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 438
INTRODUCER:	Senator Lee
SUBJECT:	Continuing Care Contracts
DATE:	January 12, 2018
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Pre-meeting**
2.			AGG	
3.			AP	
4.			RC	

I. Summary:

SB 438 revises provisions within the Insurance Code governing continuing care retirement communities (CCRC) or providers, which are regulated by the Office of Insurance Regulation (OIR). The CCRCs provide lifelong housing, household assistance, and nursing care in exchange for a sometimes-significant entrance fee and monthly fees. The CCRCs appeal to older Americans because they offer an independent lifestyle for as long as possible but also provide the reassurance that, as residents age or become sick or frail, they will receive the care they need. There are currently 70 licensed continuing care retirement communities in Florida.[1] About 26,000 residents lived in a CCRC during 2016.[2] The types of units provided at these facilities include rental units, skilled nursing beds, assisted living units, and independent living units.

Many of the financial accountability, solvency, and consumer protection provisions of the bill are in response to the allegations of violations of the Insurance Code by University Village, a CCRC located in Tampa, Florida. According to the OIR, unapproved owners and managers failed to cooperate with examination by the OIR and to comply with other provisions of state laws. In March 2015, within weeks of beginning an examination, the OIR and the Department of Financial Services (DFS) began the process to place University Village into receivership. As of November 2017, DFS has not been appointed as receiver due to ongoing litigation and the preemption of state authority by federal bankruptcy filings. A buyer of University Village has not been found. Residents, former residents, and estates of residents are currently owed over $9 million in unpaid refunds.

The bill provides the following changes to ch. 651, F.S.:

[1] Office of Insurance Regulation, *Presentation to the Governor's Continuing Care Advisory Council* (Aug. 2017), available at https://www.floir.com/siteDocuments/CCRCAdvisoryCouncilOIRPresentation08172017.pdf (last viewed Jan. 11, 2018).
[2] *Id.*

Solvency/Financial Accountability. The bill creates an impairment framework similar to the Insurance Code, which has been an effective early intervention tool in preventing, or mitigating the impact of insurer insolvencies. This process will allow the OIR to work with the provider much earlier when negative financial trends are identified in order to mitigate or resolve any potential issues that would put resident interests in jeopardy.

If the provider's performance falls below one of the three indicators, the provider must submit a company information report. If the provider's performance falls below two of the three key indicators, the provider is required to submit a corrective action plan and the OIR is required to conduct an examination of the provider and issue a corrective order specifying any corrective actions that the OIR deems necessary. A provider would be considered impaired if it does not meet the requirements for minimum liquid reserves, maintaining occupancy, days cash on hand, and debt service coverage ratios. Under current law, the intervention framework in ch. 651, F.S., is triggered after a provider becomes insolvent, meaning the provider is unable to pay its obligations as they come due in the normal course of business and the CCRC residents are at risk of not receiving their benefits at the CCRC or receiving a refund due to the insolvency.

Protections and Transparency for Residents. The bill creates a number of new reporting requirements for the provider to submit to the residents or residents' council. These would help residents and prospective residents to remain apprised of the status and stability of the provider and to take action to protect their interests.

For example a CCRC is required to provide notice of any new financing or refinancing to the residents' council at least 30 days before the closing date of the transaction. The notice must include a general outline of the transaction and the intended use of proceeds. This will allow residents the ability to object to financing transactions that concern them.

Further, providers are required to furnish the information to the chair of the residents' council, such as a notice of the issuance of any examination reports, a notice of the initiation of any legal or administrative proceedings by the OIR or the DFS, the reasons for any increase in the monthly fee that exceeds the rate of inflation, and a notice of any change in ownership filing submitted to the OIR.

The bill also provides an expanded process for resident complaints against providers, including the establishment of a complaint tracking system and a requirement that the OIR provide a written report to the complainant upon the disposition of a complaint.

Regulatory Oversight. The bill provides the OIR with additional authority to approve or disapprove management. To prevent actions to the detriment of the interests of the residents, the bill would also allow the OIR to institute an expedited administrative proceeding in the event a disapproved manager is not timely removed by the CCRC.

The bill changes the application requirements for a provisional certificate of authority. Owners, providers, and managers would be required to provide evidence that they are "competent and trustworthy" on their applications. Under current law, the OIR has the authority to suspend a CCRC if it finds that an officer or director is not responsible or is not of reputable character.

However, as the OIR notes, the University Village situation demonstrated, this authority is not sufficient to allow the OIR to remove an officer or director before significant damage occurs.

The bill clarifies the duty of every person being examined, and its officers, attorneys, employees, agents, and representatives, to "make freely available" to the OIR the accounts, records, documents during an examination or investigation. The bill also specifies, "any individual who willfully obstructs the department, the office, or the examiner in the examinations or investigations authorized by this part is guilty of a misdemeanor." This change directly ties to problems the OIR encountered with University Village, which refused to produce records upon request.

The bill also authorizes the OIR to examine any affiliate that has a contractual or financial relationship with the provider. The books and records of affiliates often reflect on the financial state of the provider and may be relevant to the ability of the CCRC to provide the care promised to residents. In the University Village situation, the OIR was challenged on whether or not the OIR had authority to obtain books and records of affiliates.

The bill clarifies and streamlines existing regulatory requirements. For example, the bill consolidates the application process for the acquisition of a facility and the issuance of certificate of authority into a single application.

II. Present Situation:

Continuing Care Retirement Communities (CCRC)

A continuing care facility or CCRC provide shelter and nursing care or personal services upon the payment of an entrance fee.[3] The CCRCs offer a transitional approach to the aging process, accommodating residents' changing level of care. A CCRC can include independent living apartments or houses, as well as an assisted living facility or a nursing home. The CCRCs may also offer at-home programs that provide residents CCRC services while continuing to live in their own homes until they are ready to move to the CCRC.[4] In addition to the entrance fee, a CCRC also generally charge residents monthly fees to cover costs related to health care and other aspects of community living. [5]

Regulatory oversight responsibility of CCRCs in Florida is shared primarily between the Agency for Health Care Administration (agency) and the OIR.[6] The OIR regulates CCRC providers[7] as specialty insurers. The agency 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.[8]

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[3] Sections 651.011(2), F.S.
[4] Sections 651.057 and 651.118, F.S.
[5] AARP, *About Continuing Care Retirement Communities*, available at http://www.aarp.org/relationships/caregiving-resource-center/info-09-2010/ho_continuing_care_retirement_communities.html (last viewed Jan. 7, 2018).
[6] Chapter 651, F.S.
[7] Section 651.011(12), F.S., a provider means an owner or operator.
[8] Agency for Health Care Administration reports, available at *http://www.floridahealthfinder.gov/reports-guides/nursinghomesfl.aspx* (last viewed Jan. 7, 2018) and s. 651.118, F.S.

Oversight by the Office of Insurance Regulation

Certificate of Authority

Because residents may pay, in some cases, considerable amounts in entrance fees and ongoing monthly fees, the OIR is given primary responsibility to regulate and monitor the operation of CCRCs and to determine facilities' financial condition and the management capabilities of their managers and owners.[9] If a provider is accredited through a process "substantially equivalent" to the requirements of ch. 651, F.S., the OIR may waive requirements of the chapter.[10]

In order to operate a CCRC in Florida, a provider must obtain from the OIR a COA predicated upon first receiving a provisional certificate.[11] The application process involves submitting a market feasibility study and various financial statements and information, including projected revenues and expenses, current assets and liabilities of the applicant, and expectations of the financial condition of the project, and copies of contracts.[12] Further, the applicant must provide evidence that the applicant is reputable and of responsible character.[13] A certificate of authority will be issued once a provider meets the requirements prescribed in s. 651.023, F.S.[14]

OIR Enforcement Authority

If a provider fails to meet the requirements of ch. 651, F.S., relating to a provisional certificate of authority or a certificate of authority, the OIR must notify the provider of any deficiencies and require the provider to make corrective action within a period determined by the OIR. Generally, if the CCRC does not correct such deficiencies within 20 days of such notification, the OIR shall notify the Continuing Care Advisory Council (advisory council), which may assist the CCRC in formulating a remedial plan, which must be submitted to the OIR within 60 days after the notification. If the deficiencies are not corrected by the expiration of such time required by the OIR, the OIR may initiate delinquency proceedings as provided in s. 651.114, F.S., or seek other relief provided under ch. 651, F.S.

Generally, the OIR is required to examine each CCRC once every 3 years.[15] Section 651.111, F.S., allows any interested party to request an inspection of the records and financial affairs of a provider by transmitting to the OIR notice of an alleged violation of law or rule. Upon receipt of the complaint, the OIR must make a preliminary review and make an inspection if the complaint has a reasonable basis. The complainant must be advised within 30 days after the receipt of the complaint by the OIR, of the proposed course of action by the OIR.

The OIR may deny, suspend, or revoke the provisional certificate of authority or the certificate of authority of any applicant or provider for grounds specified in s. 651.106, F.S. Further, the OIR may impose administrative fines in lieu of revocation or suspension in an amount not to exceed $1,000 per violation. If a provider has knowingly and willfully violated a lawful order or

[9] See ss. 651.021, 651.22, and 651.023, F.S.
[10] Section 651.028, F.S.
[11] Section 651.022, F.S.
[12] See ss. 651.021-651.023, F.S.
[13] Section 651.022(2)(c), F.S.
[14] Section 651.023(4)(a), F.S.
[15] Section 651.105, F.S.

a provision of ch. 651, F.S., the OIR may impose a fine not to exceed $10,000 for each violation.[16]

If the OIR institutes receivership or liquidation proceedings against a CCRC, the continuing care contracts are deemed preferred claims against assets of the provider.[17] Such claims are subordinate, however, to any secured claim. Florida law does not specify the claim status of continuing care contracts in a bankruptcy proceeding.

Continuing Care Contracts

Continuing care services are governed by a contract between the facility and the resident of a CCRC. In Florida, continuing care contracts are considered an insurance product and are reviewed and approved for the market by the OIR.[18] 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 on the lower end to over $1 million. This typically represents a substantial portion of the residents' personal assets. The CCRCs offer different types of contracts that provide for varying amounts of monthly fees and levels of healthcare discounts.

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 by the resident, in the CCRC.[19] However, many contracts exceed this requirement and contain minimum refund provisions that guarantee a refund of a specified portion (typically 50 to 90 percent) of the entrance fee upon the death of the resident or termination of the contract regardless of the length of occupancy by the resident.[20]

Financial Requirements/Solvency

The CCRCs are required to file an annual report with the OIR, which includes an audited financial report, and other detailed financial information, such as a listing of assets maintained in the liquid reserve required under s. 651.035, F.S, and information about fees required of residents.[21] The OIR has the discretion to require quarterly, unaudited financial reports if such information is necessary to monitor the financial condition of a provider or facility or to protect the public interest.[22]

Section 651.033, F.S., prescribes requirements relating to the establishment and maintenance of escrow accounts. Providers are required to maintain a minimum liquid reserve, as applicable, as prescribed in s. 651.035, F.S.

[16] Section 651.108, F.S.
[17] Section 651.071, F.S.
[18] Section 651.055(1), F.S.
[19] Section 651.055, F.S.
[20] *See* Office of Insurance Regulation, *Analysis of SB 438* (Oct. 11, 2017) (on file with the Senate Committee on Banking and Insurance).
[21] Section 651.026, F.S.
[22] Section 651.0261, F.S.

Rights of Residents in a Continuing Care Retirement Community

The OIR is also authorized to discipline a facility for violations of residents' rights.[23] 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.[24]

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, and requires that the council must be established through an election by residents.[25] Further, CCRCs are required to hold quarterly meetings at which residents' organizations may be represented.[26] The meetings are for the discussion of subjects, such as the facility's income, expenditures, financial trends, and problems, as well as proposed changes in policies, programs, and services. If the CCRC proposes the imposition or increase of a monthly maintenance fee, additional duties are placed on the CCRC provider to provide notice and give reasons for the proposed action.

The CCRCs are required to maintain certain public information, available upon request, records of all cost and inspection records pertaining to that facility that have been filed with or issued by any governmental entity.[27] These records must be retained for 5 years. The annual statement and the most recent financial audit report must be filed with the council.

Department of Financial Services

The Department of Financial Services (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.[28] Typically, residents will contact the Division of Consumer Services of the Department Financial Services, which receives and resolves complaints involving products and entities regulated by OIR or DFS.[29]

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. In Florida, the Division of Rehabilitation and Liquidation (division) within the DFS is responsible for managing insurance companies placed into receivership. The typical causes of insurer insolvency include undercapitalization, uncollectible or inflated assets, insufficient loss reserves for risks assumed, fraudulent transactions, failure to monitor agents, and mismanagement by directors and/or officers. The goal of rehabilitation is to return the insurer to solvency. The goal of

[23] Section 651.083, F.S.
[24] *Id*.
[25] Section 651.081, F.S.
[26] Section 651.085, F.S.
[27] Section 651.091, F.S.
[28] *See* Rules 69O-193.062 and 69O-193.063, F.A.C.
[29] Section 624.307, F.S.

liquidation, however, is to liquidate the business of the insurer and use the proceeds to pay claims, including those of policyholders, creditors, employees.

III. Effect of Proposed Changes:

Section 1 amends s. 651.011, F.S., to create definitions of the following terms: actuarial opinion, actuarial study, actuary, company information level event, corrective order, days cash on hand, debt service coverage ratio, impaired, manager or management company, occupancy, and regulatory action level event. In addition, the section revises the definition of records to include all documents and correspondence in any format. The current definition refers to "permanent" records without specifying how permanence is determined and leaving open the possibility that providers could simply declare a record as nonpermanent to allow deletion.

Solvency/Financial Accountability

Section 27 amends s. 651.114, F.S., to clarify that the OIR is not prohibited from taking other regulatory action while a corrective action plan is under review. A provider must make a plan for obtaining compliance or solvency within 30 days after a request from the advisory council or the office. However, the availability of remedial rights will not delay or prevent OIR from taking regulatory measures it deems necessary. The provider must give residents notice of proceedings under ch. 631, F.S., within 3 days of initiation. Prospective residents must also be given such notice in writing. If a ch. 631, F.S. show cause order be issued, the provider must respond within 20 days after service, but no less than 15 days prior to the hearing. Any hearing must be held within 60 days after the order to show cause. According to the OIR, University Village successfully delayed receivership proceedings by asserting that the OIR was prohibited from further action, although a court ultimately rejected the assertion.

The section provides that, notwithstanding s. 631.011, F.S., impairment of a provider, for purposes of s. 631.051, is defined according to the term, "impaired" in s. 651.011, F.S.

Section 11 creates s. 651.025, F.S., which will create consistency between insolvency provisions applicable to CCRCs and the provision applicable to other insurance related entities pursuant to s. 624.4073, F.S. This section requires an officer, director, or manager of an insolvent facility to demonstrate that his or her personal actions or omissions were not a significant contributing cause to the insolvency before they assume such role in the future. The intent of this provision is to keep out "bad actors" while also providing a mechanism by which those who made good faith attempts to save a provider in distress may be approved to serve with another provider.

Sections 12 and 13 amend ss. 651.026 and 651.0261, F.S., respectively to revise financial reporting requirements. Section 12 provides conforming changes relating to financial reporting. Section 13 codifies the current discretionary monthly financial reporting rule. The monthly reporting is used to monitor the financial condition of a provider or as otherwise needed to protect the public interest. Further, the section requires providers to submit a detailed listing of assets in the minimum liquid reserve with the quarterly unaudited financial statement filings, which will enable the OIR to determine whether the provider is impaired and to take action to assist providers who may fall below the impairment threshold.

Section 14 amends s. 651.033, F.S., to clarify the duties of escrow agents. The section provides that an escrow agent must receive the OIR's prior approval before releasing escrowed funds. According to the OIR, these changes are based on conversations with escrow agents who expressed confusion over their statutory responsibilities because some of the requirements are beyond those customarily undertaken by escrow agents. The section also clarifies permissible investment of escrowed funds and removes references to pt. II of ch. 625, F.S., which are based on statutory accounting practices and therefore do not apply to CCRCs.

Section 15 creates s. 651.034, F.S., to establish a financial and operating framework of required actions if a provider fails to meet three key indicators: occupancy, days cash on hand, and debt service coverage ratios as well as minimum liquid reserve. This section details the information the provider must submit to the OIR if a company level event or regulatory action level event occurs. A company level event occurs if a provider fails to meet specified debt service coverage, days cash on hand, or occupancy rate. A regulatory action level event occurs if two of the three indicators fall below minimum requirements. If impairment occurs, OIR must take action, up to and including "any remedy available under ch. 631, F.S." If the provider's performance falls below one of the three indicators (debt service coverage ratio, days cash on hand, or occupancy), the provider must submit a company information report. The company information report must identify the conditions that contributed to performance, corrective actions that will be taken, and provide projections for future results.. If the provider's performance fails to meet the key indicators, the OIR is required to conduct an examination of the provider and issue a corrective order specifying any corrective actions that the OIR deems necessary.

The impairment framework, as it exists in other lines of insurance, has been an effective tool in preventing or minimizing the impact of insurer insolvencies. Under the current provisions of ch. 651, F.S., the regulatory intervention framework is triggered after a provider becomes insolvent, meaning the provider is unable to pay its obligations as they come due in the normal course of business. The bill creates a definition for "impaired" to allow for earlier intervention by the OIR to prevent harm to Florida consumers (see Section 1 of the bill).

Section 16 amends s. 651.035, F.S., relating to the minimum liquid reserve requirements and reporting. The annual filing date for the minimum liquid reserve calculation form is changed from May 1, or 120 days after the end of a provider's fiscal year for those providers whose fiscal year end is not December 31, to 60 days before the provider's fiscal year end date. Funding of the newly calculated reserve amount remains due 60 days after the date the form is submitted although the annual funding date will change due to the change in form filing dates. This change aligns the providers' funding year and fiscal year, so that reserves reflect anticipated costs for the same time.

The section authorizes the OIR to require the transfer of reserve funds into the custody of the Bureau of Collateral Management of the Department of Financial Services if the OIR finds that the provider is impaired or insolvent in order to ensure the safety of those assets.

The section also 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. This change modifies the current requirement that providers hold funds equivalent to one year's property taxes in escrow as a reserve.

Regulatory Oversight

Section 3 amends s. 651.013, F.S., to expand the scope of laws applicable to CCRCs. Sections 624.307, 624.312, and 624.318, F.S., are added. These provisions would clarify that CCRCs must appoint the Chief Financial Officer for service of process; clarify the role of DFS Division of Consumer Services in resolving consumer complaints; and clarify the authority of the OIR in regards to examinations and investigations. Section 624.318, F.S., which applies generally to insurers, provides that it is the duty of every person being examined, and its officers, attorneys, employees, agents, and representatives, to "make freely available" to the OIR the accounts, records, documents during an examination or investigation. This section also specifies, "any individual who willfully obstructs the DFS, the OIR, or the examiner in the examinations or investigations authorized by this part is guilty of a misdemeanor." This proposal directly ties to problems the OIR encountered with University Village, which refused to produce records upon request. Finally, s. 624.312, F.S., provides that reproductions and certified copies of records are admissible as evidence. These requirements are consistent with the oversight of other licensees and consumer complaint handling subject to the Insurance Code.

Section 6 amends s. 651.022, F.S., relating to provisional certificate of authority applications, to change the current requirement of an applicant to meet the standard of being "reputable and of responsible character" and instead require the applicant to be "competent and trustworthy," which is the standard applied to all other insurer applicants. There is a significant amount of history and practice behind the "competent and trustworthy" requirement, which will allow the OIR to apply it consistently and should make it easier for applicants to determine what should be submitted in support of this requirement. The "reputable and responsible" standard has been interpreted by applicants to mean that the individual need only be a good citizen and have a favorable reputation in the community to be granted a license. In one case where it was disputed, the Division of Administrative Hearings and First District Court of Appeal ultimately rejected the applicant's assertion, but without codifying the "competent and trustworthy" standard.

The number of days for the OIR to complete its review, and act on, an application is increased from 45 days to 90 days to be consistent with other licensing requirements in the Insurance Code and ch. 120, F.S. The section clarifies that an applicant must disclose material changes that occur while a provisional certificate of authority application is pending before the OIR, which is consistent with other requirements in the Insurance Code. Under current law, the OIR can be required to disapprove an application solely because of an impending deemer date. To address this situation, the bill creates definitions for actuarial opinion, actuarial study, and actuary and clarifies that an actuarial study is required as part of a licensing application (see Section 1 of the bill). The OIR currently requests an actuarial study as part of the application under s. 651.022, F.S. Establishing the requirement in statute enables a potential applicant to anticipate the need to meet the requirement and prevents delays with the licensing process.

The bill changes the timing for completing licensing applications to be upon receipt of all requested information and correction of any errors or omissions. The current 15-day notification requirements are difficult to enforce and not in line with the rest of the Insurance Code. The change moves CCRC applications in line with insurers.

Section 7 amends s. 651.023, F.S., relating to the certificate of authority to revise the minimum unit reservation required to be eligible to submit an application for a certificate of authority from 30 percent to 50 percent. Current statute requires that "no certificate of authority shall be issued until the project has a minimum of 50 percent of the units reserved," while allowing for a certificate of authority application to be filed after 30 percent of units are reserved. Since the timeframe for a provider to obtain reservations varies, there is no way to tell how long it will take a provider to go from 30 percent to 50 percent of units reserved, possibly resulting in an application being pended for an excessive amount of time. The bill changes the timing of completion for licensing applications to be upon receipt of all requested information and correction of any errors or omissions. The current 15-day notification requirements are difficult to enforce and not in line with the rest of the Insurance Code. The change moves CCRC applications in line with the requirements of insurers.

Section 8 amends s. 651.024, F.S., relating to acquisitions, to clarify which application for acquisition statute applies to each type of transaction, including the new, streamlined provisions of s. 651.0245, F.S. The section clarifies that the assumption of the role of a general partner of a CCRC or the assumption of ownership, or possession of, or control over, 10 percent or more of a provider's assets requires an acquisition filing. For example, University Village is a limited partnership structure and in early 2014 there was a change in the limited partners. The OIR's position, which requires a person acquiring the general partnership in a CCRC to file an acquisition application, was upheld in litigation with IHM Healthcare, LLC, which was denied approval to acquire the general partnership of University Village. Codifying the ruling in statute will make this requirement clear to those seeking to acquire partnership interests in the future.

The section establishes that the Securities and Exchange Commission (SEC) Schedule 13G form may be filed in lieu of a disclaimer of control or acquisition application. For situations where a parent is publicly traded, this change would allow the filing of a 13G in lieu of a disclaimer of control or acquisition filing. A 13G is a SEC filing used to report a party's ownership of stock in a company. Insurers are able to use this filing, and some CCRCs have requested that the OIR accept such filings from them.

Section 9 creates s. 651.0245, F.S., to establish a simultaneous acquisition of a facility and issuance of a certificate of authority. Under current law, if a person applies to acquire an existing facility and become the provider, they must submit an acquisition application, a provisional certificate of authority application, and a certificate of authority application. This section streamlines the application process by creating a single combined application and removing the requirement for an applicant to file three separate filings with somewhat duplicative requirements. The language used for this section is derived from the current provisions of ss. 628.4615, 651.022 and 651.023, F.S.

Section 10 creates s. 651.0246, F.S., relating to expansions, to require only initial approval from the OIR to expand. The section establishes requirements regarding expansions that add more than 20 percent of the existing units or 20 percent more continuing care at-home contracts. Such expansion applications will require feasibility and actuarial studies. The section prescribes the factors OIR must consider in deciding whether to approve the application. It also requires 75 percent of the initial entrance fees/reservation deposits for continuing care contracts, and 50 percent of the moneys paid for initial fees for continuing care at-home contracts to be placed

in escrow or on deposit with DFS. Up to 25 percent of the money may be used for construction or financing. The escrow may be released under certain conditions. Only the provider, escrow agent, and OIR have standing under ch. 120, F.S., to seek redress regarding OIR's decision regarding the release of escrow funds. The OIR has 90 days to review and act upon complete expansion applications.

Section 17 creates s. 651.043, F.S., relating to management and contracts. This section requires management contracts be in writing, and requires providers to file notices of a change in management within 5 days of appointment of new management. The OIR has 30 days after the filing of the completed written contract to approve or disapprove. Disapproved management must be removed within 30 days after receipt of the OIR's notice. Currently, the OIR does not have authority to disapprove unaffiliated management except by taking action against the certificate of authority (COA) of the provider. It creates criteria for the OIR to determine whether management meets minimum qualification standards and allows for disapproval and removal of unqualified management.

Currently, Rule 690-193.002(13), F.A.C., specifies that a manager or management company agrees to administer the day-to-day activities of a facility pursuant to a written contract with the provider. However, the rule does not address situations where a manager or management company does not have a written contract with the provider. This change closes a loophole that has allowed management serving under an oral contract to evade regulation by the OIR.

Section 18 amends s. 651.051, F.S., to clarify that all records and assets must be maintained in the state unless prior written approval from the OIR allows for their removal. The section also allows electronic storage of records on a web-based, secured storage platform with prior approval by the OIR. In the University Village case, documents and records were created and maintained outside of the state and the OIR was not able to gain access to them.

Section 22 amends s. 651.105, F.S., which provides that the OIR, to the extent necessary to ascertain the financial condition of a provider, may examine any affiliate that has a contractual or financial relationship with the provider. The books and records of affiliates often reflect on the financial state of the provider and may be relevant to the ability of the CCRC to provide the care promised to residents. In the University Village situation, the OIR was challenged on whether or not the Office had authority to obtain books and records of affiliates.

Section 23 creates s. 651.1055, F.S., to specify that a provider has a duty to cooperate with and respond to the OIR. This provision would address situations the OIR has experienced where providers do not respond to the OIR's request for information regarding monthly, quarterly, and other filings

Section 24 amends s. 651.106, F.S., to provide additional grounds to refuse, suspend, or revoke a COA. The section is amended to add impairment to the list of grounds for suspension or revocation of a COA. The section also clarifies that the OIR may suspend or revoke a COA if owners, managers, or controlling persons are found to be incompetent, untrustworthy, or without sufficient experience to operate a CCRC.

Section 25 creates s. 651.1065, F.S., relating to soliciting or accepting new contracts by impaired or insolvent facilities or providers. Insolvency and impairment constitute grounds for suspension and revocation under the provisions of the bill. One component of suspension is preventing a provider from writing contracts where there may not be financial strength to fund those contracts. This section would require an impaired or insolvent provider to receive prior approval of the OIR before writing new contracts if its officers, directors, or managers know, or reasonably should know, that the CCRC is impaired or insolvent, even if the provider has not been formally suspended. This provision would help to protect potential residents who may be considering investing substantial funds into the purchase of a CCRC contract. The OIR would have discretion to allow the issuance of new contracts where safeguards are adequate. The provision provides that a violation of this section is a felony of the third degree, which is consistent with regulations for other insurance entities.

Section 28 creates s. 651.1141, F.S. to clarify that certain statutory violations are an immediate danger to the public health, safety, or welfare, which would authorize the OIR to issue an immediate final order to cease and desist. This change will allow the OIR to take more expedited action to protect the assets of the provider and the significant investments of the residents. Non-compliance with the following statutes would constitute grounds for an immediate final order:

- Section 651.024, F.S. – Acquisition
- Section 651.0245, F.S. – Application for the simultaneous acquisition of a facility and issuance of a certificate of authority
- Section 651.025, F.S. – Insolvent facilities or providers
- Section 651.035(3), F.S. – Minimum liquid reserve funding
- Section 651.043, F.S. – Approval of change in management
- Section 651.083, F.S. – Residents' rights
- Section 651.105, F.S. – Examinations and inspections

Section 29 amends s. 651.1151, F.S., relating to administrative, vendor, and management contracts. This section creates a duty for providers to disclose contracts with affiliates. The current statute allows the OIR to request submission of an affiliated contract, but provides no mechanism for the OIR to discover the existence of such contracts.

The section is amended to clarify when the OIR may disapprove an affiliated contract based on the fees charged to the provider. Under current law, the OIR can disapprove a fee that is "unreasonably high in relation to the service provided." This section bases the determination of excess fees on the charges paid by similar providers and a determination that the fee is detrimental to the facility or its residents. This would allow the OIR to protect the residents' assets by ensuring that affiliated transactions are not exploited as a mechanism to drain provider assets.

Increased Transparency and Protections for Residents

Section 4 amends s. 651.019, F.S., to revise financing filing provisions. A provider must notify the residents' council of any new financing or refinancing at least 30 days before the closing date of the transaction. The notice must include a general outline of the transaction and the intended use of proceeds. This will allow residents to object to financing transactions that concern them. Under current law, the residents' council receives notice of all financing documents filed with

the OIR. Such documents must be submitted to the OIR to at least 30 days after the closing date to remove the perception that the OIR can prevent a provider from securing new financing, additional financing, or refinancing that may be hazardous to the residents. Currently, providers are required to file a general outline and intended use of proceeds with the OIR prior to the closing date of the financing.

Section 20 amends s. 651.071, F.S., to deem all continuing care and continuing care at-home contracts preferred claims or policyholder loss claims pursuant to s. 631.271(1)(b), F.S., in the event the provider is liquidated or put into receivership. The intent of this provision is to protect the claims of residents in the event of a liquidation.

Section 21 amends s. 651.091, F.S., to create additional provider reporting requirements to the residents or residents' council. These reports would help residents and prospective residents to remain apprised of the status and stability of the provider and to take action to protect their interests. The section requires the provider to timely 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, the reasons for any increase in the monthly fee that exceeds the rate of inflation, a notice of any change in ownership filing submitted to the OIR, and any master plans approved by the provider's governing board including any plans for expansion or phased development.

Further, the section requires the provider to furnish the following items, if applicable, 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, a statement that the entrance fee is the property of the provider after the expiration of the 7-day escrow requirement, a disclosure of any distribution and the method of distribution of assets or income between facilities that may occur if the provider owns multiple facilities, and a disclosure of any holding company or obligated group of which the provider is a member.

Section 22 amends s. 651.105, F.S., to revise the current complaint or inspection process. The section revises the process for resident to file complaints against providers. The revisions include the establishment of a complaint tracking system and a requirement that the OIR provide a written statement to the complainant upon disposition of a complaint.

Section 26 amends s. 651.111, F.S., relating to resident complaints and inspections by the OIR to provide more guidance as to inspections or investigations by the OIR regarding the status and resolution of the complaint.

Section 30 amends s. 651.121, F.S., relating to the Continuing Care Advisory Council, to increase the number of residents on the council from three to four and remove the requirement that one of the 10 members is an attorney.

Section 32 provides the bill will take effect July 1, 2018.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill would provide additional consumer protections for current and potential residents of a CCRC.

A CCRC whose performance falls below the key indicators may incur costs in providing additional information to the OIR. Costs of acquisition should be lowered due to the consolidation of the three currently required filings into one filing.

C. Government Sector Impact:

The bill would provide the OIR with additional regulatory tools to intervene when a CCRC is not complying with the Insurance Code, which mitigate or prevent insolvencies and the impact on residents of a CCRC.

Office of Insurance Regulation. The OIR[30] indicates that it would need one additional FTE, a Reinsurance Financial Specialist, to implement the provisions of the bill.
Base Salary - $45,043
Benefits - $19,204
Standard Expense Package with new FTE - $9,895
TOTAL - $74,141

VI. Technical Deficiencies:

The OIR[31] provided the following comments:

[30] Office of Insurance Regulation, *Analysis of SB 438* (Oct. 11, 2017) (on file with Banking and Insurance Committee).
[31] *Id.*

- Section 651.024(2), F.S., waives the requirement to file a provisional certificate of authority (PCOA) application but does not waive the requirement to have a PCOA. It may be desirable to specify that an applicant under s. 651.0245, F.S., is not required to hold a PCOA.
- The bill clarifies that disclosures are required for material changes that occur while a PCOA application is pending before the OIR, which is consistent with other requirements in the Insurance Code. This requirement should also apply to an application for a COA pursuant to s. 651.023, F.S., and an expansion application pursuant to s. 651.0246, F.S.
- Section 651.051.022(2)(h), F.S., "actuarial study" has been omitted from the requirements for an acquisition application.
- The terms "cash equivalents" and "investment grade bonds" are not defined.
- It is unclear why the bill does not specify that a provider must escrow for property taxes in lieu of creating a monthly deposit requirement for providers without debt on the facility. As drafted, it would appear that the provider would need to deposit property taxes into escrow every month even if the existing deposit is more than the amount required to be held. This could create a situation in which a provider petitions monthly to withdraw funds immediately after depositing them or in which a provider accrues a significant excess of escrowed funds due to the monthly deposits. No mechanism is provided to terminate the deposits when an appropriate level is reached.

The Department of Financial Services[32] provided the following comments:

- The new language in s. 651.034, F.S., stating that the term "impaired" under s. 651.051, F.S., supersedes the definition of impairment at s. 631.011, F.S., appears to conflict with s. 631.021(7), F.S., which states that pt. I of ch. 631, F.S., prevails over any conflicting law. Also, the new language at s. 651.114(7), F.S., limiting the definition of "impaired" to ch. 651, F.S., also appears to conflict with s. 631.021(7), F.S., which states that pt. I, ch. 631, F.S., prevails over any conflicting law.
- The phrase "preferred claim" is not used in s. 631.271(1)(b), F.S. Rather, the statute focuses on policyholder's claims, whether first party or third party, and the claims of guaranty associations, and all claims related to a patient's healthcare coverage. So, its use in the bill as additional language in s. 651.071(1), F.S., when describing the priority of claims in the event of receivership or liquidation proceedings may be problematic.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 651.011, 651.012, 651.013, 651.019, 651.021, 651.022, 651.023, 651.024, 651.026, 651.0261, 651.033, 651.035, 651.051, 651.057, 651.071, 651.091, 651.105, 651.106, 651.111, 651.114, 651.1151, 651.121, and 651.125.

[32] Department of Financial Services, *Analysis of SB 438* (Oct. 16, 2017) (on file with Senate Banking and Insurance Committee).

This bill creates the following sections of the Florida Statutes: 651.0245, 651.0246, 651.025, 651.034. 651.043, 651.1055, 651.1065, and 651.1141.

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.