

1 A bill to be entitled
2 An act relating to insurance regulations; amending s.
3 48.151, F.S.; providing that the Chief Financial
4 Officer is the agent for service of process on health
5 maintenance organizations; amending s. 252.63, F.S.;
6 revising the content of a publication from the
7 Commissioner of Insurance Regulation relating to
8 orders applicable to insurance in areas under the
9 state of emergency; amending s. 624.4085, F.S.;
10 revising the definition of the term "life and health
11 insurer"; amending s. 624.422, F.S.; providing that
12 the appointment of the Chief Financial Officer for
13 service of process applies to insurers withdrawing
14 from and ceasing operations in this state until all
15 insurers' liabilities in this state are extinguished;
16 amending s. 624.45, F.S.; conforming a provision to
17 changes made by the act; amending s. 624.610, F.S.;
18 removing certain provisions relating to credits
19 allowed in specified reinsurance circumstances and
20 relating to assuming insurers' accreditations;
21 requiring filing fees from reinsurers requesting to
22 operate in this state; removing applicability
23 provisions; amending s. 626.9651, F.S.; requiring the
24 Office of Insurance Regulation and the Financial
25 Services Commission to adopt rules on cybersecurity of

26 | certain insurance data; providing requirements for
27 | such rules; providing duties of the office; amending
28 | s. 627.062, F.S.; prohibiting personal residential
29 | property insurers from submitting more than one "use
30 | and file" filing under certain circumstances;
31 | providing an exception; amending s. 627.0621, F.S.;
32 | requiring certain rate filings with the office from
33 | residential property insurers to include rate
34 | transparency reports; providing for acceptance or
35 | rejection by the office of such reports; providing
36 | requirements for such reports; requiring insurers to
37 | provide such reports to consumers; requiring the
38 | office to define terms used in such reports; requiring
39 | the office to establish and maintain a specified
40 | center on its website; providing requirements for the
41 | website; amending s. 627.0645, F.S.; revising
42 | requirements of rate filing with the office; amending
43 | s. 627.0651, F.S.; prohibiting motor vehicle insurers
44 | from submitting more than one "use and file" filing
45 | under certain circumstances; amending s. 627.4554,
46 | F.S.; requiring that certain forms be posted on the
47 | website of the Department of Financial Services,
48 | rather than the office; amending s. 627.6699, F.S.;
49 | removing and revising definitions; removing provisions
50 | relating to the creation of the Florida Small Employer

51 Health Reinsurance Program; amending s. 627.711, F.S.;
52 requiring the office to contract with a state
53 university to design, operate, upgrade, and maintain a
54 specified database; requiring property insurers to
55 file certain policyholder forms in the database;
56 requiring the commission to adopt rules; amending s.
57 627.7152, F.S.; removing provisions relating to
58 requirements for reporting and rulemaking regarding
59 property insurance claims paid under assignment
60 agreements; creating s. 627.9145, F.S.; providing
61 reporting requirements for residential property
62 insurers; requiring the commission to adopt rules;
63 amending s. 627.915, F.S.; revising reporting
64 requirements for private passenger automobile
65 insurers; requiring the commission to adopt rules;
66 providing requirements for such rules; removing
67 reporting requirement provisions for certain insurers;
68 amending ss. 628.081 and 628.091, F.S.; removing the
69 requirement that domestic insurer incorporators
70 execute articles of incorporation and file them with
71 the office in triplicate; amending s. 628.111, F.S.;
72 removing the requirement that domestic insurers make
73 copies of amendments to articles of incorporation in
74 triplicate; amending s. 628.461, F.S.; specifying the
75 method of sending notifications regarding transactions

76 | or proposed transactions of voting securities of stock
77 | insurers or controlling companies; revising the method
78 | of filing certain statements; amending s. 628.4615,
79 | F.S.; revising the method by which amendments to
80 | certain applications must be sent to specialty
81 | insurers; amending s. 628.717, F.S.; revising
82 | requirements for the office's responses upon receipt
83 | of articles of incorporation; amending s. 628.719,
84 | F.S.; revising the method by which mutual insurance
85 | holding companies show their adoption of article of
86 | incorporation amendments and deliver the amendments to
87 | the office; revising the requirements for the office's
88 | responses upon receipt of amendments; amending s.
89 | 628.910, F.S.; removing the requirement that captive
90 | insurance company incorporators file articles of
91 | incorporation in triplicate; revising the office's
92 | responses upon receipt of captive insurance company
93 | articles of incorporation; amending s. 629.011, F.S.;
94 | revising and providing definitions; amending s.
95 | 629.071, F.S.; authorizing assessable and
96 | nonassessable reciprocal insurers, rather than
97 | domestic reciprocal insurers, to transact insurance if
98 | they maintain specified amounts of surplus funds;
99 | amending s. 629.081, F.S.; conforming a provision to
100 | changes made by the act; creating s. 629.082, F.S.;

101 providing that attorneys in fact of reciprocals are
102 affiliates of the reciprocals for specified purposes;
103 creating s. 629.1015, F.S.; requiring documentation
104 supporting that fees, commissions, and other financial
105 considerations and payments to affiliates by
106 reciprocal insurers are fair and reasonable; providing
107 guidelines for the office in determining whether the
108 fees, commissions, and other financial considerations
109 and payments are fair and reasonable; providing
110 requirements for documentation of such fees; amending
111 s. 629.121, F.S.; providing that certain bonds filed
112 with the office as security are filed by attorneys in
113 fact, rather than attorneys of domestic reciprocal
114 insurers; increasing the bond amount; creating s.
115 629.162, F.S.; authorizing reciprocal insurers to
116 require subscriber contributions; providing disclosure
117 and reporting requirements for subscriber
118 contributions; creating s. 629.163, F.S.; authorizing
119 reciprocal insurers to establish subscriber savings
120 accounts; providing construction; providing
121 requirements for subscriber savings accounts; creating
122 s. 629.164, F.S.; authorizing reciprocal insurers to
123 make distributions to subscribers from subscriber
124 savings accounts; granting to subscribers' advisory
125 committees sole authority to authorize distributions,

126 subject to prior written approval by the office;
127 providing requirements for reciprocal insurers that
128 prohibit subscribers from receiving distributions for
129 a specified period of time; providing construction;
130 authorizing reciprocal insurers to return to
131 subscribers unused premiums, savings, and credits
132 accruing to their accounts; authorizing domestic
133 reciprocal insurers to pay portions of unassigned
134 funds; providing distribution limits; prohibiting
135 distribution discriminations; amending s. 629.171,
136 F.S.; revising requirements for filing with the office
137 annual statements by reciprocal insurers; amending s.
138 629.181, F.S.; replacing surplus deposits of
139 subscribers with subscriber contributions; providing
140 limits on subscriber contributions; amending s.
141 629.201, F.S.; requiring that each domestic reciprocal
142 insurer have a subscribers' advisory committee;
143 requiring that such committee be formed in compliance
144 with specified laws; requiring that rules and
145 amendments adopted by subscribers have prior approval
146 by the office; revising subscribers' advisory
147 committees' duties and membership; providing for
148 election and terms; repealing s. 629.271, F.S.,
149 relating to distribution of savings; amending s.
150 629.291, F.S.; providing that forms filed with the

151 office for plans to merge a reciprocal insurer with
152 another reciprocal insurer or to convert a reciprocal
153 insurer to a stock or mutual insurer are adopted by
154 the commission rather than the office; amending s.
155 629.301, F.S.; specifying the manner in which impaired
156 reciprocal insurers are proceeded against if they
157 cannot make up deficiencies in assets; specifying the
158 manner in which assessments are levied upon
159 subscribers if reciprocal insurers are liquidated;
160 providing that assessments are subject to specified
161 limits; repealing ss. 629.401 and 629.520, F.S.,
162 relating to insurance exchange and the authority of a
163 limited reciprocal insurer, respectively; creating s.
164 629.56, F.S.; requiring reciprocal insurers to
165 maintain unearned premium reserves at all times;
166 amending s. 634.401, F.S.; revising provisions
167 relating to coverage for accidental damage under a
168 service warranty; creating s. 641.2012, F.S.;
169 providing applicability of service of process
170 provisions to health maintenance organizations;
171 amending s. 641.26, F.S.; revising requirements for
172 filing annual and quarterly reports by health
173 maintenance organizations; creating s. 641.283, F.S.;
174 providing applicability of administrative supervision
175 and hazardous insurer condition provisions to health

176 maintenance organizations; amending s. 651.011, F.S.;

177 providing and revising definitions; amending s.

178 651.018, F.S.; providing duties for the office if

179 certain conditions exist in continuing care

180 facilities; amending s. 651.019, F.S.; requiring

181 continuing care providers to provide to the office

182 specified information on financing and intended use of

183 proceeds under certain circumstances; creating s.

184 651.0212, F.S.; requiring and authorizing the office

185 to deny or revoke a provider's authority to engage in

186 certain continuing care activities under certain

187 circumstances; amending s. 651.0215, F.S.; revising

188 the timeframe for the office to examine and respond to

189 consolidated applications for provisional certificates

190 of authority and certificates of authority for

191 providers of continuing care; removing provisions

192 relating to the duties of the office in responding to

193 such applications; amending s. 651.022, F.S.; revising

194 requirements for applications for provisional

195 certificates of authority of providers of continuing

196 care; removing provisions relating to duties of the

197 office in responding to such applications; amending s.

198 651.023, F.S.; conforming cross-references and

199 provisions to changes made by the act; amending s.

200 651.024, F.S.; providing applicability of certain

201 specialty insurer provisions and nonapplicability of
202 certain continuing care provider requirements to
203 bondholders under certain circumstances; defining the
204 term "consent rights"; providing applicability of such
205 provisions to certain entities under certain
206 circumstances; amending s. 651.0246, F.S.; revising
207 requirements for applications for expansion of
208 certificated continuing care facilities; removing
209 specified duties of the office in responding to such
210 applications; revising the timeframe for the office to
211 review such applications; amending s. 651.026, F.S.;
212 revising requirements for annual reports filed by
213 providers of continuing care; providing requirements
214 for quarterly reports; amending s. 651.0261, F.S.;
215 providing additional requirements for quarterly
216 reports filed by continuing care facilities; amending
217 s. 651.033, F.S.; requiring office approval before
218 execution of an agreement for establishing an escrow
219 account; defining the terms "emergency" and "business
220 day"; specifying circumstances under which providers
221 of continuing care may withdraw a specified percentage
222 of the required minimum liquid reserve; revising the
223 timeframe for the office to deny petitions for
224 emergency withdrawals; providing duties of escrow
225 agents; amending s. 651.034, F.S.; revising duties of

226 the office relating to impaired continuing care
227 providers; amending s. 651.035, F.S.; providing
228 requirements for continuing care providers' minimum
229 liquid reserve accounts in escrow; providing
230 requirements for debt service reserve transfers from
231 one financial institution or lender to another;
232 revising and providing requirements for continuing
233 care providers' operating reserves in escrow; amending
234 s. 651.043, F.S.; revising circumstances under which
235 certain notices of management changes must be provided
236 to the office; amending s. 651.055, F.S.; conforming
237 cross-references; amending s. 651.071, F.S.; providing
238 that continuing care and continuing care at-home
239 contracts are not subordinate to any secured claims
240 and must be treated with higher priority over all
241 other claims in the event of receivership or
242 liquidation proceedings against a provider; providing
243 an exception; amending s. 651.085, F.S.; requiring
244 designated resident representatives in continuing care
245 facilities to perform their duties in good faith;
246 requiring each continuing care facility to have its
247 own designated resident representative; specifying the
248 methods for notifications to designated resident
249 representatives of certain meetings; creating s.
250 651.087, F.S.; providing requirements for certain

251 collection and distribution of funds by residents of
252 continuing care facilities; providing duties of
253 providers relating to such funds; providing
254 requirements for providers who borrow or solicit funds
255 from residents; providing that failure to comply with
256 specified collection and distribution provisions is a
257 violation of minimum liquid reserve requirements;
258 authorizing the commission to require certain
259 statements or filing to be submitted by electronic
260 means; amending s. 651.091, F.S.; requiring continuing
261 care facilities to post notices of bankruptcy
262 proceedings; providing requirements for such notices;
263 requiring continuing care facilities to maintain
264 certain records; requiring providers of continuing
265 care to make certain records available for review and
266 to deliver copies of specified disclosure statements;
267 providing liability and penalties; providing
268 applicability; prohibiting persons from filing or
269 maintaining actions under certain circumstances;
270 creating s. 651.104, F.S.; prohibiting persons from
271 acting or holding themselves out as management
272 companies for continuing care retirement communities
273 without a certificate of authority; providing
274 requirements for certificate of authority
275 applications; prohibiting the office from issuing

276 certificates of authority under certain circumstances;
277 creating s. 651.1041, F.S.; providing applicability of
278 specified insurer provisions to acquisitions of
279 management companies; creating s. 651.1043, F.S.;
280 providing requirements for management company annual
281 and quarterly financial statements; requiring
282 acquisition application filings under certain
283 circumstances; requiring monthly statement filings
284 under certain circumstances; providing fines for
285 noncompliance; providing rulemaking authority;
286 creating s. 651.1045, F.S.; providing grounds for the
287 office to refuse, suspend, and revoke management
288 company certificates of authority; providing that
289 revocation of a management company's certificate of
290 authority does not relieve a provider from specified
291 obligations to residents and from annual statement
292 filings and license fees; authorizing the office to
293 seek enforcement actions; amending s. 651.105, F.S.;
294 authorizing the office to examine the businesses of
295 management companies and their parents, subsidiaries,
296 and affiliates under certain circumstances; requiring
297 the office to notify management companies of
298 compliance deficiencies and to require corrective
299 actions or plans; requiring management companies to
300 respond to such notices; amending s. 651.1065, F.S.;

301 prohibiting management companies from engaging in
302 certain acts if delinquency proceedings have been or
303 are to be initiated; providing penalties; creating s.
304 651.1068, F.S.; prohibiting officers and directors of
305 insolvent providers or management companies from
306 serving as officers and directors of providers and
307 management companies and from having control over the
308 selection of officers and directors under certain
309 circumstances; amending s. 651.107, F.S.; requiring
310 management companies to file annual statements and pay
311 license fees during periods of certificate of
312 authority suspension; providing for automatic
313 reinstatement or revocation of certificates of
314 authority; amending s. 651.108, F.S.; providing
315 administrative fines for management companies for
316 certain violations; creating s. 651.113, F.S.;
317 defining the term "negative fund balance"; providing
318 guidelines for the commissioner to determine whether a
319 provider or facility is insolvent or in imminent
320 danger of becoming insolvent; requiring providers and
321 facilities determined to be insolvent or in danger of
322 insolvency to prepare a plan; authorizing the office
323 to issue an order requiring a provider or facility to
324 engage in certain acts under certain circumstances;
325 authorizing the office to issue immediate final orders

326 requiring certain acts; providing construction;
 327 amending s. 651.114, F.S.; removing provisions
 328 relating to continuing care facility trustees and
 329 lenders; creating s. 651.1165, F.S.; requiring the
 330 office to record notices of lien against continuing
 331 care facilities' properties; providing requirements
 332 for such liens; providing for lien foreclosures in
 333 civil actions; providing that such liens are preferred
 334 to all liens, mortgages, and other encumbrances upon
 335 the property and all unrecorded liens, mortgages, and
 336 other encumbrances; providing conditions for lien
 337 releases; amending ss. 627.642, 627.6475, 627.657, and
 338 627.66997, F.S.; conforming cross-references;
 339 providing applicability dates; providing effective
 340 dates.

341
 342 Be It Enacted by the Legislature of the State of Florida:

343
 344 **Section 1. Subsection (3) of section 48.151, Florida**
 345 **Statutes, is amended to read:**

346 48.151 Service on statutory agents for certain persons.—
 347 (3) The Chief Financial Officer is the agent for service
 348 of process on all insurers applying for authority to transact
 349 insurance in this state, all licensed nonresident insurance
 350 agents, all nonresident disability insurance agents licensed

351 pursuant to s. 626.835, any unauthorized insurer under s.
352 626.906 or s. 626.937, domestic reciprocal insurers, fraternal
353 benefit societies under chapter 632, warranty associations under
354 chapter 634, prepaid limited health service organizations under
355 chapter 636, health maintenance organizations under chapter 641,
356 and persons required to file statements under s. 628.461. The
357 Department of Financial Services shall create a secure online
358 portal as the sole means to accept service of process on the
359 Chief Financial Officer under this section.

360 **Section 2. Subsection (3) of section 252.63, Florida**
361 **Statutes, is amended to read:**

362 252.63 Commissioner of Insurance Regulation; powers in a
363 state of emergency.—

364 (3) The commissioner shall publish in the next available
365 publication of the Florida Administrative Register a notice
366 identifying the date the emergency order was issued and shall
367 include a hyperlink or website address providing direct access
368 to the emergency order ~~copy of the text of any order issued~~
369 ~~under this section, together with a statement describing the~~
370 ~~modification or suspension and explaining how the modification~~
371 ~~or suspension will facilitate recovery from the emergency.~~

372 **Section 3. Paragraph (g) of subsection (1) of section**
373 **624.4085, Florida Statutes, is amended to read:**

374 624.4085 Risk-based capital requirements for insurers.—

375 (1) As used in this section, the term:

376 (g) "Life and health insurer" means an insurer authorized
 377 or eligible under the Florida Insurance Code to underwrite life
 378 or health insurance. The term includes a property and casualty
 379 insurer that writes accident and health insurance only.
 380 ~~Effective January 1, 2015,~~ The term also includes a health
 381 maintenance organization that is authorized in this state ~~and~~
 382 ~~one or more other states, jurisdictions, or countries~~ and a
 383 prepaid limited health service organization that is authorized
 384 in this state and one or more other states, jurisdictions, or
 385 countries.

386 **Section 4. Subsection (3) of section 624.422, Florida**
 387 **Statutes, is renumbered as subsection (4), and a new subsection**
 388 **(3) is added to that section to read:**

389 624.422 Service of process; appointment of Chief Financial
 390 Officer as process agent.—

391 (3) The appointment of the Chief Financial Officer under
 392 this section applies to any insurer that withdraws from or
 393 ceases operations in this state until the insurer has completed
 394 its runoff of, or otherwise extinguished, all liabilities in
 395 Florida.

396 **Section 5. Subsection (2) of section 624.45, Florida**
 397 **Statutes, is amended to read:**

398 624.45 Participation of financial institutions in
 399 reinsurance and in insurance exchanges.—Subject to applicable
 400 laws relating to financial institutions and to any other

401 applicable provision of the Florida Insurance Code, any
402 financial institution or aggregation of such institutions may:

403 (2) Participate, directly or indirectly, as an
404 underwriting member or as an investor in an underwriting member
405 of any insurance exchange ~~authorized in accordance with s.~~
406 ~~629.401~~, which underwriting member transacts only aggregate or
407 specific excess insurance over underlying self-insurance
408 coverage for self-insurance organizations authorized under the
409 Florida Insurance Code, for multiple-employer welfare
410 arrangements, or for workers' compensation self-insurance
411 trusts, in addition to any reinsurance the underwriting member
412 may transact.

413

414 Nothing in this section shall be deemed to prohibit a financial
415 institution from engaging in any presently authorized insurance
416 activity.

417 **Section 6. Subsection (15) of section 624.610, Florida**
418 **Statutes, is renumbered as subsection (16), paragraph (b) of**
419 **subsection (3), paragraph (b) of subsection (12), and present**
420 **subsection (16) are amended, and a new subsection (15) is added**
421 **to that section, to read:**

422 624.610 Reinsurance.—

423 (3)

424 (b)1. Credit must be allowed when the reinsurance is ceded
425 to an assuming insurer that is accredited as a reinsurer in this

426 state. An accredited reinsurer is one that:

427 a. Files with the office evidence of its submission to
428 this state's jurisdiction;

429 b. Submits to this state's authority to examine its books
430 and records;

431 c. Is licensed or authorized to transact insurance or
432 reinsurance in at least one state or, in the case of a United
433 States branch of an alien assuming insurer, is entered through,
434 licensed, or authorized to transact insurance or reinsurance in
435 at least one state;

436 d. Files annually with the office a copy of its annual
437 statement filed with the insurance department of its state of
438 domicile any quarterly statements if required by its state of
439 domicile or such quarterly statements if specifically requested
440 by the office, and a copy of its most recent audited financial
441 statement; and

442 (I) Maintains a surplus as regards policyholders in an
443 amount not less than \$20 million and whose accreditation has not
444 been denied by the office within 90 days after its submission;
445 or

446 (II) Maintains a surplus as regards policyholders in an
447 amount not less than \$20 million and whose accreditation has
448 been approved by the office.

449 2. The office may deny or revoke an assuming insurer's
450 accreditation if the assuming insurer does not submit the

451 required documentation pursuant to subparagraph 1., if the
452 assuming insurer fails to meet all of the standards required of
453 an accredited reinsurer, or if the assuming insurer's
454 accreditation would be hazardous to the policyholders of this
455 state. In determining whether to deny or revoke accreditation,
456 the office may consider the qualifications of the assuming
457 insurer with respect to all the following subjects:

- 458 a. Its financial stability;
- 459 b. The lawfulness and quality of its investments;
- 460 c. The competency, character, and integrity of its
461 management;
- 462 d. The competency, character, and integrity of persons who
463 own or have a controlling interest in the assuming insurer; and
- 464 e. Whether claims under its contracts are promptly and
465 fairly adjusted and are promptly and fairly paid in accordance
466 with the law and the terms of the contracts.

467 3. Credit must not be allowed a ceding insurer if the
468 assuming insurer's accreditation has been revoked by the office
469 after notice and the opportunity for a hearing.

470 ~~4. The actual costs and expenses incurred by the office to~~
471 ~~review a reinsurer's request for accreditation and subsequent~~
472 ~~reviews must be charged to and collected from the requesting~~
473 ~~reinsurer. If the reinsurer fails to pay the actual costs and~~
474 ~~expenses promptly when due, the office may refuse to accredit~~
475 ~~the reinsurer or may revoke the reinsurer's accreditation.~~

476 (12)

477 (b) The summary statement must be signed and attested to
478 by either the chief executive officer or the chief financial
479 officer of the reporting insurer. In addition to the summary
480 statement, the office may require the filing of any supporting
481 information relating to the ceding of such risks as it deems
482 necessary. If the summary statement prepared by the ceding
483 insurer discloses that the net effect of a reinsurance treaty or
484 treaties (or series of treaties with one or more affiliated
485 reinsurers entered into for the purpose of avoiding the
486 following threshold amount) at any time results in an increase
487 of more than 25 percent to the insurer's surplus as to
488 policyholders, then the insurer shall certify in writing to the
489 office that the relevant reinsurance treaty or treaties comply
490 with the accounting requirements contained in any rule adopted
491 by the commission under subsection (16) ~~(15)~~. If such
492 certificate is filed after the summary statement of such
493 reinsurance treaty or treaties, the insurer shall refile the
494 summary statement with the certificate. In any event, the
495 certificate must state that a copy of the certificate was sent
496 to the reinsurer under the reinsurance treaty.

497 (15) Any application filed with the office to review a
498 reinsurer's request to operate in this state under this section
499 must be accompanied by a filing fee equal to the application fee
500 charged under s. 624.501(1)(a).

501 ~~(16) This act shall apply to all sessions on or after~~
 502 ~~January 1, 2001, under reinsurance agreements that have an~~
 503 ~~inception, anniversary, or renewal date on or after January 1,~~
 504 ~~2001.~~

505 **Section 7. Section 626.9651, Florida Statutes, is amended**
 506 **to read:**

507 626.9651 Security of consumer data ~~Privacy.~~

508 (1) The department and commission shall ~~must~~ each adopt
 509 rules consistent with other provisions of the Florida Insurance
 510 Code to govern the use of a consumer's nonpublic personal
 511 financial and health information. These rules must be based on,
 512 consistent with, and not more restrictive than the Privacy of
 513 Consumer Financial and Health Information Regulation, adopted
 514 September 26, 2000, by the National Association of Insurance
 515 Commissioners; however, the rules must permit the use and
 516 disclosure of nonpublic personal health information for
 517 scientific, medical, or public policy research, in accordance
 518 with federal law. In addition, these rules must be consistent
 519 with, and not more restrictive than, the standards contained in
 520 Title V of the Gramm-Leach-Bliley Act of 1999, Pub. L. No. 106-
 521 102, as amended in Title LXXV of the Fixing America's Surface
 522 Transportation (FAST) Act, Pub. L. No. 114-94. If the office
 523 determines that a health insurer or health maintenance
 524 organization is in compliance with, or is actively undertaking
 525 compliance with, the consumer privacy protection rules adopted

526 by the United States Department of Health and Human Services, in
527 conformance with the Health Insurance Portability and
528 Affordability Act, that health insurer or health maintenance
529 organization is in compliance with this subsection ~~section~~.

530 (2) The office and the commission shall adopt rules
531 consistent with state law, including the Florida Insurance Code,
532 to ensure the cybersecurity of a consumer's nonpublic insurance
533 data. These rules may not be more restrictive than the National
534 Association of Insurance Commissioners Insurance Data Security
535 Model Law, adopted as of October 2017, and subsequent amendments
536 thereto if the methodology remains substantially consistent. The
537 rules must:

538 (a) Apply to all entities acting as insurers, transacting
539 insurance, or otherwise engaging in insurance activities in this
540 state, including entities licensed under chapter 641, and any
541 entity that has been contracted to maintain, store, or process
542 personal information on behalf of a covered entity;

543 (b) Require the development and implementation of an
544 information security program as defined in the model law;

545 (c) Require investigation and notification of a
546 cybersecurity event as required under the model law;

547 (d) Require that each insurer submit to the department or
548 office all or part of the information required to be reported to
549 the department or office in a computer-readable form compatible
550 with the electronic data processing system of the department or

551 office; and

552 (e) Require that the office be copied on any notice
553 provided to the Attorney General under s. 501.171.

554 (3) Upon receiving information under this section, the
555 office shall review the information and may initiate an
556 examination or investigation under s. 624.316, s. 624.3161, or
557 s. 626.8828.

558 **Section 8. Paragraph (a) of subsection (2) of section**
559 **627.062, Florida Statutes, is amended to read:**

560 627.062 Rate standards.—

561 (2) As to all such classes of insurance:

562 (a) Insurers or rating organizations shall establish and
563 use rates, rating schedules, or rating manuals that allow the
564 insurer a reasonable rate of return on the classes of insurance
565 written in this state. A copy of rates, rating schedules, rating
566 manuals, premium credits or discount schedules, and surcharge
567 schedules, and changes thereto, must be filed with the office
568 under one of the following procedures:

569 1. If the filing is made at least 90 days before the
570 proposed effective date and is not implemented during the
571 office's review of the filing and any proceeding and judicial
572 review, such filing is considered a "file and use" filing. In
573 such case, the office shall finalize its review by issuance of a
574 notice of intent to approve or a notice of intent to disapprove
575 within 90 days after receipt of the filing. If the 90-day period

576 ends on a weekend or a holiday under s. 110.117(1)(a)-(i), it
577 must be extended until the conclusion of the next business day.
578 The notice of intent to approve and the notice of intent to
579 disapprove constitute agency action for purposes of the
580 Administrative Procedure Act. Requests for supporting
581 information, requests for mathematical or mechanical
582 corrections, or notification to the insurer by the office of its
583 preliminary findings does not toll the 90-day period during any
584 such proceedings and subsequent judicial review. The rate shall
585 be deemed approved if the office does not issue a notice of
586 intent to approve or a notice of intent to disapprove within 90
587 days after receipt of the filing.

588 2. If the filing is not made in accordance with
589 subparagraph 1., such filing must be made as soon as
590 practicable, but within 30 days after the effective date, and is
591 considered a "use and file" filing. An insurer making a "use and
592 file" filing is potentially subject to an order by the office to
593 return to policyholders those portions of rates found to be
594 excessive, as provided in paragraph (h). For purposes of this
595 subparagraph, a personal residential property insurer may not
596 submit more than one "use and file" filing affecting
597 policyholders within a single policy period, unless the filing
598 is exclusively related to reinsurance.

599 3. For all property insurance filings made or submitted
600 after January 25, 2007, but before May 1, 2012, an insurer

601 seeking a rate that is greater than the rate most recently
 602 approved by the office shall make a "file and use" filing. For
 603 purposes of this subparagraph, motor vehicle collision and
 604 comprehensive coverages are not considered property coverages.

605
 606 The provisions of this subsection do not apply to workers'
 607 compensation, employer's liability insurance, and motor vehicle
 608 insurance.

609 **Section 9. Subsection (2) of section 627.0621, Florida**
 610 **Statutes, is renumbered as subsection (3), present subsection**
 611 **(2) is amended, and a new subsection (2) is added to that**
 612 **section, to read:**

613 627.0621 Transparency in rate regulation.—

614 (2) RATE TRANSPARENCY REPORT.—

615 (a) Beginning October 1, 2025, every rate filing
 616 requesting a rate change for residential property coverage from
 617 a property insurer must include a rate transparency report for
 618 acceptance for use or modification by the office. The office may
 619 accept the rate transparency report for filing, or if the office
 620 finds that the report fails to provide the required information
 621 in concise and plain language which aids consumers in their
 622 understanding of insurance, or finds the report to be
 623 misleading, the office shall return the rate transparency report
 624 to the property insurer for modification. The office's
 625 acceptance for use or modification of the report may not be

626 deemed approval pursuant to s. 627.062. The report shall be
627 compiled in a uniform format prescribed by the commission and
628 must include a graphical representation identifying a percentage
629 breakdown of rating factors anticipated of the company, book, or
630 program affected by the filing.

631 (b) Along with an offer of coverage and upon renewal, an
632 insurer must provide the corresponding copy of the rate
633 transparency report for the consumer's offered rate to aid
634 consumers in their understanding of insurance. If the report has
635 not been accepted for use or modified by the office, the report
636 must indicate that it is preliminary and subject to modification
637 by the office.

638 (c) The rate transparency report must include the
639 following categories of the book or program at the cumulative
640 level:

641 1. The percentage of the total rate factor associated with
642 the cost of reinsurance.

643 2. The percentage of the total rate factor associated with
644 the cost of claims.

645 3. The percentage of the total rate factor associated with
646 the defense containment and costs.

647 4. The percentage of the total rate factor associated with
648 fees and commissions.

649 5. The percentage of the rate factor associated with
650 profit and contingency of the insurer.

651 6. Any other categories deemed necessary by the office or
 652 commission.

653
 654 An estimated percentage of the influence of each listed factor
 655 must be provided to equal 100 percent.

656 (d) The insurer shall provide the rate transparency report
 657 to the office upon the filing of a rate change with the office.

658 (e) The rate transparency report must also include the
 659 following information:

660 1. Any major adverse findings by the office for the
 661 previous 3 calendar years.

662 2. Whether the insurer uses affiliated entities to perform
 663 functions of the insurer.

664 3. Contact information, to include a telephone number,
 665 hours of service, and e-mail address for the Division of
 666 Consumer Services of the department.

667 4. Contact information for the office.

668 5. Address for the website for public access to rate
 669 filing and affiliate information outlined in subsection (3).

670 6. Any changes in the total insured value from the last
 671 policy period.

672 (f) The office shall define, in concise and plain
 673 language, any terms used with the rate transparency report to
 674 aid consumers in their understanding of insurance.

675 (3)(2) WEBSITE FOR PUBLIC ACCESS TO RATE FILING

676 INFORMATION.—

677 (a) The office shall establish and maintain a
678 comprehensive resource center on its website that uses concise
679 and plain language to aid consumers in their understanding of
680 insurance. The website must include substantive information on
681 the current and historical dynamics of the market, data
682 concerning the financial condition and market conduct of
683 insurance companies available to consumers, and choices
684 available to consumers. At a minimum, the website must contain
685 the following:

686 1. Reports, using graphical information wherever possible,
687 which outline information about the state of the market and
688 adverse and positive trends affecting it.

689 2. Tools that aid consumers in finding insurers.

690 3. Tools that aid consumers in selecting the coverages
691 beneficial to them.

692 4. Information about mitigation credits and the My Safe
693 Florida Home Program, as well as other credits insurers may
694 offer beyond wind mitigation.

695 5. Access to the rate transparency report, annual
696 statements, market conduct information, and other information
697 related to each insurer.

698 6. Information on the Citizens Property Insurance
699 Corporation takeout process, the clearinghouse, and general
700 information as reported by the office.

701 ~~7.(a)~~ With respect to any residential property rate
702 filing, ~~the office shall provide the following information on a~~
703 ~~publicly accessible Internet website:~~

704 ~~a.1.~~ The overall rate change requested by the insurer.

705 ~~b.2.~~ The rate change approved by the office along with all
706 of the actuary's assumptions and recommendations forming the
707 basis of the office's decision.

708 ~~c.3.~~ Certification by the office's actuary that, based on
709 the actuary's knowledge, his or her recommendations are
710 consistent with accepted actuarial principles.

711 d. Whether the insurer uses affiliated entities to perform
712 administrative, claims handling, or other functions of the
713 insurer and, if so, the total percentage of direct written
714 premium paid to the affiliated entities by the insurer in the
715 preceding annual calendar year.

716 (b) For any rate filing, regardless of whether ~~or not~~ the
717 filing is subject to a public hearing, the office shall provide
718 on its website a means for any policyholder who may be affected
719 by a proposed rate change to send an e-mail regarding the
720 proposed rate change. Such e-mail must be accessible to the
721 actuary assigned to review the rate filing.

722 (c) The statewide average requested rate change and final
723 approved statewide average rate change within a filing is not a
724 trade secret as defined in s. 688.002 or s. 812.081(1) and is
725 not subject to the public records exemption for trade secrets

726 provided in s. 119.0715 or s. 624.4213.

727 (d) County rating examples submitted to the office through
 728 the rate collection system for the purposes of displaying rates
 729 on the office website are not a trade secret as defined in s.
 730 688.002 or s. 812.081(1) and are not subject to the public
 731 records exemption for trade secrets provided in s. 119.0715 or
 732 s. 624.4213.

733 **Section 10. Paragraph (b) of subsection (3) of section**
 734 **627.0645, Florida Statutes, is amended to read:**

735 627.0645 Annual filings.—

736 (3) The filing requirements of this section shall be
 737 satisfied by one of the following methods:

738 (b) If no rate change is proposed, a filing which consists
 739 of a certification by an actuary that the existing rate level
 740 produces rates which are actuarially sound and which are not
 741 inadequate, as defined in s. 627.062. However, a full rate
 742 filing is required after 2 consecutive years of certification
 743 under this paragraph.

744 **Section 11. Paragraph (b) of subsection (1) of section**
 745 **627.0651, Florida Statutes, is amended to read:**

746 627.0651 Making and use of rates for motor vehicle
 747 insurance.—

748 (1) Insurers shall establish and use rates, rating
 749 schedules, or rating manuals to allow the insurer a reasonable
 750 rate of return on motor vehicle insurance written in this state.

751 A copy of rates, rating schedules, and rating manuals, and
752 changes therein, shall be filed with the office under one of the
753 following procedures:

754 (b) If the filing is not made in accordance with the
755 provisions of paragraph (a), such filing shall be made as soon
756 as practicable, but no later than 30 days after the effective
757 date, and shall be considered a "use and file" filing. An
758 insurer making a "use and file" filing is potentially subject to
759 an order by the office to return to policyholders portions of
760 rates found to be excessive, as provided in subsection (11). For
761 purposes of this paragraph, an insurer may not submit more than
762 one "use and file" filing impacting policyholders within a
763 single policy period.

764 **Section 12. Effective upon this act becoming a law,**
765 **paragraph (a) of subsection (5) of section 627.4554, Florida**
766 **Statutes, is amended to read:**

767 627.4554 Suitability in annuity transactions.—

768 (5) DUTIES OF INSURERS AND AGENTS.—

769 (a) An agent, when making a recommendation of an annuity,
770 shall act in the best interest of the consumer under the
771 circumstances known at the time the recommendation is made,
772 without placing the financial interest of the agent or insurer
773 ahead of the consumer's interest. An agent has acted in the best
774 interest of the consumer if the agent has satisfied the
775 following obligations regarding care, disclosure, conflict of

776 interest, and documentation:

777 1.a. The agent, in making a recommendation, shall exercise
778 reasonable diligence, care, and skill to:

779 (I) Know the financial situation, insurance needs, and
780 financial objectives of the customer.

781 (II) Understand the available options after making a
782 reasonable inquiry into options available to the agent.

783 (III) Have a reasonable basis to believe the recommended
784 option effectively addresses the consumer's financial situation,
785 insurance needs, and financial objectives over the life of the
786 product, as evaluated in light of the consumer profile
787 information.

788 (IV) Communicate the reason or reasons for the
789 recommendation.

790 b. The requirements of sub-subparagraph a. include:

791 (I) Making reasonable efforts to obtain consumer profile
792 information from the consumer before the recommendation of an
793 annuity.

794 (II) Requiring an agent to consider the types of products
795 the agent is authorized and licensed to recommend or sell which
796 address the consumer's financial situation, insurance needs, and
797 financial objectives. This does not require analysis or
798 consideration of any products outside the authority and license
799 of the agent or other possible alternative products or
800 strategies available in the market at the time of the

801 recommendation. Agents shall be held to standards applicable to
802 agents with similar authority and licensure.

803 (III) Having a reasonable basis to believe the consumer
804 would benefit from certain features of the annuity, such as
805 annuitization, death or living benefit, or other insurance-
806 related features.

807 c. The requirements of this subsection do not create a
808 fiduciary obligation or relationship and only create a
809 regulatory obligation as provided in this section.

810 d. The consumer profile information; characteristics of
811 the insurer; and product costs, rates, benefits, and features
812 are those factors generally relevant in making a determination
813 whether an annuity effectively addresses the consumer's
814 financial situation, insurance needs, and financial objectives,
815 but the level of importance of each factor under the care
816 obligation of this paragraph may vary depending on the facts and
817 circumstances of a particular case. However, each factor may not
818 be considered in isolation.

819 e. The requirements under sub-subparagraph a. apply to the
820 particular annuity as a whole and the underlying subaccounts to
821 which funds are allocated at the time of purchase or exchange of
822 an annuity, and riders and similar product enhancements, if any.

823 f. Sub-subparagraph a. does not require that the annuity
824 with the lowest one-time occurrence compensation structure or
825 multiple occurrence compensation structure shall necessarily be

826 recommended.

827 g. Sub-subparagraph a. does not require the agent to have
828 ongoing monitoring obligations under the care obligation,
829 although such an obligation may be separately owed under the
830 terms of a fiduciary, consulting, investment, advising, or
831 financial planning agreement between the consumer and the agent.

832 h. In the case of an exchange or replacement of an
833 annuity, the agent shall consider the whole transaction, which
834 includes taking into consideration whether:

835 (I) The consumer will incur a surrender charge; be subject
836 to the commencement of a new surrender period; lose existing
837 benefits, such as death, living, or other contractual benefits;
838 or be subject to increased fees, investment advisory fees, or
839 charges for riders and similar product enhancements.

840 (II) The replacing product would substantially benefit the
841 consumer in comparison to the replaced product over the life of
842 the product.

843 (III) The consumer has had another annuity exchange or
844 replacement and, in particular, an exchange or replacement
845 within the preceding 60 months.

846 i. This section does not require an agent to obtain any
847 license other than an agent license with the appropriate line of
848 authority to sell, solicit, or negotiate insurance in this
849 state, including, but not limited to, any securities license, in
850 order to fulfill the duties and obligations contained in this

851 section; provided, the agent does not give advice or provide
852 services that are otherwise subject to securities laws or engage
853 in any other activity requiring other professional licenses.

854 2.a. Before the recommendation or sale of an annuity, the
855 agent shall prominently disclose to the consumer, on a form
856 substantially similar to that posted on the department ~~office~~
857 website as Appendix A, related to an insurance agent disclosure
858 for annuities:

859 (I) A description of the scope and terms of the
860 relationship with the consumer and the role of the agent in the
861 transaction.

862 (II) An affirmative statement on whether the agent is
863 licensed and authorized to sell the following products:

- 864 (A) Fixed annuities.
865 (B) Fixed indexed annuities.
866 (C) Variable annuities.
867 (D) Life insurance.
868 (E) Mutual funds.
869 (F) Stocks and bonds.
870 (G) Certificates of deposit.

871 (III) An affirmative statement describing the insurers for
872 which the agent is authorized, contracted, or appointed, or
873 otherwise able to sell insurance products, using the following
874 descriptions:

- 875 (A) From one insurer;

876 (B) From two or more insurers; or

877 (C) From two or more insurers, although primarily
878 contracted with one insurer.

879 (IV) A description of the sources and types of cash
880 compensation and noncash compensation to be received by the
881 agent, including whether the agent is to be compensated for the
882 sale of a recommended annuity by commission as part of premium
883 or other remuneration received from the insurer, intermediary,
884 or other agent, or by fee as a result of a contract for advice
885 or consulting services.

886 (V) A notice of the consumer's right to request additional
887 information regarding cash compensation described in sub-
888 subparagraph b.

889 b. Upon request of the consumer or the consumer's
890 designated representative, the agent shall disclose:

891 (I) A reasonable estimate of the amount of cash
892 compensation to be received by the agent, which may be stated as
893 a range of amounts or percentages.

894 (II) Whether the cash compensation is a one-time or
895 multiple occurrence amount; and if a multiple occurrence amount,
896 the frequency and amount of the occurrence, which may be stated
897 as a range of amounts or percentages.

898 c. Before or at the time of the recommendation or sale of
899 an annuity, the agent shall have a reasonable basis to believe
900 the consumer has been informed of various features of the

901 annuity, such as the potential surrender period and surrender
902 charge; potential tax penalty if the consumer sells, exchanges,
903 surrenders, or annuitizes the annuity; mortality and expense
904 fees; any annual fees; investment advisory fees; potential
905 charges for and features of riders or other options of the
906 annuity; limitations on interest returns; potential changes in
907 nonguaranteed elements of the annuity; insurance and investment
908 components; and market risk.

909 3. An agent shall identify and avoid or reasonably manage
910 and disclose material conflicts of interest, including material
911 conflicts of interest related to an ownership interest.

912 4. An agent shall at the time of the recommendation or
913 sale:

914 a. Make a written record of any recommendation and the
915 basis for the recommendation, subject to this section.

916 b. Obtain a consumer-signed statement on a form
917 substantially similar to that posted on the department ~~office~~
918 website as Appendix B, related to a consumer's refusal to
919 provide information, documenting:

920 (I) A customer's refusal to provide the consumer profile
921 information, if any.

922 (II) A customer's understanding of the ramifications of
923 not providing his or her consumer profile information or
924 providing insufficient consumer profile information.

925 c. Obtain a consumer-signed statement on a form

926 substantially similar to that posted on the department office
927 website as Appendix C, related to a consumer's decision to
928 purchase an annuity not based on a recommendation, acknowledging
929 the annuity transaction is not recommended if a customer decides
930 to enter into an annuity transaction that is not based on the
931 agent's recommendation.

932 5. Any requirement applicable to an agent under this
933 subsection applies to every agent who has exercised material
934 control or influence in the making of a recommendation and has
935 received direct compensation as a result of the recommendation
936 or sale, regardless of whether the agent has had any direct
937 contact with the consumer. Activities such as providing or
938 delivering marketing or education materials, product wholesaling
939 or other back office product support, and general supervision of
940 an agent do not, in and of themselves, constitute material
941 control or influence.

942 **Section 13. Paragraphs (c) through (o) and (r) through (w)**
943 **of subsection (3) of section 627.6699, Florida Statutes, are**
944 **redesignated as paragraphs (b) through (n) and (o) through (t),**
945 **respectively, subsections (12) through (17) are renumbered as**
946 **subsections (11) through (16), respectively, and present**
947 **paragraphs (b), (p), (q), and (s) of subsection (3), paragraph**
948 **(d) of subsection (9), paragraphs (b) and (c) of subsection**
949 **(10), and present subsection (11) of that section are amended,**
950 **to read:**

951 627.6699 Employee Health Care Access Act.—
 952 (3) DEFINITIONS.—As used in this section, the term:
 953 ~~(b) "Board" means the board of directors of the program.~~
 954 ~~(p) "Plan of operation" means the plan of operation of the~~
 955 ~~program, including articles, bylaws, and operating rules,~~
 956 ~~adopted by the board under subsection (11).~~
 957 ~~(q) "Program" means the Florida Small Employer Carrier~~
 958 ~~Reinsurance Program created under subsection (11).~~
 959 (p)~~(s)~~ "Reinsuring carrier" means a small employer carrier
 960 that elects to comply with reinsurance ~~the requirements set~~
 961 ~~forth in subsection (11).~~
 962 (9) SMALL EMPLOYER CARRIER'S ELECTION TO BECOME A RISK-
 963 ASSUMING CARRIER OR A REINSURING CARRIER.—
 964 (d) A small employer carrier that elects to cease
 965 participating as a reinsuring carrier and to become a risk-
 966 assuming carrier is prohibited from reinsuring or continuing to
 967 reinsure any small employer health benefits plan ~~under~~
 968 ~~subsection (11)~~ as soon as the carrier becomes a risk-assuming
 969 carrier and must pay a prorated assessment based upon business
 970 issued as a reinsuring carrier for any portion of the year that
 971 the business was reinsured. A small employer carrier that elects
 972 to cease participating as a risk-assuming carrier and to become
 973 a reinsuring carrier is permitted to reinsure small employer
 974 health benefit plans ~~under the terms set forth in subsection~~
 975 ~~(11)~~ and must pay a prorated assessment based upon business

976 | issued as a reinsuring carrier for any portion of the year that
 977 | the business was reinsured.

978 | (10) ELECTION PROCESS TO BECOME A RISK-ASSUMING CARRIER.—

979 | (b) In determining whether to approve an application by a
 980 | small employer carrier to become a risk-assuming carrier, the
 981 | office shall consider:

982 | 1. The carrier's financial ability to support the
 983 | assumption of the risk of small employer groups.

984 | 2. The carrier's history of rating and underwriting small
 985 | employer groups.

986 | 3. The carrier's commitment to market fairly to all small
 987 | employers in the state or its service area, as applicable.

988 | 4. The carrier's ability to assume and manage the risk of
 989 | enrolling small employer groups ~~without the protection of the~~
 990 | ~~reinsurance program provided in subsection (11).~~

991 | (c) A small employer carrier that becomes a risk-assuming
 992 | carrier pursuant to this subsection is not subject to
 993 | reinsurance ~~the assessment provisions of subsection (11).~~

994 | ~~(11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.—~~

995 | ~~(a) There is created a nonprofit entity to be known as the~~
 996 | ~~"Florida Small Employer Health Reinsurance Program."~~

997 | ~~(b)1. The program shall operate subject to the supervision~~
 998 | ~~and control of the board.~~

999 | ~~2. Effective upon this act becoming a law, the board shall~~
 1000 | ~~consist of the director of the office or his or her designee,~~

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1001 ~~who shall serve as the chairperson, and 13 additional members~~
1002 ~~who are representatives of carriers and insurance agents and are~~
1003 ~~appointed by the director of the office and serve as follows:~~

1004 ~~a. Five members shall be representatives of health~~
1005 ~~insurers licensed under chapter 624 or chapter 641. Two members~~
1006 ~~shall be agents who are actively engaged in the sale of health~~
1007 ~~insurance. Four members shall be employers or representatives of~~
1008 ~~employers. One member shall be a person covered under an~~
1009 ~~individual health insurance policy issued by a licensed insurer~~
1010 ~~in this state. One member shall represent the Agency for Health~~
1011 ~~Care Administration and shall be recommended by the Secretary of~~
1012 ~~Health Care Administration.~~

1013 ~~b. A member appointed under this subparagraph shall serve~~
1014 ~~a term of 4 years and shall continue in office until the~~
1015 ~~member's successor takes office, except that, in order to~~
1016 ~~provide for staggered terms, the director of the office shall~~
1017 ~~designate two of the initial appointees under this subparagraph~~
1018 ~~to serve terms of 2 years and shall designate three of the~~
1019 ~~initial appointees under this subparagraph to serve terms of 3~~
1020 ~~years.~~

1021 ~~3. The director of the office may remove a member for~~
1022 ~~cause.~~

1023 ~~4. Vacancies on the board shall be filled in the same~~
1024 ~~manner as the original appointment for the unexpired portion of~~
1025 ~~the term.~~

1026 ~~(c)1. The board shall submit to the office a plan of~~
 1027 ~~operation to assure the fair, reasonable, and equitable~~
 1028 ~~administration of the program. The board may at any time submit~~
 1029 ~~to the office any amendments to the plan that the board finds to~~
 1030 ~~be necessary or suitable.~~

1031 ~~2. The office shall, after notice and hearing, approve the~~
 1032 ~~plan of operation if it determines that the plan submitted by~~
 1033 ~~the board is suitable to assure the fair, reasonable, and~~
 1034 ~~equitable administration of the program and provides for the~~
 1035 ~~sharing of program gains and losses equitably and~~
 1036 ~~proportionately in accordance with paragraph (j).~~

1037 ~~3. The plan of operation, or any amendment thereto,~~
 1038 ~~becomes effective upon written approval of the office.~~

1039 ~~(d) The plan of operation must, among other things:~~

1040 ~~1. Establish procedures for handling and accounting for~~
 1041 ~~program assets and moneys and for an annual fiscal reporting to~~
 1042 ~~the office.~~

1043 ~~2. Establish procedures for selecting an administering~~
 1044 ~~carrier and set forth the powers and duties of the administering~~
 1045 ~~carrier.~~

1046 ~~3. Establish procedures for reinsuring risks.~~

1047 ~~4. Establish procedures for collecting assessments from~~
 1048 ~~participating carriers to provide for claims reinsured by the~~
 1049 ~~program and for administrative expenses, other than amounts~~
 1050 ~~payable to the administrative carrier, incurred or estimated to~~

1051 ~~be incurred during the period for which the assessment is made.~~

1052 ~~5. Provide for any additional matters at the discretion of~~
1053 ~~the board.~~

1054 ~~(e) The board shall recommend to the office market conduct~~
1055 ~~requirements and other requirements for carriers and agents,~~
1056 ~~including requirements relating to:~~

1057 ~~1. Registration by each carrier with the office of its~~
1058 ~~intention to be a small employer carrier under this section;~~

1059 ~~2. Publication by the office of a list of all small~~
1060 ~~employer carriers, including a requirement applicable to agents~~
1061 ~~and carriers that a health benefit plan may not be sold by a~~
1062 ~~carrier that is not identified as a small employer carrier;~~

1063 ~~3. The availability of a broadly publicized, toll-free~~
1064 ~~telephone number for access by small employers to information~~
1065 ~~concerning this section;~~

1066 ~~4. Periodic reports by carriers and agents concerning~~
1067 ~~health benefit plans issued; and~~

1068 ~~5. Methods concerning periodic demonstration by small~~
1069 ~~employer carriers and agents that they are marketing or issuing~~
1070 ~~health benefit plans to small employers.~~

1071 ~~(f) The program has the general powers and authority~~
1072 ~~granted under the laws of this state to insurance companies and~~
1073 ~~health maintenance organizations licensed to transact business,~~
1074 ~~except the power to issue health benefit plans directly to~~
1075 ~~groups or individuals. In addition thereto, the program has~~

1076 ~~specific authority to:~~

1077 1. ~~Enter into contracts as necessary or proper to carry~~

1078 ~~out the provisions and purposes of this act, including the~~

1079 ~~authority to enter into contracts with similar programs of other~~

1080 ~~states for the joint performance of common functions or with~~

1081 ~~persons or other organizations for the performance of~~

1082 ~~administrative functions.~~

1083 2. ~~Sue or be sued, including taking any legal action~~

1084 ~~necessary or proper for recovering any assessments and penalties~~

1085 ~~for, on behalf of, or against the program or any carrier.~~

1086 3. ~~Take any legal action necessary to avoid the payment of~~

1087 ~~improper claims against the program.~~

1088 4. ~~Issue reinsurance policies, in accordance with the~~

1089 ~~requirements of this act.~~

1090 5. ~~Establish rules, conditions, and procedures for~~

1091 ~~reinsurance risks under the program participation.~~

1092 6. ~~Establish actuarial functions as appropriate for the~~

1093 ~~operation of the program.~~

1094 7. ~~Assess participating carriers in accordance with~~

1095 ~~paragraph (j), and make advance interim assessments as may be~~

1096 ~~reasonable and necessary for organizational and interim~~

1097 ~~operating expenses. Interim assessments shall be credited as~~

1098 ~~offsets against any regular assessments due following the close~~

1099 ~~of the calendar year.~~

1100 8. ~~Appoint appropriate legal, actuarial, and other~~

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1101 ~~committees as necessary to provide technical assistance in the~~
1102 ~~operation of the program, and in any other function within the~~
1103 ~~authority of the program.~~

1104 ~~9. Borrow money to effect the purposes of the program. Any~~
1105 ~~notes or other evidences of indebtedness of the program which~~
1106 ~~are not in default constitute legal investments for carriers and~~
1107 ~~may be carried as admitted assets.~~

1108 ~~10. To the extent necessary, increase the \$5,000~~
1109 ~~deductible reinsurance requirement to adjust for the effects of~~
1110 ~~inflation.~~

1111 ~~(g) A reinsuring carrier may reinsure with the program~~
1112 ~~coverage of an eligible employee of a small employer, or any~~
1113 ~~dependent of such an employee, subject to each of the following~~
1114 ~~provisions:~~

1115 ~~1. Except in the case of a late enrollee, a reinsuring~~
1116 ~~carrier may reinsure an eligible employee or dependent within 60~~
1117 ~~days after the commencement of the coverage of the small~~
1118 ~~employer. A newly employed eligible employee or dependent of a~~
1119 ~~small employer may be reinsured within 60 days after the~~
1120 ~~commencement of his or her coverage.~~

1121 ~~2. A small employer carrier may reinsure an entire~~
1122 ~~employer group within 60 days after the commencement of the~~
1123 ~~group's coverage under the plan.~~

1124 ~~3. The program may not reimburse a participating carrier~~
1125 ~~with respect to the claims of a reinsured employee or dependent~~

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1126 ~~until the carrier has paid incurred claims of at least \$5,000 in~~
1127 ~~a calendar year for benefits covered by the program. In~~
1128 ~~addition, the reinsuring carrier shall be responsible for 10~~
1129 ~~percent of the next \$50,000 and 5 percent of the next \$100,000~~
1130 ~~of incurred claims during a calendar year and the program shall~~
1131 ~~reinsure the remainder.~~

1132 ~~4. The board annually shall adjust the initial level of~~
1133 ~~claims and the maximum limit to be retained by the carrier to~~
1134 ~~reflect increases in costs and utilization within the standard~~
1135 ~~market for health benefit plans within the state. The adjustment~~
1136 ~~shall not be less than the annual change in the medical~~
1137 ~~component of the "Consumer Price Index for All Urban Consumers"~~
1138 ~~of the Bureau of Labor Statistics of the Department of Labor,~~
1139 ~~unless the board proposes and the office approves a lower~~
1140 ~~adjustment factor.~~

1141 ~~5. A small employer carrier may terminate reinsurance for~~
1142 ~~all reinsured employees or dependents on any plan anniversary.~~

1143 ~~6. The premium rate charged for reinsurance by the program~~
1144 ~~to a health maintenance organization that is approved by the~~
1145 ~~Secretary of Health and Human Services as a federally qualified~~
1146 ~~health maintenance organization pursuant to 42 U.S.C. s.~~
1147 ~~300e(c)(2)(A) and that, as such, is subject to requirements that~~
1148 ~~limit the amount of risk that may be ceded to the program, which~~
1149 ~~requirements are more restrictive than subparagraph 3., shall be~~
1150 ~~reduced by an amount equal to that portion of the risk, if any,~~

1151 ~~which exceeds the amount set forth in subparagraph 3. which may~~
1152 ~~not be ceded to the program.~~

1153 ~~7. The board may consider adjustments to the premium rates~~
1154 ~~charged for reinsurance by the program for carriers that use~~
1155 ~~effective cost containment measures, including high-cost case~~
1156 ~~management, as defined by the board.~~

1157 ~~8. A reinsuring carrier shall apply its case management~~
1158 ~~and claims handling techniques, including, but not limited to,~~
1159 ~~utilization review, individual case management, preferred~~
1160 ~~provider provisions, other managed care provisions or methods of~~
1161 ~~operation, consistently with both reinsured business and~~
1162 ~~nonreinsured business.~~

1163 ~~(h)1. The board, as part of the plan of operation, shall~~
1164 ~~establish a methodology for determining premium rates to be~~
1165 ~~charged by the program for reinsuring small employers and~~
1166 ~~individuals pursuant to this section. The methodology shall~~
1167 ~~include a system for classification of small employers that~~
1168 ~~reflects the types of case characteristics commonly used by~~
1169 ~~small employer carriers in the state. The methodology shall~~
1170 ~~provide for the development of basic reinsurance premium rates,~~
1171 ~~which shall be multiplied by the factors set for them in this~~
1172 ~~paragraph to determine the premium rates for the program. The~~
1173 ~~basic reinsurance premium rates shall be established by the~~
1174 ~~board, subject to the approval of the office. The premium rates~~
1175 ~~set by the board may vary by geographical area, as determined~~

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1176 ~~under this section, to reflect differences in cost. The~~
1177 ~~multiplying factors must be established as follows:~~

1178 ~~a. The entire group may be reinsured for a rate that is~~
1179 ~~1.5 times the rate established by the board.~~

1180 ~~b. An eligible employee or dependent may be reinsured for~~
1181 ~~a rate that is 5 times the rate established by the board.~~

1182 ~~2. The board periodically shall review the methodology~~
1183 ~~established, including the system of classification and any~~
1184 ~~rating factors, to assure that it reasonably reflects the claims~~
1185 ~~experience of the program. The board may propose changes to the~~
1186 ~~rates which shall be subject to the approval of the office.~~

1187 ~~(i) If a health benefit plan for a small employer issued~~
1188 ~~in accordance with this subsection is entirely or partially~~
1189 ~~reinsured with the program, the premium charged to the small~~
1190 ~~employer for any rating period for the coverage issued must be~~
1191 ~~consistent with the requirements relating to premium rates set~~
1192 ~~forth in this section.~~

1193 ~~(j)1. Before July 1 of each calendar year, the board shall~~
1194 ~~determine and report to the office the program net loss for the~~
1195 ~~previous year, including administrative expenses for that year,~~
1196 ~~and the incurred losses for the year, taking into account~~
1197 ~~investment income and other appropriate gains and losses.~~

1198 ~~2. Any net loss for the year shall be recouped by~~
1199 ~~assessment of the carriers, as follows:~~

1200 ~~a. The operating losses of the program shall be assessed~~

1201 ~~in the following order subject to the specified limitations. The~~
1202 ~~first tier of assessments shall be made against reinsuring~~
1203 ~~carriers in an amount which shall not exceed 5 percent of each~~
1204 ~~reinsuring carrier's premiums from health benefit plans covering~~
1205 ~~small employers. If such assessments have been collected and~~
1206 ~~additional moneys are needed, the board shall make a second tier~~
1207 ~~of assessments in an amount which shall not exceed 0.5 percent~~
1208 ~~of each carrier's health benefit plan premiums. Except as~~
1209 ~~provided in paragraph (m), risk-assuming carriers are exempt~~
1210 ~~from all assessments authorized pursuant to this section. The~~
1211 ~~amount paid by a reinsuring carrier for the first tier of~~
1212 ~~assessments shall be credited against any additional assessments~~
1213 ~~made.~~

1214 ~~b. The board shall equitably assess carriers for operating~~
1215 ~~losses of the plan based on market share. The board shall~~
1216 ~~annually assess each carrier a portion of the operating losses~~
1217 ~~of the plan. The first tier of assessments shall be determined~~
1218 ~~by multiplying the operating losses by a fraction, the numerator~~
1219 ~~of which equals the reinsuring carrier's earned premium~~
1220 ~~pertaining to direct writings of small employer health benefit~~
1221 ~~plans in the state during the calendar year for which the~~
1222 ~~assessment is levied, and the denominator of which equals the~~
1223 ~~total of all such premiums earned by reinsuring carriers in the~~
1224 ~~state during that calendar year. The second tier of assessments~~
1225 ~~shall be based on the premiums that all carriers, except risk-~~

1226 ~~assuming carriers, earned on all health benefit plans written in~~
1227 ~~this state. The board may levy interim assessments against~~
1228 ~~carriers to ensure the financial ability of the plan to cover~~
1229 ~~claims expenses and administrative expenses paid or estimated to~~
1230 ~~be paid in the operation of the plan for the calendar year prior~~
1231 ~~to the association's anticipated receipt of annual assessments~~
1232 ~~for that calendar year. Any interim assessment is due and~~
1233 ~~payable within 30 days after receipt by a carrier of the interim~~
1234 ~~assessment notice. Interim assessment payments shall be credited~~
1235 ~~against the carrier's annual assessment. Health benefit plan~~
1236 ~~premiums and benefits paid by a carrier that are less than an~~
1237 ~~amount determined by the board to justify the cost of collection~~
1238 ~~may not be considered for purposes of determining assessments.~~

1239 ~~e. Subject to the approval of the office, the board shall~~
1240 ~~make an adjustment to the assessment formula for reinsuring~~
1241 ~~carriers that are approved as federally qualified health~~
1242 ~~maintenance organizations by the Secretary of Health and Human~~
1243 ~~Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent,~~
1244 ~~if any, that restrictions are placed on them that are not~~
1245 ~~imposed on other small employer carriers.~~

1246 ~~3. Before July 1 of each year, the board shall determine~~
1247 ~~and file with the office an estimate of the assessments needed~~
1248 ~~to fund the losses incurred by the program in the previous~~
1249 ~~calendar year.~~

1250 ~~4. If the board determines that the assessments needed to~~

1251 ~~fund the losses incurred by the program in the previous calendar~~
1252 ~~year will exceed the amount specified in subparagraph 2., the~~
1253 ~~board shall evaluate the operation of the program and report its~~
1254 ~~findings, including any recommendations for changes to the plan~~
1255 ~~of operation, to the office within 180 days following the end of~~
1256 ~~the calendar year in which the losses were incurred. The~~
1257 ~~evaluation shall include an estimate of future assessments, the~~
1258 ~~administrative costs of the program, the appropriateness of the~~
1259 ~~premiums charged and the level of carrier retention under the~~
1260 ~~program, and the costs of coverage for small employers. If the~~
1261 ~~board fails to file a report with the office within 180 days~~
1262 ~~following the end of the applicable calendar year, the office~~
1263 ~~may evaluate the operations of the program and implement such~~
1264 ~~amendments to the plan of operation the office deems necessary~~
1265 ~~to reduce future losses and assessments.~~

1266 ~~5. If assessments exceed the amount of the actual losses~~
1267 ~~and administrative expenses of the program, the excess shall be~~
1268 ~~held as interest and used by the board to offset future losses~~
1269 ~~or to reduce program premiums. As used in this paragraph, the~~
1270 ~~term "future losses" includes reserves for incurred but not~~
1271 ~~reported claims.~~

1272 ~~6. Each carrier's proportion of the assessment shall be~~
1273 ~~determined annually by the board, based on annual statements and~~
1274 ~~other reports considered necessary by the board and filed by the~~
1275 ~~carriers with the board.~~

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1276 ~~7. Provision shall be made in the plan of operation for~~
1277 ~~the imposition of an interest penalty for late payment of an~~
1278 ~~assessment.~~

1279 ~~8. A carrier may seek, from the office, a deferment, in~~
1280 ~~whole or in part, from any assessment made by the board. The~~
1281 ~~office may defer, in whole or in part, the assessment of a~~
1282 ~~carrier if, in the opinion of the office, the payment of the~~
1283 ~~assessment would place the carrier in a financially impaired~~
1284 ~~condition. If an assessment against a carrier is deferred, in~~
1285 ~~whole or in part, the amount by which the assessment is deferred~~
1286 ~~may be assessed against the other carriers in a manner~~
1287 ~~consistent with the basis for assessment set forth in this~~
1288 ~~section. The carrier receiving such deferment remains liable to~~
1289 ~~the program for the amount deferred and is prohibited from~~
1290 ~~reinsuring any individuals or groups in the program if it fails~~
1291 ~~to pay assessments.~~

1292 ~~(k) Neither the participation in the program as reinsuring~~
1293 ~~carriers, the establishment of rates, forms, or procedures, nor~~
1294 ~~any other joint or collective action required by this act, may~~
1295 ~~be the basis of any legal action, criminal or civil liability,~~
1296 ~~or penalty against the program or any of its carriers either~~
1297 ~~jointly or separately.~~

1298 ~~(l) The board shall monitor compliance with this section,~~
1299 ~~including the market conduct of small employer carriers, and~~
1300 ~~shall report to the office any unfair trade practices and~~

1301 ~~misleading or unfair conduct by a small employer carrier that~~
1302 ~~has been reported to the board by agents, consumers, or any~~
1303 ~~other person. The office shall investigate all reports and, upon~~
1304 ~~a finding of noncompliance with this section or of unfair or~~
1305 ~~misleading practices, shall take action against the small~~
1306 ~~employer carrier as permitted under the insurance code or~~
1307 ~~chapter 641. The board is not given investigatory or regulatory~~
1308 ~~powers, but must forward all reports of cases or abuse or~~
1309 ~~misrepresentation to the office.~~

1310 ~~(m) Notwithstanding paragraph (j), the administrative~~
1311 ~~expenses of the program shall be recouped by assessment of risk-~~
1312 ~~assuming carriers and reinsuring carriers and such amounts shall~~
1313 ~~not be considered part of the operating losses of the plan for~~
1314 ~~the purposes of this paragraph. Each carrier's portion of such~~
1315 ~~administrative expenses shall be determined by multiplying the~~
1316 ~~total of such administrative expenses by a fraction, the~~
1317 ~~numerator of which equals the carrier's earned premium~~
1318 ~~pertaining to direct writing of small employer health benefit~~
1319 ~~plans in the state during the calendar year for which the~~
1320 ~~assessment is levied, and the denominator of which equals the~~
1321 ~~total of such premiums earned by all carriers in the state~~
1322 ~~during such calendar year.~~

1323 ~~(n) The board shall advise the office, the Agency for~~
1324 ~~Health Care Administration, the department, other executive~~
1325 ~~departments, and the Legislature on health insurance issues.~~

1326 ~~Specifically, the board shall:~~

1327 ~~1. Provide a forum for stakeholders, consisting of~~
 1328 ~~insurers, employers, agents, consumers, and regulators, in the~~
 1329 ~~private health insurance market in this state.~~

1330 ~~2. Review and recommend strategies to improve the~~
 1331 ~~functioning of the health insurance markets in this state with a~~
 1332 ~~specific focus on market stability, access, and pricing.~~

1333 ~~3. Make recommendations to the office for legislation~~
 1334 ~~addressing health insurance market issues and provide comments~~
 1335 ~~on health insurance legislation proposed by the office.~~

1336 ~~4. Meet at least three times each year. One meeting shall~~
 1337 ~~be held to hear reports and to secure public comment on the~~
 1338 ~~health insurance market, to develop any legislation needed to~~
 1339 ~~address health insurance market issues, and to provide comments~~
 1340 ~~on health insurance legislation proposed by the office.~~

1341 ~~5. Issue a report to the office on the state of the health~~
 1342 ~~insurance market by September 1 each year. The report shall~~
 1343 ~~include recommendations for changes in the health insurance~~
 1344 ~~market, results from implementation of previous recommendations,~~
 1345 ~~and information on health insurance markets.~~

1346 **Section 14. Paragraphs (c), (d), and (e) are added to**
 1347 **subsection (2) of section 627.711, Florida Statutes, to read:**

1348 627.711 Notice of premium discounts for hurricane loss
 1349 mitigation; uniform mitigation verification inspection form.—

1350 (2)

1351 (c) The office shall contract with a state university to
1352 design, operate, upgrade, and maintain a statewide database for
1353 uniform mitigation verification inspection forms. This database
1354 must be managed by the office to collect and evaluate mitigation
1355 features of residential properties within the state.

1356 (d) Beginning January 1, 2026, each insurer shall
1357 electronically file a copy of uniform mitigation inspection
1358 forms submitted by policyholders in the database created
1359 pursuant to paragraph (c) within 15 business days after receipt
1360 using the electronic format prescribed by the office.

1361 (e) The Financial Services Commission shall adopt rules to
1362 implement this subsection.

1363 **Section 15. Effective upon this act becoming a law,**
1364 **subsection (12) of section 627.7152, Florida Statutes, is**
1365 **amended to read:**

1366 627.7152 Assignment agreements.—

1367 ~~(12) The office shall require each insurer to report by~~
1368 ~~January 30, 2022, and each year thereafter data on each~~
1369 ~~residential and commercial property insurance claim paid in the~~
1370 ~~prior calendar year under an assignment agreement. The Financial~~
1371 ~~Services Commission shall adopt by rule a list of the data~~
1372 ~~required, which must include specific data about claims~~
1373 ~~adjustment and settlement timeframes and trends, grouped by~~
1374 ~~whether litigated or not litigated and by loss adjustment~~
1375 ~~expenses.~~

1376 **Section 16. Section 627.9145, Florida Statutes, is created**
1377 **to read:**

1378 627.9145 Reports by residential property insurers.-
1379 Beginning March 1, 2026, and by March 1 every year thereafter,
1380 each authorized insurer and surplus lines insurer transacting
1381 residential property insurance in this state shall file with the
1382 office a report addressing the following areas:

1383 (1) Policy types, perils covered, statuses, and premiums.

1384 (2) Location and limits of writings in this state.

1385 (3) Coverages, deductibles, and exclusions.

1386 (4) Mitigation discounts.

1387 (5) Claims reporting requirements.

1388 (6) Any other information deemed necessary by the
1389 commission to provide the office with the ability to track
1390 mitigation and resiliency trends occurring in the residential
1391 property market.

1392
1393 The commission shall adopt rules specifying the information
1394 required to be reported under this section and the format
1395 required for the reports.

1396 **Section 17. Subsections (2) and (5) of section 627.915,**
1397 **Florida Statutes, are amended, and a new subsection (2) is added**
1398 **to that section, to read:**

1399 627.915 Insurer experience reporting.-

1400 (2) Beginning January 1, 2026, each insurer transacting

1401 private passenger automobile insurance in this state shall file
1402 monthly with the office a report addressing the following areas:

1403 (a) Policy coverage categories, including policies in
1404 force and total direct premiums earned and written.

1405 (b) Type, location, and limits of writings in this state.

1406 (c) Claims reporting requirements.

1407 (d) Any other information deemed necessary by the
1408 commission to provide the office with the ability to track
1409 trends occurring in the private passenger automobile insurance
1410 market.

1411
1412 The commission shall adopt rules specifying the information
1413 required to be reported under this subsection and the format
1414 required for the reports.

1415 ~~(2) Each insurer transacting fire, homeowner's multiple~~
1416 ~~peril, commercial multiple peril, medical malpractice, products~~
1417 ~~liability, workers' compensation, private passenger automobile~~
1418 ~~liability, commercial automobile liability, private passenger~~
1419 ~~automobile physical damage, commercial automobile physical~~
1420 ~~damage, officers' and directors' liability insurance, or other~~
1421 ~~liability insurance shall report, for each such line of~~
1422 ~~insurance, the information specified in this subsection to the~~
1423 ~~office. The information shall be reported for direct Florida~~
1424 ~~business only and shall be reported on a calendar-year basis~~
1425 ~~annually by April 1 for the preceding calendar year:~~

- 1426 ~~(a) Direct premiums written.~~
- 1427 ~~(b) Direct premiums earned.~~
- 1428 ~~(c) Loss reserves for all known claims:~~
 - 1429 ~~1. At beginning of the year.~~
 - 1430 ~~2. At end of the year.~~
- 1431 ~~(d) Reserves for losses incurred but not reported:~~
 - 1432 ~~1. At beginning of the year.~~
 - 1433 ~~2. At end of the year.~~
- 1434 ~~(e) Allocated loss adjustment expense:~~
 - 1435 ~~1. Reserve at beginning of the year.~~
 - 1436 ~~2. Reserve at end of the year.~~
 - 1437 ~~3. Paid during the year.~~
- 1438 ~~(f) Unallocated loss adjustment expense:~~
 - 1439 ~~1. Reserve at beginning of the year.~~
 - 1440 ~~2. Reserve at end of the year.~~
 - 1441 ~~3. Paid during the year.~~
- 1442 ~~(g) Direct losses paid.~~
- 1443 ~~(h) Underwriting income or loss.~~
- 1444 ~~(i) Commissions and brokerage fees.~~
- 1445 ~~(j) Taxes, licenses, and fees.~~
- 1446 ~~(k) Other acquisition costs.~~
- 1447 ~~(l) General expenses.~~
- 1448 ~~(m) Policyholder dividends.~~
- 1449 ~~(n) Net investment gain or loss and other income gain or~~
- 1450 ~~loss allocated pro rata by earned premium to Florida business~~

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1451 ~~utilizing the investment allocation formula contained in the~~
1452 ~~National Association of Insurance Commissioner's Profitability~~
1453 ~~Report by line by state.~~

1454 ~~(5) Any insurer or insurer group which does not write at~~
1455 ~~least 0.5 percent of the Florida market based on premiums~~
1456 ~~written shall not have to file any report required by subsection~~
1457 ~~(2) other than a report indicating its percentage of the market~~
1458 ~~share. That percentage shall be calculated by dividing the~~
1459 ~~current premiums written by the preceding year's total premiums~~
1460 ~~written in the state for that line of insurance.~~

1461 **Section 18. Effective upon this act becoming a law,**
1462 **subsection (2) of section 628.081, Florida Statutes, is amended**
1463 **to read:**

1464 628.081 Incorporation of domestic insurer.—

1465 (2) The incorporators shall execute articles of
1466 incorporation ~~in triplicate~~. At least three of them shall
1467 acknowledge execution before an officer authorized to take
1468 acknowledgments.

1469 **Section 19. Effective upon this act becoming a law,**
1470 **subsections (2), (3), and (4) of section 628.091, Florida**
1471 **Statutes, are amended to read:**

1472 628.091 Filing, approval of articles of incorporation.—

1473 (2) The incorporators shall file the ~~triplicate originals~~
1474 ~~of the~~ articles of incorporation with the office, accompanied by
1475 the filing fee specified in s. 624.501.

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1476 (3) The office shall promptly examine the articles of
1477 incorporation. If it finds that the articles of incorporation
1478 conform to law, and that a permit has been or will be issued, it
1479 shall endorse its approval on ~~each of the triplicate originals~~
1480 ~~of the articles of incorporation, retain one copy for its files,~~
1481 and return the articles of incorporation ~~remaining copies~~ to the
1482 incorporators for filing with the Department of State.

1483 (4) If the office does not so find, it shall refuse to
1484 approve the articles of incorporation ~~and shall return the~~
1485 ~~originals.~~

1486 **Section 20. Effective upon this act becoming a law,**
1487 **subsections (2) and (3) of section 628.111, Florida Statutes,**
1488 **are amended to read:**

1489 628.111 Amendment of articles of incorporation; mutual
1490 insurer.-

1491 (2) (a) Upon adoption of the amendment, the insurer shall
1492 make ~~in triplicate under its corporate seal~~ a certificate
1493 thereof, setting forth the amendment and the date and manner of
1494 the adoption thereof, which certificate shall be executed by the
1495 insurer's president or vice president and secretary or assistant
1496 secretary and acknowledged before an officer authorized to take
1497 acknowledgments. The insurer shall deliver ~~the triplicate~~
1498 ~~originals~~ of the certificate to the office, together with the
1499 filing fee specified in s. 624.501.

1500 (b) The office shall promptly examine the certificate of

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1501 amendment, ~~and~~ if it finds that the certificate and the
1502 amendment comply with law, it shall endorse its approval on the
1503 certificate of amendment ~~upon each of the triplicate originals,~~
1504 ~~place one on file in its office, and return the remaining sets~~
1505 ~~to the insurer.~~ The insurer shall forthwith file such endorsed
1506 certificate ~~certificates~~ of amendment with the Department of
1507 State. The amendment shall be effective when filed with and
1508 approved by the Department of State.

1509 (3) If the office finds that the proposed amendment or
1510 certificate does not comply with the law, it shall not approve
1511 the same, ~~and shall return the triplicate~~ certificate of
1512 amendment to the insurer.

1513 **Section 21. Paragraph (a) of subsection (1) and paragraph**
1514 **(b) of subsection (4) of section 628.461, Florida Statutes, are**
1515 **amended to read:**

1516 628.461 Acquisition of controlling stock.—

1517 (1) A person may not, individually or in conjunction with
1518 any affiliated person of such person, acquire directly or
1519 indirectly, conclude a tender offer or exchange offer for, enter
1520 into any agreement to exchange securities for, or otherwise
1521 finally acquire 10 percent or more of the outstanding voting
1522 securities of a domestic stock insurer or of a controlling
1523 company, unless:

1524 (a) The person or affiliated person has filed with the
1525 office and sent by registered mail to the principal office of

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1526 the insurer and controlling company a letter of notification
1527 regarding the transaction or proposed transaction within 5 days
1528 after any form of tender offer or exchange offer is proposed, or
1529 within 5 days after the acquisition of the securities if no
1530 tender offer or exchange offer is involved. The notification
1531 must be provided on forms prescribed by the commission
1532 containing information determined necessary to understand the
1533 transaction and identify all purchasers and owners involved;
1534
1535 A filing required under this subsection must be made for any
1536 acquisition that equals or exceeds 10 percent of the outstanding
1537 voting securities.

1538 (4)

1539 (b) Any corporation, association, or trust filing the
1540 statement required by this section shall give all required
1541 information that is within the knowledge of the directors,
1542 officers, or trustees (or others performing functions similar to
1543 those of a director, officer, or trustee) of the corporation,
1544 association, or trust making the filing and of any person
1545 controlling either directly or indirectly such corporation,
1546 association, or trust. A copy of the statement and any
1547 amendments to the statement shall be sent ~~by registered mail~~ to
1548 the insurer at its principal office within the state and to any
1549 controlling company at its principal office. If any material
1550 change occurs in the facts set forth in the statement filed with

1551 the office and sent to such insurer or controlling company
 1552 pursuant to this section, an amendment setting forth such
 1553 changes shall be filed immediately with the office and sent
 1554 immediately to such insurer and controlling company.

1555 **Section 22. Paragraph (b) of subsection (5) of section**
 1556 **628.4615, Florida Statutes, is amended to read:**

1557 628.4615 Specialty insurers; acquisition of controlling
 1558 stock, ownership interest, assets, or control; merger or
 1559 consolidation.—

1560 (5)

1561 (b) Any person filing the statement required by this
 1562 section shall give all required information that is within the
 1563 knowledge of:

1564 1. The directors, officers, or trustees, if a corporation,
 1565 or

1566 2. The partners, owners, managers, or joint venturers, or
 1567 others performing functions similar to those of a director,
 1568 officer, or trustee, if not a corporation,

1569
 1570 of the person making the filing and of any person controlling
 1571 either directly or indirectly such person. If any material
 1572 change occurs in the facts set forth in the application filed
 1573 with the office pursuant to this section, an amendment setting
 1574 forth such changes shall be filed immediately with the office,
 1575 and a copy of the amendment shall be sent ~~by registered mail~~ to

1576 the principal office of the specialty insurer and to the
 1577 principal office of the controlling company.

1578 **Section 23. Effective upon this act becoming a law,**
 1579 **subsection (2) of section 628.717, Florida Statutes, is amended**
 1580 **to read:**

1581 628.717 Filing of articles of incorporation.—

1582 (2) The office shall promptly examine the articles of
 1583 incorporation, and if it finds that the articles of
 1584 incorporation comply with law, the office shall endorse its
 1585 approval on the certificate of amendment ~~upon each of the~~
 1586 ~~originals, place one on file in its office, and return the~~
 1587 ~~remaining sets to the incorporators.~~ The incorporators shall
 1588 promptly file such endorsed articles of incorporation with the
 1589 Department of State. The articles of incorporation shall be
 1590 effective when filed with and approved by the Department of
 1591 State.

1592 **Section 24. Effective upon this act becoming a law,**
 1593 **subsection (2) of section 628.719, Florida Statutes, is amended**
 1594 **to read:**

1595 628.719 Amendment of articles of incorporation.—

1596 (2) (a) Upon adoption of an amendment, the mutual insurance
 1597 holding company shall make ~~under its corporate seal~~ a
 1598 certificate thereof, setting forth the amendment and the date
 1599 and manner of the adoption thereof, which certificate shall be
 1600 executed by the mutual insurance holding company's president or

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1601 vice president and secretary or assistant secretary and
1602 acknowledged before an officer authorized to take
1603 acknowledgments. The mutual insurance holding company shall
1604 deliver ~~the originals of~~ the certificate to the office.

1605 (b) The office shall promptly examine the certificate of
1606 amendment, and~~7~~ if the office finds that the certificate and the
1607 amendment comply with law, the office shall endorse its approval
1608 on the certificate of amendment ~~upon each of the originals,~~
1609 ~~place one on file in its office, and return the remaining sets~~
1610 ~~to the mutual insurance holding company.~~ The mutual insurance
1611 holding company shall promptly file such endorsed certificate
1612 ~~certificates~~ of amendment with the Department of State. The
1613 amendment shall be effective when filed with and approved by the
1614 Department of State.

1615 **Section 25. Effective upon this act becoming a law,**
1616 **subsection (4) of section 628.910, Florida Statutes, is amended**
1617 **to read:**

1618 628.910 Incorporation options and requirements.—

1619 (4) In the case of a captive insurance company formed as a
1620 corporation or a nonprofit corporation, before the articles of
1621 incorporation are transmitted to the Secretary of State, the
1622 incorporators shall file the articles of incorporation ~~in~~
1623 ~~triplicate~~ with the office. The office shall promptly examine
1624 the articles of incorporation. If it finds that the articles of
1625 incorporation conform to law, it shall endorse its approval on

1626 ~~each of the triplicate originals of the articles of~~
1627 ~~incorporation, retain one copy for its files, and return the~~
1628 ~~articles of incorporation remaining copies~~ to the incorporators
1629 for filing with the Department of State.

1630 **Section 26. Subsection (5) of section 629.011, Florida**
1631 **Statutes, is amended, and subsections (6), (7), and (8) are**
1632 **added to that section, to read:**

1633 629.011 Definitions.—As used in this part, the term:

1634 (5) "Reciprocal insurer" means an unincorporated
1635 aggregation of subscribers operating individually and
1636 collectively through an attorney in fact to provide reciprocal
1637 insurance among themselves.

1638 (a) An assessable reciprocal insurer is a reciprocal
1639 insurer that is able to levy an assessment on its subscribers to
1640 make up any shortfall in capital and surplus to cover claims and
1641 expenses as specified in s. 629.231.

1642 (b) A nonassessable reciprocal insurer is a reciprocal
1643 insurer authorized under s. 629.091(3) or s. 629.291(5) to issue
1644 policies where there is no recourse against subscribers for any
1645 shortfall in capital and surplus to cover claims and expenses.

1646 (6) "Subscriber contribution" means any transfer of money
1647 by a subscriber of a reciprocal insurer to the reciprocal
1648 insurer in excess of the premium approved by the office, when
1649 such money is counted as surplus for the reciprocal insurer or
1650 used to pay surplus notes.

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1651 (7) "Subscriber savings account" means any account in
1652 which a reciprocal insurer allocates money to be held in whole
1653 or in part for the benefit of an individual subscriber, other
1654 than accounts holding money for the payment of a specific claim
1655 by or settlement of a specific legal dispute with that
1656 individual subscriber.

1657 (8) "Subscribers' advisory committee" means the governing
1658 committee of a domestic reciprocal insurer which is formed in
1659 compliance with s. 629.201 and represents the interests of the
1660 subscribers.

1661 **Section 27. Section 629.071, Florida Statutes, is amended**
1662 **to read:**

1663 629.071 Surplus funds required.—

1664 (1) An assessable ~~A domestic~~ reciprocal insurer ~~hereunder~~
1665 ~~formed~~, if it has otherwise complied with the applicable
1666 provisions of this code, may be authorized to transact insurance
1667 if it has and thereafter maintains surplus funds of not less
1668 than \$3 million ~~\$250,000~~.

1669 (2) A nonassessable reciprocal insurer, if it has
1670 otherwise complied with the applicable provisions of this code,
1671 may be authorized to transact insurance if it has and thereafter
1672 maintains a surplus as to policyholders which is equal to that
1673 required under s. 624.408 for a domestic stock insurer
1674 authorized to transact like kinds of insurance ~~In addition to~~
1675 ~~the surplus required to be maintained under subsection (1), the~~

1676 ~~insurer shall have, when first so authorized, an expendable~~
 1677 ~~surplus of not less than \$750,000.~~

1678 **Section 28. Effective upon this act becoming a law,**
 1679 **subsection (3) of section 629.081, Florida Statutes, is amended**
 1680 **to read:**

1681 629.081 Organization of reciprocal insurer.—

1682 (3) The filing must be accompanied by the application fee
 1683 ~~required by s. 624.501(1)(a).~~

1684 **Section 29. Section 629.082, Florida Statutes, is created**
 1685 **to read:**

1686 629.082 Reciprocal affiliates.—The attorney in fact of a
 1687 reciprocal is an affiliate of the reciprocal for purposes of s.
 1688 624.10.

1689 **Section 30. Section 629.1015, Florida Statutes, is created**
 1690 **to read:**

1691 629.1015 Affiliate fees.—

1692 (1) Each reciprocal insurer doing business in this state
 1693 which pays a fee, commission, or other financial consideration
 1694 or payment to any affiliate directly or indirectly must provide
 1695 to the office documentation supporting that such fee,
 1696 commission, or other financial consideration or payment to any
 1697 affiliate is fair and reasonable for each service being provided
 1698 by contract. In determining whether the fee, commission, or
 1699 other financial consideration or payment is fair and reasonable,
 1700 the office must consider the following:

1701 (a) The actual cost of each service provided by an
1702 affiliate;

1703 (b) The relative financial condition of the reciprocal
1704 insurer and of the attorney in fact;

1705 (c) The level of debt and how that debt is serviced;

1706 (d) The amount of dividends paid by the attorney in fact
1707 and its affiliates and for what purpose;

1708 (e) Whether the terms of the written contract benefit the
1709 reciprocal insurer and are in the best interest of the
1710 subscribers; and

1711 (f) Any other such information as the office reasonably
1712 requires in making this determination.

1713 (2) For each agreement with an affiliate in force on July
1714 1, 2025, each domestic reciprocal insurer shall provide to the
1715 office no later than October 1, 2025, the cost incurred by the
1716 affiliate to provide each service, the amount charged to the
1717 domestic reciprocal insurer for each service, and the dollar
1718 amount of fees forgiven, waived, or reimbursed by the affiliate
1719 for the 2 most recent preceding years. If the total dollar
1720 amount charged to the domestic reciprocal insurer was greater
1721 than the total cost to provide services for either year, the
1722 domestic reciprocal insurer must explain how it determined the
1723 fee was fair and reasonable. For any proposed contract with an
1724 affiliate effective after July 1, 2025, the domestic reciprocal
1725 insurer must provide documentation to support that the fee,

1726 commission, or other financial consideration or payment to the
 1727 affiliate is fair and reasonable.

1728 **Section 31. Section 629.121, Florida Statutes, is amended**
 1729 **to read:**

1730 629.121 Attorney in fact ~~Attorney's~~ bond.—

1731 (1) Concurrently with the filing of the declaration
 1732 provided for in s. 629.081, the attorney in fact of a domestic
 1733 reciprocal insurer shall file with the office a bond in favor of
 1734 this state for the benefit of all persons damaged as a result of
 1735 breach by the attorney in fact of the conditions of his or her
 1736 bond as set forth in subsection (2). The bond shall be executed
 1737 by the attorney in fact and by an authorized corporate surety
 1738 and shall be subject to the approval of the office.

1739 (2) The bond shall be in the sum of \$300,000 ~~\$100,000~~,
 1740 aggregate in form, the bond conditioned that the attorney in
 1741 fact will faithfully account for all moneys and other property
 1742 of the insurer coming into his or her hands, and that he or she
 1743 will not withdraw or appropriate to his or her own use from the
 1744 funds of the insurer any moneys or property to which he or she
 1745 is not entitled under the power of attorney.

1746 (3) The bond shall provide that it is not subject to
 1747 cancellation unless 30 days' advance notice in writing of
 1748 cancellation is given both the attorney in fact and the office.

1749 **Section 32. Section 629.162, Florida Statutes, is created**
 1750 **to read:**

1751 629.162 Subscriber contributions.—

1752 (1) Reciprocal insurers may, subject to prior approval by
1753 the office, require contributions from subscribers in addition
1754 to premiums approved by the office.

1755 (2) A reciprocal insurer shall clearly disclose required
1756 subscriber contributions on the declarations page of any policy
1757 issued by the reciprocal insurer, separate from any cost
1758 associated with the premium.

1759 (3) Reciprocal insurers must provide subscribers an annual
1760 report detailing how each dollar of subscriber contributions was
1761 allocated or spent.

1762 **Section 33. Section 629.163, Florida Statutes, is created**
1763 **to read:**

1764 629.163 Subscriber savings accounts.—

1765 (1) Reciprocal insurers may establish subscriber savings
1766 accounts.

1767 (2) Moneys placed in subscriber savings accounts are not
1768 considered distributions under s. 629.164.

1769 (3) Subscriber savings accounts are subject to the
1770 following requirements:

1771 (a) Reciprocal insurers must inform each subscriber, in
1772 writing, of the limitations and restrictions imposed upon the
1773 use or possession of moneys held in subscriber savings accounts.

1774 (b) Reciprocal insurers must inform each subscriber, in
1775 writing, of the procedures used to distribute moneys to

1776 subscriber savings accounts and any calculations used to
1777 determine the amount of moneys to be distributed to subscriber
1778 savings accounts.

1779 (c) Advertisements marketing the benefits of subscriber
1780 savings accounts must note the limitations and restrictions
1781 imposed upon the use or possession of moneys held in subscriber
1782 savings accounts.

1783 (d) Upon cancellation or nonrenewal of a subscriber's
1784 policy, the subscriber is entitled to all moneys held in the
1785 subscriber's savings account, except when such moneys are
1786 otherwise allocated by law or contract, or when such
1787 distribution is prohibited by order of the office.

1788 **Section 34. Section 629.164, Florida Statutes, is created**
1789 **to read:**

1790 629.164 Subscriber distributions.—

1791 (1) Reciprocal insurers may make distributions to
1792 subscribers from their subscriber savings accounts.

1793 (2) The subscribers' advisory committee shall have the
1794 sole authority to authorize distributions, subject to prior
1795 written approval by the office.

1796 (3) Any reciprocal insurer that otherwise authorizes
1797 distributions but prohibits subscribers from receiving
1798 distributions for a specified period of time, including after
1799 initial subscription, must renew the subscriber's policy for
1800 that period of time plus 1 additional policy year. This

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1801 subsection does not prohibit the cancellation or nonrenewal of a
1802 policy pursuant to s. 624.4133 or by order of the office.

1803 (4) A reciprocal insurer may return to its subscribers any
1804 unused premiums, savings, or credits accruing to their accounts.
1805 Such distribution may not unfairly discriminate between classes
1806 of risks or policies, or between subscribers, but may vary as to
1807 classes of subscribers based on the experience of the classes.

1808 (5) In addition to the option provided in subsection (4),
1809 a domestic reciprocal insurer may, upon the prior written
1810 approval of the office, pay to its subscribers a portion of
1811 unassigned funds of up to 10 percent of surplus, with
1812 distribution limited to 50 percent of net income from the
1813 previous calendar year. Such distribution may not unfairly
1814 discriminate between classes of risks or policies, or between
1815 subscribers, but may vary as to classes of subscribers based on
1816 the experience of the classes.

1817 **Section 35. Section 629.171, Florida Statutes, is amended**
1818 **to read:**

1819 629.171 Annual statement.—

1820 (1) The subscribers' advisory committee shall procure an
1821 audited annual statement of the accounts and records of the
1822 insurer and the attorney in fact. The statement of the insurer
1823 must be prepared by an independent auditor at the expense of the
1824 reciprocal insurer and must be available for inspection by any
1825 subscriber. The statement of the attorney in fact must be

1826 prepared by an independent auditor at the expense of the
 1827 attorney in fact.

1828 (2)-(1) The annual statement filing of a reciprocal insurer
 1829 must shall be submitted made and filed by its attorney in fact.

1830 (3)-(2) The audited statement of the attorney in fact must
 1831 shall be submitted with the annual statement filing of the
 1832 reciprocal insurer, as required under s. 624.424, and
 1833 supplemented by such information as may be required by the
 1834 office relative to the affairs and transactions of the attorney
 1835 in fact relating insofar as they relate to the reciprocal
 1836 insurer.

1837 **Section 36. Subsection (1) of section 629.181, Florida**
 1838 **Statutes, is amended to read:**

1839 629.181 Financial condition; method of determining.—In
 1840 determining the financial condition of a reciprocal insurer, the
 1841 office shall apply the following rules:

1842 (1) Subscriber contributions are ~~The surplus deposits of~~
 1843 ~~subscribers shall be~~ allowed as assets, except that any premium
 1844 deposits delinquent for 90 days must shall first be charged
 1845 against such subscriber contributions. Subscriber contributions
 1846 may not exceed 2 percent of each individual subscribers' policy
 1847 premium for a nonassessable reciprocal insurer and 10 percent of
 1848 each individual subscribers' policy premium for an assessable
 1849 reciprocal insurer surplus deposit.

1850 **Section 37. Section 629.201, Florida Statutes, is amended**

1851 **to read:**

1852 629.201 Subscribers' advisory committee.—Each domestic
 1853 reciprocal insurer must have a subscribers' advisory committee
 1854 representing the interests of the subscribers.

1855 (1) The subscribers' advisory committee of a domestic
 1856 reciprocal insurer exercising the subscribers' rights must ~~shall~~
 1857 be formed in compliance with this section and ~~selected~~ under
 1858 such rules as the subscribers adopt. Such rules, along with any
 1859 amendments, must be approved by the office before becoming
 1860 effective.

1861 ~~(2) Not less than two-thirds of such committee shall be~~
 1862 ~~subscribers other than the attorney, or any person employed by,~~
 1863 ~~representing, or having a financial interest in the attorney.~~

1864 (2)(3) The subscribers' advisory committee shall perform
 1865 all of the following duties:

1866 (a) Supervise the finances of the insurer. ~~‡~~

1867 (b) Supervise the insurer's operations to such extent as
 1868 to ensure ~~assure~~ conformity with the subscribers' agreement, and
 1869 power of attorney, and other governing documents. ~~‡~~

1870 (c) Hire independent auditors, counsel, and other experts
 1871 at the expense of the insurer as necessary to fulfill the
 1872 committee's duties. ~~Procure the audit of the accounts and~~
 1873 ~~records of the insurer and of the attorney at the expense of the~~
 1874 ~~insurer; and~~

1875 (d) Exercise any ~~Have such~~ additional powers and functions

1876 as may be conferred by the subscribers' agreement.

1877 (3) The initial subscribers' advisory committee must be
1878 appointed by the original subscribers or the attorney in fact.
1879 Within 6 months after the reciprocal insurer is authorized to
1880 transact insurance, at least two-thirds of the committee members
1881 must be elected as provided for in subsections (4) and (5).

1882 (4) The subscribers' advisory committee must consist of
1883 subscribers of the reciprocal insurer. At least two-thirds of
1884 the subscribers' advisory committee must consist of subscribers
1885 who are independent of, not employed by, not representing, not
1886 selected by, and without any financial interest in the attorney
1887 in fact. The independent subscribers must be elected by the
1888 subscribers of the reciprocal insurer.

1889 (5) Any rules governing the election of subscribers to the
1890 subscribers' advisory committee require all of the following:

1891 (a) An electorate composed exclusively of all subscribers
1892 of the reciprocal insurer.

1893 (b) Terms of not more than 5 years.

1894 (c) A process that allows subscribers to nominate other
1895 subscribers for election to the subscribers' advisory committee.

1896 (6) If a reciprocal insurer has more than 50 subscribers,
1897 the attorney in fact must provide a platform by which
1898 subscribers can communicate with each other regarding the
1899 subscribers' advisory committee election process.

1900 **Section 38.** Section 629.271, Florida Statutes, is

1901 repealed.

1902 **Section 39. Effective upon this act becoming a law,**
 1903 **subsections (1) and (2) of section 629.291, Florida Statutes,**
 1904 **are amended to read:**

1905 629.291 Merger or conversion.—

1906 (1) A reciprocal insurer, upon affirmative vote of not
 1907 less than two-thirds of its subscribers who vote on such merger
 1908 or conversion pursuant to due notice, and subject to approval by
 1909 the office of the terms therefor, may merge with another
 1910 reciprocal insurer or be converted to a stock or mutual insurer,
 1911 to be thereafter governed by the applicable sections of the
 1912 Florida Insurance Code. However, a domestic stock insurer may
 1913 not convert to a reciprocal insurer.

1914 (2) A plan to merge a reciprocal insurer with another
 1915 reciprocal insurer or for conversion of the reciprocal insurer
 1916 to a stock or mutual insurer must be filed with the office on
 1917 forms adopted by the commission ~~office~~ and must contain such
 1918 information as the office reasonably requires to evaluate the
 1919 transaction.

1920 **Section 40. Section 629.301, Florida Statutes, is amended**
 1921 **to read:**

1922 629.301 Impaired reciprocal insurers.—

1923 (1) If the assets of a domestic reciprocal insurer are at
 1924 any time insufficient to discharge its liabilities, other than
 1925 any liability on account of funds contributed by the attorney in

1926 fact or others, and to maintain the required surplus, its
 1927 attorney shall forthwith make up the deficiency or levy an
 1928 assessment upon the subscribers for the amount needed to make up
 1929 the deficiency, but subject to the limitation set forth in the
 1930 power of attorney or policy.

1931 (2) If the attorney in fact fails to make up such
 1932 deficiency or to make the assessment within 30 days after the
 1933 office orders the attorney in fact ~~him or her~~ to do so, or if
 1934 the deficiency is not fully made up within 60 days after the
 1935 date the assessment was made, the insurer shall be deemed
 1936 insolvent and shall be proceeded against in the same manner as
 1937 any other insurer under chapter 631 and the insurance as
 1938 ~~authorized by this~~ code.

1939 (3) If liquidation of a reciprocal ~~such an~~ insurer is
 1940 ordered, the receiver shall levy an assessment ~~shall be levied~~
 1941 upon the subscribers an assessment for such an amount as the
 1942 receiver determines to be necessary to discharge all liabilities
 1943 of the insurer. The liabilities must be, ~~subject to limits as~~
 1944 ~~provided by this chapter, as the office determines to be~~
 1945 ~~necessary to discharge all liabilities of the insurer,~~ exclusive
 1946 of any funds contributed by the attorney in fact or other
 1947 persons, but inclusive of ~~including~~ the reasonable cost of the
 1948 liquidation. The assessment is subject to any limits set forth
 1949 in the power of attorney, the policy, or this chapter.

1950 **Section 41.** Section 629.401, Florida Statutes, is

1951 repealed.

1952 **Section 42.** Section 629.520, Florida Statutes, is
 1953 repealed.

1954 **Section 43. Section 629.56, Florida Statutes, is created**
 1955 **to read:**

1956 629.56 Unearned premium reserves.—A reciprocal insurer
 1957 must maintain an unearned premium reserve at all times and as
 1958 required under s. 625.051.

1959 **Section 44. Paragraph (c) of subsection (13) of section**
 1960 **634.401, Florida Statutes, is amended to read:**

1961 634.401 Definitions.—As used in this part, the term:

1962 (13) "Service warranty" means any warranty, guaranty,
 1963 extended warranty or extended guaranty, maintenance service
 1964 contract equal to or greater than 1 year in length or which does
 1965 not meet the exemption in paragraph (a), contract agreement, or
 1966 other written promise for a specific duration to perform the
 1967 repair, replacement, or maintenance of a consumer product, or
 1968 for indemnification for repair, replacement, or maintenance, for
 1969 operational or structural failure due to a defect in materials
 1970 or workmanship, normal wear and tear, power surge, or accidental
 1971 damage from handling in return for the payment of a segregated
 1972 charge by the consumer; however:

1973 (c) All contracts that include coverage for accidental
 1974 damage from handling must be covered by the contractual
 1975 liability policy referred to in s. 634.406(3), unless issued by

1976 | an association not required to establish an unearned premium
 1977 | reserve or maintain contractual liability insurance under s.
 1978 | 634.406(7).

1979 | **Section 45. Section 641.2012, Florida Statutes, is created**
 1980 | **to read:**

1981 | 641.2012 Service of process.—Sections 624.422 and 624.423
 1982 | apply to health maintenance organizations.

1983 | **Section 46. Subsections (1) and (3), paragraph (a) of**
 1984 | **subsection (5), and subsection (6) of section 641.26, Florida**
 1985 | **Statutes, are amended to read:**

1986 | 641.26 Annual and quarterly reports.—

1987 | (1) Every health maintenance organization shall file an
 1988 | annual statement covering the preceding calendar year on or
 1989 | before March 1, and quarterly statements covering the periods
 1990 | ending on March 31, June 30, and September 30 within 45 days
 1991 | after each such date, ~~annually within 3 months after the end of~~
 1992 | ~~its fiscal year, or within an extension of time therefor as the~~
 1993 | ~~office, for good cause, may grant, in a form prescribed by the~~
 1994 | ~~commission, file a report with the office, verified by the oath~~
 1995 | of two officers of the organization or, if not a corporation, of
 1996 | two persons who are principal managing directors of the affairs
 1997 | of the organization, properly notarized, showing its condition
 1998 | on the last day of the immediately preceding reporting period.
 1999 | Such report shall include:

2000 | (a) A financial statement of the health maintenance

2001 organization filed by electronic means in a computer-readable
 2002 form using a format acceptable to the office.

2003 (b) A financial statement of the health maintenance
 2004 organization filed on forms acceptable to the office.

2005 (c) An audited financial statement of the health
 2006 maintenance organization, including its balance sheet and a
 2007 statement of operations for the preceding year certified by an
 2008 independent certified public accountant, prepared in accordance
 2009 with statutory accounting principles.

2010 (d) The number of health maintenance contracts issued and
 2011 outstanding and the number of health maintenance contracts
 2012 terminated.

2013 (e) The number and amount of damage claims for medical
 2014 injury initiated against the health maintenance organization and
 2015 any of the providers engaged by it during the reporting year,
 2016 broken down into claims with and without formal legal process,
 2017 and the disposition, if any, of each such claim.

2018 (f) An actuarial certification that:

2019 1. The health maintenance organization is actuarially
 2020 sound, which certification shall consider the rates, benefits,
 2021 and expenses of, and any other funds available for the payment
 2022 of obligations of, the organization.

2023 2. The rates being charged or to be charged are
 2024 actuarially adequate to the end of the period for which rates
 2025 have been guaranteed.

2026 3. Incurred but not reported claims and claims reported
2027 but not fully paid have been adequately provided for.

2028 4. The health maintenance organization has adequately
2029 provided for all obligations required by s. 641.35(3)(a).

2030 (g) A report prepared by the certified public accountant
2031 and filed with the office describing material weaknesses in the
2032 health maintenance organization's internal control structure as
2033 noted by the certified public accountant during the audit. The
2034 report must be filed with the annual audited financial report as
2035 required in paragraph (c). The health maintenance organization
2036 shall provide a description of remedial actions taken or
2037 proposed to correct material weaknesses, if the actions are not
2038 described in the independent certified public accountant's
2039 report.

2040 (h) Such other information relating to the performance of
2041 health maintenance organizations as is required by the
2042 commission or office.

2043 (3) Every health maintenance organization shall file
2044 quarterly, for the first three calendar quarters of each year,
2045 an unaudited financial statement of the organization as
2046 described in paragraphs (1)(a) and (b). ~~The statement for the~~
2047 ~~quarter ending March 31 shall be filed on or before May 15, the~~
2048 ~~statement for the quarter ending June 30 shall be filed on or~~
2049 ~~before August 15, and the statement for the quarter ending~~
2050 ~~September 30 shall be filed on or before November 15. The~~

2051 quarterly report shall be verified by the oath of two officers
 2052 of the organization, properly notarized.

2053 (5) Each authorized health maintenance organization shall
 2054 retain an independent certified public accountant, referred to
 2055 in this section as "CPA," who agrees by written contract with
 2056 the health maintenance organization to comply with the
 2057 provisions of this part.

2058 (a) The CPA shall provide to the HMO audited financial
 2059 statements consistent with this part and s. 624.424.

2060 (6) To facilitate uniformity in financial statements and
 2061 to facilitate office analysis, the commission may by rule adopt
 2062 the form for financial statements of a health maintenance
 2063 organization, requiring the financial statement to comply with
 2064 s. 624.424 ~~including supplements as approved by the National~~
 2065 ~~Association of Insurance Commissioners in 1995, and may adopt~~
 2066 ~~subsequent amendments thereto if the methodology remains~~
 2067 ~~substantially consistent,~~ and may by rule require each health
 2068 maintenance organization to submit to the office all or part of
 2069 the information contained in the annual statement in a computer-
 2070 readable form compatible with the electronic data processing
 2071 system specified by the office.

2072 **Section 47. Section 641.283, Florida Statutes, is created**
 2073 **to read:**

2074 641.283 Administrative supervision and hazardous insurer
 2075 conditions.—Sections 624.80-624.87 apply to health maintenance

2076 organizations.

2077 **Section 48. Subsections (5) through (15) and (16) through**
 2078 **(29) of section 651.011, Florida Statutes, are renumbered as**
 2079 **subsections (7) through (17) and (19) through (32),**
 2080 **respectively, present subsections (7), (8), (19), and (26) are**
 2081 **amended, and new subsections (5), (6), and (18) are added to**
 2082 **that section, to read:**

2083 651.011 Definitions.—As used in this chapter, the term:

2084 (5) "Affiliate" means an entity that exercises control
 2085 over or is directly or indirectly controlled by the insurer
 2086 provider through:

2087 (a) Equity ownership of voting securities;

2088 (b) Common managerial control; or

2089 (c) Collusive participation by the management of the
 2090 insurer and affiliate in the management of the insurer or the
 2091 affiliate.

2092 (6) "Affiliated person" of another person means:

2093 (a) The spouse of the other person;

2094 (b) The parents of the other person and their lineal
 2095 descendants, or the parents of the other person's spouse and
 2096 their lineal descendants;

2097 (c) A person who directly or indirectly owns or controls,
 2098 or holds with the power to vote, 10 percent or more of the
 2099 outstanding voting securities of the other person;

2100 (d) A person 10 percent or more of whose outstanding

2101 voting securities are directly or indirectly owned or
 2102 controlled, or held with power to vote, by the other person;

2103 (e) A person or group of persons who directly or
 2104 indirectly control, are controlled by, or are under common
 2105 control with the other person;

2106 (f) An officer, director, partner, copartner, or employee
 2107 of the other person;

2108 (g) If the other person is an investment company, an
 2109 investment adviser of such company, or a member of an advisory
 2110 board of such company;

2111 (h) If the other person is an unincorporated investment
 2112 company not having a board of directors, the depositor of such
 2113 company; or

2114 (i) A person who has entered into a written or unwritten
 2115 agreement to act in concert with the other person in acquiring
 2116 or limiting the disposition of securities of a domestic stock
 2117 insurer provider or controlling company.

2118 (9)-(7)- "Continuing care at-home" means, pursuant to a
 2119 contract other than a contract described in subsection (7) ~~(5)~~,
 2120 furnishing to a resident who resides outside the facility the
 2121 right to future access to shelter and nursing care or personal
 2122 services, whether such services are provided in the facility or
 2123 in another setting designated in the contract, by an individual
 2124 not related by consanguinity or affinity to the resident, upon
 2125 payment of an entrance fee.

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2126 (10)(8) "Control," "controlling," "controlled by," "under
2127 common control with," or "controlling company" means any
2128 corporation, trust, or association that directly or indirectly
2129 owns 10 25 percent or more of either the following:

2130 (a) The direct or indirect possession of the power to
2131 direct or cause the direction of the management and policies of
2132 a person, whether through the ownership of voting securities, by
2133 contract other than a commercial contract for goods or
2134 nonmanagement services, or otherwise. Control is presumed to
2135 exist if a person, directly or indirectly, owns, controls, holds
2136 with the power to vote, or holds proxies representing 10 percent
2137 or more of the voting securities of another person; or

2138 (b) A management company exercising control through a
2139 management agreement whereby the management company is
2140 responsible for the day-to-day business operations of the
2141 provider or the day-to-day decisionmaking on behalf of the
2142 provider.

2143 ~~(a) The voting securities of one or more providers that~~
2144 ~~are stock corporations; or~~

2145 ~~(b) The ownership interest of one or more providers that~~
2146 ~~are not stock corporations.~~

2147 (18) "Governing body" or "full governing body" means a
2148 board of directors, a management company, a body of a provider,
2149 or an obligated group whose members are elected or appointed to
2150 set strategy, oversee management or operations of a provider,

2151 facility, or obligated group, and protect the interests of the
2152 provider, facility, or group.

2153 ~~(22)-(19)~~ "Manager," "management," or "management company"
2154 means a person who administers the day-to-day business
2155 operations of a facility for a provider, is part of a committee
2156 that supervises the activities of a business that provides
2157 continuing care or a member of the full governing body of a
2158 business that provides continuing care, or is subject to the
2159 policies, directives, and oversight of the provider or governing
2160 body.

2161 ~~(29)-(26)~~ "Regulatory action level event" means that any
2162 two of the following have occurred:

2163 (a) The provider's debt service coverage ratio is less
2164 than the greater of the minimum ratio specified in the
2165 provider's bond covenants or lending agreement for long-term
2166 financing or 1.20:1 as of the most recent ~~annual~~ report filed
2167 with the office pursuant to s. 651.026 or s. 651.0261, or, if
2168 the provider does not have a debt service coverage ratio
2169 required by its lending institution, the provider's debt service
2170 coverage ratio is less than 1.20:1 as of the most recent ~~annual~~
2171 report filed with the office pursuant to s. 651.026 or s.
2172 651.0261. If the provider is a member of an obligated group
2173 having cross-collateralized debt, the obligated group's debt
2174 service coverage ratio must be used as the provider's debt
2175 service coverage ratio.

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2176 (b) The provider's days cash on hand is less than the
2177 greater of the minimum number of days cash on hand specified in
2178 the provider's bond covenants or lending agreement for long-term
2179 financing or 100 days. If the provider does not have a days cash
2180 on hand required by its lending institution, the days cash on
2181 hand may not be less than 100 as of the most recent ~~annual~~
2182 report filed with the office pursuant to s. 651.026 or s.
2183 651.0261. If the provider is a member of an obligated group
2184 having cross-collateralized debt, the days cash on hand of the
2185 obligated group must be used as the provider's days cash on
2186 hand.

2187 (c) The occupancy of the provider's facility is less than
2188 80 percent averaged over the 12-month period immediately
2189 preceding the annual report filed with the office pursuant to s.
2190 651.026.

2191 **Section 49. Section 651.018, Florida Statutes, is amended**
2192 **to read:**

2193 651.018 Administrative supervision.—The office may place a
2194 facility in administrative supervision pursuant to part VI of
2195 chapter 624. If the office finds that any of the following
2196 conditions exist, the office shall place a facility in
2197 administrative supervision until the condition is resolved to
2198 the satisfaction of the office:

- 2199 (1) The facility is insolvent or impaired.
2200 (2) The facility is at a regulatory action level, pursuant

2201 to s. 651.034.

2202 (3) The facility reports a negative debt service reserve.

2203 (4) The facility has failed to file a monthly, quarterly,
 2204 or annual financial statement or an audited financial statement
 2205 as required by this chapter.

2206 (5) The facility was issued a financial statement with a
 2207 going concern issue by an independent certified public
 2208 accountant.

2209 (6) The facility is found to be in hazardous financial
 2210 condition pursuant to s. 651.113.

2211 (7) The facility has entered into a forbearance agreement
 2212 with a lender.

2213 **Section 50. Paragraph (a) of subsection (1) of section**
 2214 **651.019, Florida Statutes, is amended to read:**

2215 651.019 New financing, additional financing, or
 2216 refinancing.—

2217 (1)(a) A provider shall provide a written general outline
 2218 of the amount and the anticipated terms of any new financing or
 2219 refinancing, and the intended use of proceeds, to the office and
 2220 the residents' council at least 30 days before the closing date
 2221 of the financing or refinancing transaction. If there is a
 2222 material change in the noticed information, a provider shall
 2223 provide an updated notice to the office and the residents'
 2224 council within 10 business days after the provider becomes aware
 2225 of such change.

2226 **Section 51. Section 651.0212, Florida Statutes, is created**
 2227 **to read:**

2228 651.0212 General eligibility requirements to operate in
 2229 this state.-

2230 (1) The office must deny or revoke a provider's authority
 2231 to conduct business relating to continuing care in this state,
 2232 including, but not limited to, the authority to enter into
 2233 contracts, provide continuing care or continuing care at-home,
 2234 or construct facilities for the purpose of providing continuing
 2235 care in this state, if the office determines that any of the
 2236 following applies to the provider's management, officers, or
 2237 directors:

2238 (a) They are incompetent or untrustworthy.

2239 (b) They lack sufficient experience in continuing care
 2240 management, posing a risk to contract holders.

2241 (c) They lack the experience, ability, or reputation
 2242 necessary to ensure a reasonable likelihood of successful
 2243 operation.

2244 (d) They are affiliated, directly or indirectly, with
 2245 individuals or entities whose business practices have harmed
 2246 residents, stockholders, investors, creditors, or the public
 2247 through asset manipulation, fraudulent accounting, or bad faith
 2248 actions.

2249 (2) The office must deny or revoke a provider's authority
 2250 to conduct business relating to continuing care in this state,

2251 including, but not limited to, the authority to enter into
2252 contracts, provide continuing care or continuing care at-home,
2253 or construct facilities for the purpose of providing continuing
2254 care in this state, if the office determines that any general
2255 partner, subscriber, stockholder, or incorporator who exercises
2256 or has the ability to exercise effective control of the
2257 provider, or who influences or has the ability to influence the
2258 provider's business transactions, lacks the financial standing
2259 and business experience necessary for the provider's successful
2260 operation.

2261 (3) The office may deny, suspend, or revoke a provider's
2262 authority to conduct business relating to continuing care in
2263 this state, including, but not limited to, the authority to
2264 enter into contracts, provide continuing care or continuing care
2265 at-home, or construct facilities for the purpose of providing
2266 continuing care, if the office determines that any general
2267 partner, subscriber, stockholder, or incorporator who exercises
2268 or has the ability to exercise effective control of the
2269 provider, or who influences or has the ability to influence the
2270 provider's business transactions, has been found guilty of, or
2271 has pleaded guilty or nolo contendere to, any felony or crime
2272 punishable by imprisonment of 1 year or more under the laws of
2273 the United States, any state, or any other country, if the crime
2274 involves moral turpitude, regardless of whether a judgment of
2275 conviction has been entered by the court. However, if a provider

2276 operates under a valid certificate of authority, the provider
2277 must immediately remove any such person from his or her role in
2278 the business upon discovery of the conditions set forth in this
2279 subsection or remove such person upon the order of the office.
2280 Failure to remove such person constitutes grounds for suspension
2281 or revocation of the provider's certificate of authority.

2282 (4) The office may deny, suspend, or revoke a provider's
2283 authority to conduct business relating to continuing care in
2284 this state, including, but not limited to, the authority to
2285 enter into contracts, provide continuing care or continuing care
2286 at-home, or construct facilities for providing continuing care,
2287 if the office determines that any general partner, subscriber,
2288 stockholder, or incorporator who exercises or has the ability to
2289 exercise effective control of the provider, or who influences or
2290 has the ability to influence the provider's business
2291 transactions, is now or was previously affiliated, directly or
2292 indirectly, through ownership of 10 percent or more, with any
2293 business, corporation, or entity that has been found guilty of,
2294 or has pleaded guilty or nolo contendere to, any felony or crime
2295 punishable by imprisonment for 1 year or more under the laws of
2296 the United States, any state, or any other country. However, if
2297 a provider operates under a valid certificate of authority, the
2298 provider must immediately remove any such person from his or her
2299 role in the business or notify the office upon discovery of the
2300 conditions set forth in this subsection. Failure to remove the

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2301 person, provide notice to the office, or comply with an order
2302 from the office to remove the person from his or her role
2303 constitutes grounds for suspension or revocation of the
2304 provider's certificate of authority.

2305 **Section 52. Subsections (6) through (10) of section**
2306 **651.0215, Florida Statutes, are renumbered as subsections (5)**
2307 **through (9), respectively, and subsection (4) and present**
2308 **subsection (5) of that section are amended to read:**

2309 651.0215 Consolidated application for a provisional
2310 certificate of authority and a certificate of authority;
2311 required restrictions on use of entrance fees.-

2312 (4) Within 30 ~~45~~ days after receipt of the information
2313 required under subsection (2), the office shall examine the
2314 information and notify the applicant in writing, specifically
2315 requesting any additional information that the office is
2316 authorized to require. An application is deemed complete when
2317 the office receives all requested information and the applicant
2318 corrects any error or omission of which the applicant was timely
2319 notified or when the time for such notification has expired.
2320 ~~Within 15 days after receipt of all of the requested additional~~
2321 ~~information, the office shall notify the applicant in writing~~
2322 ~~that all of the requested information has been received and that~~
2323 ~~the application is deemed complete as of the date of the notice.~~
2324 ~~Failure to notify the applicant in writing within the 15-day~~
2325 ~~period constitutes acknowledgment by the office that it has~~

2326 ~~received all requested additional information, and the~~
 2327 ~~application is deemed complete for purposes of review on the~~
 2328 ~~date the applicant files all of the required additional~~
 2329 ~~information.~~

2330 ~~(5) Within 45 days after an application is deemed complete~~
 2331 ~~as set forth in subsection (4) and upon completion of the~~
 2332 ~~remaining requirements of this section, the office shall~~
 2333 ~~complete its review and issue or deny a certificate of authority~~
 2334 ~~to the applicant. If a certificate of authority is denied, the~~
 2335 ~~office shall notify the applicant in writing, citing the~~
 2336 ~~specific failures to satisfy this chapter, and the applicant is~~
 2337 ~~entitled to an administrative hearing pursuant to chapter 120.~~

2338 **Section 53. Subsections (7) and (8) of section 651.022,**
 2339 **Florida Statutes, are renumbered as subsections (6) and (7),**
 2340 **respectively, and subsections (3) and (5) and present subsection**
 2341 **(6) of that section are amended to read:**

2342 651.022 Provisional certificate of authority;
 2343 application.-

2344 (3) In addition to the information required in subsection
 2345 (2), an applicant for a provisional certificate of authority
 2346 shall submit a feasibility study, prepared by an independent
 2347 consultant, with appropriate financial, marketing, and actuarial
 2348 assumptions for the first 5 years of operations. The feasibility
 2349 study must include at least the following information:

2350 (a) A description of the proposed facility, including the

2351 location, size, anticipated completion date, and the proposed
 2352 construction program.

2353 (b) An identification and evaluation of the primary and,
 2354 if appropriate, the secondary market areas of the facility and
 2355 the projected unit sales per month.

2356 (c) Projected revenues, including anticipated entrance
 2357 fees; monthly service fees; nursing care revenues, if
 2358 applicable; and all other sources of revenue.

2359 (d) Projected expenses, including staffing requirements
 2360 and salaries; cost of property, plant, and equipment, including
 2361 depreciation expense; interest expense; marketing expense; and
 2362 other operating expenses.

2363 (e) A projected balance sheet.

2364 (f) Expectations of the financial condition of the
 2365 project, including the projected cash flow, and an estimate of
 2366 the funds anticipated to be necessary to cover startup losses.

2367 (g) The inflation factor, if any, assumed in the
 2368 feasibility study for the proposed facility and how and where it
 2369 is applied.

2370 (h) Project costs and the total amount of debt financing
 2371 required, marketing projections, resident fees and charges, the
 2372 competition, resident contract provisions, and other factors
 2373 that affect the feasibility of the facility.

2374 (i) Appropriate population projections, including
 2375 morbidity and mortality assumptions.

2376 (j) The name of the person who prepared the feasibility
2377 study and the experience of such person in preparing similar
2378 studies or otherwise consulting in the field of continuing care.
2379 The preparer of the feasibility study may be the provider or a
2380 contracted third party.

2381 (k) Any other information that the applicant deems
2382 relevant and appropriate to enable the office to make a more
2383 informed determination.

2384 (5)~~(a)~~ Within 30 days after receipt of an application for
2385 a provisional certificate of authority, the office shall examine
2386 the application and shall notify the applicant in writing,
2387 specifically setting forth and specifically requesting any
2388 additional information the office is permitted by law to
2389 require. If the application submitted is determined by the
2390 office to be substantially incomplete so as to require
2391 substantial additional information, including biographical
2392 information, the office may return the application to the
2393 applicant with a written notice that the application as received
2394 is substantially incomplete and, therefore, unacceptable for
2395 filing without further action required by the office. Any filing
2396 fee received shall be refunded to the applicant.

2397 ~~(b) Within 15 days after receipt of all of the requested~~
2398 ~~additional information, the office shall notify the applicant in~~
2399 ~~writing that all of the requested information has been received~~
2400 ~~and the application is deemed to be complete as of the date of~~

2401 ~~the notice. Failure to so notify the applicant in writing within~~
2402 ~~the 15-day period shall constitute acknowledgment by the office~~
2403 ~~that it has received all requested additional information, and~~
2404 ~~the application shall be deemed to be complete for purposes of~~
2405 ~~review upon the date of the filing of all of the requested~~
2406 ~~additional information.~~

2407 ~~(6) Within 45 days after the date an application is deemed~~
2408 ~~complete as set forth in paragraph (5)(b), the office shall~~
2409 ~~complete its review and issue a provisional certificate of~~
2410 ~~authority to the applicant based upon its review and a~~
2411 ~~determination that the application meets all requirements of~~
2412 ~~law, that the feasibility study was based on sufficient data and~~
2413 ~~reasonable assumptions, and that the applicant will be able to~~
2414 ~~provide continuing care or continuing care at home as proposed~~
2415 ~~and meet all financial and contractual obligations related to~~
2416 ~~its operations, including the financial requirements of this~~
2417 ~~chapter. If the application is denied, the office shall notify~~
2418 ~~the applicant in writing, citing the specific failures to meet~~
2419 ~~the provisions of this chapter. Such denial entitles the~~
2420 ~~applicant to a hearing pursuant to chapter 120.~~

2421 **Section 54. Subsections (4) through (9) of section**
2422 **651.023, Florida Statutes, are renumbered as subsections (3)**
2423 **through (8), respectively, and paragraphs (c) and (h) of**
2424 **subsection (1), subsection (2), and present subsections (3) and**
2425 **(7) of that section are amended to read:**

2426 | 651.023 Certificate of authority; application.-

2427 | (1) After issuance of a provisional certificate of
 2428 | authority, the office shall issue to the holder of such
 2429 | provisional certificate a certificate of authority if the holder
 2430 | of the provisional certificate provides the office with the
 2431 | following information:

2432 | (c) Subject to subsection (3) ~~(4)~~, a provider may submit
 2433 | an application for a certificate of authority and any required
 2434 | exhibits upon submission of documents evidencing that the
 2435 | project has a minimum of 30 percent of the units reserved for
 2436 | which the provider is charging an entrance fee.

2437 | (h) Documents evidencing that the applicant has complied
 2438 | with the escrow requirements of subsection (4) ~~(5)~~ or subsection
 2439 | (6) ~~(7)~~ and will be able to comply with s. 651.035.

2440 |
 2441 | If any material change occurs in the facts set forth in an
 2442 | application filed with the office pursuant to this subsection,
 2443 | an amendment setting forth such change must be filed with the
 2444 | office within 10 business days after the applicant becomes aware
 2445 | of such change, and a copy of the amendment must be sent by
 2446 | registered mail to the principal office of the facility and to
 2447 | the principal office of the controlling company.

2448 | (2) Within 30 days after receipt of the information
 2449 | required under subsection (1), the office shall examine such
 2450 | information and notify the provider in writing, specifically

2451 requesting any additional information the office is permitted by
2452 law to require. ~~Within 15 days after receipt of all of the~~
2453 ~~requested additional information, the office shall notify the~~
2454 ~~provider in writing that all of the requested information has~~
2455 ~~been received and the application is deemed to be complete as of~~
2456 ~~the date of the notice. Failure to notify the applicant in~~
2457 ~~writing within the 15-day period constitutes acknowledgment by~~
2458 ~~the office that it has received all requested additional~~
2459 ~~information, and the application shall be deemed complete for~~
2460 ~~purposes of review on the date of filing all of the required~~
2461 ~~additional information.~~

2462 ~~(3) Within 45 days after an application is deemed complete~~
2463 ~~as set forth in subsection (2), and upon completion of the~~
2464 ~~remaining requirements of this section, the office shall~~
2465 ~~complete its review and issue or deny a certificate of authority~~
2466 ~~to the holder of a provisional certificate of authority. If a~~
2467 ~~certificate of authority is denied, the office must notify the~~
2468 ~~holder of the provisional certificate in writing, citing the~~
2469 ~~specific failures to satisfy the provisions of this chapter. If~~
2470 ~~denied, the holder of the provisional certificate is entitled to~~
2471 ~~an administrative hearing pursuant to chapter 120.~~

2472 (6) ~~(7)~~ In lieu of the provider fulfilling the requirements
2473 imposed under ~~in~~ subsection (4) ~~(5)~~ and paragraphs (5) (b) ~~(6) (b)~~
2474 and (c), the office may authorize the release of escrowed funds
2475 to retire all outstanding debts on the facility and equipment

2476 upon application of the provider and upon the provider's showing
2477 that the provider will grant to the residents a first mortgage
2478 on the land, buildings, and equipment that constitute the
2479 facility, and that the provider has satisfied paragraphs (5) (a)
2480 ~~(6) (a)~~ and (d). Such mortgage shall secure the refund of the
2481 entrance fee in the amount required by this chapter. The
2482 granting of such mortgage is subject to the following:

2483 (a) The first mortgage is granted to an independent trust
2484 that is beneficially held by the residents. The document
2485 creating the trust must include a provision that agrees to an
2486 annual audit and will furnish to the office all information the
2487 office may reasonably require. The mortgage may secure payment
2488 on bonds issued to the residents or trustee. Such bonds are
2489 redeemable after termination of the residency contract in the
2490 amount and manner required by this chapter for the refund of an
2491 entrance fee.

2492 (b) Before granting a first mortgage to the residents, all
2493 construction must be substantially completed and substantially
2494 all equipment must be purchased. No part of the entrance fees
2495 may be pledged as security for a construction loan or otherwise
2496 used for construction expenses before the completion of
2497 construction.

2498 (c) If the provider is leasing the land or buildings used
2499 by the facility, the leasehold interest must be for a term of at
2500 least 30 years.

2501 **Section 55. Subsection (3) of section 651.024, Florida**
2502 **Statutes, is renumbered as subsection (5), and new subsections**
2503 **(3) and (4) are added to that section to read:**

2504 651.024 Acquisition.—

2505 (3) A bondholder that obtains consent rights from a
2506 provider which allow the bondholder to have oversight or
2507 decisionmaking authority over a facility or in the financial
2508 decisions of the facility is subject to s. 628.4615 and is not
2509 required to submit filings pursuant to s. 651.022, s. 651.023,
2510 or s. 651.0245. For purposes of this subsection, the term
2511 "consent rights" includes, but is not limited to, all of the
2512 following:

2513 (a) Approving or initiating the sale of a facility.

2514 (b) Approving or entering into an affiliation arrangement
2515 on behalf of the facility.

2516 (c) Approving or executing new or amended financing for
2517 the facility.

2518 (d) Approving or entering into a forbearance agreement for
2519 the facility.

2520 (4) A continuing care retirement community that enters
2521 into an affiliation agreement with another entity resulting in a
2522 change of officers, directors, or effective control is subject
2523 to s. 628.4615 and is not required to submit filings pursuant to
2524 s. 651.022, s. 651.023, or s. 651.0245.

2525 **Section 56. Paragraph (a) of subsection (2), paragraph (a)**

2526 **of subsection (5), and subsection (6) of section 651.0246,**
 2527 **Florida Statutes, are amended to read:**

2528 651.0246 Expansions.—

2529 (2) A provider applying for expansion of a certificated
 2530 facility must submit all of the following:

2531 (a) A feasibility study prepared by an independent
 2532 certified public accountant. The feasibility study must include
 2533 at least the following information:

2534 1. A description of the facility and proposed expansion,
 2535 including the location, the size, the anticipated completion
 2536 date, and the proposed construction program.

2537 2. An identification and evaluation of the primary and, if
 2538 applicable, secondary market areas of the facility and the
 2539 projected unit sales per month.

2540 3. Projected revenues, including anticipated entrance
 2541 fees; monthly service fees; nursing care revenues, if
 2542 applicable; and all other sources of revenue.

2543 4. Projected expenses, including for staffing requirements
 2544 and salaries; the cost of property, plant, and equipment,
 2545 including depreciation expense; interest expense; marketing
 2546 expense; and other operating expenses.

2547 5. A projected balance sheet of the applicant.

2548 6. The expectations for the financial condition of the
 2549 project, including the projected cash flow and an estimate of
 2550 the funds anticipated to be necessary to cover startup losses.

2551 7. The inflation factor, if any, assumed in the study for
2552 the proposed expansion and how and where it is applied.

2553 8. Project costs; the total amount of debt financing
2554 required; marketing projections; resident rates, fees, and
2555 charges; the competition; resident contract provisions; and
2556 other factors that affect the feasibility of the facility.

2557 9. Appropriate population projections, including morbidity
2558 and mortality assumptions.

2559 10. The name of the person who prepared the feasibility
2560 study and his or her experience in preparing similar studies or
2561 otherwise consulting in the field of continuing care.

2562 11. Financial forecasts or projections prepared in
2563 accordance with standards adopted by the American Institute of
2564 Certified Public Accountants or in accordance with standards for
2565 feasibility studies for continuing care retirement communities
2566 adopted by the Actuarial Standards Board.

2567 12. An independent evaluation and examination opinion for
2568 the first 5 years of operations, or a comparable opinion
2569 acceptable to the office, by the certified public accountant who
2570 prepared the study, of the underlying assumptions used as a
2571 basis for the forecasts or projections in the study and that the
2572 assumptions are reasonable and proper and the project as
2573 proposed is feasible.

2574 13. The description of and plan for the ongoing operation
2575 of existing facilities.

2576 14.13. Any other information that the provider deems
2577 relevant and appropriate to provide to enable the office to make
2578 a more informed determination.

2579
2580 If any material change occurs in the facts set forth in an
2581 application filed with the office pursuant to this section, an
2582 amendment setting forth such change must be filed with the
2583 office within 10 business days after the applicant becomes aware
2584 of such change, and a copy of the amendment must be sent by
2585 registered mail to the principal office of the facility and to
2586 the principal office of the controlling company.

2587 (5) (a) Within 30 days after receipt of an application for
2588 expansion, the office shall examine the application and shall
2589 notify the applicant in writing, specifically requesting any
2590 additional information that the office is authorized to require.
2591 ~~Within 15 days after the office receives all the requested~~
2592 ~~additional information, the office shall notify the applicant in~~
2593 ~~writing that the requested information has been received and~~
2594 ~~that the application is deemed complete as of the date of the~~
2595 ~~notice. Failure to notify the applicant in writing within the~~
2596 ~~15-day period constitutes acknowledgment by the office that it~~
2597 ~~has received all requested additional information, and the~~
2598 ~~application is deemed complete for purposes of review on the~~
2599 ~~date the applicant files all of the required additional~~
2600 ~~information.~~ If the application submitted is determined by the

2601 office to be substantially incomplete so as to require
2602 substantial additional information, including biographical
2603 information, the office may return the application to the
2604 applicant with a written notice stating that the application as
2605 received is substantially incomplete and, therefore, is
2606 unacceptable for filing without further action required by the
2607 office. Any filing fee received must be refunded to the
2608 applicant.

2609 (6) Within 45 ~~30~~ days after the date on which an
2610 application is deemed complete as provided in paragraph (5)(b),
2611 the office shall complete its review and, based upon its review,
2612 approve an expansion by the applicant and issue a determination
2613 that the application meets all requirements of law, that the
2614 feasibility study was based on sufficient data and reasonable
2615 assumptions, and that the applicant will be able to provide
2616 continuing care or continuing care at-home as proposed and meet
2617 all financial and contractual obligations related to its
2618 operations, including the financial requirements of this
2619 chapter. If the application is denied, the office must notify
2620 the applicant in writing, citing the specific failures to meet
2621 the requirements of this chapter. The denial entitles the
2622 applicant to a hearing pursuant to chapter 120.

2623 **Section 57. Subsections (3) through (10) of section**
2624 **651.026, Florida Statutes, are renumbered as subsections (5)**
2625 **through (12), respectively, subsection (1), paragraphs (e) and**

2626 (f) of subsection (2), and present subsection (6) are amended,
 2627 paragraphs (g) and (h) are added to subsection (2), and new
 2628 subsections (3) and (4) are added to that section, to read:

2629 651.026 Annual and quarterly reports.—

2630 (1) Annually, on or before May 1, the provider shall file
 2631 an annual report and such other information and data showing its
 2632 condition as of the last day of the preceding calendar year,
 2633 except as provided in subsection (7) ~~(5)~~. If the office does not
 2634 receive the required information on or before May 1, a late fee
 2635 may be charged pursuant to s. 651.015(2)(c). The office may
 2636 approve an extension of up to 30 days.

2637 (2) The annual report shall be in such form as the
 2638 commission prescribes and shall contain at least the following:

2639 (e) ~~Each facility shall file with the office annually,~~
 2640 ~~together with the annual report required by this section,~~ A
 2641 computation of its minimum liquid reserve calculated in
 2642 accordance with s. 651.035 on a form prescribed by the
 2643 commission.

2644 (f) ~~If, due to a change in generally accepted accounting~~
 2645 ~~principles, the balance sheet, statement of income and expenses,~~
 2646 ~~statement of equity or fund balances, or statement of cash flows~~
 2647 ~~is known by any other name or title, the annual report must~~
 2648 ~~contain~~ Financial statements using the changed name ~~names~~ or
 2649 title ~~titles~~ that most closely corresponds ~~correspond~~ to a
 2650 balance sheet, statement of income and expenses, statement of

2651 equity or fund balances, and statement of changes in cash flows,
2652 in the event that, due to a change in generally accepted
2653 accounting principles, the balance sheet, statement of income
2654 and expenses, statement of equity or fund balances, or statement
2655 of cash flows is known by another name or title.

2656 (g) An accounts payable aging schedule that lists all
2657 outstanding debt obligations and the corresponding amounts owed
2658 to each vendor.

2659 (h) Details on any debt that has been forgiven or deferred
2660 during the period. Details must include the entity the debt is
2661 due to, the amount forgiven or deferred, an explanation as to
2662 why the debt was forgiven or deferred, and whether the debt has
2663 been assumed by another party on behalf of the facility.

2664 (3) Each facility shall file quarterly with the office all
2665 escrow bank statements for the last quarter of the reporting
2666 period which support the funds held in each of the minimum
2667 liquid reserves bank accounts. The liquid reserves funds include
2668 the debt service reserve, the operating reserve, and the renewal
2669 and replacement reserve.

2670 (4) Any provider that has been placed into administrative
2671 supervision under s. 651.018 shall provide a compiled 2-year
2672 forecast, submitted on a form prescribed by the office, as long
2673 as the provider operates under administrative supervision. The
2674 compiled data in the 2-year forecast shall be presented on a
2675 monthly basis.

2676 ~~(8)-(6)~~ The workpapers, account analyses, descriptions of
 2677 basic assumptions, and other information necessary for a full
 2678 understanding of the annual statement of a provider as filed
 2679 with the office shall be made available for visual inspection by
 2680 the office at the facility or, if the office requests, at
 2681 another agreed-upon site. Photocopies shall be provided to the
 2682 office upon request ~~may not be made unless consented to by the~~
 2683 ~~provider.~~

2684 **Section 58. Subsections (2), (3), and (4) of section**
 2685 **651.0261, Florida Statutes, are renumbered as subsections (3),**
 2686 **(4), and (5), respectively, subsection (1) and present**
 2687 **subsection (3) are amended, and a new subsection (2) is added to**
 2688 **that section, to read:**

2689 651.0261 Quarterly and monthly statements.—

2690 (1) Within 45 days after the end of each fiscal quarter,
 2691 each provider shall file a quarterly unaudited financial
 2692 statement of the provider or of the facility in the form
 2693 prescribed by commission rule and days cash on hand, occupancy,
 2694 debt service coverage ratio, and a detailed listing of the
 2695 assets maintained in the liquid reserve as required under s.
 2696 651.035. The last quarterly statement for a fiscal year is not
 2697 required if a provider does not have pending a regulatory action
 2698 level event, impairment, or a corrective action plan. If a
 2699 provider falls below two or more of the thresholds set forth in
 2700 s. 651.011(29) ~~s. 651.011(26)~~ at the end of any fiscal quarter,

2701 the provider shall submit to the office, at the same time as the
2702 quarterly statement, an explanation of the circumstances and a
2703 description of the actions it will take to meet the
2704 requirements.

2705 (2) Each provider shall file with the office quarterly,
2706 together with the quarterly statement required by this section:

2707 (a) All escrow bank statements for each quarter which
2708 support the funds held in each of the minimum liquid reserve
2709 bank account, including, but not limited to, the debt service
2710 reserve, the operating reserve, and the renewal and replacement
2711 reserve.

2712 (b) An accounts payable aging schedule that lists all
2713 outstanding debt obligations and the corresponding amounts owed
2714 to vendors.

2715 (c) Details on any debt that has been forgiven or deferred
2716 during the period. Such details must include the entity the debt
2717 is due to, the amount forgiven or deferred, an explanation as to
2718 why the debt was forgiven or deferred, and whether the debt has
2719 been assumed by another party on behalf of the facility. If a
2720 facility is required to file monthly financial statements with
2721 the office, the facility is required to include details on
2722 forgiven or deferred debt with the monthly filing.

2723 (4)~~(3)~~ A filing under subsection (3)~~(2)~~ may be required
2724 if any of the following applies:

2725 (a) The provider is:

2726 1. Subject to administrative supervision proceedings;
 2727 2. Subject to a corrective action plan resulting from a
 2728 regulatory action level event and for up to 2 years after the
 2729 factors that caused the regulatory action level event have been
 2730 corrected; or

2731 3. Subject to delinquency or receivership proceedings or
 2732 has filed for bankruptcy.

2733 (b) The provider or facility displays a declining
 2734 financial position.

2735 (c) A change of ownership of the provider or facility has
 2736 occurred within the previous 2 years.

2737 (d) The provider is found to be impaired.

2738 **Section 59. Paragraph (c) of subsection (1), subsection**
 2739 **(2), paragraph (a) of subsection (3), and paragraph (c) of**
 2740 **subsection (5) of section 651.033, Florida Statutes, are**
 2741 **amended, and subsection (7) is added to that section, to read:**

2742 651.033 Escrow accounts.—

2743 (1) When funds are required to be deposited in an escrow
 2744 account pursuant to s. 651.0215, s. 651.022, s. 651.023, s.
 2745 651.0246, s. 651.035, or s. 651.055:

2746 (c) Any agreement establishing an escrow account required
 2747 under this chapter is subject to approval by the office before
 2748 execution. The agreement must be in writing and contain, in
 2749 addition to any other provisions required by law, a provision
 2750 whereby the escrow agent agrees to abide by the duties imposed

2751 by paragraphs (b) and (e), (3) (a) and (b), (5) (a), and
2752 subsection (6).

2753 (2) (a) As used in this subsection, the term "emergency"
2754 means conditions that exist beyond the control of the provider,
2755 such as severe damage to the provider's physical premises caused
2756 by a natural or manmade disaster or another event of comparable
2757 gravity and severity.

2758 (b) Notwithstanding s. 651.035(7), in the event of an
2759 emergency and upon written petition by the provider to the
2760 office, on a form prescribed by the office, the office may allow
2761 a withdrawal of up to 10 percent of the required minimum liquid
2762 reserve, consistent with the requirements governing how funds
2763 can be used under s. 651.035. Before submitting the petition to
2764 the office, the provider must meet with the office to review the
2765 emergency petition. In the meeting, the provider must address
2766 the details of the emergency, the circumstances leading to the
2767 need for an emergency petition, the provider's plan to mitigate
2768 the emergency, the amount being requested, and the provider's
2769 plan and timeline to restore the minimum liquid reserves into
2770 compliance with s. 651.035. The office shall have 10 business ~~3~~
2771 ~~working~~ days to deny the petition for the emergency 10-percent
2772 withdrawal. If the office fails to deny the petition within 10
2773 business ~~3-working~~ days, the petition is deemed to have been
2774 granted by the office. For purposes of this section, the term
2775 "business day ~~working day~~" means each day that is not a

2776 Saturday, Sunday, or legal holiday as defined by Florida law.
 2777 Also, for purposes of this section, the day the petition is
 2778 received by the office is not counted as one of the 10 ~~3~~ days.

2779 (3) When entrance fees are required to be deposited in an
 2780 escrow account pursuant to s. 651.0215, s. 651.022, s. 651.023,
 2781 s. 651.0246, or s. 651.055:

2782 (a) The provider shall deliver to the resident a written
 2783 receipt. The receipt must show the payor's name and address, the
 2784 date, the price of the care contract, and the amount of money
 2785 paid. A copy of each receipt, together with the funds, must be
 2786 deposited with the escrow agent or as provided in paragraph (c).
 2787 The escrow agent must release such funds to the provider 7 days
 2788 after the date of receipt of the funds by the escrow agent if
 2789 the provider, operating under a certificate of authority issued
 2790 by the office, has met the requirements of s. 651.0215(7) ~~s.~~
 2791 ~~651.0215(8)~~, s. 651.023(5) ~~s. 651.023(6)~~, or s. 651.0246.
 2792 However, if the resident rescinds the contract within the 7-day
 2793 period, the escrow agent must release the escrowed fees to the
 2794 resident.

2795 (5) When funds are required to be deposited in an escrow
 2796 account pursuant to s. 651.0215, s. 651.022, s. 651.023, s.
 2797 651.0246, or s. 651.035, the following apply:

2798 (c) In accordance with the annual and quarterly filing
 2799 deadlines set forth in ss. 651.026 and 651.0261 ~~On or before the~~
 2800 ~~20th day of the month following the quarter for which the~~

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2801 ~~statement is due~~, the provider shall file with the office a copy
2802 of the escrow agent's statement or, if the provider has not
2803 received the escrow agent's statement, a copy of the written
2804 request to the escrow agent for the statement.

2805 (7) The escrow agent shall provide prompt written
2806 notification to the office upon withdrawal of any funds from an
2807 account required by s. 651.035. Any escrow agreement established
2808 to meet any requirement of s. 651.035 must contain this
2809 provision.

2810 **Section 60. Subsection (2) of section 651.034, Florida**
2811 **Statutes, is amended to read:**

2812 651.034 Financial and operating requirements for
2813 providers.—

2814 ~~(2) Except when the office's remedial rights are suspended~~
2815 ~~pursuant to s. 651.114(11)(a),~~ The office must take action
2816 necessary to place an impaired provider under regulatory
2817 control, including administrative supervision or any remedy
2818 available under part I of chapter 631. An impairment is
2819 sufficient grounds for the department to be appointed as
2820 receiver as provided in chapter 631, except when the office's
2821 remedial rights are suspended pursuant to s. 651.114(11)(a). If
2822 the office's remedial rights are suspended pursuant to s.
2823 651.114(11)(a), the impaired provider must make available to the
2824 office copies of any corrective action plan approved by the
2825 third party lender or trustee to cure the impairment and any

2826 ~~related required report.~~ For purposes of s. 631.051, ~~impairment~~
 2827 ~~of a provider is defined according to the term "impaired" has~~
 2828 the same meaning as in ~~under~~ s. 651.011. The office may forego
 2829 taking action for up to 90 ~~180~~ days after the impairment if the
 2830 office finds there is a reasonable expectation that the
 2831 impairment may be eliminated within the 90-day ~~180-day~~ period.

2832 **Section 61. Subsections (1) and (3), paragraph (b) of**
 2833 **subsection (7), and subsection (8) of section 651.035, Florida**
 2834 **Statutes, are amended to read:**

2835 651.035 Minimum liquid reserve requirements.—

2836 (1) A provider shall maintain in escrow a minimum liquid
 2837 reserve consisting of the following reserves, as applicable.
 2838 Each established account must be separate and unique to a
 2839 facility, unencumbered, and not commingled with any other funds
 2840 from any other account, facility, affiliate, or obligated group.
 2841 Funds held in escrow under paragraphs (a), (c), and (d) must be
 2842 held completely separate from any funds held by a trustee under
 2843 paragraph (b), meaning the debt service, operating, and renewal
 2844 and replacement reserves must have their own distinct account
 2845 number:

2846 (a) Each provider shall maintain in escrow as a debt
 2847 service reserve the aggregate amount of all principal and
 2848 interest payments due during the fiscal year on any mortgage
 2849 loan or other long-term financing of the facility, including
 2850 property taxes as recorded in the audited financial report

2851 required under s. 651.026. The amount must include any leasehold
2852 payments and all costs related to such payments. If principal
2853 payments are not due during the fiscal year, the provider must
2854 maintain in escrow as a minimum liquid reserve an amount equal
2855 to interest payments due during the next 12 months on any
2856 mortgage loan or other long-term financing of the facility,
2857 including property taxes. If a provider does not have a mortgage
2858 loan or other financing on the facility, the provider must
2859 deposit monthly in escrow as a minimum liquid reserve an amount
2860 equal to one-twelfth of the annual property tax liability as
2861 indicated in the most recent tax notice provided pursuant to s.
2862 197.322(3), and must annually pay property taxes out of such
2863 escrow.

2864 (b) A provider that has outstanding indebtedness that
2865 requires a debt service reserve to be held in escrow pursuant to
2866 a trust indenture or mortgage lien on the facility and for which
2867 the debt service reserve may only be used to pay principal and
2868 interest payments on the debt that the debtor is obligated to
2869 pay, and which may include property taxes and insurance, may
2870 include such debt service reserve in computing the minimum
2871 liquid reserve needed to satisfy this subsection if the provider
2872 furnishes to the office a copy of the agreement under which such
2873 debt service reserve is held, together with a statement of the
2874 amount being held in escrow for the debt service reserve,
2875 certified by the lender or trustee and the provider to be

2876 correct. The trustee shall provide the office with any
2877 information concerning the debt service reserve account upon
2878 request of the provider or the office. In addition, the trust
2879 indenture, loan agreement, or escrow agreement must provide that
2880 the provider, trustee, lender, escrow agent, or a person
2881 designated to act in its place shall notify the office in
2882 writing at least 10 days before the withdrawal of any portion of
2883 the debt service reserve funds required to be held in escrow as
2884 described in this paragraph. The notice must include an
2885 affidavit sworn to by the provider, the trustee, or a person
2886 designated to act in its place which includes the amount of the
2887 scheduled debt service payment, the payment due date, the amount
2888 of the withdrawal, the accounts from which the withdrawal will
2889 be made, and a plan with a schedule for replenishing the
2890 withdrawn funds. If the plan is revised by a consultant that is
2891 retained as prescribed in the provider's financing documents,
2892 the revised plan must be submitted to the office within 10 days
2893 after the approval by the lender or trustee. If a debt service
2894 reserve is transferred from one financial institution or lender
2895 to another, the provider must provide notice to the office at
2896 least 10 days before the transfer takes place. The notice must
2897 include an affidavit sworn to by the provider and include the
2898 name of the institution where the debt service reserve is being
2899 transferred, the date of transfer, the amount being transferred,
2900 a copy of the agreement requiring the transfer to the new

2901 financial institution, and the contact information for the
2902 escrow agent of the new account. The new escrow agreement must
2903 comply with s. 651.033. Any funds held pursuant to this section
2904 do not negate the requirement to maintain an escrow account as
2905 required in paragraph (a). Any such separate debt service
2906 reserves are not subject to the transfer provisions set forth in
2907 subsection (8).

2908 (c) Each provider shall maintain in escrow an operating
2909 reserve equal to or greater than the following amounts:

2910 1. Thirty ~~30~~ percent of the total operating expenses
2911 projected in the feasibility study required by s. 651.023 for
2912 the first 12 months of operation.

2913 2. After the first 12 months of operation, 30 percent of
2914 the operating reserve in the annual report filed pursuant to s.
2915 651.026.

2916 3. Once a provider maintains an occupancy level in excess
2917 of 80 percent for at least 12 months and has presented in its
2918 most recent annual report that it has reached stabilized
2919 occupancy, 15 percent of the total operating reserve upon
2920 approval of the office.

2921 4. If the provider has been found to meet any of the
2922 following conditions, 50 percent of the total operating reserve:

2923 a. Is insolvent or financially impaired.

2924 b. Is at regulatory action level under s. 651.034.

2925 c. Is placed under administrative supervision.

- 2926 d. Is in a hazardous financial condition under s. 651.113.
- 2927 e. Entered into a forbearance agreement with a lender.
- 2928 f. Filed or has notified the office of its intent to file
- 2929 for bankruptcy.
- 2930 g. Failed to maintain minimum liquid reserve requirements
- 2931 under subsections (10) and (11).

2932

2933 Upon notice from the office that a condition identified in this

2934 subparagraph exists, the provider has 10 days within which to

2935 fund the operating reserve at 50 percent and provide evidence of

2936 the funding to the office.

2937 (d) Before reducing the operating reserve required under

2938 paragraph (c), the provider must obtain written approval from

2939 the office ~~Thereafter, each provider shall maintain in escrow an~~

2940 ~~operating reserve equal to 15 percent of the total operating~~

2941 ~~expenses in the annual report filed pursuant to s. 651.026.~~

2942 (e) If a provider has been in operation for more than 12

2943 months, the total annual operating expenses must be determined

2944 by averaging the total annual operating expenses reported to the

2945 office by the number of annual reports filed with the office

2946 within the preceding 3-year period subject to adjustment if

2947 there is a change in the number of facilities owned. For

2948 purposes of this subsection, total annual operating expenses

2949 include all expenses of the facility except depreciation and

2950 amortization; interest and property taxes included in paragraph

2951 (a); extraordinary expenses that are adequately explained and
2952 documented in accordance with generally accepted accounting
2953 principles; liability insurance premiums in excess of those paid
2954 in calendar year 1999; and changes in the obligation to provide
2955 future services to current residents. For providers initially
2956 licensed during or after calendar year 1999, liability insurance
2957 must be included in the total operating expenses in an amount
2958 not to exceed the premium paid during the first 12 months of
2959 facility operation. The operating reserves required under this
2960 subsection must be in an unencumbered account held in escrow for
2961 the benefit of the residents. Such funds may not be encumbered
2962 or subject to any liens or charges by the escrow agent or
2963 judgments, garnishments, or creditors' claims against the
2964 provider or facility. However, if a facility had a lien,
2965 mortgage, trust indenture, or similar debt instrument in place
2966 before January 1, 1993, which encumbered all or any part of the
2967 reserves required by this subsection and such funds were used to
2968 meet the requirements of this subsection, then such arrangement
2969 may be continued, unless a refinancing or acquisition has
2970 occurred, and the provider is in compliance with this
2971 subsection.

2972 (f) ~~(d)~~ Each provider shall maintain in escrow a renewal
2973 and replacement reserve equal to 15 percent of the total
2974 accumulated depreciation based on the audited financial
2975 statement required to be filed pursuant to s. 651.026, not to

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2976 exceed 15 percent of the facility's average operating expenses
2977 for the past 3 fiscal years based on the audited financial
2978 statements for each of those years. For a provider who is an
2979 operator of a facility but is not the owner and depreciation is
2980 not included as part of the provider's financial statement, the
2981 renewal and replacement reserve required by this paragraph must
2982 equal 15 percent of the total operating expenses of the
2983 provider, as described in this section. ~~Each provider licensed~~
2984 ~~before October 1, 1983, shall fully fund the renewal and~~
2985 ~~replacement reserve by October 1, 2003, by multiplying the~~
2986 ~~difference between the former escrow requirement and the present~~
2987 ~~escrow requirement by the number of years the facility has been~~
2988 ~~in operation after October 1, 1983.~~

2989 (3) If principal and interest payments are paid to a trust
2990 that is beneficially held by the residents as described in s.
2991 651.023(6) ~~s. 651.023(7)~~, the office may waive all or any
2992 portion of the escrow requirements for mortgage principal and
2993 interest contained in subsection (1) if the office finds that
2994 such waiver is not inconsistent with the security protections
2995 intended by this chapter.

2996 (7)

2997 (b)1. For all other proposed withdrawals, in order to
2998 receive the consent of the office, the provider must file
2999 documentation showing why the withdrawal is necessary for the
3000 continued operation of the facility and such additional

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3001 information as the office reasonably requires.

3002 2. The office shall notify the provider when the filing is
3003 deemed complete. If the provider has complied with all prior
3004 requests for information, the filing is deemed complete after 30
3005 days without communication from the office.

3006 3. Within 30 days after the date a file is deemed
3007 complete, the office shall provide the provider with written
3008 notice of its approval or disapproval of the request. The
3009 provider may not withdraw funds until the office provides such
3010 written notice. The office may disapprove any request to
3011 withdraw such funds if it determines that the withdrawal is not
3012 in the best interest of the residents.

3013 (8) The office may order the immediate transfer of up to
3014 100 percent of the funds held in the minimum liquid reserve to
3015 the custody of the department pursuant to part III of chapter
3016 625 if the office finds that the provider is impaired or
3017 insolvent, or if the facility fails to fund the minimum liquid
3018 reserve required by subsection (10) or subsection (11). The
3019 office may order such a transfer regardless of whether the
3020 office has suspended or revoked, or intends to suspend or
3021 revoke, the certificate of authority of the provider.

3022 **Section 62. Subsection (2) of section 651.043, Florida**
3023 **Statutes, is amended to read:**

3024 651.043 Approval of change in management.—

3025 (2) A provider or management company shall notify the

3026 office, in writing or electronically, of any change in the
3027 information required by s. 651.022(2) ~~management~~ within 10
3028 business days. For each new management company or manager not
3029 employed by a management company, the provider shall submit to
3030 the office the information required by s. 651.022(2) and a copy
3031 of the written management contract, if applicable.

3032 **Section 63. Subsection (2) of section 651.055, Florida**
3033 **Statutes, is amended to read:**

3034 651.055 Continuing care contracts; right to rescind.—

3035 (2) A resident has the right to rescind a continuing care
3036 contract and receive a full refund of any funds paid, without
3037 penalty or forfeiture, within 7 days after executing the
3038 contract. However, if an individual signs a reservation contract
3039 pursuant to s. 651.023(3) ~~s. 651.023(4)~~ and fails to cancel such
3040 contract within 30 days after executing the contract and
3041 subsequently signs a residency contract pursuant to this section
3042 and rescinds the contract within 7 days, the forfeiture penalty
3043 authorized under s. 651.023(3) ~~s. 651.023(4)~~ may be deducted
3044 from the refund unless there is evidence of extenuating
3045 circumstances such as, but not limited to, the death, illness,
3046 or diagnosis of a chronic or terminal illness of the individual
3047 or the individual's spouse or partner or a change in financial
3048 or asset position which warrants cancellation of the contract. A
3049 resident may not be required to move into the facility
3050 designated in the contract before the expiration of the 7-day

3051 period. During the 7-day period, the resident's funds must be
 3052 held in an escrow account, or the provider may hold the check
 3053 until the 7-day period expires pursuant to s. 651.033(3)(c).

3054 **Section 64. Subsection (1) of section 651.071, Florida**
 3055 **Statutes, is amended to read:**

3056 651.071 Contracts as preferred claims on liquidation or
 3057 receivership.—

3058 (1) In the event of receivership or liquidation
 3059 proceedings against a provider, all continuing care and
 3060 continuing care at-home contracts executed by a provider are
 3061 deemed preferred claims against all assets owned by the
 3062 provider.~~;~~ however, Such claims are not subordinate to any
 3063 secured claim and must be treated with higher priority over all
 3064 other claims, except Class 1 claims. For purposes of s. 631.271,
 3065 such contracts are deemed Class 2 claims.

3066 **Section 65. Subsections (2) and (3) of section 651.085,**
 3067 **Florida Statutes, are amended to read:**

3068 651.085 Quarterly meetings between residents and the
 3069 governing body of the provider; resident representation before
 3070 the governing body of the provider.—

3071 (2) A residents' council formed pursuant to s. 651.081,
 3072 members of which are elected by the residents, shall nominate
 3073 and elect a designated resident representative to represent them
 3074 before the governing body of the provider on matters specified
 3075 in subsection (3). The initial designated resident

3076 representative elected under this section shall be elected to
3077 serve at least 12 months. The designated resident representative
3078 does not have to be a current member of the residents' council;
3079 however, such individual must be a resident, as defined in s.
3080 651.011. Designated resident representatives shall perform their
3081 duties in good faith. For providers that own or operate more
3082 than one facility in the state, each facility must have its own
3083 designated resident representative.

3084 (3) The designated resident representative shall be
3085 notified in writing or electronically by a representative of the
3086 provider at least 14 days in advance of any meeting of the full
3087 governing body at which the annual budget and proposed changes
3088 or increases in resident fees or services are on the agenda or
3089 will be discussed before presenting the increases in resident
3090 fees or services to all residents. The designated resident
3091 representative shall be invited to attend and participate in
3092 that portion of the meeting designated for the discussion of
3093 such changes. Designated resident representatives shall perform
3094 their duties in good faith. For providers that own or operate
3095 more than one facility in the state, each facility must have its
3096 own designated resident representative.

3097 **Section 66. Section 651.087, Florida Statutes, is created**
3098 **to read:**

3099 651.087 Resident funds for charitable or operational
3100 purposes.—

3101 (1) The organized collection and distribution of funds by
3102 residents for charitable or benevolent purposes may not be under
3103 the control of a provider or management company. Any provider or
3104 management company assisting in the collection or distribution
3105 of funds from its residents for the purpose of creating a
3106 benevolence or charitable fund, and which is outside the
3107 approved operational fees, is subject to the following
3108 requirements:

3109 (a) The provider must notify the office and the residents'
3110 council that a fund is being established.

3111 (b) The provider, under the direction and approval of the
3112 residents' council, must establish written policies that govern
3113 the funds. The written policies must include, in detail, how the
3114 entity will be governed, the collection of funds, and the
3115 criteria to be used for the distribution of funds. Any changes
3116 to the written policy must be agreed upon by the residents'
3117 council.

3118 (c) Within 60 days after the fund is established, the
3119 provider must provide the written policy to the office and
3120 current residents and post it in a prominent position in the
3121 facility which is accessible to all residents and the general
3122 public. Additionally, the written policy must be given to all
3123 prospective residents.

3124 (d) The provider must include in its annual and quarterly
3125 reports a statement detailing the financial position of the fund

3126 as of the annual or quarter period end date and a summary
3127 breakdown of how any funds were used during that reporting
3128 period, excluding any personally identifiable information.

3129 (2) A provider may not borrow or solicit funds from
3130 residents for operational purposes without prior written
3131 approval from the office.

3132 (a) Before any funds are eligible for distribution to the
3133 provider, the provider must submit to the office:

3134 1. A request to borrow funds, with notice to the
3135 residents' council, which must include the requested amount, a
3136 detailed summary of the intended use of the funds, and any
3137 additional information that supports the provider's need to
3138 borrow funds from the residents. The requested amount may not
3139 exceed 10 percent of the funds available from residents and
3140 shall be restricted to use for only operational expenses, which
3141 must solely benefit the residents of the facility. Funds may not
3142 be used for the benefit of management, the board of directors,
3143 or the general partner.

3144 2. An anticipated payment schedule for repayment of the
3145 borrowed funds. Full repayment shall be completed within 12
3146 months after the distribution.

3147 3. A board resolution and sworn affidavit signed by two
3148 officers or the general partner of the provider which indicates
3149 support for the request to borrow funds and the repayment plan.

3150 (b) Within 30 days after receipt of the borrowed funds,

3151 the provider shall begin repayment to the fund in equal monthly
3152 payments that allow for a complete funding of the borrowed funds
3153 within 12 months.

3154 (c) The provider must acknowledge that it is required to
3155 repay the full amount borrowed before the office may approve
3156 additional funds to be borrowed from residents.

3157 (d) The office shall receive written majority support from
3158 the residents' council before approving the provider's request.

3159 (3) Upon receipt of approval from the office, the provider
3160 shall comply with the following:

3161 (a) Maintain a 50 percent operating reserve pursuant to s.
3162 651.035(1)(c)4. for the duration of the repayment period.

3163 Following the repayment period, the provider must obtain the
3164 office's prior written approval to reduce the operating reserve
3165 amount.

3166 (b) Within 5 days after receiving the office's approval,
3167 submit supporting documentation to the office as evidence that
3168 the operating reserve has been increased in compliance with this
3169 section.

3170 (c) In order to protect the residents' investment,
3171 immediately transfer up to 100 percent of the funds held in the
3172 minimum liquid reserve operating reserve account to the custody
3173 of the department pursuant to part III of chapter 625. The
3174 provider shall fund the account with the department within 15
3175 days after receiving the office's approval. The office may not

3176 approve the provider's request unless it has confirmation that
3177 the provider has established the account with the department.

3178 (4) Any provider that has benevolent or charitable funds
3179 established before July 1, 2025, shall fully comply with this
3180 section by October 1, 2025.

3181 (5) Any provider that has borrowed funds from residents
3182 before July 1, 2025, shall provide notice to the office by
3183 October 1, 2025. Notice must include the date the funds were
3184 borrowed, the amount borrowed, and any documentation supporting
3185 the request and approval of the borrowed funds.

3186 (6) In the event that a provider triggers an impairment or
3187 insolvency or enters into a forbearance agreement with a lender,
3188 the repayment of any outstanding borrowed funds shall be
3189 accelerated. Within 5 days after a provider becomes aware of an
3190 impairment or insolvency or the need to enter into a forbearance
3191 agreement with a lender, the provider shall provide notice of
3192 the triggering event to the residents' council and repay any
3193 outstanding amounts due under a repayment plan. Notice must also
3194 be given to the office within the same 5 days.

3195 (7) Failure to comply with this section is a violation of
3196 s. 651.035, and the provider will be considered impaired
3197 pursuant to s. 651.011(16).

3198 (8) The commission may by rule require all or part of the
3199 statements or filings required under this section to be
3200 submitted by electronic means in a computer-readable form

3201 compatible with the electronic data format specified by the
3202 commission.

3203 **Section 67. Paragraphs (h) through (n) of subsection (2)**
3204 **of section 651.091, Florida Statutes, are redesignated as**
3205 **paragraphs (i) through (o), respectively, present paragraph (h)**
3206 **of subsection (2) and paragraph (d) of subsection (3) are**
3207 **amended, a new paragraph (h) and paragraph (p) are added to**
3208 **subsection (2), and subsection (5) is added to that section, to**
3209 **read:**

3210 651.091 Availability, distribution, and posting of reports
3211 and records; requirement of full disclosure.—

3212 (2) Every continuing care facility shall:

3213 (h) Post a notice of any bankruptcy proceedings in a
3214 prominent location within the facility which is accessible to
3215 all residents and the general public. Such notice must include a
3216 summary of the bankruptcy proceedings and specify where the full
3217 legal record of the bankruptcy proceedings can be inspected
3218 within the facility. The facility shall also designate and make
3219 available a management representative to discuss the bankruptcy
3220 proceedings and address questions from residents. The notice
3221 required under this paragraph must also include a listing of all
3222 court documents related to the bankruptcy proceedings and the
3223 designated representative's contact information.

3224 (i) ~~(h)~~ Deliver the information described in s. 651.085(4)
3225 in writing or electronically to the president or chair of the

3226 residents' council and make supporting documentation available
 3227 upon request.

3228 (p) Maintain records showing compliance with the
 3229 requirements of this subsection, including how, where, and when
 3230 the required information was provided.

3231 (3) Before entering into a contract to furnish continuing
 3232 care or continuing care at-home, the provider undertaking to
 3233 furnish the care, or the agent of the provider, shall make full
 3234 disclosure, obtain written acknowledgment of receipt, and
 3235 provide copies of the disclosure documents to the prospective
 3236 resident or his or her legal representative, of the following
 3237 information:

3238 (d) In keeping with the intent of this subsection relating
 3239 to disclosure, the provider shall make available for review:

- 3240 1. Master plans approved by the provider's board or
 3241 governing body;
- 3242 2. Any proposed or approved and any plans for expansion or
 3243 phased development within the next 3 years; and
- 3244 3. Any known legal impediments to the plans disclosed in
 3245 subparagraphs 1. and 2., including, but not limited to, pending
 3246 legal action to stop or modify the plans, the denial of building
 3247 permits, or a failure to secure financing, to the extent that
 3248 the availability of such plans does not put at risk real estate,
 3249 financing, acquisition, negotiations, or other implementation of
 3250 operational plans and thus jeopardize the success of

3251 ~~negotiations, operations, and development.~~

3252 (5) (a) A provider that enters into a contract for
3253 continuing care at a facility without first delivering a true
3254 and complete copy of the full disclosure document to the
3255 contracting party, or that enters into a contract based on a
3256 disclosure document that omits a material fact required to be
3257 stated or necessary to prevent misleading statements, is liable
3258 for actual damages and any interest thereon, reasonable attorney
3259 fees, and court costs and shall refund fees paid to the
3260 contracting party. However, the provider shall deduct the
3261 contractual value of care and lodging provided before the
3262 violation, misstatement, or omission was discovered or should
3263 have reasonably been discovered from the fees to be refunded to
3264 the contracting party.

3265 (b) This section applies regardless of whether the
3266 provider had actual knowledge of the misstatement or omission.

3267 (c) A person may not file or maintain an action under this
3268 section if, before filing the action, the person received a
3269 written offer citing this section for a refund of all amounts
3270 paid the provider, plus interest at the prime rate, less the
3271 contractual value of care and lodging provided before receipt of
3272 the offer, and failed to accept it within 30 days after actual
3273 receipt.

3274 **Section 68. Section 651.104, Florida Statutes, is created**
3275 **to read:**

3276 651.104 Certificate of authority to act as a management
 3277 company.—
 3278 (1) It is unlawful for any person to act as or hold
 3279 himself or herself out to be management company for a continuing
 3280 care retirement community in this state without a valid
 3281 certificate of authority issued by the office pursuant to this
 3282 section. A management company that was operating in this state
 3283 as of June 30, 2025, may continue to operate until January 1,
 3284 2026, as a management company without a certificate of authority
 3285 and is not in violation of the requirement to possess a valid
 3286 certificate of authority as a management company during that
 3287 period of time. To qualify for and hold authority to act as a
 3288 management company in this state, a management company must
 3289 otherwise be in compliance pursuant to this section and with its
 3290 organizational agreement. A person who, on or after January 1,
 3291 2026, does not hold a certificate of authority to act as a
 3292 management company while operating as a management company is
 3293 subject to a fine of \$10,000 per violation per day.
 3294 (2) A management company shall file with the office an
 3295 application for a certificate of authority on a form adopted by
 3296 the commission and furnished by the office. The application must
 3297 include or have attached the following information and
 3298 documents:
 3299 (a) All basic organizational documents of the management
 3300 company, such as the articles of incorporation, articles of

3301 association, partnership agreement, trade name certificate,
3302 trust agreement, shareholder agreement, and other applicable
3303 documents, and all amendments to those documents.

3304 (b) The bylaws, rules, and regulations or similar
3305 documents regulating the conduct or the internal affairs of the
3306 management company.

3307 (c) The names, addresses, official positions, and
3308 professional qualifications of the individuals employed or
3309 retained by the management company who are responsible for the
3310 conduct of the affairs of the management company, including all
3311 members of the board of directors, board of trustees, executive
3312 committee, or other governing board or committee, and the
3313 principal officers, or equivalent, or for a partnership or
3314 association of the management company, the partners or members.

3315 (d) Audited annual financial statements, prepared in
3316 accordance with generally accepted accounting principles, for
3317 the 2 most recent fiscal years, which prove that the applicant
3318 has a positive net worth in both fiscal years. If the applicant
3319 has been in existence for less than 2 fiscal years, the
3320 application must include financial statements or reports,
3321 certified by an officer of the applicant and prepared in
3322 accordance with generally accepted accounting principles, for
3323 any completed fiscal years and for any month during the current
3324 fiscal year for which such financial statements or reports have
3325 been completed. If the applicant reports net losses for either

3326 of the 2 most recent fiscal years, the applicant must provide
3327 pro forma financial statements up to the period of time that the
3328 applicant demonstrates 2 consecutive years of profitability. Pro
3329 forma financial statements must include the balance sheet,
3330 income statement, and cash flow statement. An audited financial
3331 statement or report prepared on a consolidated basis must
3332 include a columnar consolidating or combining worksheet that
3333 must be filed with the report and comply with the following:

- 3334 1. Amounts shown on the consolidated audited financial
3335 report must be shown on the worksheet;
- 3336 2. Amounts for each entity must be stated separately; and
- 3337 3. Explanations of consolidating and eliminating entries
3338 must be included.

3339 (e) Any information as the office may require in order to
3340 review the current financial condition of the applicant.

3341 (f) A statement describing the business plan, including
3342 information on staffing levels and activities proposed or
3343 ongoing, in this state and nationwide. The plan must provide
3344 details setting forth the applicant's capability of providing a
3345 sufficient number of experienced and qualified personnel in the
3346 areas of issuing continuing care life contracts and managing
3347 continuing care retirement communities or similar communities,
3348 compliance with statutory requirements, and claims processing,
3349 recordkeeping, and underwriting.

3350 (g) If the applicant is not currently acting as a

3351 management company, a statement of the amounts and sources of
3352 the funds available for organization expenses and the proposed
3353 arrangements for reimbursement and compensation of incorporators
3354 or other principals.

3355 (h) Such other data, financial statements, and pertinent
3356 information as the commission or office may reasonably require
3357 with respect to the management company, its directors, or its
3358 trustees, or with respect to any parent, subsidiary, or
3359 affiliate, if the management company relies on a contractual or
3360 financial relationship with such parent, subsidiary, or
3361 affiliate in order to meet the financial requirements of this
3362 chapter, to determine the financial status of the management
3363 company and the management capabilities of its managers and
3364 owners.

3365 (3) An applicant must also submit all of the following for
3366 all individuals referenced in paragraph (2) (c):

3367 (a) A complete biographical statement on a form prescribed
3368 by the commission.

3369 (b) An independent background report as prescribed by the
3370 commission.

3371 (c) A full set of fingerprints to the office or to a
3372 vendor, entity, or agency authorized by s. 943.053(13). The
3373 office, vendor, entity, or agency, as applicable, shall forward
3374 the fingerprints to the Department of Law Enforcement for state
3375 processing, and the Department of Law Enforcement shall forward

3376 the fingerprints to the Federal Bureau of Investigation for
3377 national processing in accordance with s. 943.053 and 28 C.F.R.
3378 s. 20.

3379 (d) A self-disclosure of any administrative, civil, or
3380 criminal complaints, settlements, or discipline of the
3381 applicant, or any of the applicant's affiliates, which relates
3382 to a violation of the insurance laws or continuing care
3383 retirement community laws, in any state.

3384 (4) (a) The applicant shall make available for inspection
3385 by the office copies of all contracts and contract templates
3386 relating to services provided by the management company to
3387 providers or other persons using the services of the management
3388 company.

3389 (b) The applicant shall also make available for inspection
3390 by the office copies of all contracts and contract templates
3391 with any provider.

3392 (5) The office may not issue a certificate of authority if
3393 it determines that the management company or any individual
3394 specified in paragraph (2) (c) is not competent, trustworthy,
3395 financially responsible, or of good personal and business
3396 reputation.

3397 (6) A certificate of authority issued under this section
3398 remains valid, unless suspended or revoked by the office, so
3399 long as the certificateholder continues in business in this
3400 state.

3401 **Section 69. Section 651.1041, Florida Statutes, is created**
3402 **to read:**

3403 651.1041 Acquisition of a management company.—An
3404 acquisition of a management company is governed by s. 628.4615
3405 as if the company were a specialty insurer.

3406 **Section 70. Section 651.1043, Florida Statutes, is created**
3407 **to read:**

3408 651.1043 Management company annual and quarterly financial
3409 statements; notice of change of ownership; fines for
3410 noncompliance.—

3411 (1) Each authorized management company shall annually file
3412 with the office a full and true statement of its financial
3413 condition, transactions, and affairs within 3 months after the
3414 end of the management company's fiscal year or within such
3415 extension of time as the office may grant for good cause. The
3416 statement must be for the preceding fiscal year and must be in
3417 such form and contain such matters as the commission prescribes
3418 and must be verified by at least two officers of the management
3419 company.

3420 (2) Each authorized management company shall also annually
3421 file an audited financial statement prepared in accordance with
3422 generally accepted accounting principles by an independent
3423 certified public accountant. The audited financial statement
3424 must be filed with the office within 3 months after the end of
3425 the management company's fiscal year and be for the preceding

3426 fiscal year. An audited financial statement prepared on a
3427 consolidated basis must include a columnar consolidating or
3428 combining worksheet that must be filed with the statement and
3429 must comply with all of the following:

3430 (a) Amounts shown on the consolidated audited financial
3431 statement must be shown on the worksheet.

3432 (b) Amounts for each entity must be stated separately.

3433 (c) Explanations of consolidating and eliminating entries
3434 must be included.

3435 (3) For the purpose of determining the financial status of
3436 the management company and the management capabilities of its
3437 managers and owners, the management company must submit such
3438 other data, financial statements, and pertinent information as
3439 the commission or office may reasonably require with respect to
3440 the management company, its directors, or its trustees, or with
3441 respect to any parent, subsidiary, or affiliate if the
3442 management company relies on a contractual or financial
3443 relationship with such parent, subsidiary, or affiliate in order
3444 to meet the financial requirements of this chapter.

3445 (4) For any material change in its ownership, a management
3446 company shall file an acquisition application as required by s.
3447 651.024.

3448 (5) Within 45 days after the end of each fiscal quarter,
3449 each management company shall file a quarterly unaudited
3450 financial statement in the form prescribed by commission rule.

3451 (6) If the office finds that such information is needed to
3452 properly monitor the financial condition of a management company
3453 or is otherwise needed to protect the public interest, the
3454 office may require the management company to file:

3455 (a) Within 25 days after the end of each month, a monthly
3456 unaudited financial statement of the management company in the
3457 form prescribed by the commission by rule.

3458 (b) For the purpose of determining the financial status of
3459 the management company and the management capabilities of its
3460 managers and owners, such other data, financial statements, and
3461 pertinent information as the office may reasonably require with
3462 respect to the management company, its directors, or its
3463 trustees, or with respect to any parent, subsidiary, or
3464 affiliate if the management company relies on a contractual or
3465 financial relationship with such parent, subsidiary, or
3466 affiliate in order to meet the financial requirements of this
3467 chapter.

3468 (7) Any management company that fails to file an annual
3469 financial report or quarterly financial report in the form and
3470 within the time required by this section shall forfeit to the
3471 office an amount set by order of the office which does not
3472 exceed \$1,000 for each of the first 10 days of noncompliance and
3473 does not exceed \$2,000 for each subsequent day of noncompliance.
3474 Upon notice by the office that the management company is not in
3475 compliance with this section, the management company's authority

3476 to perform in the capacity of a management company for any
3477 provider or facility in this state ceases until the office
3478 determines the management company to be in compliance. The
3479 office may not collect more than \$100,000 under this subsection
3480 with respect to any particular report.

3481 (8) All moneys collected by the office under this section
3482 must be deposited to the credit of the Insurance Regulatory
3483 Trust Fund.

3484 (9) The commission may by rule require all or part of the
3485 statements or filings required under this section to be
3486 submitted by electronic means in a computer-readable form
3487 compatible with the electronic data format specified by the
3488 commission.

3489 **Section 71. Section 651.1045, Florida Statutes, is created**
3490 **to read:**

3491 651.1045 Management company grounds for discretionary
3492 denial, suspension, or revocation of certificate of authority.-

3493 (1) The office may deny an application or suspend or
3494 revoke the certificate of authority of any applicant or
3495 management company if it finds that any one or more of the
3496 following grounds applicable to the applicant or management
3497 company exist:

3498 (a) Failing to continue to meet the requirements for the
3499 certificate of authority originally granted.

3500 (b) Failing to meet one or more of the qualifications for

3501 the certificate of authority under this chapter.

3502 (c) Making a material misstatement or misrepresentation to
3503 obtain the certificate of authority or committing fraud in
3504 obtaining or in attempting to obtain the certificate of
3505 authority.

3506 (d) Demonstrating a lack of fitness or trustworthiness.

3507 (e) Engaging in fraudulent or dishonest practices of
3508 management in the conduct of business.

3509 (f) Misappropriating, converting, or withholding moneys.

3510 (g) Failing to comply with, or violating, any lawful order
3511 or rule issued by the office or commission or violating any
3512 provision of this chapter.

3513 (h) Becoming insolvent or financially impaired or
3514 conducting business in a manner that poses a risk to the public.

3515 (i) Refusing to be examined or to produce accounts,
3516 records, and files for examination, refusing to give information
3517 with respect to its affairs, or refusing to perform any other
3518 legal obligation under this chapter when required by the office.

3519 (j) Failing to comply with the requirements of s.
3520 651.1043.

3521 (k) Failing to maintain full compliance with escrow
3522 accounts or funds as required by this chapter, if responsible
3523 for the day-to-day operations of the provider.

3524 (l) Failing to meet the requirements of this chapter for
3525 disclosure of information to residents concerning the facility,

3526 its ownership, its management, its development, or its financial
3527 condition, or failing to honor its continuing care or continuing
3528 care at-home contracts, if responsible for the day-to-day
3529 operations of the provider.

3530 (m) Having any cause for which issuance of the license
3531 could have been denied had it then existed and been known to the
3532 office.

3533 (n) Having owners, managers, officers, or directors who
3534 have been found guilty of, or have pleaded guilty or nolo
3535 contendere to, a felony in this state or any other state,
3536 regardless of whether a judgment or conviction was entered by
3537 the court having jurisdiction of such cases.

3538 (o) Engaging in unfair methods of competition or in unfair
3539 or deceptive acts or practices prohibited under part IX of
3540 chapter 626.

3541 (p) Demonstrating a pattern of bankrupt enterprises.

3542 (q) Including in ownership, control, or management any
3543 person who:

3544 1. Is not reputable and of responsible character;

3545 2. Is so lacking in management expertise as to make the
3546 operation of the provider hazardous to potential and existing
3547 residents;

3548 3. Is so lacking in management experience, ability, and
3549 standing as to jeopardize the reasonable promise of successful
3550 operation;

3551 4. Is affiliated, directly or indirectly, through
3552 ownership or control, with any person whose business operations
3553 are or have been marked by business practices or conduct that is
3554 detrimental to the public, contract holders, investors, or
3555 creditors; by manipulation of assets, finances, or accounts; or
3556 by bad faith; or

3557 5. Has business operations marked by business practices or
3558 conduct that is detrimental to the public, contract holders,
3559 investors, or creditors; by manipulation of assets, finances, or
3560 accounts; or by bad faith.

3561 (r) Failing to file a notice of change in management,
3562 failing to remove a disapproved manager, or persisting in
3563 appointing disapproved managers.

3564 (2) Revocation of a management company's certificate of
3565 authority under this section does not relieve a provider of the
3566 provider's obligation to residents under the terms and
3567 conditions of any continuing care or continuing care at-home
3568 contract between the provider and residents or this chapter. The
3569 management company shall continue to file its annual statement
3570 and pay license fees to the office as required under this
3571 chapter as if the certificate of authority had continued in full
3572 force, but the management company may not issue any new
3573 contracts on behalf of a provider.

3574 (3) The office may seek an action in the circuit court of
3575 the Second Judicial Circuit, in and for Leon County, to enforce

3576 the office's order and the provisions of this section.

3577 **Section 72. Subsections (1), (4), (5), and (6) of section**
3578 **651.105, Florida Statutes, are amended to read:**

3579 651.105 Examination.—

3580 (1) The office may at any time, and shall at least once
3581 every 3 years, examine the business of any applicant for a
3582 certificate of authority and any provider or management company
3583 engaged in the execution of care contracts or engaged in the
3584 performance of obligations under such contracts, in the same
3585 manner as is provided for the examination of insurance companies
3586 pursuant to ss. 624.316 and 624.318. For a provider or
3587 management company as deemed accredited under s. 651.028, such
3588 examinations must take place at least once every 5 years. An
3589 examination covering the preceding 3 or 5 fiscal years of the
3590 provider or management company, as applicable, must be commenced
3591 within 12 months after the end of the most recent fiscal year
3592 covered by the examination. Such examination may include events
3593 subsequent to the end of the most recent fiscal year and the
3594 events of any prior period which relate to possible violations
3595 of this chapter or which affect the present financial condition
3596 of the provider or management company. At least once every 3 or
3597 5 fiscal years, as applicable, the office shall conduct an
3598 interview in person, telephonically, or through electronic
3599 communication with the current president or chair of the
3600 residents' council, or another designated officer of the council

3601 if the president or chair is not available, as part of the
3602 examination process. The examinations must be made by a
3603 representative or examiner designated by the office whose
3604 compensation will be fixed by the office pursuant to s. 624.320.
3605 Routine examinations may be made by having the necessary
3606 documents submitted to the office ~~and~~ and ~~for~~ for this purpose,
3607 financial documents and records conforming to commonly accepted
3608 accounting principles and practices, as required under s.
3609 651.026, are deemed adequate. The final written report of each
3610 examination must be filed with the office and, when so filed,
3611 constitutes a public record. Any provider or management company
3612 being examined shall, upon request, give reasonable and timely
3613 access to all of its records. The representative or examiner
3614 designated by the office may at any time examine the records and
3615 affairs and inspect the physical property of any provider or
3616 management company, whether in connection with a formal
3617 examination or not.

3618 (4) The office shall notify the provider or management
3619 company and the executive officer of the governing body of the
3620 provider or management company in writing of all deficiencies in
3621 its compliance with the provisions of this chapter and the rules
3622 adopted pursuant to this chapter and shall set a reasonable
3623 length of time for compliance by the provider or management
3624 company. In addition, the office shall require corrective action
3625 or request a corrective action plan from the provider or

3626 management company which plan demonstrates a good faith attempt
3627 to remedy the deficiencies by a specified date. If the provider
3628 or management company fails to comply within the established
3629 length of time, the office may initiate action against the
3630 provider or management company in accordance with the provisions
3631 of this chapter.

3632 (5) A provider or management company shall respond to
3633 written correspondence from the office and provide data,
3634 financial statements, and pertinent information as requested by
3635 the office. The office has standing to petition a circuit court
3636 for mandatory injunctive relief to compel access to and require
3637 the provider or management company to produce the documents,
3638 data, records, and other information requested by the office.
3639 The office may petition the circuit court in the county in which
3640 the facility is situated or the Circuit Court of Leon County to
3641 enforce this section.

3642 ~~(6) Unless a provider is impaired or subject to a~~
3643 ~~regulatory action level event, any parent, subsidiary, or~~
3644 ~~affiliate is not subject to examination by the office as part of~~
3645 ~~a routine examination. However, If a provider, ~~or~~ facility, or~~
3646 management company relies on a contractual or financial
3647 relationship with a parent, a subsidiary, or an affiliate in
3648 order to meet the financial requirements of this chapter, the
3649 office may examine any parent, subsidiary, or affiliate that has
3650 a contractual or financial relationship with the provider, ~~or~~

3651 facility, or management company to the extent necessary to
3652 ascertain the financial condition of the provider or management
3653 company. For any provider that has been placed into
3654 administrative supervision under s. 651.018, any parent,
3655 subsidiary, or affiliate is subject to examination by the
3656 office.

3657 **Section 73. Section 651.1065, Florida Statutes, is amended**
3658 **to read:**

3659 651.1065 Soliciting or accepting new continuing care
3660 contracts by impaired or insolvent facilities or providers.—

3661 (1) Regardless of whether delinquency proceedings as to a
3662 continuing care facility have been or are to be initiated, a
3663 proprietor, a general partner, a member, an officer, a director,
3664 a trustee, ~~or~~ a manager, or a management company of a continuing
3665 care facility may not actively solicit, approve the solicitation
3666 or acceptance of, or accept new continuing care contracts in
3667 this state after the proprietor, general partner, member,
3668 officer, director, trustee, ~~or~~ manager, or a management company
3669 knew, or reasonably should have known, that the continuing care
3670 facility was impaired or insolvent except with the written
3671 permission of the office. If the facility has declared
3672 bankruptcy, the bankruptcy court or trustee appointed by the
3673 court has jurisdiction over such matters. The office must
3674 approve or disapprove the continued marketing of new contracts
3675 within 15 days after receiving a request from a provider.

3676 (2) A proprietor, a general partner, a member, an officer,
 3677 a director, a trustee, ~~or~~ a manager, or a management company
 3678 that who violates this section commits a felony of the third
 3679 degree, punishable as provided in s. 775.082, s. 775.083, or s.
 3680 775.084.

3681 **Section 74. Section 651.1068, Florida Statutes, is created**
 3682 **to read:**

3683 651.1068 Officers and directors of insolvent providers or
 3684 management companies.—Any person who was an officer or director
 3685 of a provider or management company doing business in this state
 3686 and who served in that capacity within the 2-year period before
 3687 the date the provider or management company became insolvent,
 3688 for any insolvency that occurs on or after July 1, 2025, may not
 3689 thereafter serve as an officer or director of a provider or
 3690 management company authorized in this state or have direct or
 3691 indirect control over the selection or appointment of an officer
 3692 or director of a provider or management company through contract
 3693 or trust or by operation of law, unless the officer or director
 3694 demonstrates that his or her personal actions or omissions were
 3695 not a significant contributing cause to the insolvency.

3696 **Section 75. Subsections (2) and (3) of section 651.107,**
 3697 **Florida Statutes, are amended to read:**

3698 651.107 Duration of suspension; obligations during
 3699 suspension period; reinstatement.—

3700 (2) During the period of suspension, the provider or

3701 management company shall file its annual statement and pay
 3702 license fees and taxes as required under this chapter as if the
 3703 certificate had continued in full force, ~~+~~ but the provider shall
 3704 issue no new contracts.

3705 (3) Upon expiration of the suspension period, if within
 3706 such period the certificate of authority has not otherwise
 3707 terminated, the provider's or management company's certificate
 3708 of authority shall automatically be reinstated unless the office
 3709 finds that the causes for the suspension have not been removed
 3710 or that the provider or management company is otherwise not in
 3711 compliance with the requirements of this chapter. If not so
 3712 automatically reinstated, the certificate of authority shall be
 3713 deemed to be revoked as of the end of the suspension period or
 3714 upon failure of the provider or management company to continue
 3715 the certificate during the suspension period, whichever event
 3716 first occurs.

3717 **Section 76. Subsection (2) of section 651.108, Florida**
 3718 **Statutes, is amended to read:**

3719 651.108 Administrative fines.—

3720 (2) If it is found that the provider or management company
 3721 has knowingly and willfully violated a lawful order of the
 3722 office or a provision of this chapter, the office may impose a
 3723 fine of up to ~~in an amount not to exceed~~ \$10,000 for each such
 3724 violation.

3725 **Section 77. Section 651.113, Florida Statutes, is created**

3726 **to read:**

3727 651.113 Hazardous facility or provider standards; office's
3728 evaluation and enforcement authority; immediate final order.-

3729 (1) As used in this section, the term "negative fund
3730 balance" means a financial position of a provider or facility in
3731 which the assets of a provider or facility do not exceed its
3732 liabilities as required under generally accepted accounting
3733 principles. The Commissioner of Insurance Regulation may deem a
3734 provider or facility that has a negative fund balance to be
3735 insolvent or in imminent danger of becoming insolvent if any of
3736 the following hazardous financial condition standards or factors
3737 is applicable or present:

3738 (a) The provider's or facility's financial statements
3739 contain findings or conditions that the commissioner considers
3740 detrimental to its financial stability.

3741 (b) An independent auditor has identified significant
3742 financial risks or issued a going concern opinion.

3743 (c) The provider's or facility's current or projected
3744 ratio of total assets, including required reserves, to total
3745 liabilities indicates financial impairment or deterioration, or
3746 trends suggest a potential decline in operations, working
3747 capital, or equity.

3748 (d) The provider's or facility's current or projected
3749 ratio of current assets to current liabilities indicates
3750 financial impairment or deterioration, or trends suggest a

3751 potential decline in operations, working capital, or equity.

3752 (e) The provider or facility is unable to carry out normal
3753 daily activities and meet its obligations as they become due,
3754 based on its current or projected cash flow and liquidity
3755 position.

3756 (f) The provider's or facility's past-year operating
3757 losses or projected operating losses are significant enough to
3758 jeopardize daily operations or long-term viability.

3759 (g) The insolvency of an affiliated provider or facility
3760 or other affiliated person results in legal liability of the
3761 provider or facility for payments and expenses of such magnitude
3762 as to jeopardize the provider's or facility's ability to meet
3763 its obligations as they become due, without substantial
3764 disposition of assets outside the ordinary course of business,
3765 any restructuring of debt, or externally forced revisions of its
3766 operations.

3767 (h) The provider or facility has receivables that are more
3768 than 90 days past due.

3769 (i) The insolvency is not temporary and the provider or
3770 facility cannot demonstrate a significant reduction or
3771 resolution of the financial shortfall.

3772 (j) The provider or facility faces financial difficulties
3773 due to reporting entrance fees as deferred revenue, factoring in
3774 generally accepted accounting principles and the overall impact
3775 on net income.

3776 (k) A startup provider, a facility undergoing plant
3777 expansion, or an entity refinancing its debt has developed a
3778 financial condition that could seriously jeopardize current or
3779 future operation.

3780 (2) The provider or facility shall prepare a plan to
3781 address and correct any condition that has led to a
3782 determination of insolvency or imminent danger of insolvency by
3783 the Commissioner of Insurance Regulation. The plan must be
3784 presented to the commissioner within 30 days after the date of
3785 the insolvency determination. If the plan to correct the
3786 condition is disapproved by the commissioner, if the plan does
3787 not correct the condition leading to the commissioner's
3788 determination of insolvency, or if the provider's or facility's
3789 hazardous condition is such that it cannot be significantly
3790 corrected or eliminated, the commissioner may proceed with
3791 liquidation under chapter 631.

3792 (3) If the office determines that the continued operations
3793 of a provider or facility authorized to transact business in
3794 this state may be hazardous to its residents or to the general
3795 public, the office may issue an order requiring the provider or
3796 facility to do any of the following:

3797 (a) Obtain additional financing or revenues to maintain
3798 solventy.

3799 (b) Reduce expenses by specified methods or amounts.

3800 (c) Increase the operating reserve.

3801 (d) File reports in a form acceptable to the office
3802 concerning the market value of the provider's or facility's
3803 assets.

3804 (e) Limit or withdraw from certain investments or
3805 discontinue certain investment practices to the extent the
3806 office deems necessary.

3807 (f) Document the adequacy of income and operating reserves
3808 in relation to expenses.

3809 (g) File, in addition to regular annual statements,
3810 interim financial reports on a form prescribed by the
3811 commission.

3812 (h) Correct corporate governance practice deficiencies and
3813 adopt and use governance practices acceptable to the office.

3814 (i) Provide a business plan acceptable to the office in
3815 order to continue to transact business in this state.

3816 (j) Notwithstanding any other law limiting the frequency
3817 or amount of rate adjustments, adjust rates for any non-life
3818 insurance product written by the insurer which the office
3819 considers necessary to improve the financial condition of the
3820 insurer.

3821 (4) The office may, pursuant to ss. 120.569 and 120.57, in
3822 its discretion and without advance notice or hearing, issue an
3823 immediate final order to any insurer requiring the actions
3824 specified in subsection (3).

3825 (5) This section may not be interpreted to limit the

3826 powers granted to the office by any laws of this state, nor may
 3827 it be interpreted to supersede any laws of this state.

3828 **Section 78. Subsection (11) of section 651.114, Florida**
 3829 **Statutes, is amended to read:**

3830 651.114 Delinquency proceedings; remedial rights.—

3831 ~~(11) (a) The rights of the office described in this section~~
 3832 ~~are subordinate to the rights of a trustee or lender pursuant to~~
 3833 ~~the terms of a resolution, ordinance, loan agreement, indenture~~
 3834 ~~of trust, mortgage, lease, security agreement, or other~~
 3835 ~~instrument creating or securing bonds or notes issued to finance~~
 3836 ~~a facility, and the office, subject to paragraph (c), may not~~
 3837 ~~exercise its remedial rights provided under this section and ss.~~
 3838 ~~651.018, 651.106, 651.108, and 651.116 with respect to a~~
 3839 ~~facility that is subject to a lien, mortgage, lease, or other~~
 3840 ~~encumbrance or trust indenture securing bonds or notes issued in~~
 3841 ~~connection with the financing of the facility, if the trustee or~~
 3842 ~~lender, by inclusion or by amendment to the loan documents or by~~
 3843 ~~a separate contract with the office, agrees that the rights of~~
 3844 ~~residents under a continuing care or continuing care at home~~
 3845 ~~contract will be honored and will not be disturbed by a~~
 3846 ~~foreclosure or conveyance in lieu thereof as long as the~~
 3847 ~~resident:~~

3848 ~~1. Is current in the payment of all monetary obligations~~
 3849 ~~required by the contract;~~

3850 ~~2. Is in compliance and continues to comply with all~~

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3851 ~~provisions of the contract; and~~

3852 ~~3. Has asserted no claim inconsistent with the rights of~~
3853 ~~the trustee or lender.~~

3854 ~~(b) This subsection does not require a trustee or lender~~
3855 ~~to:~~

3856 ~~1. Continue to engage in the marketing or resale of new~~
3857 ~~continuing care or continuing care at-home contracts;~~

3858 ~~2. Pay any rebate of entrance fees as may be required by a~~
3859 ~~resident's continuing care or continuing care at-home contract~~
3860 ~~as of the date of acquisition of the facility by the trustee or~~
3861 ~~lender and until expiration of the period described in paragraph~~
3862 ~~(d);~~

3863 ~~3. Be responsible for any act or omission of any owner or~~
3864 ~~operator of the facility arising before the acquisition of the~~
3865 ~~facility by the trustee or lender; or~~

3866 ~~4. Provide services to the residents to the extent that~~
3867 ~~the trustee or lender would be required to advance or expend~~
3868 ~~funds that have not been designated or set aside for such~~
3869 ~~purposes.~~

3870 ~~(c) If the office determines, at any time during the~~
3871 ~~suspension of its remedial rights as provided in paragraph (a),~~
3872 ~~that:~~

3873 ~~1. The trustee or lender is not in compliance with~~
3874 ~~paragraph (a);~~

3875 ~~2. A lender or trustee has assigned or has agreed to~~

3876 ~~assign all or a portion of a delinquent or defaulted loan to a~~
3877 ~~third party without the office's written consent;~~

3878 ~~3. The provider engaged in the misappropriation,~~
3879 ~~conversion, or illegal commitment or withdrawal of minimum~~
3880 ~~liquid reserve or escrowed funds required under this chapter;~~

3881 ~~4. The provider refused to be examined by the office~~
3882 ~~pursuant to s. 651.105(1); or~~

3883 ~~5. The provider refused to produce any relevant accounts,~~
3884 ~~records, and files requested as part of an examination,~~

3885
3886 ~~the office shall notify the trustee or lender in writing of its~~
3887 ~~determination, setting forth the reasons giving rise to the~~
3888 ~~determination and specifying those remedial rights afforded to~~
3889 ~~the office which the office shall then reinstate.~~

3890 ~~(d) Upon acquisition of a facility by a trustee or lender~~
3891 ~~and evidence satisfactory to the office that the requirements of~~
3892 ~~paragraph (a) have been met, the office shall issue a 90-day~~
3893 ~~temporary certificate of authority granting the trustee or~~
3894 ~~lender the authority to engage in the business of providing~~
3895 ~~continuing care or continuing care at home and to issue~~
3896 ~~continuing care or continuing care at home contracts subject to~~
3897 ~~the office's right to immediately suspend or revoke the~~
3898 ~~temporary certificate of authority if the office determines that~~
3899 ~~any of the grounds described in s. 651.106 apply to the trustee~~
3900 ~~or lender or that the terms of the contract used as the basis~~

3901 ~~for the issuance of the temporary certificate of authority by~~
 3902 ~~the office have not been or are not being met by the trustee or~~
 3903 ~~lender since the date of acquisition.~~

3904 **Section 79. Section 651.1165, Florida Statutes, is created**
 3905 **to read:**

3906 651.1165 Recording of lien by the office.-

3907 (1) The office shall, as a condition to granting a
 3908 provisional certificate of authority to an applicant, record
 3909 with the county recorder of any county a notice of lien against
 3910 the facility's properties on behalf of all residents and
 3911 contract holders who enter into life care contracts with the
 3912 applicant to secure performance of the provider's obligations to
 3913 residents and contract holders pursuant to life care contracts.

3914 (2) From the time of the recording under subsection (1),
 3915 there exists a lien for an amount equal to the reasonable value
 3916 of services to be performed under a life care contract in favor
 3917 of each resident and contract holder on the land and
 3918 improvements of the facility's properties owned by the provider,
 3919 not exempt from execution, which are listed in the notice of
 3920 lien filed pursuant to subsection (3) and which are located in
 3921 the county in which the notice of lien is recorded.

3922 (3) The lien shall be perfected by the office by executing
 3923 by affidavit the notice and claim of lien, which must contain:

3924 (a) The legal description of the lands and improvements to
 3925 be charged with a lien.

3926 (b) The name of the owner of the property affected.

3927 (c) A statement that the lien has been filed by the office
3928 pursuant to this section.

3929 (4) The lien may be released or partially released at the
3930 request of the applicant if, in the judgment of the director,
3931 such release or partial release inures to the benefit of the
3932 residents and contract holders and the performance of the
3933 provider's obligations to the residents and contract holders.

3934 (5) The lien may be foreclosed by civil action. Any number
3935 of persons claiming liens against the same property pursuant to
3936 this section may join in the same action. If separate actions
3937 are commenced, the court may consolidate such actions. The court
3938 shall, as part of the costs, allow reasonable attorney fees for
3939 each claimant who is a party to the action.

3940 (6) In a civil action filed pursuant to this section, the
3941 judgment must be entered in favor of each resident and contract
3942 holder having a lien who has joined in the foreclosure action
3943 for the amount equal to the reasonable value of services to be
3944 performed under a life care contract in favor of each resident
3945 and contract holder. The court shall order the sheriff to sell
3946 any property subject to the lien at the time judgment is given,
3947 in the same manner as real and personal property is sold on
3948 execution. The lien for the reasonable value of services to be
3949 performed under a life care contract must be on equal footing
3950 with claims of other residents and contract holders. If a sale

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3951 is ordered and the property sold and the proceeds of the sale
3952 are not sufficient to discharge all liens of residents and
3953 contract holders against the property, the proceeds must be
3954 prorated among the respective residents and contract holders.

3955 (7) The lien provided for in this section is preferred to
3956 all liens, mortgages, or other encumbrances upon the property
3957 attaching subsequently to the time the lien is recorded and is
3958 preferred to all unrecorded liens, mortgages, and other
3959 encumbrances. The amount secured by any lien having priority to
3960 the lien filed pursuant to this section may not be increased
3961 without prior approval of the office.

3962 (8) The office shall file a release of the lien upon proof
3963 of complete performance of all obligations to residents and
3964 contract holders pursuant to life care contracts.

3965 (9) The office may subordinate any lien filed pursuant to
3966 this section to the lien of a first mortgage or other long-term
3967 financing obtained by the provider, regardless of the time at
3968 which the subsequent lien attaches.

3969 **Section 80. Subsection (3) of section 627.642, Florida**
3970 **Statutes, is amended to read:**

3971 627.642 Outline of coverage.—

3972 (3) In addition to the outline of coverage, a policy as
3973 specified in s. 627.6699(3)(j) ~~s. 627.6699(3)(k)~~ must be
3974 accompanied by an identification card that contains, at a
3975 minimum:

3976 (a) The name of the organization issuing the policy or the
 3977 name of the organization administering the policy, whichever
 3978 applies.

3979 (b) The name of the contract holder.

3980 (c) The type of plan only if the plan is filed in the
 3981 state, an indication that the plan is self-funded, or the name
 3982 of the network.

3983 (d) The member identification number, contract number, and
 3984 policy or group number, if applicable.

3985 (e) A contact phone number or electronic address for
 3986 authorizations and admission certifications.

3987 (f) A phone number or electronic address whereby the
 3988 covered person or hospital, physician, or other person rendering
 3989 services covered by the policy may obtain benefits verification
 3990 and information in order to estimate patient financial
 3991 responsibility, in compliance with privacy rules under the
 3992 Health Insurance Portability and Accountability Act.

3993 (g) The national plan identifier, in accordance with the
 3994 compliance date set forth by the federal Department of Health
 3995 and Human Services.

3996
 3997 The identification card must present the information in a
 3998 readily identifiable manner or, alternatively, the information
 3999 may be embedded on the card and available through magnetic
 4000 stripe or smart card. The information may also be provided

4001 through other electronic technology.

4002 **Section 81. Paragraph (a) of subsection (2), paragraphs**
4003 **(a), (e), and (g) of subsection (7), and paragraph (a) of**
4004 **subsection (8) of section 627.6475, Florida Statutes, are**
4005 **amended to read:**

4006 627.6475 Individual reinsurance pool.—

4007 (2) DEFINITIONS.—As used in this section:

4008 (a) ~~"Board,"~~ "Carrier," and "health benefit plan" have the
4009 same meaning ascribed in s. 627.6699(3).

4010 (7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.—

4011 (a) The individual health reinsurance program shall
4012 operate subject to the supervision and control of the board of
4013 the small employer health reinsurance program ~~established~~
4014 ~~pursuant to s. 627.6699(11)~~. The board shall establish a
4015 separate, segregated account for eligible individuals reinsured
4016 pursuant to this section, which account may not be commingled
4017 with the small employer health reinsurance account.

4018 (e)1. Before March 1 of each calendar year, the board
4019 shall determine and report to the office the program net loss in
4020 the individual account for the previous year, including
4021 administrative expenses for that year and the incurred losses
4022 for that year, taking into account investment income and other
4023 appropriate gains and losses.

4024 2. Any net loss in the individual account for the year
4025 shall be recouped by assessing the carriers as follows:

4026 a. The operating losses of the program shall be assessed
4027 in the following order subject to the specified limitations. The
4028 first tier of assessments shall be made against reinsuring
4029 carriers in an amount that may not exceed 5 percent of each
4030 reinsuring carrier's premiums for individual health insurance.
4031 If such assessments have been collected and additional moneys
4032 are needed, the board shall make a second tier of assessments in
4033 an amount that may not exceed 0.5 percent of each carrier's
4034 health benefit plan premiums.

4035 b. Except as provided in paragraph (f), risk-assuming
4036 carriers are exempt from all assessments authorized pursuant to
4037 this section. The amount paid by a reinsuring carrier for the
4038 first tier of assessments shall be credited against any
4039 additional assessments made.

4040 c. The board shall equitably assess reinsuring carriers
4041 for operating losses of the individual account based on market
4042 share. The board shall annually assess each carrier a portion of
4043 the operating losses of the individual account. The first tier
4044 of assessments shall be determined by multiplying the operating
4045 losses by a fraction, the numerator of which equals the
4046 reinsuring carrier's earned premium pertaining to direct
4047 writings of individual health insurance in the state during the
4048 calendar year for which the assessment is levied, and the
4049 denominator of which equals the total of all such premiums
4050 earned by reinsuring carriers in the state during that calendar

4051 year. The second tier of assessments shall be based on the
4052 premiums that all carriers, except risk-assuming carriers,
4053 earned on all health benefit plans written in this state. The
4054 board may levy interim assessments against reinsuring carriers
4055 to ensure the financial ability of the plan to cover claims
4056 expenses and administrative expenses paid or estimated to be
4057 paid in the operation of the plan for the calendar year prior to
4058 the association's anticipated receipt of annual assessments for
4059 that calendar year. Any interim assessment is due and payable
4060 within 30 days after receipt by a carrier of the interim
4061 assessment notice. Interim assessment payments shall be credited
4062 against the carrier's annual assessment. Health benefit plan
4063 premiums and benefits paid by a carrier that are less than an
4064 amount determined by the board to justify the cost of collection
4065 may not be considered for purposes of determining assessments.

4066 d. Subject to the approval of the office, the board shall
4067 adjust the assessment formula for reinsuring carriers that are
4068 approved as federally qualified health maintenance organizations
4069 by the Secretary of Health and Human Services pursuant to 42
4070 U.S.C. s. 300e(c)(2)(A) to the extent, if any, that restrictions
4071 are placed on them which are not imposed on other carriers.

4072 3. Before March 1 of each year, the board shall determine
4073 and file with the office an estimate of the assessments needed
4074 to fund the losses incurred by the program in the individual
4075 account for the previous calendar year.

4076 4. If the board determines that the assessments needed to
4077 fund the losses incurred by the program in the individual
4078 account for the previous calendar year will exceed the amount
4079 specified in subparagraph 2., the board shall evaluate the
4080 operation of the program and report its findings and
4081 recommendations to the office ~~in the format established in s.~~
4082 ~~627.6699(11) for the comparable report for the small employer~~
4083 ~~reinsurance program.~~

4084 (g) Except as otherwise provided in this section, the
4085 board and the office shall have all powers, duties, and
4086 responsibilities with respect to carriers that issue and
4087 reinsure individual health insurance, ~~as specified for the board~~
4088 ~~and the office in s. 627.6699(11) with respect to small employer~~
4089 ~~carriers,~~ including, but not limited to, ~~the provisions of s.~~
4090 ~~627.6699(11) relating to:~~

4091 1. Use of assessments that exceed the amount of actual
4092 losses and expenses.

4093 2. The annual determination of each carrier's proportion
4094 of the assessment.

4095 3. Interest for late payment of assessments.

4096 4. Authority for the office to approve deferment of an
4097 assessment against a carrier.

4098 5. Limited immunity from legal actions or carriers.

4099 6. Development of standards for compensation to be paid to
4100 agents. Such standards shall be limited to those specifically

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4101 enumerated in s. 627.6699(11)(d) ~~s. 627.6699(12)(d)~~.

4102 7. Monitoring compliance by carriers with this section.

4103 (8) STANDARDS TO ASSURE FAIR MARKETING.—

4104 (a) Each health insurance issuer that offers individual
4105 health insurance shall actively market coverage to eligible
4106 individuals in the state. The provisions of s. 627.6699(11) ~~s.~~
4107 ~~627.6699(12)~~ that apply to small employer carriers that market
4108 policies to small employers shall also apply to health insurance
4109 issuers that offer individual health insurance with respect to
4110 marketing policies to individuals.

4111 **Section 82. Subsection (2) of section 627.657, Florida**
4112 **Statutes, is amended to read:**

4113 627.657 Provisions of group health insurance policies.—

4114 (2) The medical policy as specified in s. 627.6699(3)(j)
4115 ~~s. 627.6699(3)(k)~~ must be accompanied by an identification card
4116 that contains, at a minimum:

4117 (a) The name of the organization issuing the policy or
4118 name of the organization administering the policy, whichever
4119 applies.

4120 (b) The name of the certificateholder.

4121 (c) The type of plan only if the plan is filed in the
4122 state, an indication that the plan is self-funded, or the name
4123 of the network.

4124 (d) The member identification number, contract number, and
4125 policy or group number, if applicable.

4126 (e) A contact phone number or electronic address for
 4127 authorizations and admission certifications.

4128 (f) A phone number or electronic address whereby the
 4129 covered person or hospital, physician, or other person rendering
 4130 services covered by the policy may obtain benefits verification
 4131 and information in order to estimate patient financial
 4132 responsibility, in compliance with privacy rules under the
 4133 Health Insurance Portability and Accountability Act.

4134 (g) The national plan identifier, in accordance with the
 4135 compliance date set forth by the federal Department of Health
 4136 and Human Services.

4137
 4138 The identification card must present the information in a
 4139 readily identifiable manner or, alternatively, the information
 4140 may be embedded on the card and available through magnetic
 4141 stripe or smart card. The information may also be provided
 4142 through other electronic technology.

4143 **Section 83. Subsection (1) of section 627.66997, Florida**
 4144 **Statutes, is amended to read:**

4145 627.66997 Stop-loss insurance.—

4146 (1) A self-insured health benefit plan established or
 4147 maintained by a small employer, as defined in s. 627.6699(3)(s)
 4148 ~~s. 627.6699(3)(v)~~, is exempt from s. 627.6699 and may use a
 4149 stop-loss insurance policy issued to the employer. For purposes
 4150 of this subsection, the term "stop-loss insurance policy" means

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4151 an insurance policy issued to a small employer which covers the
4152 small employer's obligation for the excess cost of medical care
4153 on an equivalent basis per employee provided under a self-
4154 insured health benefit plan.

4155 (a) A small employer stop-loss insurance policy is
4156 considered a health insurance policy and is subject to s.
4157 627.6699 if the policy has an aggregate attachment point that is
4158 lower than the greatest of:

4159 1. Two thousand dollars multiplied by the number of
4160 employees;

4161 2. One hundred twenty percent of expected claims, as
4162 determined by the stop-loss insurer in accordance with actuarial
4163 standards of practice; or

4164 3. Twenty thousand dollars.

4165 (b) Once claims under the small employer health benefit
4166 plan reach the aggregate attachment point set forth in paragraph
4167 (a), the stop-loss insurance policy authorized under this
4168 section must cover 100 percent of all claims that exceed the
4169 aggregate attachment point.

4170 **Section 84.** Reciprocal insurers licensed before July 1,
4171 2025, have until July 1, 2026, to comply with the changes made
4172 to subscribers' advisory committees in s. 629.201, Florida
4173 Statutes. Reciprocal insurers licensed before July 1, 2025, have
4174 until July 1, 2027, to comply with the changes made to unearned
4175 premium reserve requirements imposed under s. 629.56, Florida

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4176 | Statutes.

4177 | **Section 85.** Except as otherwise expressly provided in this
4178 | act and except for this section, which shall take effect upon
4179 | this act becoming a law, this act shall take effect July 1,
4180 | 2025.