequently signs a contract and rescinds the contract within 7 days, the forfeiture penalty authorized under s. 651.023(4)(b) may be deducted from the refund unless the individual can demonstrate extenuating circumstances, such as, but not limited to, the death or illness of a spouse or partner, a diagnosis of a chronic or terminal illness of the individual, or a change in financial or asset position which warrants cancellation of the contract. A resident may not be required to move into the facility designated in the contract before the expiration of the 7-day period. During the 7-day period, the resident's funds must be held in an escrow account or the provider may hold the check until the 7-day period expires ~~unless otherwise requested by the resident~~ pursuant to s. 651.033(3)(c).

Section 8. Paragraphs (a) and (d) of subsection (2) of section 651.081, Florida Statutes, are amended to read:

651.081 Residents' council.—

(2)(a) Each facility shall establish a residents' council created for the purpose of representing residents on matters set

forth in s. 651.085. A residents' council has authority to establish and maintain its own governance documents, such as bylaws or operating agreements, policies, and operating procedures, which may include establishment of committees. A person is eligible to participate in residents' council matters, including elections, if the person meets the definition of a resident under s. 651.011. The residents' council shall be established through an election in which the residents, as defined in s. 651.011, vote by ballot, physically or by proxy. If the election is to be held during a meeting, a notice of the organizational meeting must be provided to all residents of the community at least 10 business days before the meeting. Notice may be given through internal mailboxes, communitywide newsletters, bulletin boards, in-house television stations, and other similar means of communication. An election creating a residents' council is valid if at least 40 percent of the total resident population participates in the election and a majority of the participants vote affirmatively for the council. The initial residents' council created under this section is valid for at least 12 months. A residents' organization formalized by bylaws and elected officials must be recognized as the residents' council under this section and s. 651.085. Within 30 days after the election of a newly elected president or chair of the residents' council, the provider shall give the president or chair a copy of this chapter and rules adopted thereunder, or direct him or her to the appropriate public website to obtain this information. Only one residents' council may represent residents before the governing body of the provider as described in s. 651.085(2).

(d) ~~A residents' council shall adopt its own bylaws and governance documents subject to the vote and approval of the residents. The residents' council shall provide for open meetings when appropriate.~~ The residents' council governing documents shall define the manner in which residents may submit an issue to the council and define a reasonable timeframe in which the residents' council shall respond to a resident submission or inquiry. A residents' council may include term limits in its governing documents to ensure consistent integration of new leaders. If a licensed facility files for bankruptcy under chapter 11 of the United States Bankruptcy Code, 11 U.S.C. chapter 11, the facility, in its required filing of the 20 largest unsecured creditors with the United States Trustee, shall include the name and contact information of a designated resident selected by the residents' council, and a statement explaining that the designated resident was chosen by the residents' council to serve as a representative of the residents' interest on the creditors' committee, if appropriate.

Section 9. Paragraph (f) of subsection (1) of section 651.083, Florida Statutes, is amended to read:

651.083 Residents' rights.—

(1) No resident of any facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, by the State Constitution, or by the United States Constitution solely by reason of status as a resident of a facility. Each resident of a facility has the right to:

(f) 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. This right includes access to ombudsman volunteers or staff and advocates and the right to be a member of, and active in, and to associate with, advocacy or special interest groups or associations.

Section 10. Subsections (2), (3), and (5) of section 651.085, Florida Statutes, are amended to read:

651.085 Quarterly meetings between residents and the governing body of the provider; resident representation before the governing body of the provider.—

(2) A residents' council formed pursuant to s. 651.081, members of which are elected by the residents, shall nominate and elect ~~designate~~ a designated resident representative to represent them on matters specified in subsection (3) before the governing body of the provider. The initial designated resident representative elected under this section shall be elected to serve at least 12 months. The designated resident representative need not be a current member of the residents' council; however, such individual must meet the definition of a resident under s. 651.011.

(3) The designated resident representative shall be notified by a representative of the provider at least 14 days in advance of any meeting of the full governing body at which the annual budget and proposed changes or increases in resident fees or services are on the agenda or will be discussed. The designated resident representative shall be invited to attend and participate in that portion of the meeting designated for the discussion of such changes. A designated resident representative shall perform his or her duties in good faith. For a provider that owns or operates more than one facility in

this state, each facility must have its own designated resident representative.

(5) The board of directors or governing board of a licensed provider may at its sole discretion allow a resident of the facility to be a voting member of the board or governing body of the facility. The board of directors or governing board of a licensed provider may establish specific criteria for the nomination, selection, and term of a resident as a member of the board or governing body. If the board or governing body of a licensed provider operates more than one licensed facility, regardless of whether the facility is in-state or out-of-state, the board or governing body may select at its sole discretion one resident from among its facilities to serve on the board of directors or governing body on a rotating basis. A resident who serves as a member of a board or governing body of the facility shall perform his or her duties in a fiduciary manner, including the duty of confidentiality, duty of care, duty of loyalty, and duty of obedience, as required of any individual serving on the board or governing body.

Section 11. Present paragraphs (e) through (k) and (l) of subsection (2) of section 651.091, Florida Statutes, are redesignated as paragraphs (f) through (l) and (n), respectively, new paragraph (e) and paragraph (m) are added to that subsection, and paragraph (m) is added to subsection (3) of that section, to read:

651.091 Availability, distribution, and posting of reports and records; requirement of full disclosure.—

(2) Every continuing care facility shall:

(e) Provide 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 and the president or chair of the residents' council within 60 days after issuance of the report.

(m) Notify the president or chair of the residents' council in writing of a change in management within 10 business days after the change.

(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, obtain written acknowledgment of receipt, and provide copies of the disclosure documents to the prospective resident or his or her legal representative, of the following information:

(m) Disclosure of whether the provider has one or more residents serving on its board or governing body and whether that individual has a vote or is serving in a nonvoting, ex officio capacity.

Section 12. Subsections (1) and (6) of section 651.105, Florida Statutes, are amended to read:

651.105 Examination.—

(1)(a) 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. For a provider as deemed accredited under s. 651.028, such examinations must take place at least

once every 5 years. The examination must cover the preceding 3 or 5 fiscal years of the provider, whichever is applicable, and must be commenced within 12 months after the end of the most recent fiscal year covered by the examination. The examination may include events subsequent to the end of the most recent fiscal year and the events of any prior period which affect the present financial condition of the provider. As part of the examination, the office shall conduct an interview in person, telephonically, or through electronic communication with the current president or chair of the residents' council, or another designated officer of the council if the president or chair is not available.

(b) Such examinations must 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.

~~(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.~~

Section 13. Subsection (7) of section 651.118, Florida Statutes, is amended to read:

651.118 Agency for Health Care Administration; certificates of need; sheltered beds; community beds.—

(7) Notwithstanding subsection (2), at the discretion of the provider, sheltered nursing home beds may be used for persons who are not residents of the continuing care facility and who are not parties to a continuing care contract for up to 5 years after the date of issuance of the initial nursing home license. A provider whose 5-year period has expired or is expiring may request an extension from the Agency for Health Care Administration, not to exceed 30 percent of the total sheltered nursing home beds or 30 sheltered beds, whichever is greater, if the utilization by residents of the nursing home facility in the sheltered beds will not generate sufficient income to cover nursing home facility expenses, as evidenced by one of the following:

(a) The nursing home facility has a net loss for the most recent fiscal year as determined under generally accepted accounting principles, excluding the effects of extraordinary or unusual items, as demonstrated in the most recently audited financial statement.

(b) The nursing home facility would have had a pro forma loss for the most recent fiscal year, excluding the effects of extraordinary or unusual items, if revenues were reduced by the amount of revenues from persons in sheltered beds who were not

residents, as reported by a certified public accountant.

The Agency for Health Care Administration may grant an extension to the provider based on the evidence required in this subsection. The Agency for Health Care Administration may request a continuing care facility to use up to 25 percent of the patient days generated by new admissions of nonresidents during the extension period to serve Medicaid recipients for those beds authorized for extended use if there is a demonstrated need in the respective service area and if funds are available. A provider who obtains an extension is prohibited from applying for additional sheltered beds under subsection (2), unless additional residential units are built or the provider can demonstrate need by continuing care facility residents to the Agency for Health Care Administration. The 5-year limit does not apply to sheltered beds designated for post-acute care as part of a contractual agreement with a health care delivery system with at least one facility licensed under chapter 395 or up to five sheltered beds designated for inpatient hospice care as part of a contractual arrangement with a hospice licensed under part IV of chapter 400. A continuing care facility that uses such beds after the 5-year period shall report such use to the Agency for Health Care Administration. For purposes of this subsection, "resident" means a person who, upon admission to the continuing care facility, initially resides in a part of the continuing care facility not licensed under part II of chapter 400, or who contracts for continuing care at-home.

Section 14. 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(24) ~~ss. 632.637(1)(c) and 651.011(23)~~ must provide written disclosure of such exemption to each person admitted to the facility. This disclosure must be written using language likely to be understood by the person and must briefly explain the exemption.

Section 15. Subsection (1) of 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. The last quarterly statement for a fiscal year is not required if a provider does not have pending a regulatory action level event, impairment, or a corrective action plan. If a provider falls below two or more of the thresholds set forth in s. 651.011(26) ~~s. 651.011(25)~~ at the end of any fiscal quarter, the provider shall submit to the office, at the same time as the quarterly statement, an explanation of the circumstances and a description of the actions it will take to meet the requirements.

Section 16. This act shall take effect July 1, 2023.

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

April 5 2023
Meeting Date

Banking and Insurance
Committee

622
Bill Number or Topic

strike all
Amendment Barcode (if applicable)

Name Bennett Napier

Phone 850-906-9314

Address 325 John Knox Road, L103
Street

Email bennett@executiveoffice.org

Tallahassee FL 32303
City *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Florida Life Care Residents Association

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

April 5, 2023
Meeting Date

Banking and Insurance
Committee

SB 622
Bill Number or Topic

Amendment Barcode (if applicable)

Name Steve Bahmer

Phone (850) 671-3700

Address 1812 Riggins Road
Street

Email sbahmer@leadingageflorida.org

Tallahassee FL 32308
City *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
LeadingAge Florida

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

Committee Agenda Request

To: Senator Jim Boyd, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: February 23, 2023

I respectfully request that **Senate Bill #622**, relating to Continuing Care Contracts, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Clay Yarborough

Senator Clay Yarborough
Florida Senate, District 4

File signed original with committee office

S-020 (03/2004)

From: Johnson, Lisa
To: Canty, Amaura
Subject: CCRC CS/SB 622 fiscal
Date: Thursday, April 6, 2023 5:30:45 PM

Referenced in footnote 69 of the analysis.

From: Jacobs, Kevin <Kevin.Jacobs@floir.com>
Sent: Tuesday, April 4, 2023 5:07 PM
To: Johnson, Lisa <Johnson.Lisa@flsenate.gov>; Lloyd, Eric <Eric.Lloyd@myfloridahouse.gov>
Cc: Wheeler, Jillian <Jillian.Wheeler@floir.com>
Subject: CCRC fiscal

To ensure that CCRC exams and investigations of consumer inquiries and complaints are completed in a timely manner, OIR would need one additional Financial Control Analyst. OIR requires an additional $90,000 in salaries and benefits ($60,000 in rate) as well as $11,051 in expense with $4,682 nonrecurring to fill this new position. Additionally, OIR needs an additional $15,000 in salaries and benefits ($10,000 in rate) to address vacancies, retain current employees, and reduce attrition.

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Banking and Insurance
ITEM: SB 622
FINAL ACTION: Favorable with Committee Substitute
MEETING DATE: Wednesday, April 5, 2023
TIME: 8:30—10:30 a.m.
PLACE: 412 Knott Building

FINAL VOTE			4/05/2023 1 Motion to vote "YEA" after Roll Call Powell		4/05/2023 2 Motion to vote "YEA" after Roll Call Burgess		4/05/2023 3 Delete-all Amendment 528586 Yarborough	
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
		Broxson						
VA		Burgess						
X		Burton						
X		Hutson						
X		Ingoglia						
X		Mayfield						
VA		Powell						
X		Thompson						
		Torres						
		Trumbull						
X		DiCeglie, VICE CHAIR						
X		Boyd, CHAIR						
9	0	**TOTALS**	FAV	-	FAV	-	-	RS
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Banking and Insurance
ITEM: SB 622
FINAL ACTION: Favorable with Committee Substitute
MEETING DATE: Wednesday, April 5, 2023
TIME: 8:30—10:30 a.m.
PLACE: 412 Knott Building

	4/05/2023 4 Substitute Amendment 140214 Yarborough							
SENATORS	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
Broxson								
Burgess								
Burton								
Hutson								
Ingoglia								
Mayfield								
Powell								
Thompson								
Torres								
Trumbull								
DiCeglie, VICE CHAIR								
Boyd, CHAIR								
TOTALS	RCS **Yea**	- **Nay**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

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 1344
INTRODUCER:	Senator Bradley
SUBJECT:	Medical Treatment Under the Workers' Compensation Law
DATE:	April 5, 2023
REVISED:	

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

I. Summary:

SB 1344 increases the maximum medical reimbursements for physicians and surgical procedures and the maximum fees for expert witnesses under ch. 440, F.S., "Workers Compensation Law" (law) The law requires employers to provide injured employees all medically necessary remedial treatment, care, and attendance for such period as the nature of the injury or the process of recovery may require.

The bill increases the maximum reimbursement allowances (MRA) for physicians and surgical procedures to 200 percent of Medicare. Currently, the maximum reimbursement allowance for a physician licensed under ch. 458, F.S., or ch. 459, F.S., is 110 percent of Medicare and the maximum reimbursement allowance for surgical procedures is 140 percent of Medicare.

In regards to expert medical witnesses, the law currently limits the amount a health care provider can be paid for expert testimony during depositions on a workers' compensation claim to $200 per hour, unless they only provided an expert medical opinion following a medical record review or provided direct personal services unrelated to the case in dispute, then they are limited to a maximum of $200, per day. The bill increases the maximum hourly amount allowed expert witnesses $300, per hour. For those expert witnesses subject to the daily rate, the maximum amount allowed is increased to $300, per day.

The bill has a negative, but likely insignificant, impact on state and local government.

II. Present Situation:

Florida Workers' Compensation System

Florida's Workers' Compensation Law[1] requires employers to provide injured employees all medically necessary remedial treatment, care, and attendance for such period as the nature of the injury or the process of recovery may require.[2] The Division of Workers' Compensation within the Department of Financial Services (DFS), provides regulatory oversight of Florida's workers' compensation system, including the workers' compensation health care delivery system.

Reimbursement for Healthcare Providers

Healthcare providers must receive authorization from the insurer before providing treatment, and submit treatment reports to the insurer.[3] Insurers must reimburse an individual physician, hospital, ambulatory surgical center, pain program, or work-hardening program at either the agreed-upon contract price or the maximum reimbursement allowance in the appropriate schedule. DFS mediates utilization and reimbursement disputes.[4]

A three-member panel (panel) consisting of the Chief Financial Officer (CFO) or his or her designee and two Governor's appointees sets the MRAs.[5] The DFS incorporates the statewide schedules of the MRAs by rule in reimbursement manuals. In establishing the MRA manuals, the panel considers the usual and customary levels of reimbursement for treatment, services, and care;[6] the cost impact to employers for providing reimbursement that ensures that injured workers have access to necessary medical care; and the financial impact of the MRAs on healthcare providers and facilities.[7] Florida law requires the panel to develop MRA manuals that are reasonable, promote the workers' compensation system's healthcare cost containment and efficiency, and are sufficient to ensure that medically necessary treatment is available for injured workers.[8]

The panel develops four different reimbursement manuals to determine statewide schedules of maximum reimbursement allowances. The healthcare provider manual limits the maximum reimbursement for licensed physicians to 110 percent of Medicare reimbursement,[9] while reimbursement for surgical procedures is limited to 140 percent of Medicare.[10] The hospital manual sets maximum reimbursement for outpatient scheduled surgeries at 60 percent of usual and customary charges,[11] while other outpatient services are limited to 75 percent of usual and customary charges.[12] Reimbursement of inpatient hospital care is limited based on a schedule of per diem rates approved by the panel.[13] The ambulatory surgical centers manual limits reimbursement to 60 percent of usual and customary as such services are generally scheduled outpatient surgeries. The prescription drug reimbursement manual limits reimbursement to the

[1] Ch. 440, F.S.
[2] Section 440.13(2)(a), F.S.
[3] Section 440.13, F.S.
[4] Section 440.13(12)(a), F.S.
[5] Section 440.13(12)(a), F.S.
[6] Section 440.13(12)(d)1., F.S.
[7] Section 440.13(12)(d)2., F.S.
[8] Section 440.13(12)(d)3., F.S.
[9] Section 440.13(12)(b)4., F.S.
[10] Section 440.13(12)(b)5., F.S.
[11] Section 440.13(12)(b)3., F.S.
[12] Section 440.13(12)(a), F.S.
[13] Section 440.13(12)(a), F.S.

average wholesale price plus a $4.18 dispensing fee.[14] Repackaged or relabeled prescription medication dispensed by a dispensing practitioner has a maximum reimbursement of 112.5 percent of the average wholesale price plus an $8.00 dispensing fee.[15] Fees may not exceed the schedules adopted under Ch. 440, F.S., and department rule.[16]

DFS incorporates the MRAs approved by the Three-Member Panel in reimbursement manuals[17] through the rulemaking process provided by the Administrative Procedures Act.[18]

Expert Witness Fees for Health Care Providers

Chapter 440.13, F.S., limits the amount a health care provider can be paid for expert testimony during depositions on a workers' compensation claim. As an expert medical witness, a workers' compensation health care provider is limited to a maximum $200 per hour. , An expert witness who only provided an expert medical opinion following a medical record review or provided direct personal services unrelated to the case in dispute is limited to a maximum witness fee of $200 per day.[19]

III. Effect of Proposed Changes:

Section 1 amends s. 440.13, F.S. Subsection (10) is amended to increase the maximum amount a health care provider can be paid for expert testimony during a deposition on a workers' compensation claim from $200 to $300 per hour. A health care provider that only provided an expert medical opinion following a medical record review or provided direct personal services unrelated to the case in dispute, is limited to a maximum witness fee of $300 rather than $200 per day.

Subsection (13) is amended to increase the maximum reimbursement for a physician licensed under ch. 458, F.S., or ch. 459, F.S., from 110 percent to 200 percent of Medicare, using appropriate codes and modifiers or the medical reimbursement level adopted by the three-member panel as of January 1, 2003, whichever is greater. The maximum reimbursement for surgical procedures is increased from 140 percent to 200 percent of the reimbursement allowed by Medicare, using appropriate codes and modifiers or the medical reimbursement level adopted by the three-member panel as of January 1, 2003, whichever is greater.

Section 2 provides that act takes effect July 1, 2023.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

[14] Section 440.13(12)(c), F.S.
[15] *Id.*
[16] Section 440.13(13)(b), F.S. The department also has rulemaking authority under s. 440.591, F.S.
[17] Sections 440.13(12) and 440.13(13), F.S., and Ch. 69L-7, F.A.C.
[18] Ch. 120, F.S.
[19] S. 440.13(10), F.S.

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 increase payments to medical providers who appear as expert medical witnesses in litigated workers' compensation claims.

The bill would increase payments to physicians, and surgical procedures (including all scheduled, non-emergency clinical laboratory and radiology services; and outpatient physical, occupational, and speech therapy services). The bill is estimated to increase workers' compensation premiums, as described below.

The National Council on Compensation Insurance, Inc., Analysis of SB 1344[20]

The National Council on Compensation Insurance, Inc., (NCCI) provided the following analysis of the impact of changing maximum reimbursement allowances (MRAs) in the 2016 edition of the Health Care Provider Reimbursement Manual. The Division of Workers' Compensation of DFS asked NCCI to analyze an additional four scenarios.

The current state multiplier for surgical is 140 percent and the current state multiplier for all others is 110 percent. The state-specific multipliers for HB 1299/SB1344 (scenario 3 increases both multipliers to 200 percent), as well as four additional scenarios are summarized below:

[20] NCCI, Analysis of Florida Medical Fee Schedule Changes (HB 1299/SB 1344) (Mar. 28, 2023). On file with Banking and Insurance Committee.

Type of Service	Proposed Multiplier by Scenario				
	1	2	3	4	5
Surgical	150 percent	175 percent	200 percent	225 percent	250 percent
All Other	150 percent	175 percent	200 percent	225 percent	250 percent

NCCI estimates that the changes to the MRAs, proposed to be effective July 1, 2023, would result in the following estimated impacts on overall Florida workers compensation system costs under each of the proposed scenarios, where Scenario 3 is the estimated impact of HB 1299/SB 1344:

Scenario	Estimated Percentage Impact	Estimated Impact on Overall Costs[21]
1	+3.1	+$122 million
2	+5.2	+$204 million
3	+7.3	+$286 million
4	+9.4	+$369 million
5	+11.5	+$451 million

In addition to physician services, the proposed changes would also impact MRAs for the following hospital outpatient services contained in the Florida Workers' Compensation Reimbursement Manual for Hospitals:

- All scheduled, non-emergency clinical laboratory and radiology services; and
- Outpatient physical, occupational, and speech therapy services.

The changes to the HCPRM also impact certain hospital outpatient services. In Florida, payments for hospital outpatient services represent 18.4 percent of medical costs, and hospital outpatient services subject to the HCPRM MRAs represent 3.3 percent of total hospital outpatient costs.

Expert Medical Witness Fees

Currently, the reimbursement for an expert medical witness cannot exceed $200/hour. HB 1299/SB 1344 seek to increase the maximum reimbursement amount to $300/hour, an increase of 50 percent (= $300 / $200 – 1). Comprehensive data on expert medical witness payments by employers/insurers is not readily available to NCCI. While the magnitude of the increase in workers compensation system costs resulting from the proposed change in the hourly rate for expert medical witness depositions is uncertain,

[21] Overall system costs are based on 2021 net written premium for insurance companies including an estimate of self-insured premium as provided by the Florida Division of Workers' Compensation. For each scenario, the estimated dollar impact is displayed for illustrative purposes only and calculated as the respective percentage impact multiplied by $3,921M. These figures do not include the policyholder retained portion of deductible policies, or adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impact assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs.

NCCI anticipates that any such potential increase would be minimal. Minimal is defined in this context to be an impact on overall system costs of less than +0.2 percent.

C. Government Sector Impact:

See analysis above, in Private Sector Impact. Indeterminate.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 440.13 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 Bradley

6-01070-23 20231344__

A bill to be entitled

An act relating to medical treatment under the Workers' Compensation Law; amending s. 440.13, F.S.; increasing limits on witness fees charged by certain witnesses; increasing maximum reimbursement allowances for physicians and surgical procedures; providing an effective date.

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

Section 1. Subsection (10) and paragraph (b) of subsection (12) of section 440.13, Florida Statutes, are amended to read:

440.13 Medical services and supplies; penalty for violations; limitations.—

(10) WITNESS FEES.—Any health care provider who gives a deposition shall be allowed a witness fee. The amount charged by the witness may not exceed $300 ~~$200~~ per hour. An expert witness who has never provided direct professional services to a party but has merely reviewed medical records and provided an expert opinion or has provided only direct professional services that were unrelated to the workers' compensation case may not be allowed a witness fee in excess of $300 ~~$200~~ per day.

(12) CREATION OF THREE-MEMBER PANEL; GUIDES OF MAXIMUM REIMBURSEMENT ALLOWANCES.—

(b) It is the intent of the Legislature to increase the schedule of maximum reimbursement allowances for selected physicians effective January 1, 2004, and to pay for the increases through reductions in payments to hospitals. Revisions developed pursuant to this subsection are limited to the

6-01070-23 20231344__

following:

1. Payments for outpatient physical, occupational, and speech therapy provided by hospitals shall be reduced to the schedule of maximum reimbursement allowances for these services which applies to nonhospital providers.

2. Payments for scheduled outpatient nonemergency radiological and clinical laboratory services that are not provided in conjunction with a surgical procedure shall be reduced to the schedule of maximum reimbursement allowances for these services which applies to nonhospital providers.

3. Outpatient reimbursement for scheduled surgeries shall be reduced from 75 percent of charges to 60 percent of charges.

4. Maximum reimbursement for a physician licensed under chapter 458 or chapter 459 shall be increased to 200 ~~110~~ percent of the reimbursement allowed by Medicare, using appropriate codes and modifiers or the medical reimbursement level adopted by the three-member panel as of January 1, 2003, whichever is greater.

5. Maximum reimbursement for surgical procedures shall be increased to 200 ~~140~~ percent of the reimbursement allowed by Medicare or the medical reimbursement level adopted by the three-member panel as of January 1, 2003, whichever is greater.

The department, as requested, shall provide data to the panel, including, but not limited to, utilization trends in the workers' compensation health care delivery system. The department shall provide the panel with an annual report regarding the resolution of medical reimbursement disputes and any actions pursuant to subsection (8). The department shall

provide administrative support and service to the panel to the extent requested by the panel. For prescription medication purchased under the requirements of this subsection, a dispensing practitioner shall not possess such medication unless payment has been made by the practitioner, the practitioner's professional practice, or the practitioner's practice management company or employer to the supplying manufacturer, wholesaler, distributor, or drug repackager within 60 days of the dispensing practitioner taking possession of that medication.

Section 2. This act shall take effect July 1, 2023.

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

4/5/23
Meeting Date

Banking & Insurance
Committee

1344
Bill Number or Topic

Amendment Barcode (if applicable)

Name Fraser Cobbe

Phone 813-215-7140

Address 319 S. Glen Arven Avenue
Street

Email fcobbe@cobbemanagement.com

Temple Terrace FL 33617
City *State* *Zip*

Speaking: [X] For [ ] Against [ ] Information **OR** Waive Speaking: [ ] In Support [ ] Against

PLEASE CHECK ONE OF THE FOLLOWING:

[ ] I am appearing without compensation or sponsorship.

[ ] I am a registered lobbyist, representing:

[X] I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

Florida Orthopaedic Society

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/5/23
Meeting Date

SB 1344
Bill Number (if applicable)

Topic Workers Comp.

Amendment Barcode (if applicable)

Name Stephen Winn

Job Title Lobbyist

Address 1424 Ox Bottom Rd.
Street

Phone 850-878-3056

Tall. Fla. 32312
City *State* *Zip*

Email winnsr@earthlink.net

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Fla. Osteopathic Medical Assoc.

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
Senate professional staff conducting the meeting

4-5-23
Meeting Date

Banking & Insurance
Committee

1344
Bill Number or Topic

Amendment Barcode (if applicable)

Name Jarrod Fowler

Phone 850-224-6496

Address 1430 Piedmont Dr. E
Street

Tallahassee FL 32308
City State Zip

Email jfowler@flmedical.org

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing: Florida Medical Association

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Committee on Criminal and Civil Justice, *Chair*
Criminal Justice, *Vice Chair*
Appropriations
Appropriations Committee on Health and Human Services
Children, Families, and Elder Affairs
Community Affairs
Regulated Industries

SELECT COMMITTEE:
Select Committee on Resiliency

SENATOR JENNIFER BRADLEY
6th District

March 7, 2023

Senator Jim Boyd, Chairman
Senate Committee on Banking and Insurance
418 Senate Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Chairman Boyd:

I respectfully request that Senate Bill 1344 be placed on the committee's agenda at your earliest convenience. This bill relates to medical treatment under the workers' compensation law.

Thank you for your consideration.

Sincerely,

Jennifer Bradley

Jennifer Bradley

cc: James Knudson, Staff Director
Amaura Canty, Administrative Assistant

REPLY TO:
❒ 1845 East West Parkway, Suite 5, Fleming Island, Florida 32003 (904) 278-2085
❒ 410 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5006

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

KATHLEEN PASSIDOMO
President of the Senate

DENNIS BAXLEY
President Pro Tempore

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Banking and Insurance
ITEM: SB 1344
FINAL ACTION: Favorable
MEETING DATE: Wednesday, April 5, 2023
TIME: 8:30—10:30 a.m.
PLACE: 412 Knott Building

FINAL VOTE			4/05/2023 1 Motion to vote "YEA" after Roll Call Burgess		4/05/2023 2 Motion to vote "YEA" after Roll Call Powell			
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
		Broxson						
VA		Burgess						
X		Burton						
X		Hutson						
X		Ingoglia						
X		Mayfield						
VA		Powell						
X		Thompson						
		Torres						
		Trumbull						
X		DiCeglie, VICE CHAIR						
X		Boyd, CHAIR						
9	0	**TOTALS**	FAV	-	FAV	-		
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

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 Community Affairs

BILL:	CS/SB 1614
INTRODUCER:	Banking and Insurance Committee and Senator Rodriguez
SUBJECT:	Public Safety Emergency Communications Systems
DATE:	April 7, 2023
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Hackett	Ryon	CA	**Favorable**
2.	Thomas	Knudson	BI	**Fav/CS**
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1614 Amends the Florida Building Codes Act to require the installation of a two-way radio communications enhancement system (radio enhancement system) if the interior of the building does not meet the minimum radio signal strength as required in the Florida Fire Prevention Code. If an assessment of a new building's interior radio coverage determines that installation of a radio enhancement system is required, a properly licensed contractor must submit a design for a radio enhancement system to correct the non-compliant radio coverage. However, a temporary certificate of occupancy may not be withheld solely because a radio enhancement system is needed. The system must be installed within 180 days after a temporary certificate of occupancy is issued, but an extension of the temporary certificate of occupancy may not be unnecessarily withheld.

The bill also makes the following changes regarding radio enhancement system requirements of the Florida Fire Prevention Code (Code):

- Specifies all buildings must meet minimum radio signal strength requirements of the Code except for:
  - One- and two-family dwellings and townhouses.
  - Buildings less than 12,000 total gross square feet.
  - Apartments and transient public lodging establishments that are less than three stories and that have direct access from the apartment or guest area to an exterior means of egress.

    - Apartment buildings 75 feet or less in height that are constructed using wood framing, provided that the building has less than 150 dwelling units and that all dwelling units discharge to the exterior or to a corridor that leads directly to an exit.
- Prevents a local authority from requiring such assessments more than once every 3 years for existing high-rise buildings and existing buildings over 15,000 total gross square feet and once every 5 years for all other existing buildings, unless such building undergoes Level III building alteration or rehabilitation; or if a public safety agency reports to the local authority having jurisdiction that their communications devices failed to function correctly inside a building due to poor signal coverage.
- Requires that modifications or installations of a radio enhancement system must have the express consent of the frequency license holder of the frequency to be enhanced.
- Provides that if the public safety agency communications system is inadequate at the building's exterior, a radio enhancement system or assessment may not be required.
- Requires that a local authority must:
    - Provide a building owner at least 180 days' notice before requiring the modification of a radio enhancement system necessitated by a jurisdiction's modification to a public safety emergency communications system.
    - Allow the building owner at least 1 year to complete the retrofit of a radio enhancement system.
- Prohibits local adoption of more stringent requirements.

The bill is not expected to have a fiscal impact on state or local government.

The bill takes effect July 1, 2023.

II. Present Situation:

Florida Fire Prevention Code

The State Fire Marshal, by rule, adopts the Florida Fire Prevention Code (Florida Fire Code), which contains all firesafety laws and rules that pertain to the design, construction, erection, alteration, modification, repair, and demolition of public and private buildings, structures, and facilities, and the enforcement of such firesafety laws and rules.[1] The State Fire Marshal adopts a new edition of the Florida Fire Code every three years.[2] The Florida Fire Code is largely based on the *National Fire Protection Association's (NFPA) Standard 1, Fire Prevention Code*, along with the current edition of the *Life Safety Code, NFPA 101*.[3] The 7th, and current, edition took effect on December 31, 2020.[4] State law requires all municipalities, counties, and special districts with firesafety responsibilities to enforce the Florida Fire Code as the minimum fire prevention code to operate uniformly among local governments and in conjunction with the Florida Building Code.[5] The Florida Fire Code applies to every building and structure throughout the state with few exceptions.[6] Municipalities, counties, and special districts with firesafety

[1] Fla. Admin. Code R. 69A-60.002.
[2] Section 633.202(1), F.S.
[3] Section 633.202(2), F.S.
[4] Division of State Fire Marshal, *Florida Fire Prevention Code, available at* https://www.myfloridacfo.com/division/sfm/bfp/florida-fire-prevention-code (last visited April 2, 2023).
[5] Sections 633.108 and 633.208, F.S.
[6] Section 633.208, F.S., and Fla. Admin. Code R. 69A-60.002(1).

responsibilities may supplement the Florida Fire Code with more stringent standards adopted in accordance with s. 633.208, F.S.[7]

Radio Signal Strength for Fire Department Communications

The life safety of firefighters and citizens depends on reliable, functional communication tools that work in the harshest and most hostile of environments. All firefighters, professional and volunteer, operate in extreme environments that are markedly different from those of any other radio users. The radio is the lifeline that connects the firefighters to command and outside assistance when in the most desperate of situations.[8]

Modern focus on radio signal strength stems from difficulties experienced by firefighters attempting rescue operations on September 11, 2001, in the World Trade Towers, who found that in certain areas of the building their radio signal degraded, making live communication difficult or impossible.[9]

Two-way radio communication enhancement systems are devices installed after a building is constructed that accept and then amplify radio signals used by first responders. A radio frequency site survey may be conducted in a building to determine areas where radio signal strength drops due to materials used in construction, such as thick walls, metal construction, underground structures, and low-emissivity glass windows. The generally desired effect is that radio signal strength at ground level, where a fire rescue operation might be based, is equal to the radio signal strength in all locations throughout the building, to ensure consistent communication. Several devices are available to boost signal strength to meet required radio signal strength. These include bi-directional amplifiers and networks of indoor antennae, referred to collectively as a distributed antenna system.[10]

Minimum Radio Signal Strength

Section 633.202(18), F.S.,[11] and the Florida Fire Code provide that all new and existing buildings must maintain minimum radio signal strength at a level determined by the authority

[7] Section 633.208(3), F.S., and Fla. Admin. Code R 69A-60.002(2).
[8] Federal Emergency Management Agency, United States Fire Administration. Voice Radio Communications Guide for the Fire Service (June 2016), p. 1, *available at* https://www.usfa.fema.gov/downloads/pdf/publications/Voice_Radio_Communications_Guide_for_the_Fire_Service.pdf (last visited April 2, 2023).
[9] See *Assessment of Total Evacuation Systems for Tall Buildings: Literature Review,* National Fire Protection Association's (NFPA), *available at* https://www.nfpa.org/-/media/Files/News-and-Research/Fire-statistics-and-reports/Executive-summaries/evacsystemstallbuildingsliteraturereviewexecsum.ashx#:~:text=According%20to%20the%20definition%20of,floor%20of%20the%20highest%20occupiable (last visited April 2, 2023) and Fire Engineering, *World Trade Center Disaster: Initial Response*, https://www.fireengineering.com/firefighting/world-trade-center-disaster-initial-response/#gref (Sep 1, 2002) (last visited April 2, 2023).
[10] See *High-Rise Public Safety System Integrators,* Treasure Island Fire Department, *available at* https://www.mytreasureisland.org/residents/departments/fire_dept/local_high-rise_public_safety_system_integrators.php (last visited April 2, 2023); *Information Bulletin: Two-Way Radio Communication Enhancement System Requirements,* East Lake Tarpon Special Fire Control District, *available at* https://www.elfr.org/files/e2eae3cb2/Bulletin+East+Lake+Two+Way+Communications.pdf (last visited April 2, 2023).
[11] Enacted in 2016 and recently amended in 2021 and 2022. Chs. 2016-129, s. 27; 2021-113, s. 25; and 2022-210, L.O.F.

having jurisdiction (local fire authorities).[12] The requirements set by the local authority must be based on the existing radio signal coverage levels provided by the jurisdiction's infrastructure as measured at the exterior of the building.[13]

Two-way radio communication enhancement systems or their equivalent may be used to comply with these minimum signal strength requirements. Radio signal enhancement systems involve powered devices which accept and amplify radio signals within a building. There are many factors which vary costs associated with these systems, from building design to structural impediments to radio signal strength.

Where required by a local fire authority, two-way radio communication enhancement systems must comply with federal standards for installation, maintenance, and use of emergency services communications systems.[14] An enhancement system may not be required if the existing radio signal coverage as measured at the building's exterior is not strong enough to deliver.[15] Such a system may not be required in an apartment building provided that it is 75 feet or less in height, constructed with wood framing, contains fewer than 150 dwelling units, and each unit discharges to the exterior or to a corridor leading directly to an exit.[16]

Existing high-rise[17] buildings are not required to comply with minimum radio strength requirements until January 1, 2025.[18] However, by January 1, 2024, an existing building that is not in compliance with the requirements for minimum radio strength for fire department communications must apply for an appropriate permit for the required installation with the local government agency having jurisdiction and must demonstrate that the building will become compliant by January 1, 2025.[19]

Local Enforcement of the Florida Building Code

It is the intent of the Legislature that local governments have the power to inspect all buildings, structures, and facilities within their jurisdiction in protection of the public's health, safety, and welfare.[20]

---

[12] Florida Fire Prevention Code (7th ed.) s. 11.10.1. The "authority having jurisdiction" is typically the designated head fire and rescue officer of the county, municipality, or special district with fire safety responsibilities over an area.
[13] Florida Fire Prevention Code (7th ed., as amended Apr. 2022) s. 11.10.1.
[14] Florida Fire Prevention Code (7th ed.) s. 11.10.2.
[15] Florida Fire Prevention Code (7th ed., as amended Apr. 2022) s. 11.10.1.1, requires a delivered audio quality of 3.4, which is defined as "speech understandable with repetition only rarely required, and with some noise and/or distortion." P25 Best Practice, *Coverage Needs*, available at https://www.p25bestpractice.com/specifying/coverage-needs/#:~:text=DAQ%203.4%20is%20defined%20as,noise%20and%2For%20distortion.%E2%80%9D (last visited April 2, 2023).
[16] Section 633.202(18), F.S.
[17] A high-rise building is a building greater than 75 feet in height where the building height is measured from the lowest level of fire department vehicle access to the floor of the highest story that can be occupied. NFPA 101, Life Safety Code, 2021 edition - Ch. 3.3.37.7.
[18] Section 633.202(18), F.S.
[19] *Id.*
[20] Section 553.72, F.S.

Every local government must enforce the Building Code and issue building permits.[21] It is unlawful for a person, firm, or corporation to construct, erect, alter, repair, secure, or demolish any building without first obtaining a permit from the local government enforcing agency or from such persons as may, by resolution or regulation, be directed to issue such permit, upon the payment of reasonable fees as set forth in a schedule of fees adopted by the enforcing agency.[22]

Building Permits

It is the intent of the Legislature that local governments have the power to inspect all buildings, structures, and facilities within their jurisdiction in protection of the public's health, safety, and welfare.[23] Every local government must enforce the Building Code and issue building permits.[24]

It is unlawful for a person, firm, or corporation to construct, erect, alter, repair, secure, or demolish any building without first obtaining a building permit from the local government or from such persons as may, by resolution or regulation, be directed to issue such permit, upon the payment of reasonable fees as set forth in a schedule of fees adopted by the enforcing agency.[25] A building permit is not valid until the fees for the permit have been paid.[26]

III. Effect of Proposed Changes:

Section 1 amends s. 553.79, F.S., relating to building permits to provide that:

- If an assessment of a new building's interior radio coverage and signal strength under the Florida Fire Prevention Code determines that installation of a two-way radio communications enhancement system is required, a contractor licensed in the appropriate category under the Florida Department of Business and Professional Regulation must submit a design for a two-way radio communications enhancement system to correct the non-compliant radio coverage.
- The local authority having jurisdiction over the building may not withhold the issuance of a temporary certificate of occupancy based solely upon the need for a two-way radio communications enhancement system.
- Upon approval of the design by the local authority having jurisdiction, the jurisdiction must require the installation of the enhancement system within 180 days after the issuance of a temporary certificate of occupancy.
- A temporary certificate of occupancy extension may not be unnecessarily withheld.

Section 2 amends s. 633.202(18), F.S., governing the Florida Fire Prevention Code, to provide that:

- The local authority having jurisdiction may:
  - Require the installation of a two-way radio communications enhancement system if the interior of the building does not meet the minimum radio signal strength as required in the Florida Fire Prevention Code.

[21] Sections 125.01(1)(bb), 125.56(1), and 553.80(1), F.S.
[22] Sections 125.56(4)(a), 553.79(1), F.S.
[23] Section 553.72, F.S.
[24] Sections 125.01(1)(bb), 125.56(1), and 553.80(1), F.S.
[25] *See* ss. 125.56(4)(a) and 553.79(1), F.S.
[26] Section 109.1 of the Seventh edition of the Florida Building Code (Building).

  - Require assessment of a building's interior radio coverage and signal strength not more than once every 3 years for existing high-rise buildings and existing buildings over 15,000 total gross square feet and once every 5 years for all other existing buildings, unless such building undergoes Level III building alteration or rehabilitation[27]; or if a public safety agency reports to the local authority having jurisdiction that their communications devices failed to function correctly inside a building due to poor signal coverage.
- Any modification to an existing system or any new installation must have the consent of the license holder of the frequencies for which the device or system is intended to amplify.
- If a jurisdiction modifies its public safety emergency communications system such that modifications to existing two-way radio communications enhancement system installations are required, the jurisdiction must give owners of the two-way radio communications enhancement systems at least 180 days' notice before requiring any modification.
- A local authority that requires an existing building to retrofit its two-way radio communications enhancement system after January 1, 2025, must give the building owner at least 1 year to complete the retrofit. The 1-year period begins when the local authority having jurisdiction cites the building owner with a notice of code violation.

The following occupancies or buildings are not required to meet minimum radio signal strength requirements or have a radio signal strength assessment for public safety agency communications:
- One- and two-family dwellings and townhouses.
- Buildings less than 12,000 total gross square feet.
- Apartments and transient public lodging establishments that are less than three stories and that have direct access from the apartment or guest area to an exterior means of egress.

The bill provides that the provisions of s. 633.208, F.S. (minimum firesafety standards), and this section authorizing the adoption of requirements more stringent than those specified in the Florida Fire Prevention Code and minimum firesafety codes do not apply to the requirements of this subsection. The local authority may not enforce requirements that are more stringent than those specified in the Florida Fire Prevention Code and the provisions of this subsection.

The State Fire Marshal is authorized to incorporate these provisions in the Florida Fire Prevention Code and may adopt rules to implement, interpret, and enforce this subsection with respect to the requirement for, design of, or installation of a two-way radio communications enhancement system.

Section 3 amends s. 843.16, F.S., to provide that the installation of a two-way radio communications enhancement system to comply with the requirements of s. 633.202(18), F.S., is exempt from the crime making it unlawful to install or transport radio equipment using an assigned frequency of state or law enforcement officers.

[27] Level 3 alterations apply where the work area exceeds 50 percent of the aggregate area of the building and made within any 12-month period. Exception: Work areas in which the alteration work is exclusively plumbing, mechanical or electrical shall not be included in the computation of total area of all work areas. https://www.floridabuilding.org/fbc/commission (last accessed April 5, 2023).

Section 4 amends s. 440.103, F.S., to conform a cross-reference.

Section 5 provides that the bill takes effect July 1, 2023.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Article VII, section 18 (a) of the Florida Constitution provides in part that a county or municipality may not be bound by a general law requiring a county or municipality to spend funds or take an action that requires the expenditure of funds unless certain specified exemptions or exceptions are met.

Article VII, section 18 (d) provides eight exemptions, which, if any single one is met, exempts the law from the limitations on mandates. Laws having an "insignificant fiscal impact" are exempt from the mandate requirements, which for Fiscal Year 2022-2023 is forecast at approximately $2.3 million.[28, 29]

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

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

[28] FLA. CONST. art. VII, s. 18(d).
[29] An insignificant fiscal impact is the amount not greater than the average statewide population for the applicable fiscal year times $0.10. *See* Florida Senate Committee on Community Affairs, *Interim Report 2012-115: Insignificant Impact*, (Sept. 2011), *available at* http://www.flsenate.gov/PublishedContent/Session/2012/InterimReports/2012-115ca.pdf (last visited April 2, 2023).

B. Private Sector Impact:

Builders may be positively impacted to the extent that buildings are subject to less frequent radio signal strength assessments and are entitled to receive an earlier certificate of occupancy than otherwise in certain circumstances.

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: 553.79, 633.202, 843.16, and 440.103.

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 April 5, 2023:
The committee substitute makes the following changes:

- Provides that if an assessment of a new building's interior radio coverage determines that installation of a two-way radio communications enhancement system is required, a properly licensed contractor must submit a design for an enhancement system to correct the non-compliant radio coverage.
- The local jurisdiction may not withhold issuance of a temporary certificate of occupancy for the building based solely upon the need for a two-way radio communications enhancement system.
- Upon approval of the submitted design, the jurisdiction must require the installation of the enhancement system within 180 days after the issuance of a temporary certificate of occupancy.

The local authority may:

- Require the installation of a two-way radio communications enhancement system if the interior of the building does not meet the minimum radio signal strength as required in the Florida Fire Prevention Code.
- Require assessment of a building's interior radio coverage not more than once every 3 years for existing high-rise buildings and existing buildings over 15,000 total gross square feet and once every 5 years for all other existing buildings, unless such

building undergoes Level III building alteration or rehabilitation; or if a public safety agency reports to the local authority having jurisdiction that their communications devices failed to function correctly inside a building due to poor signal coverage.

The following occupancies or buildings are not required to meet minimum radio signal strength requirements or have a radio signal strength assessment for public safety agency communications:

- One- and two-family dwellings and townhouses.
- Buildings less than 12,000 total gross square feet.
- Apartments and transient public lodging establishments that are less than three stories and that have direct access from the apartment or guest area to an exterior means of egress.
- Apartment buildings 75 feet or less in height that are constructed using wood framing, provided that the building has less than 150 dwelling units and that all dwelling units discharge to the exterior or to a corridor that leads directly to an exit.

B. Amendments:

None.

376650

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/07/2023	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Present subsections (23), (24), and (25) of section 553.79, Florida Statutes, are redesignated as subsections (24), (25), and (26), respectively, and a new subsection (23) is added to that section, to read:

553.79 Permits; applications; issuance; inspections.—

(23) If an assessment of a new building's interior radio

376650

coverage and signal strength under the Florida Fire Prevention Code determines that installation of a two-way radio communications enhancement system is required, a contractor having the appropriate license issued by the department must submit a design for a two-way radio communications enhancement system to correct noncompliant radio coverage. The local jurisdiction may not withhold issuance of a temporary certificate of occupancy for the building based solely on the need for a two-way radio communications enhancement system. Upon approval of the design by the local authority having jurisdiction, the jurisdiction must require the installation of the two-way radio communications enhancement system within 180 days after the issuance of a temporary certificate of occupancy. A temporary certificate of occupancy extension may not be unnecessarily withheld.

Section 2. Subsection (18) of section 633.202, Florida Statutes, is amended to read:

633.202 Florida Fire Prevention Code.—

(18)(a) The authority having jurisdiction shall determine the minimum radio signal strength for fire department communications in all new and existing buildings. Two-way radio communication enhancement systems or equivalent systems may be used to comply with the minimum radio signal strength requirements. However, two-way radio communication enhancement systems or equivalent systems are not required in apartment buildings 75 feet or less in height that are constructed using wood framing, provided that the building has less than 150 dwelling units and that all dwelling units discharge to the exterior or to a corridor that leads directly to an exit as

376650

defined by the Florida Building Code. Evidence of wood frame construction shall be shown by the owner providing building permit documentation which identifies the construction type as wood frame. Existing high-rise buildings as defined by the Florida Building Code are not required to comply with minimum radio strength for fire department communications and two-way radio communication enhancement systems as required by the Florida Fire Prevention Code until January 1, 2025. However, by January 1, 2024, an existing high-rise building that is not in compliance with the requirements for minimum radio strength for fire department communications must apply for an appropriate permit for the required installation with the local government agency having jurisdiction and must demonstrate that the building will become compliant by January 1, 2025. Existing high-rise apartment buildings are not required to comply until January 1, 2025. However, existing high-rise apartment buildings are required to apply for the appropriate permit for the required communications installation by January 1, 2024.

(b) Except as modified in this subsection, all new and existing buildings must meet the minimum radio signal strength requirements for public safety agency communications as provided in the Florida Fire Prevention Code.

(c) The local authority having jurisdiction as defined in the Florida Fire Prevention Code may:

1. Require the installation of a two-way radio communications enhancement system in a new or existing building if the interior of the building does not meet the minimum radio signal strength as required in the Florida Fire Prevention Code.

2. Require assessment of a new or existing building's

376650

interior radio coverage and signal strength, for purposes of determining the need for a two-way radio communications enhancement system within the building, not more frequently than once every 3 years for existing high-rise buildings and existing buildings over 12,000 total gross square feet and once every 5 years for all other existing buildings, unless such building undergoes Level III building alteration or rehabilitation as defined in the Florida Building Code or reconstruction as determined by the Florida Fire Prevention Code or if a public safety agency reports to the local authority having jurisdiction that the agency's communications devices failed to function correctly inside a building due to poor signal coverage or upon determination of an imminent life safety threat to responders.

(d) Any modification to an existing system or any new installation must have the express consent of the frequency license holder of the frequencies for which the device or system is intended to amplify. The consent must be maintained in a recordable format that can be presented to a Federal Communications Commission representative or other relevant agency investigating radio interference.

(e) Where public safety agency communications signal strength or delivered audio quality, as defined in the Florida Fire Prevention Code, is determined by the authority having jurisdiction to be inadequate at the exterior of the building, a two-way radio communications enhancement system or minimum radio strength assessment shall not be required.

(f) If a jurisdiction modifies its public safety emergency communications system such that modifications to existing two-way radio communications enhancement system installations are

376650

required, the local authority having jurisdiction must give owners of the two-way radio communications enhancement systems at least 180 days' notice before requiring any modification.

(g) Notwithstanding paragraph (f), a local authority having jurisdiction which requires an existing building to retrofit its two-way radio communications enhancement system after the effective dates in paragraph (a) must give the building owner at least 1 year to complete the retrofit. The 1-year period begins when the local authority having jurisdiction cites the building owner with a notice of code violation in accordance with chapter 162.

(h) The following occupancies or buildings are not required to meet minimum radio signal strength requirements or have a radio signal strength assessment for public safety agency communications:

1. One- and two-family dwellings and townhouses.

2. Buildings less than 12,000 square feet with no underground areas.

3. Apartments and transient public lodging establishments that are less than three stories and that have direct access from the apartment or guest area to an exterior means of egress.

(i) The provisions of s. 633.208 and this section which authorize local adoption of more stringent requirements than those specified in the Florida Fire Prevention Code and minimum firesafety codes do not apply to the requirements of this subsection. The local authority having jurisdiction may not enforce requirements that are more stringent than those specified in the Florida Fire Prevention Code and the provisions of this subsection with respect to the requirement for, design

of, or installation of a two-way radio communications enhancement system.

(j) The State Fire Marshal shall incorporate this subsection in the Florida Fire Prevention Code and may adopt rules to implement, interpret, and enforce this subsection.

Section 3. Paragraph (f) is added to subsection (3) of section 843.16, Florida Statutes, to read:

843.16 Unlawful to install or transport radio equipment using assigned frequency of state or law enforcement officers; definitions; exceptions; penalties.—

(3) This section does not apply to the following:

(f) The installation of a two-way radio communications enhancement system to comply with the requirements of s. 633.202(18).

Section 4. Section 440.103, Florida Statutes, is amended to read:

440.103 Building permits; identification of minimum premium policy.—Every employer shall, as a condition to applying for and receiving a building permit, show proof and certify to the permit issuer that it has secured compensation for its employees under this chapter as provided in ss. 440.10 and 440.38. Such proof of compensation must be evidenced by a certificate of coverage issued by the carrier, a valid exemption certificate approved by the department, or a copy of the employer's authority to self-insure and shall be presented, electronically or physically, each time the employer applies for a building permit. As provided in s. 553.79(24) ~~s. 553.79(23)~~, for the purpose of inspection and record retention, site plans or building permits may be maintained at the worksite in the

376650

original form or in the form of an electronic copy. These plans and permits must be open to inspection by the building official or a duly authorized representative, as required by the Florida Building Code. As provided in s. 627.413(5), each certificate of coverage must show, on its face, whether or not coverage is secured under the minimum premium provisions of rules adopted by rating organizations licensed pursuant to s. 627.221. The words "minimum premium policy" or equivalent language shall be typed, printed, stamped, or legibly handwritten.

Section 5. This act shall take effect July 1, 2023.

========== 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 public safety emergency communications systems; amending s. 553.79, F.S.; requiring a licensed contractor to submit a certain design if an interior radio coverage and signal strength assessment of a new building determines a two-way radio communications enhancement system installation is required; specifying restrictions on a local jurisdiction's withholding issuance of a temporary certificate of occupancy for the building; requiring the local jurisdiction to require installation of such a system within a certain timeframe; amending s. 633.202, F.S.; requiring new and existing buildings to meet certain minimum radio

signal strength requirements, except under certain circumstances; specifying the authority of local authorities having jurisdiction relating to two-way radio communications enhancement systems; specifying requirements for, and restrictions on, such authorities; providing requirements for obtaining and maintaining the consent of frequency license holders; exempting certain occupancies and buildings from certain signal strength and assessment requirements; providing applicability and construction; requiring the State Fire Marshal to incorporate provisions in the Florida Fire Prevention Code; authorizing the State Fire Marshal to adopt rules; amending s. 843.16, F.S.; exempting certain installations of two-way radio communications enhancement systems from prohibitions against the installation or transportation of certain radio equipment; amending s. 440.103, F.S.; conforming a cross-reference; providing an effective date.

525110

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/07/2023	.	
	.	
	.	
	.	

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

Senate Amendment to Amendment (376650)

Between lines 118 and 119
insert:
4. Wood frame apartment buildings that are not required to install two-way radio communication enhancement systems or equivalent systems pursuant to paragraph (a).

By Senator Rodriguez

40-01569A-23 20231614__

A bill to be entitled

An act relating to public safety emergency communications systems; amending s. 633.202, F.S.; requiring a qualified third party to make a specified certification before a local authority having jurisdiction may require an assessment of the need for or the installation of a two-way radio communications enhancement system in certain buildings; specifying the length of time such certification is valid; limiting the number of times, under certain circumstances, that the local authority having jurisdiction may require a specified assessment; prohibiting the local authority having jurisdiction from withholding a certificate of occupancy under certain circumstances and from requiring the installation of a specified system within a certain time period after completion of a specified report; providing an effective date.

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

Section 1. Subsection (18) of section 633.202, Florida Statutes, is amended to read:

633.202 Florida Fire Prevention Code.—

(18)(a) The authority having jurisdiction shall determine the minimum radio signal strength for fire department communications in all new and existing buildings.

(b) Two-way radio communication enhancement systems or equivalent systems may be used to comply with the minimum radio

40-01569A-23 20231614__

signal strength requirements. However, two-way radio communication enhancement systems or equivalent systems are not required in apartment buildings 75 feet or less in height that are constructed using wood framing, provided that the building has less than 150 dwelling units and that all dwelling units discharge to the exterior or to a corridor that leads directly to an exit as defined by the Florida Building Code. Evidence of wood frame construction shall be shown by the owner providing building permit documentation which identifies the construction type as wood frame.

(c) Before a local authority having jurisdiction may require an assessment of the need for or the installation of a two-way radio communications enhancement system in a new or existing building, a qualified third party must certify that the jurisdiction's public safety emergency communications system meets or exceeds the minimum radio coverage design criteria for emergency services communications systems in the current edition of the National Fire Protection Association (NFPA) 1221: Standard for the Installation, Maintenance, and Use of Emergency Services Communications Systems. Such certification is valid until the next triennial adoption of the Florida Fire Prevention Code which incorporates any changes made to NFPA 1221.

(d) If a jurisdiction has a valid radio coverage design certification under paragraph (c), the local authority having jurisdiction may only require an assessment of a new or existing building's interior radio coverage and signal strength in such building once every 3 years for high-rise buildings or once every 5 years for any other buildings in order to determine the need for a two-way radio communications enhancement system.

(e)1. If an assessment of a new building's interior radio coverage and signal strength determines that installation of a two-way radio communications enhancement system is required, the local authority having jurisdiction may not withhold the issuance of a certificate of occupancy for the building if the registered architect or professional engineer who designed the building determines, in his or her professional judgment, that a two-way radio communications enhancement system is not necessary in order for the building to meet the minimum standards for interior radio coverage and signal strength.

2. The local authority having jurisdiction may not require the installation of a two-way radio communications enhancement system until at least 90 days after the building's interior radio coverage and signal strength assessment report is completed.

(f) Existing high-rise buildings as defined by the Florida Building Code are not required to comply with minimum radio strength for fire department communications and two-way radio communication enhancement systems as required by the Florida Fire Prevention Code until January 1, 2025. However, by January 1, 2024, an existing high-rise building that is not in compliance with the requirements for minimum radio strength for fire department communications must apply for an appropriate permit for the required installation with the local government agency having jurisdiction and must demonstrate that the building will become compliant by January 1, 2025. Existing high-rise apartment buildings are not required to comply until January 1, 2025. However, existing high-rise apartment buildings are required to apply for the appropriate permit for the

required communications installation by January 1, 2024.

Section 2. This act shall take effect July 1, 2023.

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

4-5-23
Meeting Date

Banking & Insurance
Committee

1614
Bill Number or Topic

Amendment Barcode (if applicable)

Name Chief Jim Millican Fl. Fire chiefs Assn. Phone 727-526-5650

Address 4360-55 Ave N
Street

Email jmillican@leagueofcities.com

St Pete FL 33714
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information **OR** **Waive Speaking:** ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☒ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

4/5/23
Meeting Date

Banking & Insurance
Committee

1614
Bill Number or Topic

Amendment Barcode (if applicable)

Name Kelly Mallette

Phone 850 224 3427

Address 104 West Jefferson St
Street

Tallahassee FL 32301
City State Zip

Email kelly@rlbookpa.com

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: Florida Apartment Association

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

Committee Agenda Request

To: Senator Jim Boyd, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: March 22, 2023

I respectfully request that **Senate Bill #1614**, relating to Public Safety Emergency Communications Systems, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Ana Maria Rodriguez
Florida Senate, District 40

File signed original with committee office

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Banking and Insurance
ITEM: SB 1614
FINAL ACTION: Favorable with Committee Substitute
MEETING DATE: Wednesday, April 5, 2023
TIME: 8:30—10:30 a.m.
PLACE: 412 Knott Building

FINAL VOTE			4/05/2023 1 Motion to vote "YEA" after Roll Call Burgess		4/05/2023 2 Motion to vote "YEA" after Roll Call DiCeglie		4/05/2023 3 Motion to vote "YEA" after Roll Call Powell	
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
X		Broxson						
VA		Burgess						
X		Burton						
X		Hutson						
X		Ingoglia						
X		Mayfield						
VA		Powell						
X		Thompson						
		Torres						
		Trumbull						
VA		DiCeglie, VICE CHAIR						
X		Boyd, CHAIR						
10	0	**TOTALS**	FAV	-	FAV	-	FAV	-
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Banking and Insurance
ITEM: SB 1614
FINAL ACTION: Favorable with Committee Substitute
MEETING DATE: Wednesday, April 5, 2023
TIME: 8:30—10:30 a.m.
PLACE: 412 Knott Building

	4/05/2023 Amendment to Amendment 525110 adopted Rodriguez		4/05/2023 5 Delete-all Amendment 376650 Rodriguez					
SENATORS	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
Broxson								
Burgess								
Burton								
Hutson								
Ingoglia								
Mayfield								
Powell								
Thompson								
Torres								
Trumbull								
DiCeglie, VICE CHAIR								
Boyd, CHAIR								
TOTALS	RCS **Yea**	- **Nay**	RCS **Yea**	- **Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

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:	SPB 7052
INTRODUCER:	Banking and Insurance Committee
SUBJECT:	Insurer Accountability
DATE:	April 5, 2023
REVISED:	

I.	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Thomas	Knudson		**BI Submitted as Comm. Bill/Fav.**

II. Summary:

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

Regarding insurance coverage the proposed bill:

- Prohibits authorized and surplus lines insurers from cancelling a property insurance policy during any pending claim until after repairs are complete;
- Requires that Citizens cover property with open claims that are being handled by FIGA (Florida Insurance Guaranty Association);
- Prohibits the Office of Insurance Regulation (OIR) from waiving its review of policy forms for 3 years for any insurer that has violated the Insurance Code;
- Provides that the prohibition on applying any other deductible under the policy if a roof deductible is applied encompasses any other loss to the property caused by the same covered peril.
- Tolls the time period for filing a property insurance claim during an insured's active duty military service; and
- Clarifies legislative intent that Chapter 2022-271, Laws of Florida, passed during Special Session A in December 2023, (SB 2-A [2022] on Property Insurance) shall not be construed to impair any right under an insurance contract in effect on or before the effective date of that chapter law (December 16, 2022).
- Clarifies that the provisions of do not impair rights under policies in effect before the act's effective date.

Regarding rates charged for insurance, the proposed bill:

- Requires that property insurance and motor vehicle rate filings must include, and the OIR must consider in reviewing rates, the combined effect of recent legislative reforms;

  - Appropriates $500,000 from the Insurance Regulatory Trust Fund for OIR to obtain an actuarial study to implement this requirement.
- Requires that property insurance mitigation discounts be updated at least every 5 years and insurers to provide consumer-friendly information on their website describing hurricane mitigation discounts available to policyholders; and
- Makes title insurance rates subject to OIR rate review.

Regarding insurer claims handling, the proposed bill:

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

Regarding regulatory oversight of insurers, the bill:

- Increases maximum administrative fines by 250 percent generally, and 500 percent for violations stemming from a state of emergency such as a hurricane.
- Requires insurers to more promptly respond to the Department of Financial Services (DFS) Division of Consumer Services and increases fines for noncompliance.
- Provides additional funding for the DFS Division of Consumer Services.
  - Appropriates five positions with associated salary rate of 325,000 and the sum of $494,774 in recurring funds and $23,410 in non-recurring funds to the DFS from the Insurance Regulatory Trust Fund.
- Specifies objective criteria to be used by OIR to:
  - Prioritize necessary financial and market conduct examinations.
  - Determine when payments to affiliates are excessive.
- Provides conditions whereby the OIR must initiate a market conduct examination.
- Requires insurers to report to the OIR any temporary suspension of writing new policies.
- Applies the standard order that OIR issues to protect consumers after hurricanes to surplus lines insurers.
- Specifies that insurance fraud referrals may be made to the statewide prosecutor for crimes that impact two or more judicial circuits.
- Requires additional reporting from regulators regarding their enforcement actions.

See Section V. Fiscal Impact Statement.

The bill is effective July 1, 2023.

III. Present Situation:

Department of Financial Services

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

DFS Division of Consumer Services

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

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

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

---

[1] *See, e.g.*, Department of Financial Services, *What is the Purpose of the Department*, https://oppaga.fl.gov/ (last accessed April 2, 2023).
[2] Section 440.107(3), F.S.
[3] Section 440.13, F.S.
[4] Sections 440.185 and 440.593, F.S.
[5] Section 440.191, F.S.
[6] DFS, *Department of Financial Services Long Range Program Plan: Fiscal Years 2023-24 through 2027-28*, 15 (Oct. 17, 2022), *available at http://floridafiscalportal.state.fl.us/Document.aspx?ID=24407&DocType=PDF* (last accessed April 2, 2023). *See also*, DFS, *Consumer Guides*, https://www.myfloridacfo.com/Division/Consumers/understandingCoverage/Guides/Default.htm (last visited April 2, 2023).
[7] Section 624.307(10)(a), F.S.

Regulation of Insurance in Florida

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

Financial Examinations

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

Market Conduct Exams

The OIR is authorized to perform a market conduct examination of, among other entities, any authorized insurer.[13] The purpose of the examination is to determine the entity's compliance with Florida law.[14] The costs of the examination are to be paid by the subject entity.[15] Section 624.3161, F.S., authorizes the OIR to subject any authorized insurer to a market conduct examination after a hurricane if the insurer:

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

[8] Section 20.121(3)(a), F.S. The Financial Services Commission, composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture, serves as agency head of the Office of Insurance Regulation for purposes of rulemaking. Further, the Financial Services Commission appoints the commissioner of the Office of Insurance Regulation.
[9] Section 624.418, F.S.
[10] Section 624.316(1)(a), F.S.
[11] Section 624.318(2), F.S.
[12] Section 624.3161, F.S.
[13] Section 624.3161(1), F.S.
[14] *Id.*
[15] Section 624.3161(4), F.S.

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

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

Annual Report on Insurer Compliance

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

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

Administrative Fines

The OIR, through its ongoing oversight and examination process, determines whether insurance companies are operating in compliance with the code. The OIR is authorized to impose administrative fines in lieu of suspension or revocation if the OIR finds that one or more grounds exist for the discretionary revocation or suspension of the certificate of authority.[20] The OIR may impose an administrative fine, not to exceed $5,000, per nonwillful violation, with a limit of $20,000 for all nonwillful violations arising out of the same action. With respect to any willful

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

violation, the OIR is authorized to assess a fine, not to exceed $40,000 per violation and $200,000 in aggregate for all willful violations arising out of the same action. Additionally, if an insurer owes restitution due to a violation, the insurer must provide the restitution and include 12 percent interest from the date of the violation or the inception of the insured's policy.

Financial Consideration or Payment by an Insurer to an Affiliate

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

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

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

Authority for Insurers in Unsound Financial Condition

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

- Conduct target market exams when there is reason to believe that an insurer's claims practices, rate requirements, investment activities, or financial statements suggest said insurer may be in an unsound financial condition.
- Monitor closely all risk-based capital reports, own-risked solvency assessments, reinsurance agreements, and financial statements filed by insurers.
- Have primary responsibility, coordinating with Florida Commission on Hurricane Loss Projection Methodology, to conduct annual catastrophe stress tests of all domestic insurers and insurers that are commercially domiciled in this state.

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

- Update required wind mitigation credits.
- Review the causes of insolvency and business practices of insurers that have been referred to the Division of Rehabilitation and Liquidation of the DFS, and make recommendations to prevent future occurrences of such insurers.
- File biannual reports on the status of the homeowners' and condominium unit owners' insurance market to the Governor, the President of the Senate, the Speaker of the House of Representatives, the Minority Leader of the Senate, the Minority Leader of the House of Representatives, and the chairs of the legislative committees with jurisdiction over matters of insurance.[27]

The section also specifies events that trigger a referral to the insurer stability unit. Expenses for the unit are to be paid from the Insurance Regulatory Trust Fund, except that, if the unit recommends that a market conduct examination or targeted market examination be conducted, the reasonable cost of the examination must be paid by the person examined.[28]

Unfair Insurance Claim Settlement Practices

Florida law prohibits a person from engaging in an unfair or deceptive act or practice involving the business of insurance.[29] The definition of unfair or deceptive acts or practices includes, in part, the following unfair claim settlement practices:

- Attempting to settle claims on the basis of a document that was altered without knowledge or consent of the insured;
- A material misrepresentation made to an insured for the purpose and with the intent of effecting settlement on less favorable terms than provided under the contract or policy;
- Committing or performing with such frequency as to indicate a general business practice certain acts, such as failing to adopt and implement standards for the proper investigation of claims;
- Failing to pay undisputed amounts of partial or full benefits owed under first-party property insurance policies within 90 days after an insurer received notice of a residential property insurance claim, determines the amounts of partial or full benefits, and agrees to coverage, unless payment of the undisputed benefits is prevented by "an act of God, prevented by the impossibility of performance, or due to actions by the insured or claimant that constitute fraud, lack of cooperation, or intentional misrepresentation regarding the claim for which benefits are owed."[30]

An insurer that violates these provisions is subject to a fine in an amount not greater than $5,000 for each nonwillful violation, not to exceed an aggregate amount of $20,000, and not greater than $40,000 for each willful violation arising from the same action, not to exceed an aggregate amount of $200,000.[31]

[27] Section 627.7154(3), F.S.
[28] Section 627.7154(4), F.S.
[29] Section 626.9521(1), F.S.
[30] Section 626.9541(1)(i), F.S.
[31] Section 626.9521(2), F.S.

DFS Insurance Fraud Investigations

The Division of Investigative and Forensic Services investigates various types of insurance fraud including Personal Injury Protection fraud, workers' compensation fraud, vehicle fraud, application fraud, licensee fraud, homeowner's insurance fraud, and healthcare fraud.[32] The Division is directed by statute to investigate fraudulent insurance acts, violations of the Unfair Insurance Trade Practices Act, [33] false and fraudulent insurance claims,[34] and willful violations of the Florida Insurance Code and rules adopted pursuant to the code.[35] The Division employs sworn law enforcement officers to investigate insurance fraud.

Mitigation Discounts

Residential property insurance rate filings must account for mitigation measures undertaken by policyholders to reduce hurricane losses.[36] Specifically, the rate filings must include actuarially reasonable discounts, credits, or other rate differentials or appropriate reductions in deductibles to consumers who implement windstorm damage mitigation techniques to their properties.[37] Upon their filing by an insurer or rating organization, the OIR determines the discounts, credits, other rate differentials and appropriate reductions in deductibles that reflect the full actuarial value of such revaluation,[38] which in turn may be used in rate filings under the rating law. Windstorm mitigation measures that must be evaluated for purposes of mitigation discounts include fixtures or construction techniques that enhance roof strength, roof covering performance, roof-to-wall strength, wall-to-floor-to-foundation strength, opening protection, and window, door, and skylight strength.[39]

Citizens Property Insurance Corporation—Overview

Citizens Property Insurance Corporation (Citizens) is a state-created, not-for-profit, tax-exempt governmental entity whose public purpose is to provide property insurance coverage to those unable to find affordable coverage in the voluntary admitted market.[40] Citizens is not a private insurance company.[41] Citizens was statutorily created in 2002 when the Florida Legislature combined the state's two insurers of last resort, the Florida Residential Property and Casualty Joint Underwriting Association (RPCJUA) and the Florida Windstorm Underwriting Association (FWUA).[42] Citizens offers property insurance through three different accounts: a personal lines account, a commercial lines account, and a coastal account.

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

Citizens operates in accordance with the provisions in s. 627.351(6), F.S., and is governed by an eight member Board of Governors (board) that administers its Plan of Operations. The Plan of Operations is reviewed and approved by the Financial Services Commission.[43] The Governor, President of the Senate, Speaker of the House of Representatives, and Chief Financial Officer each appoint two members to the board.[44] Citizens is subject to regulation by the OIR of Insurance Regulation.

Form Review

Each insurer must file with the OIR their basic insurance policy or annuity contract forms and any application form that is to be made a part of the policy or contract.[45] These forms may not be delivered or issued for delivery unless the form has been filed with the OIR.[46]

Notice of Cancellation, Nonrenewal, or Renewal of Insurance Policies

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

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

- An insurer must give written notice of cancellation, nonrenewal, or termination at least 120 days prior to the effective date of the cancellation, nonrenewal, or termination and the notice is required to include the reason for nonrenewal, cancellation, or termination;[47] and
- An insurer must give written notice of renewal premium at least 45 days prior to the renewal premium[48] and the notice of renewal premium must specify certain information, including the dollar amount of any premium increase that is due to an approved rate increase and the total dollar amount that is due to coverage changes.[49]

Separate Roof Deductibles

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

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

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

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

Claim Handling – Late Payments

Florida's property insurance prompt payment statute provides for an insurer's[51] duty to acknowledge, investigate, and settle payment of a claim, if appropriate, within certain timeframes. These laws are meant to require insurance companies to make quick payments of any claims filed and deter unnecessary delays.

The insurer must acknowledge a filed claim within 14 days of its submission,[52] and begin an investigation, as is reasonably necessary, within 14 days after receiving a proof-of-loss statement.[53] Within 90 days of receiving notice of the initial, reopened, or supplemental claim, the insurer must either pay the claim in full, pay a portion of the claim, or deny the claim.[54,55] These provisions must be complied within the stated timeframes unless the failure is caused by

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

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

Except for claims subject to a hurricane deductible, any physical inspection must be conducted within 45 days after the insurer receives the proof-of-loss statement.[57] Within 7 days of assigning an adjuster, the insurer must notify the insured that a request may be made for an estimate of the amount of the loss. If a request is received, the insurer must send such estimate to the insured within the later of 7 days after the insurer received the request or 7 days after the detailed estimate is completed.[58]

A licensed adjuster assigned to investigate a claim must provide a policyholder with written notification of his or her name and state adjuster license number, and include it on any subsequent communication with the policyholder.[59] An insurer must keep a record or log of each adjuster who communicates with the policyholder and provide a list of such adjusters to the insured, the OIR or the DFS upon request.

Notice of Property Insurance Claims

Section 627.70132, F.S., requires insureds to notify an insurer of a claim or reopened claim,[60] within 1 year after the date of loss.[61] Notice of a supplemental claim[62] must be given to the insurer within 18 months of the date of loss or such claim is barred. Section 627.706(5), F.S., requires insureds to notify an insurer of a claim, supplemental claim, or reopened sinkhole claim within 2 years after the insured knew or reasonably should have known about the loss.

OIR Emergency Order After Natural Disasters

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

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

[56] Section 627.70131(1)(a) and (3)(a), F.S.
[57] Section 627.70131(3)(b), F.S.
[58] Section 627.70131(3)(d), F.S.
[59] Section 627.70131(3)(b) and (c), F.S.
[60] Section 627.70132(1)(a), F.S., defines "reopened claim" as a claim that an insurer has previously closed, but that has been reopened upon an insured's request for additional costs for loss or damage previously disclosed to the insurer.
[61] Section 627.702(3), F.S., provides that the date of loss for claims resulting from specified and other weather-related events, such as hurricanes and tornadoes, is the date that the hurricane made landfall or the other weather-related event is verified by the National Oceanic and Atmospheric Administration.
[62] Section 627.70132(1)(b), F.S., defines "supplemental claim" as a claim for additional loss or damage from the same peril which the insured has previously adjusted or for which costs have been incurred while completing repairs or replacement pursuant to an open claim for which timely notice was previously provided to the insurer.
[63] Section 627.7019(1), F.S.

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

Title Insurance Rates

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

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

IV. Effect of Proposed Changes:

DFS Division of Consumer Services

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

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

Annual Report on Insurer Compliance

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

Quarterly Reports of the OIR Action against Insurers

Section 3 creates s. 624.3512, F.S., to require that the OIR quarterly issue a report of all agency actions taken against insurers. The report must identify the insurer, the violation, and the penalty.

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

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

Financial Examinations

Section 4 amends s. 624.316, F.S., to require the OIR to develop a risk-based selection methodology for scheduling examinations of insurers. Such methodology must include:

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

Market Conduct Exams

Section 5 amends s. 624.3161, F.S., to require the OIR to create a risk-based selection methodology for scheduling and conducting market conduct examinations of insurers and other entities regulated by the OIR. Under such methodology, the OIR must initiate a market conduct examination if any of the following conditions exist:

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

Administrative Fines

Section 6 amends s. 624.4211, F.S., to increase caps in administrative fines to:

- For violations related to a covered loss or claim arising out of a state of emergency:
  - Non-willful violations – Up to $25,000 per violation with an aggregate up to $100,000 for violations arising out of the same action.
  - Willful violations – Up to $200,000 per violation with an aggregate up to $1,000,000 for violations arising out of the same action.
- For all other violations:
  - Non-willful violations – up to $12,500 and up to an aggregate $50,000 for violations arising out of the same action.
  - Willful violations – up to $100,000 and up to an aggregate $500,000 for violations arising out of the same action.

Financial Consideration or Payment by an Insurer to an Affiliate

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

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

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

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

Notice of Temporary Suspension of Writing New Business

Section 8 creates s. 624.4301, F.S., to require insurers to give written notice to the OIR before any temporary suspension of writing new policies at least 20 business days before the effective date of the suspension or 5 business days before notifying its agents, whichever is earlier. The notice must specify the reason for and time period of the suspension and the proposed communication to its agents.

Insurance Fraud – Licensure

Section 9 amends s. 626.207, F.S., to revise the DFS licensure suspension statutes to specify that the 7-year disqualification period for misdemeanors applies to misdemeanors related to Insurance Code violations, in addition to the current ground that the violation is directly related to the financial services business.

Fines for Unfair Insurance Trade Practices

Section 10 amends s. 626.9521, F.S., to increase the fines for any person that violates the Unfair Insurance Trade Practices Act. Fines for each nonwillful violation may not exceed $12,500 (up from $5,000) and fines for each willful violation may not exceed $100,000 (up from $40,000). Fines may not exceed an aggregate amount of $50,000 (up from $20,000) for all nonwillful violations arising out of the same action or an aggregate amount of $500,000 (up from $200,000) for all willful violations arising out of the same action.

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

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

Unfair Insurance Claims Settlement Practices

Section 11 amends s. 626.9541, F.S., to provide that it is an unfair claims settlement practice to, with such frequency as to indicate a general business practice, alter or amend an insurance adjuster's report without including on the report or as an addendum to the report a detailed list of all changes made to the report and the identity of the person who ordered each change. Any change that has the effect of reducing the estimate of the loss must include a detailed explanation why such change was made.

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

Claim Settlement Practices Relating to Motor Vehicle Insurance

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

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

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

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

DFS Insurance Fraud Investigations

Section 13 amends s. 626.989, F.S., to provide that insurance fraud referrals may be made by the DFS to the statewide prosecutor for crimes that impact two or more judicial circuits.

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

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

Mitigation Discounts

Section 14 amends s. 627.0629, F.S., to require insurers to provide information on their website describing the hurricane mitigation discounts available to policyholders. The bill further provides that on or before January 1, 2025, and every five years thereafter, the OIR reevaluate and update the fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm and the discounts, credits, other rate differentials, and reductions in deductibles that reflect the full actuarial value of such fixtures or construction techniques.

Insurance of Policies with Claims of Insolvent Insurers

Section 15 amends s. 627.351, F.S., to provide that the Citizens Property Insurance Corporation may not determine that a risk is ineligible for coverage with the corporation solely because such risk has unrepaired damage caused by a covered loss that is the subject of a claim that has been filed with the Florida Insurance Guaranty Association.

Form Review

Section 16 amends s. 627.410, F.S., to provide that the OIR may not waive review of the insurance documents or forms of any insurer whom the OIR enters a final order determining that such insurer violated any provision of the Insurance Code for a period of 36 months after the date of such order.

Claims Handling Manuals

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

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

Cancellation during Pending Claims

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

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

Administration of Claims

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

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

- Retains all written communications and notes and retains a summary of all verbal communications in a reasonable manner for a period of not less than 5 years after the later of the entry of a judgment against the insured in excess of policy limits becomes final, or the conclusion of the extracontractual claim, if any, including any related appeals.
- Provides the insured, upon request, with all communications related to the insurer's handling of the claim which are not privileged as to the insured.
- Provides, at the insurer's expense, reasonable accommodations necessary to communicate effectively with an insured covered under the Americans with Disabilities Act.
- In handling third-party claims, communicates to an insured the identity of any other person or entity the insurer has reason to believe may be liable; the insurer's evaluation of the claim; the likelihood and possible extent of an excess judgment; steps the insured can take to avoid exposure to an excess judgment, including the right to secure personal counsel at the insured's expense; and the insured's duty to cooperate with the insurer, including any specific requests required because of a settlement opportunity or by the insurer in accordance with the policy, the purpose of the required cooperation, and the consequences of refusing to cooperate; and any settlement demands or offers.
- If, after the expiration of the safe harbor periods in s. 624.155(4) or (6), F.S., as applicable, the facts available to the insurer indicate that the insured's liability is likely to exceed the policy limits, initiates settlement negotiations by tendering its policy limits to the claimant in exchange for a general release of the insured.
- Gives fair consideration to a settlement offer that is not unreasonable under the facts available to the insurer and failure to settle, if possible, when a reasonably prudent person, faced with the prospect of paying the total probable exposure of the insured, would do so. The insurer must provide reasonable assistance to the insured to comply with the insured's obligations to cooperate and act reasonably to attempt to satisfy any conditions of a claimant's settlement offer. If it is not possible to settle a liability claim within the available policy limits, the insurer must act reasonably to attempt to minimize the excess exposure to the insured.
- When multiple claims arise out of a single occurrence, the combined value of all claims exceeds the total of all applicable policy limits, and the claimants are unwilling to globally settle within the policy limits, thereafter, attempts to minimize the magnitude of possible excess judgments against the insured. The insurer is entitled to great discretion to decide how much to offer each respective claimant in its attempt to protect the insured. The insurer may, in its effort to minimize the excess liability of the insured, use its discretion to offer the full available policy limits to one or more claimants to the exclusion of other claimants and may leave the insured exposed to some liability after all the policy limits are paid. An insurer does not violate this section simply because it is unable to settle all claims in a multiple claimant case.
- When a loss creates the potential for a third-party claim against more than one insured, attempts to settle the claim on behalf of all insureds against whom a claim may be presented. If it is not possible to settle on behalf of all insureds, the insurer, in consultation with the insureds, must attempt to enter into reasonable settlements of claims against certain insureds to the exclusion of other insureds.
- Responds to any request for insurance information in compliance with s. 626.9372 or s. 627.4137, F.S., as applicable.

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

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

Roof Deductibles

Section 20 amends s. 627.701(10), F.S., to provide that if a roof deductible is applied, no other deductible under the policy may be applied to the loss "or to any other loss to the property caused by the same covered peril."

Notice of Property Insurance Claims

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

OIR Emergency Order after Natural Disasters

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

Title Insurance Rates

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

Legislative Intent

Section 24 provides legislative intent that Chapter 2022-271, Laws of Florida, passed during Special Session A in December 2023, shall not be construed to impair any right under an insurance contract in effect on or before the effective date of that chapter law (December 16, 2022). The bill provides that to the extent that Chapter 2022-271, Laws of Florida, affects a right under an insurance contract, that chapter law applies to an insurance contract issued or renewed after the effective date of that chapter law. This section is intended to clarify existing law and is remedial in nature.

Insurance Rates - Change in Law

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

- Chapter 2021-77, L.O.F. (SB 76 – 2021);

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

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

DFS Program Funding

Section 26 appropriates five positions with associated salary rate of 325,000 and the sum of $494,774 in recurring funds and $23,410 in non-recurring funds from the Insurance Regulatory Trust Fund to the DFS to implement the bill.

Effective Date

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

V. 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.

VI. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill should have a positive impact on individuals and businesses whose premiums for property insurance and motor vehicle insurance will include consideration the impact of recent legislative reforms on projected losses. Property insurance customers should benefit from more frequent updates to mitigation credits and greater public awareness of their availability. Title insurance customers should benefit from full OIR review of rates to ensure they are not excessive, inadequate, or unfairly discriminatory.

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

C. Government Sector Impact:

The bill appropriates $500,000 from the Insurance Regulatory Trust Fund for the OIR to obtain an actuarial study.

The bill appropriates five positions with associated salary rate of 325,000 and the sum of $494,774 in recurring funds and $23,410 in non-recurring funds from the Insurance Regulatory Trust Fund to the DFS to implement the bill.

VII. Technical Deficiencies:

None.

VIII. Related Issues:

None.

IX. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 624.307, 624.315, 624,316, 624.3161, 624.4211, 624.424, 626.207, 626.9521, 626.9541, 626.9743, 626.989, 627.0629, 627.351, 627.410, 627.4133, 627.426, 627.701, 627.70132, 627.7019, and 627.782.

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

X. 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.

FOR CONSIDERATION By the Committee on Banking and Insurance

597-03393A-23 20237052pb

A bill to be entitled

An act relating to insurer accountability; amending s. 624.307, F.S.; authorizing electronic responses to certain requests from the Division of Consumer Services of the Department of Financial Services concerning consumer complaints; revising the timeframe in which responses must be made; revising administrative penalties; amending s. 624.315, F.S.; specifying reporting requirements for the Office of Insurance Regulation's internal auditor in the office's annual report relating to the enforcement of insurer compliance; creating s. 624.3152, F.S.; specifying requirements for the office to report quarterly to the Legislature relating to the enforcement of insurer compliance; amending s. 624.316, F.S.; requiring the office to create a specified methodology for scheduling examinations of insurers; specifying requirements for such methodology; providing construction; amending s. 624.3161, F.S.; providing that authorized property insurers must, rather than may, be subject to an additional market conduct examination after a hurricane if specified conditions are met; revising the applicability of such conditions; requiring the office to create, and the Financial Services Commission to adopt by rule, a specified methodology for scheduling examinations of insurers; specifying requirements for such methodology; providing construction; amending s. 624.4211, F.S.; revising

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

597-03393A-23 20237052pb

administrative fines the office may impose in lieu of revocation or suspension; amending s. 624.424, F.S.; revising reporting requirements for insurers that pay financial consideration or payment to affiliates; revising factors the office must consider in determining whether such financial consideration or payment is fair and reasonable; specifying reporting requirements for insurers relating to agreements with affiliates; creating s. 624.4301, F.S.; specifying requirements for insurers temporarily suspending writing new policies in notifying the office; amending s. 626.207, F.S.; revising a condition for disqualification of an insurance representative applicant or licensee; amending s. 626.9521, F.S.; revising and specifying applicable fines for unfair methods of competition and unfair or deceptive acts or practices; amending s. 626.9541, F.S.; adding an unfair claim settlement practice by an insurer; prohibiting an officer or a director of an impaired insurer to authorize or permit the insurer to pay a bonus to any officer or director of the insurer; defining the term "bonus"; providing a criminal penalty; amending s. 626.9743, F.S.; revising applicability of provisions relating to motor vehicle insurance claim settlement practices; specifying requirements, procedures, and authorized actions for insurers relating to communications, investigations, estimates, and recordkeeping; defining the terms "factors beyond the control of the insurer" and

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

"insurer"; specifying required notices by insurers; specifying requirements and procedures for insurers in paying or denying claims; providing construction and applicability; amending s. 626.989, F.S.; revising a reporting requirement for the department's Division of Investigative and Forensic Services; requiring the division to submit an annual performance report to the Legislature; specifying requirements for the report; amending s. 627.0629, F.S.; specifying requirements for residential property insurers in providing certain hurricane mitigation discount information to policyholders in a specified manner; specifying requirements for the office in reevaluating and updating certain fixtures and construction techniques; deleting obsolete dates; amending s. 627.351, F.S.; prohibiting Citizens Property Insurance Corporation from determining that a risk is ineligible for coverage solely on a specified basis; amending s. 627.410, F.S.; prohibiting the office from exempting specified insurers from form filing requirements; creating s. 627.4108, F.S.; providing legislative intent; specifying requirements for insurers in submitting claims-handling manuals to the office; authorizing the office to conduct examinations; authorizing the commission to adopt emergency rules; amending s. 627.4133, F.S.; revising prohibitions on insurers against the cancellation or nonrenewal of property insurance policies; revising applicability; providing construction; defining the term "insurer";

amending s. 627.426, F.S.; requiring the office to ensure that each liability insurer, upon receiving certain notice, takes specified actions; providing construction; amending s. 627.701, F.S.; providing that if a roof deductible is applied under a personal lines residential property insurance policy, no other deductible under the policy may be applied to any other loss to the property caused by the same covered peril; amending s. 627.70132, F.S.; providing for the tolling of certain timeframes for filing notices of property insurance claims for servicemembers; amending s. 627.7019, F.S.; providing that surplus lines insurers are subject to the commission's rulemaking authority as to requirements of insurers after natural disasters; amending s. 627.782, F.S.; revising rate filing requirements for title insurers; providing that the office, rather than the commission, must review premium rates; providing construction relating to chapter 2022-271, Laws of Florida; requiring residential property insurers and motor vehicle insurer rate filings to reflect certain savings and reductions in expenses; specifying requirements for the office in reviewing rate filings; authorizing the office to develop certain factors and contract with a vendor for a certain purpose; providing appropriations; providing an effective date.

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

Section 1. Paragraph (b) of subsection (10) of section 624.307, Florida Statutes, is amended to read:

624.307 General powers; duties.—

(10)

(b) Any person licensed or issued a certificate of authority by the department or the office shall respond, in writing or electronically, to the division within 14 ~~20~~ days after receipt of a written request for documents and information from the division concerning a consumer complaint. The response must address the issues and allegations raised in the complaint and include any requested documents concerning the consumer complaint not subject to attorney-client or work-product privilege. The division may impose an administrative penalty for failure to comply with this paragraph of up to $5,000 ~~$2,500~~ per violation upon any entity licensed by the department or ~~the office and $250 for the first violation, $500 for the second violation, and~~ up to $1,000 per ~~for the third or subsequent~~ violation by ~~upon~~ any individual licensed by the department or the office.

Section 2. Present subsection (4) of section 624.315, Florida Statutes, is redesignated as subsection (5), and a new subsection (4) is added to that section, to read:

624.315 Annual report.—

(4) The internal auditor of the office shall detail all actions of the office to enforce insurer compliance during the previous year. For each of the following, the report must detail the insurer or other licensee or registrant against whom such action was taken; whether the office found any violation of law or rule by such party, and, if so, detail such violation; and

the resolution of such action, including any penalties imposed by the office. The report must be published on the website of the office and submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives on or before February 15 of each year. The report must include, but need not be limited to:

(a) The revocation, denial, or suspension of any license or registration issued by the office.

(b) All actions taken pursuant to s. 624.310.

(c) Fines imposed by the office for violations of this code.

(d) Consent orders entered into by the office.

(e) Examinations and investigations conducted and completed by the office pursuant to ss. 624.316 and 624.3161.

(f) Investigations conducted and completed, by line of insurance, for which the office found violations of law or rule but did not take enforcement action.

Section 3. Section 624.3152, Florida Statutes, is created to read:

624.3152 Quarterly report of enforcement activity.—Each quarter, the office shall create a report detailing all actions of the office to enforce insurer compliance. The report must be submitted to the commission, the President of the Senate, the Speaker of the House of Representatives, and the legislative committees with jurisdiction over matters of insurance. For each of the following, the report must detail the insurer or other licensee or registrant against whom such action was taken; whether the office found any violation of law or rule by such party, and, if so, detail such violation; and the resolution of

such action, including any penalties imposed by the office. The report is due on or before April 30, July 31, October 31, and January 31, respectively, for the immediately preceding quarter. The report must include, but need not be limited to:

(1) The revocation, denial, or suspension of any license or registration issued by the office.

(2) All actions taken pursuant to s. 624.310.

(3) Fines imposed by the office for violations of this code.

(4) Consent orders entered into by the office.

(5) Examinations and investigations conducted and completed by the office pursuant to ss. 624.316 and 624.3161.

(6) Investigations conducted and completed, by line of insurance, for which the office found violations of law or rule but did not take enforcement action.

Section 4. Subsection (3) is added to section 624.316, Florida Statutes, to read:

624.316 Examination of insurers.—

(3) The office shall create a risk-based selection methodology for scheduling examinations of insurers subject to this section. This requirement does not restrict the authority of the office to conduct market conduct examinations as often as it deems advisable. Such methodology must include:

(a) Use of currently required risk-based capital reports to prioritize financial examinations of insurers when such reporting indicates a decline in the insurer's financial condition.

(b) Consideration of any downgrade or threatened downgrade in the insurer's financial strength rating.

(c) Prioritization of property insurers for which the office identifies significant concerns about an insurer's solvency pursuant to s. 627.7154.

(d) Any other conditions the office deems necessary for the protection of the public.

Section 5. Subsection (7) of section 624.3161, Florida Statutes, is amended, and subsection (8) is added to that section, to read:

624.3161 Market conduct examinations.—

(7) Notwithstanding subsection (1), any authorized insurer transacting property insurance business in this state must ~~may~~ be subject to an additional market conduct examination after a hurricane if, at any time more than 90 days after the end of the hurricane, the insurer:

(a) Is among the top 20 percent of insurers based upon a calculation of the ratio of hurricane-related property insurance claims filed to the number of property insurance policies in force;

(b) Is among the top 20 percent of insurers based upon a calculation of the ratio of consumer complaints made to the department to hurricane-related claims;

(c) Has made significant payments to its managing general agent since the hurricane; or

(d) Is identified by the office as necessitating a market conduct exam for any other reason.

All relevant criteria under this section and s. 624.316 shall be applied to the market conduct examination under this subsection. Such an examination must be initiated within 18 months after the

landfall of a hurricane that results in an executive order or a state of emergency issued by the Governor. This requirement does not limit in any way the authority of the office to conduct at any time a market conduct examination of a property insurer in the aftermath of a hurricane. An examination of an insurer under this subsection must also include an examination of its managing general agent as if it were the insurer.

(8) The office shall create, and the commission shall adopt by rule, a risk-based selection methodology for scheduling and conducting market conduct examinations of insurers and other entities regulated by the office. This requirement does not restrict the authority of the office to conduct market conduct examinations as often as it deems necessary. Under such selection methodology, the office must initiate a market conduct examination if any of the following conditions exist relating to an insurer or other entity regulated by the office:

(a) An insurance regulator in another state has initiated or taken regulatory action against the insurer or entity, including, but not limited to:

1. A licensure denial, suspension, or revocation;

2. Imposition of administrative fines; or

3. Issuance of a cease and desist order, consent order, or other order regarding actions or omissions of the insurer or entity.

(b) Given the insurer's market share in this state, the department or the office has received a disproportionate number of the following types of claims-handling complaints against the insurer:

1. Failure to timely communicate with respect to claims;

2. Failure to timely pay claims;

3. Untimely payments giving rise to the payment of statutory interest;

4. Failure to adjust and pay claims in accordance with the terms and conditions of the policy or contract and in compliance with state law;

5. Violations of the Unfair Insurance Trade Practices Act in part IX of chapter 626;

6. Failure to use licensed and duly appointed claims adjusters;

7. Failure to maintain reasonable claims records; or

8. Failure to adhere to the company's claims-handling manual.

(c) The results of a National Association of Insurance Commissioners Market Conduct Annual Statement indicate the insurer is a negative outlier with regard to particular metrics.

(d) There is evidence the insurer is engaged in a pattern or practice of violations of the Unfair Insurance Trade Practices Act.

(e) The insurer meets the criteria in subsection (7).

(f) Any other conditions the office deems necessary for the protection of the public.

Section 6. Section 624.4211, Florida Statutes, is amended to read:

624.4211 Administrative fine in lieu of suspension or revocation.—

(1) If the office finds that one or more grounds exist for the discretionary revocation or suspension of a certificate of authority issued under this chapter, the office may, in lieu of

such revocation or suspension, impose a fine upon the insurer.

(2)(a) With respect to a ~~any~~ nonwillful violation, such fine may not exceed:

1. Twenty-five thousand dollars per violation, up to an aggregate amount of $100,000 for all nonwillful violations arising out of the same action, related to a covered loss or claim caused by an emergency for which the Governor declared a state of emergency pursuant to s. 252.36.

2. Twelve thousand five hundred dollars ~~$5,000~~ per violation, up to~~. In no event shall such fine exceed~~ an aggregate amount of $50,000 ~~$20,000~~ for all other nonwillful violations arising out of the same action.

(b) If an insurer discovers a nonwillful violation, the insurer shall correct the violation and, if restitution is due, make restitution to all affected persons. Such restitution shall include interest at 12 percent per year from either the date of the violation or the date of inception of the affected person's policy, at the insurer's option. The restitution may be a credit against future premiums due provided that interest accumulates until the premiums are due. If the amount of restitution due to any person is $50 or more and the insurer wishes to credit it against future premiums, it shall notify such person that she or he may receive a check instead of a credit. If the credit is on a policy that is not renewed, the insurer shall pay the restitution to the person to whom it is due.

(3)(a) With respect to a ~~any~~ knowing and willful violation of a lawful order or rule of the office or commission or a provision of this code, the office may impose a fine upon the insurer in an amount not to exceed:

1. Two hundred thousand dollars for each such violation, up to an aggregate amount of $1 million for all knowing and willful violations arising out of the same action, related to a covered loss or claim caused by an emergency for which the Governor declared a state of emergency pursuant to s. 252.36.

2. One hundred thousand dollars ~~$40,000~~ for each such violation, up to~~. In no event shall such fine exceed~~ an aggregate amount of $500,000 ~~$200,000~~ for all other knowing and willful violations arising out of the same action.

(b) In addition to such fines, the insurer shall make restitution when due in accordance with subsection (2).

(4) The failure of an insurer to make restitution when due as required under this section constitutes a willful violation of this code. However, if an insurer in good faith is uncertain as to whether any restitution is due or as to the amount of such restitution, it shall promptly notify the office of the circumstances; and the failure to make restitution pending a determination thereof shall not constitute a violation of this code.

Section 7. Subsection (13) of section 624.424, Florida Statutes, is amended to read:

624.424 Annual statement and other information.—

(13)(a) Each insurer doing business in this state which pays a fee, commission, or other financial consideration or payment to any affiliate directly or indirectly must ~~is required upon request to~~ provide to the office documentation supporting that such ~~any information the office deems necessary. The~~ fee, commission, or other financial consideration or payment to any affiliate is ~~must be~~ fair and reasonable for each service being

provided by contract. In determining whether the fee, commission, or other financial consideration or payment is fair and reasonable, the office shall consider, at a minimum, the following:

1. The actual cost of each service provided by an affiliate;

2. The cost of that service, if provided by a nonaffiliate;

3. The relative financial condition of the insurer and of the managing general agent;

4. The level of holding company debt and how that debt is serviced;

5. The amount of dividends paid by the managing general agent and for what purpose; and

6. Whether the terms of the written contract benefit the insurer and are in the best interest of policyholders.

(b) For each agreement with an affiliate in force on July 1, 2023, each insurer shall provide to the office no later than October 1, 2023, the cost incurred by the affiliate to provide each service, the amount charged to the insurer for each service, and the dollar amount of fees forgiven, waived, or reimbursed by the affiliate for the two most recent preceding years. If the total dollar amount charged to the insurer was greater than the total cost to provide services for either year, the insurer must explain how it determined the fee was fair and reasonable. For any proposed contract with an affiliate effective after July 1, 2023, the insurer may include a proposal for the same services by an unaffiliated third party to support that the fee, commission, or other financial consideration or payment to the affiliate is fair and reasonable ~~among other~~

~~things, the actual cost of the service being provided~~.

Section 8. Section 624.4301, Florida Statutes, is created to read:

624.4301 Notice of temporary discontinuance of writing new policies.—Any insurer, before temporarily suspending writing new policies in this state, must give written notice to the office of the insurer's reasons for such action, the effective dates of the temporary suspension, and the proposed communication to its agents. The insurer shall submit such notice to the office the earlier of 20 business days before the effective date of the temporary suspension of writing or 5 business days before notifying its agents of the temporary suspension of writing. The insurer must provide any other information requested by the office related to the insurer's temporary suspension of writing.

Section 9. Paragraph (c) of subsection (3) of section 626.207, Florida Statutes, is amended to read:

626.207 Disqualification of applicants and licensees; penalties against licensees; rulemaking authority.—

(3) An applicant who has been found guilty of or has pleaded guilty or nolo contendere to a crime not included in subsection (2), regardless of adjudication, is subject to:

(c) A 7-year disqualifying period for all misdemeanors directly related to the financial services business or any violation of the Florida Insurance Code.

Section 10. Subsections (2) and (3) of section 626.9521, Florida Statutes, are amended to read:

626.9521 Unfair methods of competition and unfair or deceptive acts or practices prohibited; penalties.—

(2) Except as provided in subsection (3), any person who

violates any provision of this part is subject to a fine in an amount not greater than $12,500 ~~$5,000~~ for each nonwillful violation and not greater than $100,000 ~~$40,000~~ for each willful violation. Fines under this subsection imposed against an insurer may not exceed an aggregate amount of $50,000 ~~$20,000~~ for all nonwillful violations arising out of the same action or an aggregate amount of $500,000 ~~$200,000~~ for all willful violations arising out of the same action. The fines may be imposed in addition to any other applicable penalty.

(3)(a) If a person violates s. 626.9541(1)(l), the offense known as "twisting," or violates s. 626.9541(1)(aa), the offense known as "churning," the person commits a misdemeanor of the first degree, punishable as provided in s. 775.082, and an administrative fine not greater than $12,500 ~~$5,000~~ shall be imposed for each nonwillful violation or an administrative fine not greater than $187,500 ~~$75,000~~ shall be imposed for each willful violation. To impose an administrative fine for a willful violation under this paragraph, the practice of "churning" or "twisting" must involve fraudulent conduct.

(b) If a person violates s. 626.9541(1)(ee) by willfully submitting fraudulent signatures on an application or policy-related document, the person commits a felony of the third degree, punishable as provided in s. 775.082, and an administrative fine not greater than $12,500 ~~$5,000~~ shall be imposed for each nonwillful violation or an administrative fine not greater than $187,500 ~~$75,000~~ shall be imposed for each willful violation.

(c) If a person violates any provision of this part and such violation is related to a covered loss or covered claim

caused by an emergency for which the Governor declared a state of emergency pursuant to s. 252.36, such person is subject to a fine in an amount not greater than $25,000 for each nonwillful violation and not greater than $200,000 for each willful violation. Fines under this paragraph imposed against an insurer may not exceed an aggregate amount of $100,000 for all nonwillful violations arising out of the same action or an aggregate amount of $1 million for all willful violations arising out of the same action.

(d) Administrative fines under paragraphs (a) and (b) ~~this subsection~~ may not exceed an aggregate amount of $125,000 ~~$50,000~~ for all nonwillful violations arising out of the same action or an aggregate amount of $625,000 ~~$250,000~~ for all willful violations arising out of the same action.

Section 11. Paragraphs (i) and (w) of subsection (1) of section 626.9541, Florida Statutes, are 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 and unfair or deceptive acts or practices:

(i) *Unfair claim settlement practices.*—

1. Attempting to settle claims on the basis of an application, when serving as a binder or intended to become a part of the policy, or any other material document which was altered without notice to, or knowledge or consent of, the insured;

2. A material misrepresentation made to an insured or any other person having an interest in the proceeds payable under

such contract or policy, for the purpose and with the intent of effecting settlement of such claims, loss, or damage under such contract or policy on less favorable terms than those provided in, and contemplated by, such contract or policy;

3. Committing or performing with such frequency as to indicate a general business practice any of the following:

a. Failing to adopt and implement standards for the proper investigation of claims;

b. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

c. Failing to acknowledge and act promptly upon communications with respect to claims;

d. Denying claims without conducting reasonable investigations based upon available information;

e. Failing to affirm or deny full or partial coverage of claims, and, as to partial coverage, the dollar amount or extent of coverage, or failing to provide a written statement that the claim is being investigated, upon the written request of the insured within 30 days after proof-of-loss statements have been completed;

f. Failing to promptly provide a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a claim or for the offer of a compromise settlement;

g. Failing to promptly notify the insured of any additional information necessary for the processing of a claim;

h. Failing to clearly explain the nature of the requested information and the reasons why such information is necessary;

~~or~~

i. Failing to pay personal injury protection insurance claims within the time periods required by s. 627.736(4)(b). The office may order the insurer to pay restitution to a policyholder, medical provider, or other claimant, including interest at a rate consistent with the amount set forth in s. 55.03(1), for the time period within which an insurer fails to pay claims as required by law. Restitution is in addition to any other penalties allowed by law, including, but not limited to, the suspension of the insurer's certificate of authority; or

j. Altering or amending an insurance adjuster's report without including on the report or as an addendum to the report a detailed list of all changes made to the report and the identity of the person who ordered each change. Any change that has the effect of reducing the estimate of the loss must include a detailed explanation why such change was made; or

4. Failing to pay undisputed amounts of partial or full benefits owed under first-party property insurance policies within 60 days after an insurer receives notice of a residential property insurance claim, determines the amounts of partial or full benefits, and agrees to coverage, unless payment of the undisputed benefits is prevented by factors beyond the control of the insurer as defined in s. 627.70131(5).

(w) *Soliciting or accepting new or renewal insurance risks or payment of certain bonuses by insolvent or impaired insurer prohibited; penalty.*—

1. Whether or not delinquency proceedings as to the insurer have been or are to be initiated, but while such insolvency or impairment exists, no director or officer of an insurer, except with the written permission of the office, shall authorize or

permit the insurer to solicit or accept new or renewal insurance risks in this state after such director or officer knew, or reasonably should have known, that the insurer was insolvent or impaired.

2. Regardless of whether delinquency proceedings as to the insurer have been or are to be initiated, but while such insolvency or impairment exists, a director or an officer of an impaired insurer may not authorize or permit the insurer to pay a bonus to any officer or director of the insurer.

3. As used in this paragraph, the term:

a. "Bonus" means a payment, in addition to an officer's or a director's usual compensation, that is in addition to any amounts contracted for or otherwise legally due.

b. "Impaired" includes impairment of capital or surplus, as defined in s. 631.011(12) and (13).

4.~~2.~~ Any such director or officer, upon conviction of a violation of this paragraph, commits ~~is guilty of~~ a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 12. Section 626.9743, Florida Statutes, is amended to read:

626.9743 Claim settlement practices relating to motor vehicle insurance.—

(1) This section shall apply to the adjustment and settlement of first- and third-party personal and commercial motor vehicle insurance claims.

(2)(a) Upon an insurer's receiving a communication with respect to a claim, the insurer shall within 7 calendar days review and acknowledge receipt of such communication unless

payment is made within that period of time or unless the failure to acknowledge is caused by factors beyond the control of the insurer. If the acknowledgment is not in writing, a notification indicating acknowledgement must be made in the insurer's claim file and dated. A communication made to or by a representative of an insurer with respect to a claim constitutes communication to or by the insurer.

(b) Such acknowledgment must be responsive to the communication. If the communication constitutes notification of a claim, unless the acknowledgment reasonably advises the claimant that the claim appears not to be covered by the insurer, the acknowledgment must provide necessary claim forms and instructions, including an appropriate telephone number.

(3)(a) Unless otherwise provided by the policy of insurance or by law, within 7 days after an insurer receives proof-of-loss statements, the insurer shall begin such investigation as is reasonably necessary unless the failure to begin such investigation is caused by factors beyond the control of the insurer.

(b) If such investigation involves a physical inspection of the motor vehicle, the licensed adjuster assigned by the insurer must provide the policyholder with a printed or electronic document containing his or her name and state adjuster license number. An insurer must conduct any such physical inspection within 7 days after its receipt of the proof-of-loss statements.

(c) Any subsequent communication with the policyholder regarding the claim must also include the name and license number of the adjuster communicating about the claim. Communication of the adjuster's name and license number may be

included with other information provided to the policyholder.

(d) An insurer may use electronic methods to investigate the loss. Such electronic methods may include any method that provides the insurer with clear color pictures or video documenting the loss, including, but not limited to, electronic photographs or video recordings of the loss and video conferencing between the adjuster and the policyholder which includes video recording of the loss. The insurer may also allow the policyholder to use such methods to assist in the investigation of the loss. An insurer may void the insurance policy if the policyholder or any other person at the direction of the policyholder, with intent to injure, defraud, or deceive any insurer, commits insurance fraud by providing false, incomplete, or misleading information concerning any fact or thing material to a claim using electronic methods. The use of electronic methods to investigate the loss does not prohibit an insurer from assigning a licensed adjuster to physically inspect the motor vehicle.

(e) The insurer must send the policyholder a copy of any detailed estimate of the amount of the loss within 7 days after the estimate is generated by the insurer's adjuster. This paragraph does not require that an insurer create a detailed estimate of the amount of the loss if such estimate is not reasonably necessary as part of the claim investigation.

(4) An insurer shall maintain:

(a) A record or log of each adjuster who communicates with the policyholder as provided in paragraphs (3)(b) and (c) and provide a list of such adjusters to the insured, the office, or the department upon request.

(b) Claim records, including dates of:

1. Any claim-related communication made between the insurer and the policyholder or the policyholder's representative;

2. The insurer's receipt of the policyholder's proof of loss statement;

3. Any claim-related request for information made by the insurer to the policyholder or the policyholder's representative;

4. Any claim-related inspections of the property made by the insurer, including physical inspections and inspections made by electronic means;

5. Any detailed estimate of the amount of the loss generated by the insurer's adjuster;

6. The beginning and end of any tolling period provided for in subsection (8); and

7. The insurer's payment or denial of the claim.

(5) For purposes of this section, the term:

(a) "Factors beyond the control of the insurer" means:

1. Any of the following events which is the basis for the office issuing an order finding that such event renders all or specified residential property insurers reasonably unable to meet the requirements of this section in specified locations, and ordering that such insurer or insurers may have additional time as specified by the office to comply with the requirements of this section: a state of emergency declared by the Governor under s. 252.36, a breach of security that must be reported under s. 501.171(3), or an information technology issue. The office may not extend the period for payment or denial of a claim for more than 30 additional days.

2. Actions by the policyholder or the policyholder's representative which constitute fraud, lack of cooperation, or intentional misrepresentation regarding the claim for which benefits are owed when such actions reasonably prevent the insurer from complying with any requirement of this section.

(b) "Insurer" means any motor vehicle insurer.

(6)(a) When providing a preliminary or partial estimate of damage regarding a claim, an insurer shall include with the estimate the following statement printed in at least 12-point bold, uppercase type: "THIS ESTIMATE REPRESENTS OUR CURRENT EVALUATION OF THE COVERED DAMAGES TO YOUR INSURED PROPERTY AND MAY BE REVISED AS WE CONTINUE TO EVALUATE YOUR CLAIM. IF YOU HAVE QUESTIONS, CONCERNS, OR ADDITIONAL INFORMATION REGARDING YOUR CLAIM, WE ENCOURAGE YOU TO CONTACT US."

(b) When providing a payment on a claim which is not the full and final payment for the claim, an insurer shall include with the payment the following statement printed in at least 12-point bold, uppercase type: "WE ARE CONTINUING TO EVALUATE YOUR CLAIM INVOLVING YOUR INSURED PROPERTY AND MAY ISSUE ADDITIONAL PAYMENTS. IF YOU HAVE QUESTIONS, CONCERNS, OR ADDITIONAL INFORMATION REGARDING YOUR CLAIM, WE ENCOURAGE YOU TO CONTACT US."

(7) Within 60 days after an insurer receives notice of an initial or supplemental motor vehicle claim from a first- or third-party claimant, the insurer shall pay or deny such claim or a portion of the claim unless the failure to pay is caused by factors beyond the control of the insurer. The insurer shall provide a reasonable explanation in writing to the policyholder of the basis in the insurance policy, in relation to the facts

or applicable law, for the payment, denial, or partial denial of a claim. If the insurer's claim payment is less than specified in any insurer's detailed estimate of the amount of the loss, the insurer must provide a reasonable explanation in writing of the difference to the policyholder. Any payment of an initial or supplemental claim or portion of such claim made 60 days after the insurer receives notice of the claim, or made after the expiration of any additional timeframe provided to pay or deny a claim or a portion of a claim made pursuant to an order of the office finding factors beyond the control of the insurer, whichever is later, bears interest at the rate set forth in s. 55.03. Interest begins to accrue from the date the insurer receives notice of the claim. This subsection may not be waived, voided, or nullified by the terms of the insurance policy. If there is a right to prejudgment interest, the insured must select whether to receive prejudgment interest or interest under this subsection. Interest is payable when the claim or portion of the claim is paid. Failure to comply with this subsection constitutes a violation of this code. However, failure to comply with this subsection does not form the sole basis for a private cause of action.

(8) The requirements of this section are tolled:

(a) During the pendency of any mediation proceeding under s. 627.745 or any alternative dispute resolution proceeding provided for in the insurance contract. The tolling period ends upon the end of the mediation or alternative dispute resolution proceeding.

(b) Upon the failure of a policyholder or a representative of the policyholder to provide material claims information

requested by the insurer within 10 days after the request was received. The tolling period ends upon the insurer's receipt of the requested information. Tolling under this paragraph applies only to requests sent by the insurer to the policyholder or a representative of the policyholder at least 15 days before the insurer is required to pay or deny the claim or a portion of the claim under subsection (7).

(9) This section also applies to surplus lines insurers and surplus lines insurance authorized under ss. 626.913-626.937 providing motor vehicle coverage.

(10) ~~(2)~~ An insurer may not, when liability and damages owed under the policy are reasonably clear, recommend that a third-party claimant make a claim under his or her own policy solely to avoid paying the claim under the policy issued by that insurer. However, the insurer may identify options to a third-party claimant relative to the repair of his or her vehicle.

(11) ~~(3)~~ An insurer that elects to repair a motor vehicle and specifically requires a particular repair shop for vehicle repairs shall cause the damaged vehicle to be restored to its physical condition as to performance and appearance immediately prior to the loss at no additional cost to the insured or third-party claimant other than as stated in the policy.

(12) ~~(4)~~ An insurer may not require the use of replacement parts in the repair of a motor vehicle which are not at least equivalent in kind and quality to the damaged parts prior to the loss in terms of fit, appearance, and performance.

(13) ~~(5)~~ When the insurance policy provides for the adjustment and settlement of first-party motor vehicle total losses on the basis of actual cash value or replacement with

another of like kind and quality, the insurer shall use one of the following methods:

(a) The insurer may elect a cash settlement based upon the actual cost to purchase a comparable motor vehicle, including sales tax, if applicable pursuant to subsection (17) ~~(9)~~. Such cost may be derived from:

1. When comparable motor vehicles are available in the local market area, the cost of two or more such comparable motor vehicles available within the preceding 90 days;

2. The retail cost as determined from a generally recognized used motor vehicle industry source such as:

a. An electronic database if the pertinent portions of the valuation documents generated by the database are provided by the insurer to the first-party insured upon request; or

b. A guidebook that is generally available to the general public if the insurer identifies the guidebook used as the basis for the retail cost to the first-party insured upon request; or

3. The retail cost using two or more quotations obtained by the insurer from two or more licensed dealers in the local market area.

(b) The insurer may elect to offer a replacement motor vehicle that is a specified comparable motor vehicle available to the insured, including sales tax if applicable pursuant to subsection (17) ~~(9)~~, paid for by the insurer at no cost other than any deductible provided in the policy and betterment as provided in subsection (14) ~~(6)~~. The offer must be documented in the insurer's claim file. For purposes of this subsection, a comparable motor vehicle is one that is made by the same manufacturer, of the same or newer model year, and of similar

body type and that has similar options and mileage as the insured vehicle. Additionally, a comparable motor vehicle must be in as good or better overall condition than the insured vehicle and available for inspection within a reasonable distance of the insured's residence.

(c) When a motor vehicle total loss is adjusted or settled on a basis that varies from the methods described in paragraph (a) or paragraph (b), the determination of value must be supported by documentation, and any deductions from value must be itemized and specified in appropriate dollar amounts. The basis for such settlement shall be explained to the claimant in writing, if requested, and a copy of the explanation shall be retained in the insurer's claim file.

(d) Any other method agreed to by the claimant.

(14)~~(6)~~ When the amount offered in settlement reflects a reduction by the insurer because of betterment or depreciation, information pertaining to the reduction shall be maintained with the insurer's claim file. Deductions shall be itemized and specific as to dollar amount and shall accurately reflect the value assigned to the betterment or depreciation. The basis for any deduction shall be explained to the claimant in writing, if requested, and a copy of the explanation shall be maintained with the insurer's claim file.

(15)~~(7)~~ Every insurer shall, if partial losses are settled on the basis of a written estimate prepared by or for the insurer, supply the insured a copy of the estimate upon which the settlement is based.

(16)~~(8)~~ Every insurer shall provide notice to an insured before termination of payment for previously authorized storage

charges, and the notice shall provide 72 hours for the insured to remove the vehicle from storage before terminating payment of the storage charges.

(17)~~(9)~~ If sales tax will necessarily be incurred by a claimant upon replacement of a total loss or upon repair of a partial loss, the insurer may defer payment of the sales tax unless and until the obligation has actually been incurred.

(18)~~(10)~~ Nothing in this section shall be construed to authorize or preclude enforcement of policy provisions relating to settlement disputes.

Section 13. Subsection (6) of section 626.989, Florida Statutes, is amended, and subsection (10) is added to that section, to read:

626.989 Investigation by department or Division of Investigative and Forensic Services; compliance; immunity; confidential information; reports to division; division investigator's power of arrest.—

(6)(a) Any person, other than an insurer, agent, or other person licensed under the code, or an employee thereof, having knowledge or who believes that a fraudulent insurance act or any other act or practice which, upon conviction, constitutes a felony or a misdemeanor under the code, or under s. 817.234, is being or has been committed may send to the Division of Investigative and Forensic Services a report or information pertinent to such knowledge or belief and such additional information relative thereto as the department may request. Any professional practitioner licensed or regulated by the Department of Business and Professional Regulation, except as otherwise provided by law, any medical review committee as

defined in s. 766.101, any private medical review committee, and any insurer, agent, or other person licensed under the code, or an employee thereof, having knowledge or who believes that a fraudulent insurance act or any other act or practice which, upon conviction, constitutes a felony or a misdemeanor under the code, or under s. 817.234, is being or has been committed shall send to the Division of Investigative and Forensic Services a report or information pertinent to such knowledge or belief and such additional information relative thereto as the department may require.

(b) The Division of Investigative and Forensic Services shall review such information or reports and select such information or reports as, in its judgment, may require further investigation. It shall then cause an independent examination of the facts surrounding such information or report to be made to determine the extent, if any, to which a fraudulent insurance act or any other act or practice which, upon conviction, constitutes a felony or a misdemeanor under the code, or under s. 817.234, is being committed.

(c) The Division of Investigative and Forensic Services shall report any alleged violations of law which its investigations disclose to the appropriate licensing agency and state attorney or other prosecuting agency having jurisdiction, including, but not limited to, the statewide prosecutor for crimes that impact two or more judicial circuits in this state, with respect to any such violation, as provided in s. 624.310. If prosecution by the state attorney or other prosecuting agency having jurisdiction with respect to such violation is not begun within 60 days of the division's report, the state attorney or

other prosecuting agency having jurisdiction with respect to such violation shall inform the division of the reasons for the lack of prosecution.

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

(a) The total number of initial referrals received, cases opened, cases presented for prosecution, cases closed, and convictions resulting from cases presented for prosecution by the Bureau of Insurance Fraud, by type of insurance fraud and circuit.

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

(c) The number of investigations undertaken by the Bureau of Insurance Fraud which were not the result of a referral from an insurer and the outcome of those referrals.

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

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

(f) A summary of the annual report required under s. 626.9896.

(g) The total number of employees assigned to the Bureau of

Insurance Fraud, delineated by location of staff assigned; and the number and location of employees assigned to the Bureau of Insurance Fraud who were assigned to work other types of fraud cases.

(h) The average caseload and turnaround time by type of case for each investigator.

(i) The training provided during the year to insurance fraud investigators.

Section 14. Subsections (1), (3), and (4) of section 627.0629, Florida Statutes, are amended to read:

627.0629 Residential property insurance; rate filings.—

(1) It is the intent of the Legislature that insurers provide savings to consumers who install or implement windstorm damage mitigation techniques, alterations, or solutions to their properties to prevent windstorm losses. A rate filing for residential property insurance must include actuarially reasonable discounts, credits, or other rate differentials, or appropriate reductions in deductibles, for properties on which fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm have been installed or implemented. The fixtures or construction techniques must include, but are not limited to, fixtures or construction techniques that enhance roof strength, roof covering performance, roof-to-wall strength, wall-to-floor-to-foundation strength, opening protection, and window, door, and skylight strength. Credits, discounts, or other rate differentials, or appropriate reductions in deductibles, for fixtures and construction techniques that meet the minimum requirements of the Florida Building Code must be included in the rate filing.

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

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

(4) The Legislature finds that separate consideration and notice of hurricane insurance premiums will assist consumers by

providing greater assurance that hurricane premiums are lawful and by providing more complete information regarding the components of property insurance premiums. ~~Effective January 1, 1997,~~ A rate filing for residential property insurance shall be separated into two components, rates for hurricane coverage and rates for all other coverages. A premium notice reflecting a rate implemented on the basis of such a filing shall separately indicate the premium for hurricane coverage and the premium for all other coverages.

Section 15. Paragraph (ll) is added to subsection (6) of section 627.351, Florida Statutes, to read:

627.351 Insurance risk apportionment plans.—

(6) CITIZENS PROPERTY INSURANCE CORPORATION.—

(ll) The corporation may not determine that a risk is ineligible for coverage with the corporation solely because such risk has unrepaired damage caused by a covered loss that is the subject of a claim that has been filed with the Florida Insurance Guaranty Association.

Section 16. Subsection (4) of section 627.410, Florida Statutes, is amended to read:

627.410 Filing, approval of forms.—

(4) The office may, by order, exempt from the requirements of this section for so long as it deems proper any insurance document or form or type thereof as specified in such order, to which, in its opinion, this section may not practicably be applied, or the filing and approval of which are, in its opinion, not desirable or necessary for the protection of the public. The office may not exempt from the requirements of this section the insurance documents or forms of any insurer, against

whom the office enters a final order determining that such insurer violated any provision of this code, for a period of 36 months after the date of such order.

Section 17. Section 627.4108, Florida Statutes, is created to read:

627.4108 Submission of claims-handling manuals; attestation.—

(1) This section is intended to ensure that insurers are able to properly handle insurance claims, particularly during natural disasters, catastrophes, and other emergencies.

(2) Each authorized insurer and eligible surplus lines insurer conducting business in this state shall submit any and all claims-handling manuals to the office:

(a) On or before August 1, 2023;

(b) Annually thereafter, on or before May 1 of each calendar year; and

(c) Within 30 days after any updates or amendments to such manual.

(3) The insurer shall include with each such submission an attestation on a form prescribed by the commission, stating that:

(a) The insurer's claims-handling manual complies with the requirements of this code and comports to usual and customary industry claims-handling practices; and

(b) The insurer maintains adequate resources available to implement the requirements of its claims-handling manual at all times, including during extreme catastrophic events.

(4) The office may, as often as it deems necessary, conduct market conduct examinations under s. 624.3161 of insurers to

ensure compliance with this section.

(5) The commission is authorized, and all conditions are deemed met, to adopt emergency rules under s. 120.54(4), for the purpose of implementing this section. Notwithstanding any other law, emergency rules adopted under this section are effective for 6 months after adoption and may be renewed during the pendency of procedures to adopt permanent rules addressing the subject of the emergency rules.

Section 18. Paragraph (d) of subsection (2) of section 627.4133, Florida Statutes, is amended to read:

627.4133 Notice of cancellation, nonrenewal, or renewal premium.—

(2) With respect to any personal lines or commercial residential property insurance policy, including, but not limited to, any homeowner, mobile home owner, farmowner, condominium association, condominium unit owner, apartment building, or other policy covering a residential structure or its contents:

(d)1. ~~Upon a declaration of an emergency pursuant to s. 252.36 and the filing of an order by the Commissioner of Insurance Regulation,~~ An authorized insurer or surplus lines insurer may not cancel or nonrenew a personal residential or commercial residential property insurance policy covering a dwelling or residential property located in this state:

a. For a period of 90 days after the dwelling or residential property has been repaired, if such property ~~which~~ has been damaged as a result of a hurricane or wind loss that is the subject of the declaration of emergency pursuant to s. 252.36 and the filing of an order by the Commissioner of

Insurance Regulation ~~for a period of 90 days after the dwelling or residential property has been repaired~~. ~~A structure is deemed to be repaired when substantially completed and restored to the extent that it is insurable by another authorized insurer that is writing policies in this state.~~

b. Until the dwelling or residential property has been repaired, if such property was damaged by any covered peril and the provisions of sub-subparagraph a. do not apply.

2. However, an insurer or agent may cancel or nonrenew such a policy prior to the repair of the dwelling or residential property:

a. Upon 10 days' notice for nonpayment of premium; or

b. Upon 45 days' notice:

(I) For a material misstatement or fraud related to the claim;

(II) If the insurer determines that the insured has unreasonably caused a delay in the repair of the dwelling; or

(III) If the insurer has paid policy limits.

3. If the insurer elects to nonrenew a policy covering a property that has been damaged, the insurer shall provide at least 90 days' notice to the insured that the insurer intends to nonrenew the policy 90 days after the dwelling or residential property has been repaired. Nothing in this paragraph shall prevent the insurer from canceling or nonrenewing the policy 90 days after the repairs are complete for the same reasons the insurer would otherwise have canceled or nonrenewed the policy but for the limitations of subparagraph 1. The Financial Services Commission may adopt rules, and the Commissioner of Insurance Regulation may issue orders, necessary to implement

this paragraph.

4. This paragraph shall also apply to personal residential and commercial residential policies covering property that was damaged as the result of Hurricane Ian or Hurricane Nicole ~~Tropical Storm Bonnie, Hurricane Charley, Hurricane Frances, Hurricane Ivan, or Hurricane Jeanne~~.

5. For purposes of this paragraph:

a. A structure is deemed to be repaired when substantially completed and restored to the extent that it is insurable by another authorized insurer writing policies in this state.

b. "Insurer" means an authorized insurer or an eligible surplus lines insurer.

Section 19. Subsection (3) is added to section 627.426, Florida Statutes, to read:

627.426 Claims administration.—

(3)(a) The office shall ensure that each liability insurer, upon receiving actual notice of an incident or a loss that could give rise to a covered liability claim under an insurance policy:

1. Assigns a duly licensed and appointed insurance adjuster to investigate the extent of the insured's probable exposure and diligently attempts to resolve any questions concerning the existence or extent of the insured's coverage.

2. Based on available information, ethically evaluates every claim fairly, honestly, and with due regard for the interests of the insured; considers the extent of the claimant's recoverable damages; and considers the information in a reasonable and prudent manner.

3. Requests from the insured or claimant additional

relevant information the insurer reasonably deems necessary to evaluate whether to settle a claim.

4. Conducts all oral and written communications with the insured with the utmost honesty and complete candor.

5. Makes reasonable efforts to explain to persons not represented by counsel matters requiring expertise beyond the level normally expected of a layperson with no training in insurance or claims-handling issues.

6. Retains all written communications and notes and retains a summary of all verbal communications in a reasonable manner for a period of not less than 5 years after the later of the entry of a judgment against the insured in excess of policy limits becomes final or the conclusion of the extracontractual claim, if any, including any related appeals.

7. Provides the insured, upon request, with all communications related to the insurer's handling of the claim which are not privileged as to the insured.

8. Provides, at the insurer's expense, reasonable accommodations necessary to communicate effectively with an insured covered under the Americans with Disabilities Act.

9. In handling third-party claims, communicates to an insured all of the following:

a. The identity of any other person or entity the insurer has reason to believe may be liable.

b. The insurer's evaluation of the claim.

c. The likelihood and possible extent of an excess judgment.

d. Steps the insured can take to avoid exposure to an excess judgment, including the right to secure personal counsel

at the insured's expense.

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

10. If, after the expiration of the safe harbor periods in s. 624.155(4) or (6), as applicable, the facts available to the insurer indicate that the insured's liability is likely to exceed the policy limits, initiates settlement negotiations by tendering its policy limits to the claimant in exchange for a general release of the insured.

11. Gives fair consideration to a settlement offer that is not unreasonable under the facts available to the insurer and settle, if possible, when a reasonably prudent person, faced with the prospect of paying the total probable exposure of the insured, would do so. The insurer shall provide reasonable assistance to the insured to comply with the insured's obligations to cooperate and act reasonably to attempt to satisfy any conditions of a claimant's settlement offer. If it is not possible to settle a liability claim within the available policy limits, the insurer shall act reasonably to attempt to minimize the excess exposure to the insured.

12. When multiple claims arise out of a single occurrence, the combined value of all claims exceeds the total of all applicable policy limits, and the claimants are unwilling to globally settle within the policy limits, thereafter attempts to minimize the magnitude of possible excess judgments against the insured. The insurer is entitled to great discretion to decide

how much to offer each respective claimant in its attempt to protect the insured. The insurer may, in its effort to minimize the excess liability of the insured, use its discretion to offer the full available policy limits to one or more claimants to the exclusion of other claimants and may leave the insured exposed to some liability after all the policy limits are paid. An insurer does not violate this section simply because it is unable to settle all claims in a multiple claimant case.

13. When a loss creates the potential for a third-party claim against more than one insured, attempts to settle the claim on behalf of all insureds against whom a claim may be presented. If it is not possible to settle on behalf of all insureds, the insurer, in consultation with the insureds, must attempt to enter into reasonable settlements of claims against certain insureds to the exclusion of other insureds.

14. Responds to any request for insurance information in compliance with s. 626.9372 or s. 627.4137, as applicable.

15. Where it appears the insured's probable exposure is greater than policy limits, takes reasonable measures to preserve, for a reasonable period of time, evidence that is needed for the defense of the liability claim.

16. Complies with s. 627.426, if applicable.

17. Complies with any provision of the Unfair Insurance Trade Practices Act.

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

Section 20. Paragraph (a) of subsection (10) of section 627.701, Florida Statutes, is amended to read:

627.701 Liability of insureds; coinsurance; deductibles.—

(10)(a) Notwithstanding any other provision of law, an insurer issuing a personal lines residential property insurance policy may include in such policy a separate roof deductible that meets all of the following requirements:

1. The insurer has complied with the offer requirements under subsection (7) regarding a deductible applicable to losses from perils other than a hurricane.

2. The roof deductible may not exceed the lesser of 2 percent of the Coverage A limit of the policy or 50 percent of the cost to replace the roof.

3. The premium that a policyholder is charged for the policy includes an actuarially sound credit or premium discount for the roof deductible.

4. The roof deductible applies only to a claim adjusted on a replacement cost basis.

5. The roof deductible does not apply to any of the following events:

a. A total loss to a primary structure in accordance with the valued policy law under s. 627.702 which is caused by a covered peril.

b. A roof loss resulting from a hurricane as defined in s. 627.4025(2)(c).

c. A roof loss resulting from a tree fall or other hazard that damages the roof and punctures the roof deck.

d. A roof loss requiring the repair of less than 50 percent of the roof.

If a roof deductible is applied, no other deductible under the

policy may be applied to the loss or to any other loss to the property caused by the same covered peril.

Section 21. Subsection (2) of section 627.70132, Florida Statutes, is amended to read:

627.70132 Notice of property insurance claim.—

(2) A claim or reopened claim, but not a supplemental claim, under an insurance policy that provides property insurance, as defined in s. 624.604, including a property insurance policy issued by an eligible surplus lines insurer, for loss or damage caused by any peril is barred unless notice of the claim was given to the insurer in accordance with the terms of the policy within 1 year after the date of loss. A supplemental claim is barred unless notice of the supplemental claim was given to the insurer in accordance with the terms of the policy within 18 months after the date of loss. The time limitations of this subsection are tolled during any term of federal or state active duty which materially affects the ability of a servicemember as defined in s. 250.01 to file a claim, supplemental claim, or reopened claim.

Section 22. Section 627.7019, Florida Statutes, is amended to read:

627.7019 Standardization of requirements applicable to insurers after natural disasters.—

(1) The commission shall adopt by rule, pursuant to s. 120.54(1)-(3), standardized requirements that may be applied to insurers and surplus lines insurers as a consequence of a hurricane or other natural disaster. The rules shall address the following areas:

(a) Claims reporting requirements.

(b) Grace periods for payment of premiums and performance of other duties by insureds.

(c) Temporary postponement of cancellations and nonrenewals.

(2) The rules adopted under this section shall require the office to issue an order within 72 hours after the occurrence of a hurricane or other natural disaster specifying, by line of insurance, which of the standardized requirements apply, the geographic areas in which they apply, the time at which applicability commences, and the time at which applicability terminates.

(3) Any emergency rule adopted under s. 120.54(4) which is in conflict with any provision of the rules adopted under this section must be by unanimous vote of the commission.

Section 23. Section 627.782, Florida Statutes, is amended to read:

627.782 Adoption of rates.—

(1) Rates for title insurance are subject to the rating provisions of this section. Title insurers shall file with the office under the procedures set forth in s. 627.062(2)(a)1. or 2. rates, rating schedules, rating manuals, premium credits or discount schedules, and surcharge schedules, and changes thereto, ~~code, the commission must adopt a rule specifying the premium~~ to be charged in this state ~~by title insurers~~ for the respective types of title insurance contracts and, for policies issued through agents or agencies, the percentage of such premium ~~required~~ to be retained by the title insurer ~~which shall not be less than 30 percent~~. However, in a transaction subject to the Real Estate Settlement Procedures Act of 1974, 12 U.S.C.

ss. 2601 et seq., as amended, no portion of the premium attributable to providing a primary title service shall be paid to or retained by any person who does not actually perform or is not liable for the performance of such service.

(2) In reviewing ~~adopting~~ premium rates, the office ~~commission~~ must give due consideration to the following:

(a) The title insurers' loss experience and prospective loss experience under closing protection letters and policy liabilities.

(b) A reasonable margin for underwriting profit and contingencies, including contingent liability under s. 627.7865, sufficient to allow title insurers, agents, and agencies to earn a rate of return on their capital that will attract and retain adequate capital investment in the title insurance business and maintain an efficient title insurance delivery system.

(c) Past expenses and prospective expenses for administration and handling of risks.

(d) Liability for defalcation.

(e) Other relevant factors.

(3) Rates may be grouped by classification or schedule and may differ as to class of risk assumed.

(4) Rates may not be excessive, inadequate, or unfairly discriminatory.

(5) The premium applies to each $100 of insurance issued to an insured.

(6) ~~The premium rates apply throughout this state.~~

~~(7) The commission shall, in accordance with the standards provided in subsection (2), review the premium as needed, but not less frequently than once every 3 years, and shall, based~~

~~upon the review required by this subsection, revise the premium if the results of the review so warrant.~~

~~(8)~~ Each title insurance agency and insurer licensed to do business in this state and each insurer's direct or retail business in this state shall maintain and submit information, including revenue, loss, and expense data, as the office determines necessary to assist in the analysis of title insurance premium rates, title search costs, and the condition of the title insurance industry in this state. Such information shall be transmitted to the office annually by May 31 of the year after the reporting year. The commission shall adopt rules relating to the collection and analysis of the data from the title insurance industry.

Section 24. Chapter 2022-271, Laws of Florida, shall not be construed to impair any right under an insurance contract in effect on or before the effective date of that chapter law. To the extent that chapter 2022-271, Laws of Florida, affects a right under an insurance contract, that chapter law applies to an insurance contract issued or renewed after the effective date of that chapter law. This section is intended to clarify existing law and is remedial in nature.

Section 25. (1) Every residential property insurer and every motor vehicle insurer rate filing made or pending with the Office of Insurance Regulation on or after July 1, 2023, must reflect the savings or reduction in claim frequency, claim severity, and loss adjustment expenses, including for attorney fees, payment of attorney fees to claimants, and any other reduction actuarially indicated, due to the combined effect of the applicable provisions of chapters 2021-77, 2022-268, 2022-

271, and 2023-15, Laws of Florida, in order to provide rate relief to policyholders as soon as practicable.

(2) The Office of Insurance Regulation must consider in its review of such rate filings the savings or reduction in claim frequency, claim severity, and loss adjustment expenses, including for attorney fees, payment of attorney fees to claimants, and any other reduction actuarially indicated, due to the combined effect of the applicable provisions of chapters 2021-77, 2022-268, 2022-271, and 2023-15, Laws of Florida. The office may develop a factor or factors using generally accepted actuarial techniques and standards to be used in its review of rate filings governed by this section. The office may contract with an appropriate vendor to advise the office in determining such factor or factors.

(3) For the 2023-2024 fiscal year, the sum of $500,000 in nonrecurring funds is appropriated from the Insurance Regulatory Trust Fund in the Department of Financial Services to the Office of Insurance Regulation to implement this section.

Section 26. For the 2023-2024 fiscal year, five positions with associated salary rate of 325,000 and the sum of $494,774 in recurring funds and $23,410 in nonrecurring funds is appropriated from the Insurance Regulatory Trust Fund to the Department of Financial Services to implement this act.

Section 27. This act shall take effect July 1, 2023.

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

Meeting Date	Bill Number or Topic
3/5/23	7052
Committee	**Amendment Barcode (if applicable)**
BAI	

Name Carolyn Johnson Phone 521-1200

Address 136 S Bronough St Email cjohnson@flchamber.com
Street

Tallahassee FL 32301
City *State* *Zip*

Speaking: ☐ For ☑ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: FL Chamber of Commerce

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

04.05.23
Meeting Date

Banking and Insurance
Committee

7052
Bill Number or Topic

Amendment Barcode (if applicable)

Name William Large

Phone 850-222-0170

Address 210 South Monroe Street
Street

Email William@fljustice.org

Tallahassee FL 32301
City *State* *Zip*

Speaking: ☐ For ☒ Against ☐ Information **OR** **Waive Speaking:** ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:

Florida Justice Reform Institute

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/5/2023
Meeting Date

SPB 752
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Insurer Accountability

Name Dale Swope

Job Title

Address 1234 5th Ave Tampa FL
Street

Phone 813 477 4008

33605
City *State* *Zip*

Email Dales@Swopelaw.com

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Taxpayers Against Insurance Bad Faith.

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
Senate professional staff conducting the meeting

4/5/23
Meeting Date

B & I
Committee

7052
Bill Number or Topic

Amendment Barcode (if applicable)

Name Katie Webb

Phone 850 228 6016

Address 119 E Park Ave
Street

Email kwebb@colodnylass.com

Tall. FL 32301
City State Zip

Speaking: ☐ For ☐ Against ☒ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:
APCIA

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

April 5, 2023
Meeting Date

Banking & Insurance
Committee

SPB 7052
Bill Number or Topic

Amendment Barcode (if applicable)

Name Michael Carlson

Phone 850-544-9576

Address 215 S. Monroe St. Ste. 835
Street

Email michael.carlson@piff.net

Tallahassee FL 32301
City *State* *Zip*

Speaking: ☐ For ☑ Against ☐ Information **OR** **Waive Speaking:** ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Personal Insurance Federation of Florida

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

DUPLICATE

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

4/5/23
Meeting Date

Banking & Insurance
Committee

7052
Bill Number or Topic

Amendment Barcode (if applicable)

Name Gary Guzzo

Phone (850) 681-0024

Address 108 S Monroe St
Street

Email gguzzo@flapartners.com

Tallahassee FL 32312
City *State* *Zip*

Speaking: ☐ For ☑ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:

Florida Insurance Council

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

April 5, 2023
Meeting Date

SPB 7052
Bill Number or Topic

Senate Banking' Insurance
Committee

Amendment Barcode (if applicable)

Name Scott Merritt

Phone 850-681-6422

Address 249 E. Virginia St.
Street

Email Scott@FLTA.ORG

Tallahassee FL 32301
City State Zip

Speaking: ☐ For ☒ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

Section 23

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:
Florida Land Title Association

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

4/5/23
Meeting Date

Banking and Insurance
Committee

SPB 7052
Bill Number or Topic

Amendment Barcode (if applicable)

Name Ron Haynes

Phone (813) 223-2929

Address 117 S. Willow Ave
Street

Email rhaynes@ligorilaw.com

Tampa FL 33606
City State Zip

Speaking: ☐ For ☐ Against ☒ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☒ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

4/5/2023
Meeting Date

Banking & Insurance
Committee

SPB 7052
Bill Number or Topic

Amendment Barcode (if applicable)

Name Stephen Cain

Phone 305-358-6644

Address 2185 Monroe St
Street

Email scain@sfflaw.com

Tallahassee FL 32301
City State Zip

Speaking: ☐ For ☐ Against ☒ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☒ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

4/5/23
Meeting Date

B & I
Committee

7052
Bill Number or Topic

Amendment Barcode (if applicable)

Name Peter Dunbar

Phone 850/999-4100

Address 106 E. College Ave Suite 1200
Street

Email pdunbar@deenmead.com

Tallahassee 32301
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☒ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing: Real Property, Probate & Trust Law Section of the Florida Bar

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

SPB-7052

Meeting Date

Deliver both copies of this form to
Senate professional staff conducting the meeting

Bill Number or Topic

Committee

Amendment Barcode (if applicable)

Name Kamahl Kimble

Phone 689-280-0779

Address 15130 w Colonial Drive
Street

Email DynastyCutz4000@gmail

Winter Garden FL 34787
City *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

4/5
Meeting Date

Banking & Insurance
Committee

7052
Bill Number or Topic

Amendment Barcode (if applicable)

Name AUSTIN STOWERS

Phone 850 413 5939

Address 200 E GAINES
Street

Email austin.stowers@myfloridacfo.com

TALLAHASSEE FL 32399
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:
CFO. PATRONIS & DEPARTMENT OF FINANCIAL SERVICES

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

4/5/23
Meeting Date

Banking & Insurance
Committee

7052
Bill Number or Topic

Amendment Barcode (if applicable)

Name Caitlin Murray

Phone (850) 491-8424

Address
Street

Email CMurray@naminc.org

City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☒ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:
National Association of Mutual Insurance Companies

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

4-5-23
Meeting Date

Banking And Insurance
Committee

SPB7052
Bill Number or Topic

Amendment Barcode (if applicable)

Name Matt Shurman

Phone 954 994 4945

Address 10901 NW 32 Ct
Street

Email MatthewShurman1987@gmail.com

Coral Springs | FL | 33065
City | *State* | *Zip*

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

Representing Gary Rosen, PhD.
Certified Mold Free Corp

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Banking and Insurance
ITEM: SPB 7052
FINAL ACTION: Submitted and Reported Favorably as Committee Bill
MEETING DATE: Wednesday, April 5, 2023
TIME: 8:30—10:30 a.m.
PLACE: 412 Knott Building

FINAL VOTE								
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
		Broxson						
X		Burgess						
X		Burton						
X		Hutson						
		Ingoglia						
X		Mayfield						
X		Powell						
X		Thompson						
		Torres						
		Trumbull						
X		DiCeglie, VICE CHAIR						
X		Boyd, CHAIR						
8	0	**TOTALS**						
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

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:	SPB 7054
INTRODUCER:	Banking and Insurance Committee
SUBJECT:	Central Bank Digital Currency
DATE:	April 5, 2023
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Moody	Knudson	BI	**BI Submitted as Comm. Bill/Fav.**

I. Summary:

SPB 7054 aims to protect Floridians' privacy and other rights by prohibiting a United States Federal Reserve central bank digital currency (CBDC), to the extent one is developed, and foreign CBDC from being treated as money under the Florida Uniform Commercial Code (Florida UCC). The bill defines CBDC in the Florida UCC, in summary, as a digital currency that is issued by the U.S. Federal Reserve, foreign reserve system, or other specified entity, or that is processed or validated directly by them. The bill excludes CBDC from the definition of "money" in s. 671.201, F.S.

The bill has no impact on state or local revenues and expenditures and an indeterminate impact on the private sector. See Section V. Fiscal Impact Statement.

The bill provides an effective date of July 1, 2023.

II. Present Situation:

Money in the United States

The U.S. Constitution provides Congress with the power to "…coin Money, regulate the Value thereof, and of foreign Coin, and fix the Standard of Weights and Measures."[1] The Supreme Court has construed this provision to mean that Congress has exclusive power to regulate every phase of currency.[2] The Supreme Court has found that "the authority to impose requirements of uniformity and parity is an essential feature of the control of currency," and Congress may do so by adopting legislation.[3]

[1] Art. I, s. 8, cl. 5, U.S. Constitution

[2] Congress.gov, *Constitution Annotated, Art1.S8.C5.1 Congress's Coinage Power*, available at: Congress's Coinage Power | Constitution Annotated | Congress.gov | Library of Congress (last visited Mar. 31, 2023) (citing *Houston v. Moore*, 18 U.S. 1, 49 (1820); *Sturges v. Crowninshield*, 17 U.S. 122, 125 (1819)).

[3] *Norman v. Baltimore & O.R. Co.*, 294 U.S. 240, 304 (1935) (citing *Veazie Bank v. Fenno*, 8 Wall. 533, 549, 19 L.Ed. 482).

On April 2, 1792, Congress adopted the Mint Act which established the coinage system and the dollar as the unit of U.S. currency.[4] In 1793, the first U.S. coins were produced at the Philadelphia Mint and issued "Treasury notes" thereafter during times of financial stress, such as during the War of 1812, and the Mexican War of 1846.[5] In 1861, the first paper money was issued.[6]

In 1931, Congress codified the Federal Reserve Act that established the United States' Federal Reserve System and authorized the issuance of Federal Reserve notes which began in 1914.[7] In 1871, Western Union introduced the electronic fund transfer system which enabled the first electronic payment.[8]

Money serves as a medium of exchange,[9] a store of value,[10] and a unit of account.[11] In the U.S., money takes multiple forms:

- Central bank money that is a liability of the Federal Reserve Bank that comes in the form of physical currency issued by the Federal Reserve and digital balances held by commercial banks at the Federal Reserve.
- Commercial bank money is generally used by the public and is the digital form of money held in accounts at commercial banks.
- Nonbank money is digital money held as balances at nonbank financial service providers which is usually transferred by firms on their own books by using technology, such as mobile apps.[12]

Most money, over 97%, in circulation today is transacted electronically where dollars deposited online are converted into a string of digital code by commercial banks.[13] The digital processing of credit and debit card transactions and the creation of banking apps has resulted in many cash-based transactions being digitized.[14]

---

[4] National Credit Union Administration, *History of the United States Currency*, available at: History of United States Currency | MyCreditUnion.gov (hereinafter cited as "NCUA Article on the History of the U.S. Currency") (last visited Apr. 1, 2023).
[5] *Id.*
[6] *Id.*
[7] *Id.*
[8] CSG Forte, *Electronic Payments: A Brief History*, Jul. 27, 2001, available at: What Are Electronic Payments? | Electronic Payments History (forte.net) (last visited Apr. 1, 2023).
[9] "Medium of exchange" is defined as "anything generally accepted as payment in a transaction and recognized as a standard of value. Money is a medium of exchange. Garner, B., *Definition of Medium of Exchange*, Black's Law Dictionary (11th ed. 2019), available at: MEDIUM OF EXCHANGE | Secondary Sources | FE | Westlaw Edge (last visited Apr. 1, 2023).
[10] "Store of Value" is a "currency that can be stored and retrieved at a later date, without depreciating." Amoussou, M., *What is a 'Store of Value'?*, Securities.io, Jan. 4, 2023, What is a 'Store of Value'? - Securities.io (last visited Apr. 1, 2023).
[11] "Unit of account" means economics the function of money that enables the user to keep account and value transactions. Dictionary.com, *Unit of Account*, available at: Unit of account Definition & Meaning | Dictionary.com (last visited Apr. 1, 2023).
[12] Board of Governors of the Federal Reserve System, *Money and Payments: The U.S. Digital Dollar in the Age of Digital Transformation*, Jan. 2022, available at: Money and Payments: The U.S. Dollar in the Age of Digital Transformation (federalreserve.gov) (hereinafter cited as "Federal Reserve Report on Money and Payments") (last visited Apr. 1, 2023).
[13] Mookerjee, A., *What if Central Banks Issued Digital Currency?*, Harvard Business Review, Oct. 15, 2021, available at: What If Central Banks Issued Digital Currency? (hbr.org) (last visited Apr. 1, 2023).
[14] *Id.*

Digital Currencies

Digital currency is "a digital representation of value that is not available in physical form but which can be used as a medium of exchange, a unit of account, or a store of value."[15] Digital currency is transacted and stored electronically and therefore is not validated as legal tender[16] in any jurisdiction.[17] Under federal law, U.S. coins and currency, including Federal Reserve notes, but not foreign gold or silver, are "legal tender for all debts, public charges, taxes, and dues."[18]

Digital currencies can be issued in two ways: centralized or decentralized. Most privately held digital currencies, usually referred to as cryptocurrencies such as Bitcoin, are decentralized. CBDC are centralized currencies issued by central banks.[19] The Internal Revenue Service (IRS) lists cryptocurrency and stablecoins, but not CBDCs, as examples of digital assets[20] subject to taxable gains or losses that may result from transactions, such as the sale of cryptocurrency for fiat or an exchange of a digital asset for property, goods, or services.[21]

CBDC Generally

Westlaw defines CBDC as a digital or virtual currency that is "issued by a sovereign central bank as a digital representation of a certain denomination of fiat currency, such as one US dollar."[22] The value of CBDC is stable and the value changes only in relation to the underlying fiat currency changes in comparison to other fiat currencies.[23] Federal Reserve notes is the only U.S. currency still being manufactured today.[24] There are wholesale and retail CBDC. Wholesale CBDCs are primarily utilized by financial institutions and retail CBDCs are primarily used by individuals.[25]

Proponents of CBDC claim it would accomplish goals of financial inclusion and promoting the U.S. currency's international role as a reserve currency and a medium of exchange for international trade.[26] Others claim the issuance of a CBDC is not needed to digitize U.S.

---

[15] Westlaw, *Definition of Virtual Currency*, available at: Virtual Currency | Practical Law (westlaw.com) (last visited Apr. 1, 2023).
[16] "Legal tender" is money approved in a country for the payment of debts, the purchase of goods, and other exchanges for value. Black's Law Dictionary (11th ed. 2019), *Definition of Legal Tender*, available at: LEGAL TENDER | Secondary Sources | FE | Westlaw Edge (last visited Apr. 1, 2023).
[17] *Id.*
[18] 31 U.S.C. s. 5103.
[19] Frankenfield, J., *Digital Currency Types, Characteristics, Pros & Cons, Future Uses*, Investopedia, Jan. 13, 2022, available at: Digital Currency Types, Characteristics, Pros & Cons, Future Uses (investopedia.com) (last visited Mar. 31, 2023).
[20] The IRS defines "digital asset" as "any digital representation of value which is recorded on a cryptographically secured distributed ledger or any similar technology as specified by the Secretary. The Internal Revenue Service, *Digital Assets*, available at: Digital Assets | Internal Revenue Service (irs.gov) (last visited Apr. 1, 2023).
[21] *Id.*
[22] Westlaw, *Definition of Central Bank Digital Currency*, available at: Central Bank Digital Currency (CBDC) | Practical Law (westlaw.com) (last visited Apr. 1, 2023).
[23] *Id.*
[24] NCUA Article on the History of the U.S. Currency.
[25] CFI Team, *Central Bank Digital Currency (CBDC): A Form of Fiat Currency Issued by Central Banks*, CFI, Jan. 19, 2023, available at: Central Bank Digital Currency (CBDC) - Overview, Types, Benefits (corporatefinanceinstitute.com) (last visited Apr. 1, 2023).
[26] Federal Reserve Report on Money and Payments.

currency since U.S. currency is largely digital today.[27] Moreover, the issuance of a CBDC would fundamentally change the infrastructure of the U.S. banking and financial system by altering the relationship between citizens and the Federal Reserve.[28] According to the Acting Comptroller of the Currency Michael Hsu, the United States' current two-tier banking system (i.e. the use of commercial banks as intermediaries between the public and the Federal Reserve) "is not an accident. It is the result of a carefully architected monetary and banking system."[29] Further, the American Banking Association submits that a U.S. CBDC has uncertain benefits that are unlikely to be realized, there are costs associated with such a CBDC for which the Federal Reserve has not accounted, and there are more advantageous ways to achieve our shared objectives that minimize any potential risks.[30]

Eleven countries are have launched a CBDC, including the Bahamas, Jamaica, Nigeria, and eight Eastern Caribbean countries.[31] Eighteen countries are operating pilot programs for CBDC, such as China, Russia, Hong Kong, Iran, Australia, and Singapore.[32] The U.S. is reportedly in the development phase of a bank-to-bank digital currency.[33]

CBDC in the U.S.

On March 9, 2022, President Biden issued an executive order directing federal agencies to assess and report, amongst other things, the benefits and potential risks of the development and integration of a CBDC in the U.S.[34] The report made four recommendations, including:

- Advance work on a U.S. CBDC should be pursued;
- Use of an instant payment system is encouraged;
- Regulation relating to a federal framework for payments should be established; and
- Improvement of cross-border payments should be prioritized.[35]

---

[27] Morgan, R., *ABA Comments on Federal Reserve Discussion Paper Money and Payments: The US Dollar in the Age of Digital Transformation*, p. 1, May 20, 2022, available at: aba-comments-on-fed-discussion-paper-money-and-payments-05202022.pdf (hereinafter cited as "ABA Comments on Federal Reserve Discussion Paper on Money and Payments") (last visited Apr. 1, 2023).

[28] *Id.*

[29] Acting Comptroller of the Currency Michael J. Hsu, Remarks Before the Institute of International Economic Law at Georgetown University Law Center, *Thoughts on the Architecture of Stablecoins*, at p. 4, Apr. 8, 2022, available at: Acting Comptroller of the Currency Michael J. Hsu Remarks Before the Institute of International Economic Law at Georgetown University Law Center ""Thoughts on the Architecture of Stablecoins" on April 8, 2022 (occ.gov) (last visited Apr. 1, 2023) (citing Cheng, J., and Torregrossa, J., *A Lawyer's Perspective on U.S. Payment System Evolution and Money in the Digital Age*, Feb. 4, 2022).

[30] ABA Comments on Federal Reserve Discussion Paper on Money and Payments at p. 4.

[31] Atlantic Council, *Central Bank Digital Currency Tracker*, available at: Central Bank Digital Currency Tracker - Atlantic Council (last visited Mar. 31, 2023).

[32] *Id.*

[33] *Id.*; Lipsky, J., Kumar, A., *It's Official: The United State is Developing a Bank-to-Bank Digital Currency*, The Atlantic Council, Dec. 15, 2022, available at: It's official: The United States is developing a bank-to-bank digital currency - Atlantic Council (last visited Apr. 1, 2023).

[34] The American Presidency Project, *Executive Order 14067 – Ensuring Responsible Development of Digital Assets*, Mar. 9. 2022, available at: Executive Order 14067—Ensuring Responsible Development of Digital Assets | The American Presidency Project (ucsb.edu) (last visited Mar. 31, 2023).

[35] The U.S. Department of Treasury, Office of Public Affairs, *Fact Sheet: Treasury Report on the Future of Money and Payments*, Sept. 20, 2022, available at: FactSheet-Treasury-Report-Future-Money-Payments.pdf (last visited Mar. 31, 2023).

Since the report, ten banks working with an organization that is part of the Federal Reserve Bank of New York recently participated in a test for 12 weeks of an interoperable digital money platform that operates exclusively in U.S. dollars. The ten banks include: BNY Mellon, Citi, HSBC, MasterCard, PNC Bank, Swift, TD Bank, Truist, U.S. Bank, and Wells Fargo.[36]

Further, the Federal Reserve has developed the FedNow system which is an instant payment system that can "clear and settle payments in near real-time and at any time, any day of the year."[37] FedNow is expected to launch in July 2023 and it will roll out in phases.[38] The Federal Reserve will begin the formal certification of financial institutions to participate in the system beginning the first week of April 2023.[39]

U.S. legislation has recently been filed to restrict the federal government from pursuing a U.S. CBDC, such as a bill titled "CBDC Anti-surveillance Act" to prohibit the use of CBDC to implement monetary policy,[40] and other legislation that prohibits efforts to issue a U.S. CBDC.[41]

Uniform Commercial Code

2022 Amendments to Model Code

While the Federal Reserve has not made a decision about whether to issue a CBDC,[42] the Uniform Law Commission (ULC) and American Law Institute (ALI) have drafted model amendments to the Uniform Commercial Code (UCC) to provide, amongst other things, updated rules for commercial transactions involving virtual currencies and other technological developments.[43] The UCC model amendments add to the definition of "money:"

> "The term does not include an electronic record that is a medium of exchange recorded and transferable in a system that existed and operated for the medium of exchange before the medium of exchange was authorized or adopted by the government."[44]

In other words, the definition of "money" in the UCC model amendment excludes digital currency that is recorded and transferrable before it has been authorized or adopted by the federal

---

[36] PYMNTS, *10 US Banks Participating in Test of Interoperable Digital Money Platform*, Nov. 15, 2022, available at: LTK Now Enables Delivery of Social Media Ads Via Creators' Accounts (pymnts.com) (last visited Apr. 1, 2023).
[37] The Board of Governors of the Federal Reserve System, *FedNow Service*, available at: Federal Reserve Board - FedNow℠ Service (last visited Mar. 31, 2023).
[38] The Board of Governors of the Federal Reserve System, *Federal Reserve Announces July Launch for the FedNow Service*, Mar. 15, 2023, available at: Federal Reserve Board - Federal Reserve announces July launch for the FedNow Service, (last visited Mar. 31, 2023).
[39] *Id.*
[40] H.R. 1122, *CBDC Anti-Surveillance State Act* (2023-2024).
[41] *See* S. 967, *A Bill to Amend the Federal Reserve Act to Limit the Ability of Federal Reserve Banks to Issue Central Bank Digital Currency* (2023-2024); Revell, E., *Ted Cruz Introduces Bill Blocking Fed from Adopting Central Bank Digital Currency*, FoxNews, Mar. 21, 2023, available at: Ted Cruz introduces bill blocking Fed from adopting central bank digital currency | Fox Business (last visited Apr. 1, 2023).
[42] The Board of Governors of the Federal Reserve System, *Central Bank Digital Currency*, available at: Federal Reserve Board - Central Bank Digital Currency (CBDC) (last visited Mar. 31, 2023).
[43] Uniform Law Commission, *UCC, 2022 Amendments to*, available at: UCC, 2022 Amendments to - Uniform Law Commission (uniformlaws.org) (last visited Apr. 1, 2023).
[44] Uniform Law Commission and the American Law Institute, *Uniform Commercial Code Amendments (2022)*, Mar. 24, 2023, p. 7, available at: UCC Amendments (2022) Final Act with Comments 6.pdf (last visited Apr. 1, 2023).

government. In effect, the UCC model amendment opens the door for the implementation of a U.S. CBDC while excluding any other digital currency not recorded and transferrable before it was authorized by the government (e.g. Bitcoin was transferrable before it was authorized by a government as currency).[45] These suggested model amendments have not been adopted by Florida.

Florida UCC

Florida's UCC codified at chs. 670 - 680, F.S., regulates commercial and secured transactions in the state. Florida's UCC currently defines "money" as "a medium of exchange currently authorized or adopted by a domestic or foreign government. The term includes a monetary unit of account established by an intergovernmental organization or by agreement between two or more countries."[46]

III. Effect of Proposed Changes:

Section 1 creates the following definition of "central bank digital currency" in s. 671.201, F.S., of the Florida UCC general provisions:

> "[A] digital currency, a digital medium of exchange, or a digital monetary unit of account issued by the United States Federal Reserve System, a federal agency, a foreign government, a foreign central bank, or a foreign reserve system, that is made directly available to a consumer by such entities. The term includes a digital currency, a digital medium of exchange, or a digital monetary unit of account issued by the United States Federal Reserve System, a federal agency, a foreign government, a foreign central bank, or a foreign reserve system, that is processed or validated directly by such entities."

The definition of "money" in the Florida UCC under s. 671.201(24), F.S., is amended to exclude CBDC. Thus, the provisions relating to money under the Florida UCC do not apply to CBDC (as defined in the bill).

Sections 2 to 5 makes conforming cross-references to ss. 328.0015, 559.9232, 563.022, and 668.50, F.S.

Section 6 provides an effective date of July 1, 2023.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

[45] *Id.* at pp. 13-14.
[46] Section 671.201(24), F.S.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

If the federal government enacts a U.S. CBDC, the bill could implicate the Supremacy Clause of the United States Constitution.[47] Notwithstanding whether or not the federal government enacts a U.S. CBDC, the bill could also implicate the Dormant Commerce Clause.[48]

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

CBDC, as defined in the bill, may not be used as "money" for purposes of the Florida UCC. This could have an indeterminate fiscal impact on financial transactions in Florida.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

[47] "The Constitution's Supremacy Clause provides that federal law is 'the Supreme Law of the Land' notwithstanding any state law to the contrary. This language is the foundation for the doctrine of federal preemption, according to which federal law supersedes conflicting state laws." Congressional Research Service, *Federal Preemption: A Legal Primer,* Jul. 23, 2019, available at: Federal Preemption: A Legal Primer (congress.gov) (last visited Apr. 1, 2023).

[48] "In contrast to the doctrine of preemption, which generally applies in areas where Congress has acted, the so-called Dormant Commerce Clause may bar state or local regulations even where there is no relevant congressional legislation. Although the Commerce Clause is framed as a positive grant of power to Congress and not an explicit limit on states' authority, the Supreme Court has also interpreted the Clause to prohibit state laws that unduly restrict interstate commerce even in the absence of congressional legislation – i.e. where Congress is dormant…[Under the Dormant Commerce Clause,] states may not take actions that are facially neutral but unduly burden interstate commerce." Constitution Annotation, *Art1.S8.C3.7.1 Overview of Dormant Commerce Clause*, Overview of Dormant Commerce Clause | Constitution Annotated | Congress.gov | Library of Congress (last visited Apr. 1, 2023).

VIII. Statutes Affected:

This bill substantially amends sections 328.0015, 559.9232, 563.022, 668.50, and 671.201 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.

FOR CONSIDERATION By the Committee on Banking and Insurance

A bill to be entitled

An act relating to central bank digital currency; amending s. 671.201, F.S.; defining the term "central bank digital currency" and revising the definition of the term "money" for purposes of the Uniform Commercial Code; amending ss. 328.0015, 559.9232, 563.022, and 668.50, F.S.; conforming cross-references to changes made by the act; providing an effective date.

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

Section 1. Subsections (10) through (46) of section 671.201, Florida Statutes, are renumbered as subsections (11) through (47), respectively, present subsections (24), (25), and (26) of that section are amended, and a new subsection (10) is added to that section, to read:

671.201 General definitions.—Unless the context otherwise requires, words or phrases defined in this section, or in the additional definitions contained in other chapters of this code which apply to particular chapters or parts thereof, have the meanings stated. Subject to definitions contained in other chapters of this code which apply to particular chapters or parts thereof, the term:

(10) "Central bank digital currency" means a digital currency, a digital medium of exchange, or a digital monetary unit of account issued by the United States Federal Reserve System, a federal agency, a foreign government, a foreign central bank, or a foreign reserve system, that is made directly

available to a consumer by such entities. The term includes a digital currency, a digital medium of exchange, or a digital monetary unit of account issued by the United States Federal Reserve System, a federal agency, a foreign government, a foreign central bank, or a foreign reserve system, that is processed or validated directly by such entities.

(25) ~~(24)~~ "Money" means a medium of exchange that is currently authorized or adopted by a domestic or foreign government. The term includes a monetary unit of account established by an intergovernmental organization or by agreement between two or more countries. The term does not include a central bank digital currency.

(26) ~~(25)~~ Subject to subsection (28) ~~(27)~~, a person has "notice" of a fact if the person:

(a) Has actual knowledge of it;

(b) Has received a notice or notification of it; or

(c) From all the facts and circumstances known to the person at the time in question, has reason to know that it exists. A person "knows" or has "knowledge" of a fact when the person has actual knowledge of it. "Discover" or "learn" or a word or phrase of similar import refers to knowledge rather than to reason to know. The time and circumstances under which a notice or notification may cease to be effective are not determined by this section.

(27) ~~(26)~~ A person "notifies" or "gives" a notice or notification to another person by taking such steps as may be reasonably required to inform the other person in ordinary course, whether or not the other person actually comes to know of it. Subject to subsection (28) ~~(27)~~, a person "receives" a

notice or notification when:

(a) It comes to that person's attention; or

(b) It is duly delivered in a form reasonable under the circumstances at the place of business through which the contract was made or at another location held out by that person as the place for receipt of such communications.

Section 2. Paragraphs (c), (j), and (n) of subsection (2) of section 328.0015, Florida Statutes, are amended to read:

328.0015 Definitions.—

(2) The following definitions and terms also apply to this part:

(c) "Conspicuous" as defined in s. 671.201(11) ~~s. 671.201(10)~~.

(j) "Representative" as defined in s. 671.201(37) ~~s. 671.201(36)~~.

(n) "Send" as defined in s. 671.201(40) ~~s. 671.201(39)~~.

Section 3. Paragraph (f) of subsection (2) of section 559.9232, Florida Statutes, is amended to read:

559.9232 Definitions; exclusion of rental-purchase agreements from certain regulations.—

(2) A rental-purchase agreement that complies with this act shall not be construed to be, nor be governed by, any of the following:

(f) A security interest as defined in s. 671.201(39) ~~s. 671.201(38)~~.

Section 4. Paragraph (g) of subsection (2) of section 563.022, Florida Statutes, is amended to read:

563.022 Relations between beer distributors and manufacturers.—

(2) DEFINITIONS.—In construing this section, unless the context otherwise requires, the word, phrase, or term:

(g) "Good faith" means honesty in fact in the conduct or transaction concerned as defined and interpreted under s. 671.201(21) ~~s. 671.201(20)~~.

Section 5. Paragraph (d) of subsection (16) of section 668.50, Florida Statutes, is amended to read:

668.50 Uniform Electronic Transaction Act.—

(16) TRANSFERABLE RECORDS.—

(d) Except as otherwise agreed, a person having control of a transferable record is the holder, as defined in s. 671.201(22) ~~s. 671.201(21)~~, of the transferable record and has the same rights and defenses as a holder of an equivalent record or writing under the Uniform Commercial Code, including, if the applicable statutory requirements under s. 673.3021, s. 677.501, or s. 679.330 are satisfied, the rights and defenses of a holder in due course, a holder to which a negotiable document of title has been duly negotiated, or a purchaser, respectively. Delivery, possession, and indorsement are not required to obtain or exercise any of the rights under this paragraph.

Section 6. This act shall take effect July 1, 2023.

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

4/5
Meeting Date

BANKING & INSURANCE
Committee

7054
Bill Number or Topic

Amendment Barcode (if applicable)

Name AUSTIN STOWERS

Phone 850 413 5939

Address 200 E. GAINES
Street

Email austin.stowers@myfloridacfo.com

TALLAHASSEE FL 32399
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:

CFO JIMMY PATRONIS

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

4/5/23
Meeting Date

B+T
Committee

7054
Bill Number or Topic

Amendment Barcode (if applicable)

Name Anthony DiMarco

Phone 850-224-2245

Address 1001 Thomasville Rd
Street

Email advocacy@floridabankers.com

Tallahassee FL 32303
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:
FL Bankers Association

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

COMMITTEE VOTE RECORD

COMMITTEE: Banking and Insurance
ITEM: SPB 7054
FINAL ACTION: Submitted and Reported Favorably as Committee Bill
MEETING DATE: Wednesday, April 5, 2023
TIME: 8:30—10:30 a.m.
PLACE: 412 Knott Building

FINAL VOTE								
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
		Broxson						
X		Burgess						
X		Burton						
X		Hutson						
		Ingoglia						
X		Mayfield						
	X	Powell						
X		Thompson						
		Torres						
		Trumbull						
X		DiCeglie, VICE CHAIR						
X		Boyd, CHAIR						
7	1	**TOTALS**						
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
RCS=Replaced by Committee Substitute
RE=Replaced by Engrossed Amendment
RS=Replaced by Substitute Amendment
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

1270

STATE OF FLORIDA
DEPARTMENT OF STATE
Division of Elections

I, Cord Byrd, Secretary of State,
do hereby certify that

Timothy M. Cerio

is duly appointed Executive Director,

Board of Governors,
Citizens Property Insurance Corporation

for a term beginning on the First day of February, A.D., 2023, to serve at the pleasure of the Board and is subject to be confirmed by the Senate during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the First day of March, A.D., 2023.

Secretary of State

DSDE 99 (3/03)

CITIZENS PROPERTY INSURANCE CORPORATION
2101 MARYLAND CIRCLE
TALLAHASSEE, FLORIDA 32303-1001

TELEPHONE: 850.513.3757 FAX: 850-513-3903

CITIZENS
PROPERTY INSURANCE CORPORATION

February 13, 2023

Secretary of State Cord Byrd
Florida Department of State
R.A. Gray Building
500 South Bronough Street
Tallahassee, FL 32399-0250

Dear Secretary Byrd:

Please be advised the Citizens Property Insurance Corporation's Board of Governors unanimously appointed Mr. Timothy M. Cerio to serve as Executive Director at their January 31, 2023, meeting. Mr. Cerio's appointment is pursuant to F.S. 627.651 (6) and is subject to confirmation by the full Senate. His appointment is effective February 1, 2023, and he serves at the pleasure of the Board of Governors.

All questionnaires and requests for supporting documents should be directed to the following address or by email:

Citizens Property Insurance Corporation
Attn: Candace Bunker
2101 Maryland Circle
Tallahassee, Florida 32303

If your office has any questions regarding Mr. Cerio's appointment, please contact Candace Bunker, Director of Legislative & Cabinet Affairs, at 850-513-3757 or candace.bunker@citizensfla.com.

Respectfully,

Carlos Beruff, Chairman
Board of Governors

HAND DELIVERED

OATH OF OFFICE

RECEIVED
2023 FEB 24 PM 3:55
...IONS
TALLAHASSEE, FL

(Art. II. § 5(b), Fla. Const.)

STATE OF FLORIDA

County of Leon

I do solemnly swear (or affirm) that I will support, protect, and defend the Constitution and Government of the United States and of the State of Florida; that I am duly qualified to hold office under the Constitution of the State, and that I will well and faithfully perform the duties of

President/CEO and Executive Director

(Title of Office) Citizens Property Insurance Corporation

on which I am now about to enter, so help me God.

[NOTE: If you affirm, you may omit the words "so help me God." *See* § 92.52, Fla. Stat.]

Signature

Sworn to and subscribed before me by means of X *physical presence or* ___ *online notarization, this* 23 *day of* February, 2023.

Michael Maitland (Notary)

Signature of Officer Administering Oath or of Notary Public

Michael Maitland #GG 941168

Print, Type, or Stamp Commissioned Name of Notary Public

MICHAEL MAITLAND
MY COMMISSION # GG 941168
EXPIRES: April 6, 2024
Bonded Thru Notary Public Underwriters

Personally Known ☒ ***OR*** *Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

I accept the office listed in the above Oath of Office.

Mailing Address: ☑ Home ☐ Office

11412 Turkey Roost road
Street or Post Office Box

Tallahassee, Florida 32317
City, State, Zip Code

Timothy M. Cerio
Print Name

Signature

DS-DE 56 (Rev. 02/20)

4/5/23
Meeting Date

N/A
Committee

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

Confirmation
Bill Number or Topic

Amendment Barcode (if applicable)

Name Tim Cerio

Phone 850 5133757

Address 2101 Maryland Circle
Street

Email tim.cerio@citizensfla.com

Tallahassee FL 32303
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

COMMITTEE VOTE RECORD – EXECUTIVE APPOINTMENT

COMMITTEE: Banking and Insurance
NAME: Cerio, Timothy M.
BOARD: Executive Director, Citizens Property Insurance Corporation
FINAL ACTION:
MEETING DATE: Wednesday, April 5, 2023
TIME: 8:30—10:30 a.m.
PLACE: 412 Knott Building

FINAL VOTE			4/05/2023 1 Motion to Recommend Confirm Boyd					
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
		Broxson						
		Burgess						
		Burton						
		Hutson						
		Ingoglia						
		Mayfield						
		Powell						
		Thompson						
		Torres						
		Trumbull						
		DiCeglie, VICE CHAIR						
		Boyd, CHAIR						
		TOTALS	FAV	-				
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Subcommittee on Criminal and Civil Justice
Children, Families, and Elder Affairs
Commerce and Tourism
Governmental Oversight and Accountability
Military and Veterans Affairs, Space, and Domestic Security
JOINT COMMITTEES:
Joint Select Committee on Collective Bargaining

SENATOR VICTOR M. TORRES, JR.
25th District

March 30th, 2023

Jim Boyd, Chair
Banking and Insurance
404 S Monroe Street
Tallahassee, FL 32399

RE: Request for excusal from April 5th committee meeting

Dear Chair:

Due to a previously scheduled medical appointment, I am unable to attend the April 5th meeting of the Banking and Insurance Committee. Please accept this letter as a formal request for excusal of this absence. Please let me know if you have any questions or need any additional information.

Respectfully submitted,

Victor M. Torres, Jr.
Florida State Senator
District 25

C: James Knudson, Staff Director
Amaura Canty, Committee Administrative Assistant

REPLY TO:

❒ 101 Church Street, Suite 305, Kissimmee, Florida 34741 (407) 846-5187 FAX: (850) 410-4817

❒ 226 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5015

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

Kathleen Passidomo
President of the Senate

Dennis Baxley
President Pro Tempore

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Commerce and Tourism, *Chair*
Appropriations Committee on Transportation, Tourism, and Economic Development, *Vice Chair*
Appropriations Committee on Agriculture, Environment, and General Government
Banking and Insurance
Fiscal Policy
Judiciary
Transportation

SELECT COMMITTEE:
Select Committee on Resiliency

SENATOR JAY TRUMBULL
2nd District

April 4, 2023

Dear Chair Boyd,

I am respectfully requesting a formal excusal for the upcoming Banking and Insurance Committee meeting on April 5th. I regret that I will be unable to attend.

If there are any questions or concerns, please do not hesitate to call my office at (850) 487-5002.

Thank you,

Senator Jay Trumbull

REPLY TO:
❒ 840 West 11th Street, Panama City, Florida 32401 (850) 747-5454
❒ 320 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5002

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

KATHLEEN PASSIDOMO
President of the Senate

DENNIS BAXLEY
President Pro Tempore

CourtSmart Tag Report

Room: KB 412 **Case No.:** - **Type:**
Caption: Senate Banking and Insurance Committee **Judge:**

Started: 4/5/2023 8:33:53 AM
Ends: 4/5/2023 10:16:13 AM Length: 01:42:21

8:34:01 AM Chair Boyd calls meeting to order
8:34:05 AM Roll call by CAA
8:34:30 AM Quorum present
8:34:32 AM Senators Torres and Trumbull are excused
8:34:41 AM Chair Boyd makes opening remarks
8:35:10 AM Tab 4 SB 1614 by Senator Rodriguez
8:35:21 AM Take up strike all amendment 376650
8:35:27 AM Senator Rodriguez explains amendment
8:36:02 AM No questions
8:36:07 AM No appearance cards
8:36:15 AM Take up amendment to amendment 525110
8:36:33 AM Senator Rodriguez explains the amendment to the amendment
8:36:46 AM No questions
8:36:49 AM No appearance cards
8:36:52 AM Senator Rodriguez waives close
8:36:56 AM Amendment to amendment favorable
8:37:04 AM Back on main amendment 376650
8:37:19 AM Amendment adopted
8:37:25 AM Back on bill as amended
8:37:30 AM Kelly Mallette, FL Apartment Assoc. waiving in support
8:37:36 AM Chief Jim Millicon, FL Fire Chiefs Assoc. waiving in support
8:37:51 AM No debate
8:38:00 AM Senator Rodriguez waives close
8:38:03 AM Roll call SB 1614
8:38:26 AM CS/SB 1614 reported favorably
8:38:36 AM Tab 2 SB 622 by Senator Yarborough
8:39:01 AM Senator Yarborough explains the substitute amendment 140214
8:40:43 AM Questions:
8:40:46 AM Senator Thompson
8:40:56 AM Senator Yarborough
8:41:25 AM Senator Thompson
8:41:37 AM Senator Yarborough
8:41:53 AM Appearance card:
8:41:57 AM Bennett Napier, FL Life Care Residents Assoc. waiving in support
8:42:13 AM No debate
8:42:15 AM Senator Yarborough waives close on amendment
8:42:22 AM Substitute amendment favorable
8:42:29 AM Back on bill as amended
8:42:33 AM No questions
8:42:36 AM Appearance card:
8:42:39 AM Steve Bahmer, LeadingAge Florida speaking for
8:44:16 AM No debate on bill as amended
8:44:27 AM Chair Boyd comments
8:44:44 AM Senator Yarborough closes on bill as amended
8:45:21 AM Roll call CS/SB 622
8:45:45 AM CS/SB 622 reported favorably
8:45:55 AM Tab 3 SB 1344 by Senator Bradley
8:46:11 AM Senator Bradley explains the bill
8:46:46 AM No questions
8:46:50 AM Appearance cards:
8:46:55 AM Fraser Cobbe, FL Orthopedic Society speaking for
8:50:00 AM Steven Winn, FL Osteopathic Medical Assoc. waiving in support

8:50:07 AM Jarrod Fowler, FL Medical Assoc. waiving in support
8:50:18 AM No debate
8:50:25 AM Senator Bradley closes on the bill
8:50:36 AM Roll call SB 1344
8:50:59 AM SB 1344 reported favorably
8:51:06 AM Tab 7 Appointment for Tim Cerio, Executive Director of Citizens Property Insurance Corporation
8:51:31 AM Tim Cerio addresses the committee
9:01:24 AM No questions
9:01:32 AM No appearance forms
9:01:41 AM Mr. Cerio closing remarks
9:01:55 AM Chair Boyd comments
9:03:00 AM Mr. Cerio comments
9:03:16 AM Motion to recommend confirmation by Senator Mayfield
9:03:31 AM Confirmation of Mr. Cerio motion approved
9:03:47 AM Tab 5 SPB 7052 by Banking and Insurance
9:04:00 AM Senator Hutson explains SPB 7052
9:06:40 AM Questions:
9:06:46 AM Senator Thompson
9:07:19 AM Senator Hutson
9:07:39 AM Senator Thompson
9:07:53 AM Senator Hutson
9:08:00 AM Senator Thompson
9:08:30 AM Senator Hutson
9:09:04 AM Senator Thompson
9:09:24 AM Senator Hutson
9:09:43 AM Senator Thompson
9:09:56 AM Senator Hutson
9:10:20 AM Senator Powell
9:11:12 AM Senator Hutson
9:11:28 AM Senator Powell
9:11:47 AM Senator Hutson
9:12:03 AM Senator Powell
9:12:08 AM Back and forth in questions
9:16:17 AM Senator Thompson
9:16:37 AM Senator Hutson
9:16:46 AM Senator Thompson
9:16:58 AM Senator Hutson
9:17:06 AM Appearance forms:
9:17:16 AM Carolyn Johnson, FL Chamber of Commerce speaking against
9:18:42 AM William Large, FL Justice Reform Institute speaking against
9:19:59 AM Dale Swope, Taxpayers Against Insurance Bad Faith speaking for
9:22:18 AM Katie Webb, APCIA speaking for information
9:23:28 AM Michael Carlson, Personal Insurance Federation of FL speaking against
9:26:09 AM Gary Guzzo, FL Insurance Council speaking against
9:28:33 AM Scott Merritt, Executive Director FL Land Title Assoc. speaking against
9:29:30 AM Ron Haynes, FL Justice Assoc. speaking for information
9:33:32 AM Stephen Cain, speaking for information
9:36:57 AM Peter Dunbar, Real Property, Probate and Trust Law Section of the FL Bar waiving against
9:37:06 AM Austin Stowers, CFO Jimmy Patronis and Dept. of Financial Services waiving in support
9:37:13 AM Caitlin Murray, National Assoc. of Mutual Insurance Companies waiving against
9:37:21 AM Matt Shurman, Gary Rosen PhD. Certified Mold Free Corp. waiving in support
9:37:36 AM Matt Shurman, Certified Mold Free Corp. speaking
9:44:33 AM Kamahl Kimble speaking for
9:51:21 AM Debate:
9:51:24 AM Senator Powell
9:52:35 AM Senator Thompson
9:54:07 AM Chair Boyd
9:54:36 AM Senator Hutson closes on the proposed bill
9:56:22 AM Roll call on SPB 7052
9:56:41 AM SPB 7052 reported favorably as a committee bill
9:57:05 AM Tab 1 SB 46 by Senator Wright
9:57:17 AM Senator Wright explains the bill

9:58:56 AM No questions
9:58:59 AM Appearance forms:
9:59:02 AM Deborah Adamkin, FL Hemophilia Assoc. speaking for
10:03:57 AM Barney Bishop III, Small Business Pharmacy waives in support
10:04:07 AM Audrey Brown, speaking against
10:06:08 AM Donna Sabatino, FL All Copays Count speaking for
10:09:03 AM David Poole, AHF (AIDS Healthcare Foundation) waiving in support
10:09:08 AM Greg Black, FL Breast Cancer Foundation waiving in support
10:09:12 AM Toni Large, FL Society of Rheumatology waving in support
10:09:16 AM Tasha Carter, Office of the Insurance Consumer Advocate waiving in support
10:09:21 AM Jared Fowler, FL Medical Assoc. waiving in support
10:09:25 AM Chris Lyon, FL Osteopathic Medical Assoc. waiving in support
10:09:29 AM Nancy Bryan, Bio Florida, Inc. waiving in support
10:09:35 AM Susan Harbin, American Cancer Society Cancer Action Network waiving in support
10:09:41 AM Amanda Fraser, American Diabetes Association waiving in support
10:09:45 AM Jared Willis, Alliance for Patient Access waiving in support
10:09:54 AM Debate:
10:09:56 AM Senator Mayfield
10:11:42 AM Senator Wright closes on bill
10:11:49 AM Roll call SB 46
10:12:11 AM SB 46 reported favorably
10:12:17 AM Tab 6 SPB 7054 by Banking and Insurance
10:12:32 AM Senator DiCeglie explains the bill
10:12:57 AM No questions
10:13:00 AM Appearance forms:
10:13:04 AM Austin Stowers, CFO Jimmy Patronis waiving in support
10:13:11 AM Anthony DiMarco, FL Bankers Association waiving in support
10:13:27 AM No debate
10:13:30 AM Senator DiCeglie waives close
10:13:37 AM Roll call SPB 7054
10:14:03 AM SPB 7054 reported favorably as a committee bill
10:14:29 AM Senator Burgess vote after motion
10:14:45 AM Senator DiCeglie vote after motion
10:14:53 AM Senator Powell vote after motion
10:15:16 AM Senator Boyd comments
10:16:05 AM Meeting adjourned