The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1656
INTRODUCER:	Senator Collins
SUBJECT:	Office of Insurance Regulation
DATE:	March 14, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Thomas	Knudson	BI	**Pre-meeting**
2.			AEG	
3.			RC	

I. Summary:

SB 1656 revises provisions relating to the Office of Insurance Regulation (OIR). Specifically, the bill:

- Revises provisions relating to the appointment of the Chief Financial Officer as agent for service of process for insurers.
- Requires the Commissioner of Insurance to publish in the next available publication of the Florida Administrative Register a notice identifying the date an emergency order was issued and a hyperlink or website address providing direct access to the emergency order.
- Creates provisions ensuring the cybersecurity of a consumer's nonpublic insurance information.
- Limits certain insurers' ability to use "use and file" rate filings.
- Provides that even if no rate change is proposed, an insurer must submit a full rate filing after two consecutive years of certification under s. 627.0645, F.S.
- Requires that every rate filing for residential property coverage from a property insurer must include a rate transparency report.
- Repeals the Small Employer Health Reinsurance Program.
- Requires the OIR to contract with a Florida public university to design, operate, upgrade, and maintain a statewide database for uniform mitigation verification inspection forms to collect and evaluate mitigation features of residential properties within the state and require each insurer to electronically file a copy of the forms submitted by policyholders in the database.
- Requires each authorized insurer and surplus lines insurer transacting residential property insurance or private passenger automobile insurance in Florida to report annually to the OIR certain information.
- Amends provisions relating to reciprocal insurers, including:
  - Increase the amount of required surplus funds;
  - Provide that the attorney in fact is an affiliate of the reciprocal insurer;
  - Increase the amount of the attorney's bond;

  - Provide for subscriber contributions, savings accounts, and distributions;
  - Require the subscribers' advisory committee to procure an audited annual statement of the accounts and records of the insurer and the attorney in fact;
  - Revise provisions relating to the financial condition of the insurer; the subscribers' advisory committee; the merger or conversion of an insurer; and to impaired insurers;
  - Repeal provisions relating to insurance exchanges and limited reciprocal insurers;
  - Create provisions relating to unearned premium reserves; and
  - Provide dates whereby existing reciprocal insurers must comply with the revised requirements.
- Revises provisions relating to service warranty association contracts.
- Revises provisions relating to annual statements filed by health maintenance organizations and provide that the administrative supervision and hazardous insurer standard provisions of ss. 624.80-624.87, F.S., apply to health maintenance organizations.
- Amends provisions relating to the regulation of continuing care retirement communities (CCRC), including:
  - Revise provisions relating to administrative supervision; eligibility; provisional certificates of authority; certificates of authority; acquisition; expansion; annual reports; quarterly and monthly statements; escrow accounts; financial and operating requirements; liquid reserves; priority of claims on liquidation or receivership; and requirements of disclosure;
  - Provide requirements for the use of resident funds for charitable or operational purposes;
  - Require CCRC management companies to obtain a certificate of authority; provide requirements for the acquisition of a management company; require management companies to submit annual and quarterly financial statements; and require management companies to meet certain existing requirements placed on providers;
  - Provide authority to the OIR regarding CCRCs that are in a hazardous financial condition; and
  - Provide that the OIR shall record a notice of lien against the facility's properties on behalf of all residents and contract holders to secure performance of the provider's obligations to residents and contract holders.
- Makes various technical and conforming changes.

The bill has an indeterminate impact to state revenues or expenditures. See Section V. Fiscal Impact Statement.

Except as expressly provided, the bill becomes effective on July 1, 2025.

II. Present Situation:

The Regulation of Insurance in Florida

The Office of Insurance Regulation (OIR) regulates specified insurance products, insurers and other risk bearing entities in Florida.[1] As part of their regulatory oversight, the OIR may suspend

[1] Section 20.121(3)(a), F.S. The Financial Services Commission, composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture, serves as agency head of the Office of Insurance Regulation for purposes of rulemaking. Further, the Financial Services Commission appoints the commissioner of the Office of Insurance Regulation.

or revoke an insurer's certificate of authority (COA) under certain conditions.[2] The OIR is responsible for examining the affairs, transactions, accounts, records, and assets of each insurer that holds a COA to transact insurance business in Florida.[3] As part of the examination process, all persons being examined must make available to the OIR the accounts, records, documents, files, information, assets, and matters in their possession or control that relate to the subject of the examination.[4] The OIR is also authorized to conduct market conduct examinations to determine compliance with applicable provisions of the Insurance Code.[5]

Insurance companies that transact insurance in Florida or that have offices located in the state are required to obtain a COA issued by the OIR pursuant to s. 624.401, F.S. These companies, referred to as authorized or admitted insurers,[6] are broadly regulated by the OIR under the Insurance Code as to reserves, surplus as to policyholders, solvency, rates and forms, market conduct, permissible investments, and affiliate relationships.[7] Authorized insurers are also required to participate in a variety of government mandated insurance programs and pay assessments levied by state guaranty funds in the event of insurer insolvencies.[8]

The Chief Financial Officer as Agent for Service of Process on Insurers

Service of process is the formal delivery of a writ, summons, or other legal process or notice to a person affected by that document. Section 48.151, F.S., provides that the Chief Financial Officer (CFO) is the agent for service of process for:

- All insurers applying for authority to transact insurance;
- All licensed nonresident insurance agents;
- All nonresident disability insurance agents;
- Any unauthorized insurer under ss. 626.906 or 626.937, F.S.;
- All domestic reciprocal insurers;
- All fraternal benefit societies under ch. 632, F.S.;
- All warranty associations;
- All prepaid limited health service organizations under ch. 636, F.S.; and
- All persons required to file statements under s. 628.461, F.S.[9]

Each licensed insurer, whether domestic, foreign, or alien, is deemed to have appointed the CFO as its agent to receive service of all legal process and process so served is valid and binding upon the insurer.[10] Before it may transact insurance in this state, each insurer must file with the DFS designation of the name and e-mail address of the person to whom process against it served upon

[2] Section 624.418, F.S.
[3] Section 624.316(1)(a), F.S.
[4] Section 624.318(2), F.S.
[5] Section 624.3161, F.S.
[6] An "authorized" or "admitted" insurer is one duly authorized by a COA to transact insurance in this state.
[7] The Insurance Code consists of chs. 624-632, 634, 635, 636, 641, 642, 648, and 651, F.S.
[8] For example, Florida licensed direct writers of property and casualty insurance must be members of the Florida Insurance Guaranty Association, which handles the claims of insolvent insurers under part II of ch. 631, F.S., and insurers offering workers' compensation coverage in Florida must be members of the Florida Workers' Compensation Insurance Guaranty Association, which provides payment of covered claims for insurers that are declared insolvent under part V of ch. 631, F.S.
[9] Section 48.151(3), F.S.
[10] Section 624.422(1), F.S.

the CFO is to be made available through the DFS's secure online portal, as well as the name and e-mail address of the person to whom the DFS shall forward civil remedy notices filed under s. 624.155, F.S.[11] Service of process submitted through the DFS's secure online portal upon the CFO as the insurer's agent is the sole method of service of process upon an authorized domestic, foreign, or alien insurer in Florida.[12]

The Commissioner of Insurance Regulation; Powers During a State of Emergency

When the Governor declares a state of emergency pursuant to s. 252.36, F.S., the Commissioner of Insurance (Commissioner) may issue general orders applicable to all insurance companies, entities, and persons subject to the Florida Insurance Code and that serve any portion of the area of the state under the state of emergency.[13] Such an order becomes effective upon issuance and continues for 120 days unless terminated sooner and may be extended for one additional period of 120 days if the Commissioner determines that the emergency conditions that gave rise to the initial order still exist.[14] The Commissioner must publish in the next available publication of the Florida Administrative Register a copy of the text of any order issued under this section, together with a statement describing the modification or suspension and explaining how the modification or suspension will facilitate recovery from the emergency.[15]

Risk-Based Capital Requirements for Insurers

Each insurer that is domiciled in Florida must, on or before March 1 of each year, prepare and file with the National Association of Insurance Commissioners a report of its risk-based capital levels as of the end of the calendar year just ended, in a form and containing the information required in the risk-based capital instructions.[16] "Risk-based capital level" means an insurer's company action level risk-based capital, regulatory action level risk-based capital, authorized control level risk-based capital, or mandatory control level risk-based capital.[17]

For purposes of risk-based capital requirements, "life and health insurer" means an insurer authorized or eligible under the Florida Insurance Code to underwrite life or health insurance and includes a property and casualty insurer that writes accident and health insurance only.[18] The term also includes a health maintenance organization (HMO) that is authorized in this state and one or more other states, jurisdictions, or countries and a prepaid limited health service organization that is authorized in this state and one or more other states, jurisdictions, or countries.[19]

HMOs and prepaid limited health service organizations are exempt from having their risk-based capital determined in accordance with the formula for life and health insurers set forth in the

[11] Section 624.422(2), F.S.
[12] Section 624.422(3), F.S.
[13] Section 252(1), F.S.
[14] Section 252(2), F.S. By concurrent resolution, the Legislature may terminate any order issued under this section.
[15] Section 252(3), F.S.
[16] Section 624.4085(2)(a), F.S.
[17] Section 624.4085(1)(n), F.S.
[18] Section 624.4085(1)(g), F.S.
[19] *Id.*

risk-based capital instructions.[20] However, an HMO or prepaid limited health services organization must have its risk-based capital determined in accordance with the formula for property and casualty insurers.[21]

Insurance Exchanges

Any financial institution or aggregation of such institutions may:

- Own or control, directly or indirectly, any insurer which is authorized or approved by the OIR, which insurer transacts only reinsurance and which actively engages in reinsuring risks located in Florida.
- Participate, directly or indirectly, as an underwriting member or as an investor in an underwriting member of any insurance exchange authorized in accordance with s. 629.401, F.S., which underwriting member transacts only aggregate or specific excess insurance over underlying self-insurance coverage for self-insurance organizations authorized under the Florida Insurance Code, for multiple-employer welfare arrangements, or for workers' compensation self-insurance trusts, in addition to any reinsurance the underwriting member may transact.[22]

Reinsurance

Reinsurance is basically insurance for insurers. Insurers rely on reinsurance to finance the payment of losses and make them better able to withstand major catastrophes, like hurricanes.[23] Reinsurance is a major driver in the cost of insurance. As much as 40% of the premium a consumer pays goes to purchase reinsurance.[24] The OIR directly regulates authorized reinsurers domiciled and licensed in Florida as well as reinsurers licensed in Florida but domiciled in a foreign state.[25]

When an insurer cedes business to an accredited reinsurer, the insurer is permitted under statutory accounting rules to recognize a reduction in its liabilities for the amount of ceded liabilities, without a regulatory requirement for the reinsurer to post collateral to secure the reinsurer's ultimate payment of the reinsured liabilities.[26] An accredited reinsurer is one that:

- Files with the OIR evidence of its submission to the jurisdiction of Florida;
- Submits to Florida's authority to examine its books and records;
- Is licensed or authorized to transact insurance or reinsurance in at least one state or, in the case of a United States branch of an alien assuming insurer, is entered through, licensed, or authorized to transact insurance or reinsurance in at least one state;
- Files annually with the OIR a copy of its annual statement filed with the insurance department of its state of domicile and any quarterly statements if required by its state of domicile or such quarterly statements if requested by the OIR, and a copy of its most recent audited financial statement; and

[20] Section 624.4085(2)(e), F.S.
[21] *Id.*
[22] Section 624.45, F.S.
[23] https://floir.com/property-casualty/market-overview (last visited March 13, 2025).
[24] *Id.*
[25] Section 624.610(3)(a) and (b), F.S.
[26] *Id.*

- Maintains a surplus as regards policyholders in an amount not less than $20 million and whose accreditation has not been denied by the OIR within 90 days after its submission; or
- Maintains a surplus as regards policyholders in an amount not less than $20 million and whose accreditation has been approved by the OIR.

A reinsurer must pay the actual costs and expenses incurred by the OIR to review a reinsurer's request for accreditation and subsequent reviews.[27] If the reinsurer fails to pay the actual costs and expenses promptly when due, the OIR may refuse to accredit the reinsurer or may revoke the reinsurer's accreditation.[28]

Privacy of Consumer Information

The DFS and the Financial Services Commission (Commission) are charged with adopting rules to govern the use of a consumer's nonpublic personal financial and health information.[29] These rules must permit the use and disclosure of nonpublic personal health information for scientific, medical, or public policy research and must be consistent with, and not more restrictive than, the standards contained in Title V of the Gramm-Leach-Bliley Act of 1999, Pub. L. No. 106-102, as amended in Title LXXV of the Fixing America's Surface Transportation (FAST) Act, Pub. L. No. 114-94.[30]

Regulation of Insurance Rates

Part I of ch. 627, F.S., the Rating Law,[31] governs property, casualty, and surety insurance covering the subjects of insurance resident, located, or to be performed in this state.[32] The rating law provides that the rates for all classes of insurance it governs may not be excessive, inadequate, or unfairly discriminatory.[33] Though the terms "rate" and "premium" are often used interchangeably, the rating law specifies that "rate" is the unit charge that is multiplied by the measure of exposure or amount of insurance specified in the policy to determine the premium, which is the consideration paid by the consumer.[34]

All insurers or rating organizations must file rates with the OIR either 90 days before the proposed effective date of a new rate, which is considered a "file and use" rate filing, or 30 days after the effective date of a new rate, which is considered a "use and file" rate filing.[35]

Upon receiving a rate filing, the OIR reviews the filing to determine if the rate is excessive, inadequate, or unfairly discriminatory. The OIR makes that determination in accordance with generally acceptable actuarial techniques and considers the following:

- Past and prospective loss experience;

[27] Section 624.610(3)(b)4., F.S.
[28] *Id.*
[29] Section 626.9651, F.S.
[30] *Id.*
[31] Section 627.011, F.S.
[32] Section 627.021(1), F.S.
[33] Section 627.062(1), F.S.
[34] Section 627.041, F.S.
[35] Section 627.062, F.S.

- Past and prospective expenses;
- The degree of competition among insurers for the risk insured;
- Investment income reasonably expected by the insurer;
- The reasonableness of the judgment reflected in the rate filing;
- Dividends, savings, or unabsorbed premium deposits returned to policyholders;
- The adequacy of loss reserves;
- The cost of reinsurance;
- Trend factors, including trends in actual losses per insured unit for the insurer;
- Conflagration and catastrophe hazards;
- Projected hurricane losses;
- Projected flood losses, if the policy covers the risk of flood;
- The cost of medical services, if applicable;
- A reasonable margin for underwriting profit and contingencies; and
- Other relevant factors that affect the frequency or severity of claims or expenses.[36]

All insurers or rating organizations writing any line of property or casualty insurance to which this part applies must make an annual base rate filing for each such line with the OIR no later than 12 months after its previous base rate filing, demonstrating that its rates are not inadequate.[37] The annual base rate filing requirement may be satisfied, if no rate change is proposed, by filing a certification by an actuary that the existing rate level produces rates which are actuarially sound and which are not inadequate, as defined in s. 627.062, F.S.[38]

Insurer Reporting of Property Insurance Data

All insurers with a Florida COA to transact insurance business must file quarterly and annual reports with the OIR containing various financial data, including audited financial statements, actuarial opinions, and certain claims dates.[39] Each year, insurers must file an annual statement covering the preceding calendar year on or before March 1. Quarterly statements covering each period ending on March 31, June 30, and September 30 must be filed within 45 days after each such date.[40]

Under s. 627.0621, F.S., with respect to any residential property insurance rate filings, the OIR must provide the following information on an internet website:

- The overall rate change requested by the insurer;
- All assumptions made by an OIR actuary;

[36] Section 627.062(2)(b), F.S.
[37] Section 627.0645(1), F.S.
[38] Rates shall be deemed inadequate if they are clearly insufficient, together with the investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply. Section 627.062(2)(e)3., F.S. A rate shall be deemed inadequate as to the premium charged to a risk or group of risks if discounts or credits are allowed which exceed a reasonable reflection of expense savings and reasonably expected loss experience from the risk or group of risks. Section 627.062(2)(3)5., F.S.
[39] Section 624.424, F.S.
[40] Section 624.424(1)(a), F.S., except for workers' compensation and employer's liability insurance; insurance limited to coverage of commercial risks other than commercial residential multiperil and medical malpractice insurance; and certain travel insurance.

- A statement describing any assumptions that deviate from actuarial standards of the Casualty Actuarial Society or American Academy of Actuaries;
- All recommendations made by any OIR actuary who reviewed the rate filing;
- A certification by the OIR's actuary that based on the actuary's knowledge, that his or her recommendations are consistent with accepted actuarial principles; and
- The overall rate change approved by the OIR.

Duties of Insurers and Agents

Suitability in Annuity Transactions

The purpose of s. 627.4554, F.S., is to set out requirements for which insurers must comply when making recommendations to consumers regarding annuity products, and to establish a system for supervising such recommendations to ensure consumers' insurance needs and financial objectives are met at the time of the transaction.[41] Before the recommendation or sale of an annuity, the agent must prominently disclose certain information to the consumer on a form substantially similar to that posted on the OIR's website as Appendix A, relating to an insurance agent disclosure for annuities.[42]

Small Employer Health Reinsurance Program

The Employee Health Care Access Act (Act)[43] requires insurers in the small group market to guarantee the issuance of coverage to any small employer with 1-50 employees, including sole proprietors and self-employed individuals, regardless of their health condition. The Act requires small group carriers to offer the standard health benefit plan and the basic health benefit plan to each small employer applying for coverage, as well as certain benefits that must be included in each of these policies.[44] These plans do not comply with the federal Patient Protection and Affordable Care Act (PPACA)[45] essential health benefit requirements; therefore, insurers discontinued offering these policies for sale after January 1, 2014.

The Small Employer Health Reinsurance Program (Program) is a nonprofit entity created in 1992[46] to facilitate the provision of optional reinsurance coverage to small employer carriers.[47] The Program now operates as the Florida Health Insurance Advisory Board (Board).[48] The Board is required to establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals.[49] The basic reinsurance premium rates must be established by the Board, subject to the approval of the OIR.[50]

[41] Section 627.4554(1), F.S.
[42] Section 627.4554(5)(a)2.a., F.S.
[43] Section 627.6699, F.S.
[44] Section 627.6699(5), F.S.
[45] On March 23, 2010, President Obama signed into law Public Law No. 111-148, the Patient Protection and Affordable Care Act (PPACA), and on March 30, 2010, President Obama signed into law Public Law No. 111-152, the Health Care and Education Affordability Reconciliation Act of 2010, amending PPACA.
[46] Section 117, ch. 92-33, L.O.F.
[47] Section 627.6699(11), F.S.
[48] https://floir.com/life-health/florida-health-insurance-advisory-board (last visited March 13, 2025).
[49] Section 627.6699(6)(b)1., F.S.
[50] Section 627.6699(11)(h)1., F.S.

The OIR reports that:

- By the early 2000s, the Program was no longer being used by insurers for its original purpose.
- The Board is required to meet three times per year, hear reports and provide comments on health insurance market issues and issue an annual report by September 1 of each year discussing the state of the health insurance market and any legislative recommendations.
- OIR staff manage the meetings and chair the Board.
- Annually, the Board collects assessments from insurers. As the reinsurance program is not operational, these assessments go to fund the audit of the existing Board bank account, the payment of an Executive Director to facilitate the plan of operation, and other small administrative items.
- The Board's proposed budget for fiscal year 2024-2025 is $67,540. The majority ($60,000) is allocated for contracted services, including the audit.
- Since 2005, no legislative recommendation provided by the Board has been adopted by the Legislature.[51]

Residential Property Insurance Mitigation Credits, Discounts, or Other Rate Differentials

Residential property insurance rate filings must account for mitigation measures undertaken by policyholders to reduce hurricane losses.[52] Specifically, the rate filings must include actuarially reasonable discounts, credits, or other rate differentials or appropriate reductions in deductibles to consumers who implement windstorm damage mitigation techniques to their properties.[53] Upon their filing by an insurer or rating organization, the OIR determines the discounts, credits, other rate differentials and appropriate reductions in deductibles that reflect the full actuarial value of such revaluation,[54] which in turn may be used in rate filings under the rating law. Windstorm mitigation measures that must be evaluated for purposes of mitigation discounts include fixtures or construction techniques that enhance roof strength, roof covering performance, roof-to-wall strength, wall-to-floor-to-foundation strength, opening protection, and window, door, and skylight strength.[55]

An insurer is required to notify an applicant or policyholder of any personal lines residential property insurance policy, at the time of the issuance of the policy and at each renewal, of the availability of each premium discount, credit, other rate differential for properties on which fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm can be or have been installed or implemented.[56] The Commission is required to develop a uniform mitigation verification inspection form to be used by all insurers when submitted by policyholders for the purpose of factoring discounts for wind insurance.[57]

[51] Email from Seth Stubbs, Deputy Director of Legislative and Cabinet Affairs, Office of Insurance Regulation, March 12, 2025 (on file with the Senate Committee on Banking and Insurance).
[52] Section 627.062(2)(j), F.S.
[53] Section 627.0629(1), F.S.
[54] *Id.*
[55] *Id.*
[56] Section 627.711(1), F.S.
[57] Section 627.711(2)(a), F.S.

Assignment Agreements

An assignment is the voluntary transfer of the rights of one party under a contract to another party; the transfer by a party to another party of some valuable interest.[58] In 2022,[59] the Legislature prohibited the assignment, in whole or in part, of any post-loss insurance benefit under any residential property insurance policy or under any commercial property insurance policy issued on or after January 1, 2023.[60]

Insurer Experience Reporting

Each insurer transacting insurance business in Florida must report certain information annually to the OIR.[61] The information for an insurer transacting private passenger automobile insurance must be on direct insurance writings in Florida alone, represent total limits data, and be divided into the following categories: bodily injury liability; property damage liability; uninsured motorist; personal injury protection benefits; medical payments; comprehensive and collision.[62] The information for an insurer transacting fire, homeowner's multiple peril, commercial multiple peril, medical malpractice, products liability, workers' compensation, private passenger automobile liability, commercial automobile liability, private passenger automobile physical damage, commercial automobile physical damage, officers' and directors' liability insurance, or other liability insurance must be reported for direct Florida business only and be reported on a calendar-year basis annually by April 1 for the preceding calendar year.[63] The OIR must provide a summary of this information in its annual report.[64]

Insurer Organization and Procedure

Chapter 628, F.S., provides certain requirements for stock and mutual insurers, assessable mutual insurers, mutual insurance holding companies, insurance holding companies, and captive insurers. Among these are requirements related to incorporation, filing and approval of articles of incorporation, amendments to articles of incorporation, acquisition of controlling stock, merger, and consolidation. Several provisions require documents to be filed in triplicate and some require the original documents to be submitted.[65]

Reciprocal Insurers

A reciprocal insurance exchange is a form of insurance organization in which individuals and businesses exchange insurance contracts and spread the risks associated with those contracts among themselves.[66] Policyholders of a reciprocal insurance exchange are referred to as

[58] Black's Law Dictionary, 2nd Ed., https://thelawdictionary.org/assignment/ (last visited March 13, 2025).
[59] Section 21, ch. 2022-271, L.O.F.
[60] Section 627.7152(13), F.S.
[61] Section 627.915, F.S.
[62] Section 627.915(1), F.S.
[63] Section 627.915(2), F.S.
[64] Section 627.915(4), F.S.
[65] *See* ss. 628.081, 628.091, 628.111, 628.717, and 628.910, F.S.
[66] *What Is a Reciprocal Insurance Exchange?* Investopedia https://www.investopedia.com/terms/r/reciprocal-insurance-exchange.asp (last visited March 13, 2025).

subscribers.[67] In Florida, reciprocal insurers are regulated pursuant to ch. 629, F.S. A reciprocal insurer is "an unincorporated aggregation of subscribers operating individually and collectively through an attorney in fact to provide reciprocal insurance among themselves."[68] Reciprocal insurance is that resulting from "an interexchange among persons, known as subscribers, of reciprocal agreements of indemnity, the interexchange being effectuated through an attorney in fact common to all such persons.[69]

A reciprocal insurer may transact any kind of insurance other than life insurance or title insurance.[70] A domestic reciprocal insurer must maintain surplus funds of not less than $250,000 and must, when first authorized, have an expendable surplus of not less than $750,000.[71] A domestic reciprocal insurer may organize with twenty-five or more persons domiciled in Florida making application to the OIR for a permit, with such application must include:

- The name of the proposed reciprocal insurer, in accordance with s. 629.051, F.S.;
- The location of the insurer's principal office, which shall be the same as that of the proposed attorney in fact and which shall be maintained in Florida;
- The kinds of insurance proposed to be transacted;
- The names and addresses of the original 25 or more subscribers;
- The proposed designation and appointment of the proposed attorney in fact and a copy of the proposed power of attorney;
- The names and addresses of the officers and directors of the proposed attorney in fact, if a corporation, or of its members, if other than a corporation;
- The background information as specified in s. 629.227, F.S., for all officers, directors and in equivalent positions of the proposed attorney in fact, as well as, for any person with an ownership interest of 10 percent or more in the proposed attorney in fact;
- The articles of incorporation and bylaws, or equivalent documents, of the proposed attorney in fact, dated within the last year and appropriately certified;
- The proposed charter powers of the subscribers' advisory committee, and the names and terms of office of the members thereof as well as the background information as specified in s. 629.227, F.S., for each proposed member;
- A copy of the proposed subscribers' agreement;
- A copy of each policy, endorsement, and application form the insurer proposes to issue or use; and
- Any other pertinent information and documents as reasonably requested by the OIR.[72]

A domestic reciprocal insurer may seek a COA only after obtaining a permit.[73] Such application must include:

- Executed copies of any proposed or draft documents required as part of the permit application;

[67] *Id.*
[68] Section 629.011(5), F.S.
[69] Section 629.011(4), F.S.
[70] Section 629.041, F.S.
[71] Section 629.071, F.S.
[72] Section 629.081, F.S.
[73] Section 629.091(1), F.S.

- A statement affirming that all moneys paid to the reciprocal insurer must, after deducting any sum payable to the attorney in fact, be held in the name of the insurer and for the purposes specified in the subscribers' agreement;
- A statement that each of the original subscribers has in good faith applied for insurance of a kind proposed to be transacted, and that the insurer has received from each such subscriber the full premium or premium deposit required for the policy applied for, for a term of not less than six months at the rate that was filed with and approved by the OIR;
- A copy of the required bond;
- A statement of the financial condition of the insurer, a schedule of its assets, and a statement that the required surplus is on hand; and
- Such other pertinent information or documents as reasonably requested by the OIR.[74]

Rights and Powers of the Attorney in Fact

The rights and powers of the attorney in fact of a reciprocal insurer are as provided in the power of attorney given to it by the subscribers.[75] The power of attorney must set forth:

- The powers of the attorney in fact;
- That the attorney in fact is empowered to accept service of process on behalf of the insurer in actions against the insurer upon contracts exchanged;
- The place where the office of the attorney in fact is maintained;
- The general services to be performed by the attorney in fact;
- That the attorney in fact has a fiduciary duty to the subscribers of the reciprocal insurer;
- The maximum amount to be deducted from advance premiums or deposits to be paid to the attorney in fact and the general items of expense in addition to losses to be paid by the insurer; and
- Except as to nonassessable policies, a provision for a contingent several liability of each subscriber in a specified amount, which amount shall be not less than five times nor more than 10 times the premium or premium deposit stated in the policy.[76]

The terms of any power of attorney or agreement collateral thereto must be reasonable and equitable, and such power or agreement may not be used or be effective in Florida unless filed with the OIR.[77]

Attorney's Bond

The attorney of a domestic reciprocal insurer is required to file with the OIR a bond in favor of the state for the benefit of all persons damaged as a result of breach by the attorney of the conditions of his or her bond.[78] The bond must be in the sum of $100,000, aggregate in form, and conditioned that the attorney will faithfully account for all moneys and other property of the insurer coming into his or her hands, and that he or she will not withdraw or appropriate to his or

[74] Section 629.091(2), F.S.
[75] Section 629.101(1), F.S.
[76] Section 629.101(2), F.S.
[77] Section 629.101(5), F.S.
[78] Section 629.121(1), F.S.

her own use from the funds of the insurer any moneys or property to which he or she is not entitled under the power of attorney.[79]

Annual Statement

The attorney for each reciprocal insurer must file an annual statement with the OIR.[80] The statement must include such information as may be required by the OIR relative to the affairs and transactions of the attorney insofar as they relate to the reciprocal insurer.[81]

Subscribers' Advisory Committee

Each domestic reciprocal insurer must have a subscribers' advisory committee. The advisory committee exercising the subscribers' rights must be selected under such rules as the subscribers adopt.[82] Not less than two-thirds of such committee must be subscribers other than the attorney, or any person employed by, representing, or having a financial interest in the attorney.[83] The committee must:

- Supervise the finances of the insurer;
- Supervise the insurer's operations to assure conformity with the subscribers' agreement and power of attorney;
- Procure the audit of the accounts and records of the insurer and of the attorney at the expense of the insurer; and
- Have such additional powers and functions as may be conferred by the subscribers' agreement.[84]

Financial Condition

In determining the financial condition of a reciprocal insurer, the OIR must apply the following rules:

- The surplus deposits of subscribers must be allowed as assets, except that any premium deposits delinquent for 90 days must first be charged against such surplus deposit;
- An assessment levied upon subscribers, but not collected, may not be allowed as an asset; and
- The contingent liability of subscribers may not be allowed as an asset.[85]

Impaired Reciprocal Insurers

If the assets of a domestic reciprocal insurer are at any time insufficient to discharge its liabilities and to maintain the required surplus, its attorney must immediately make up the deficiency or levy an assessment upon the subscribers for the amount needed to make up the deficiency.[86] If the attorney fails to make up such deficiency or to make the assessment within 30 days after the OIR orders him or her to do so, or if the deficiency is not fully made up within 60 days after the

[79] Section 629.121(2), F.S.
[80] Section 629.171(1), F.S.
[81] Section 629.171(2), F.S.
[82] Section 629.201(1), F.S.
[83] Section 629.201(2), F.S.
[84] Section 629.201(3), F.S.
[85] Section 629.181, F.S.
[86] Section 629.301(1), F.S.

date the assessment was made, the insurer is deemed insolvent and must be proceeded against as authorized by the Insurance Code.[87] If liquidation of such an insurer is ordered, an assessment must be levied upon the subscribers for such an amount, subject to limits as provided by law, as determined to be necessary by the OIR to discharge all liabilities of the insurer, exclusive of any funds contributed by the attorney or other persons, but including the reasonable cost of the liquidation.[88]

Insurance Exchange

Section 629.401, F.S. authorizes the creation of one or more insurance exchanges, with one or more offices each, subject to such rules as are adopted by the Financial Service Commission.[89] The purposes of the exchange are:

- To provide a facility for the underwriting of reinsurance, direct insurance of all kinds on risks located entirely outside the United States, surplus lines insurance for risks located in this state eligible for export through a licensed Florida surplus lines agent, and surplus lines insurance in any other state subject to the applicable surplus lines laws of such other state for risks located entirely outside of this state.
- To manage the facility in accordance with rules adopted by the Commission.
- In no event may the exchange be considered to be an underwriter or broker with respect to any contract of insurance or reinsurance written by a member of the exchange, and the exchange may not incur any liability therefor.

Authority of a Limited Reciprocal Insurer

The authority of any limited reciprocal insurer to accept new business or renewals ended October 1, 1992; however, such limited reciprocal insurer was allowed to continue to service its obligations previously incurred.[90] All power of the OIR with respect to limited reciprocal insurers continues undiminished.[91]

Service Warranty Associations

Chapter 634, F.S., provides for the regulation of warranty associations by the OIR. There are three parts to the chapter; Part I for motor vehicle service agreement companies; Part II for home warranty associations; and Part III for service warranty associations.

A service warranty association is any business other than an authorized insurer that issues service warranties.[92] A service warranty includes, in return for the payment of a segregated charge by the consumer, any warranty, guaranty, or maintenance service contract equal to or greater than one year in length; an agreement for a specific duration to perform the repair, replacement, or maintenance of a consumer product; for indemnification for repair, replacement, or maintenance, for failure due to a defect in materials or workmanship, normal wear and tear, power surge, or

[87] Section 629.301(2), F.S.
[88] Section 629.301(3), F.S.
[89] Section 629.401(1), F.S.
[90] Section 629.520, F.S.
[91] *Id.*
[92] Section 634.401(14), F.S.

accidental damage from handling.[93] The regulation of the association and the warranties is administered by the OIR; the regulation of the sales representatives is by the DFS.[94]

A service warranty association must maintain a funded, unearned premium reserve account, consisting of unencumbered assets, equal to a minimum of 25 percent of the gross written premiums received from all warranty contracts in force in Florida.[95] A service warranty association utilizing an unearned premium reserve account must deposit with the DFS a reserve deposit equal to 10 percent of the gross written premium received on all warranty contracts in force in this state.[96]

A service warranty association is not required to establish an unearned premium reserve account if it has purchased contractual liability insurance that covers 100 percent of its claim exposure. Such liability policy must contain the following provisions:

- In the event that the service warranty association does not fulfill its obligation under contracts issued in this state, the liability insurer will pay losses and unearned premium refunds directly to the person making a claim under the contract.
- The liability insurer must assume full responsibility for the administration of claims in the event of the inability of the association to do so.
- The policy may not be canceled or not renewed unless 60 days' written notice has been given to the OIR before the date of such cancellation or nonrenewal.
- The policy must ensure all service warranty contracts which were issued while the policy was in effect whether or not the premium has been remitted to the insurer.
- If the warranty holder cancels the service warranty, it is the responsibility of the liability insurer issuer to effectuate a full refund of unearned premium.
- A service warranty association may not utilize both the unearned premium reserve and contractual liability insurance simultaneously. However, an association shall be allowed to have contractual liability coverage on service warranties previously sold and sell new service warranties covered by the unearned premium reserve, and the converse of this shall also be allowed.[97]

A service warranty association holding no other warranty association license is not required to establish an unearned premium reserve account or maintain contractual liability insurance and may allow its premiums to exceed the ratio to net assets limitations if the association complies with the following:

- The association or its parent corporation maintains a minimum net worth of at least $100 million and provides the OIR the following:
    - A copy of the association's annual audited financial statements or the audited consolidated financial statements of the association's parent corporation, prepared by an independent certified public accountant in accordance with generally accepted accounting principles, which clearly demonstrate the net worth of the association or its parent

[93] Section 634.401(13), F.S.
[94] Section 634.402, F.S.
[95] Section 634.406(1), F.S.
[96] Section 634.406(2), F.S.
[97] Section 634.406(3), F.S.

corporation to be $100 million and a quarterly written certification to the OIR that such entity continues to maintain the required net worth; and
    - The association's, or its parent corporation's, Form 10-K, Form 10-Q, or Form 20-F as filed with the United States Securities and Exchange Commission or such other documents required to be filed with a recognized stock exchange, which shall be provided on a quarterly and annual basis within 10 days after the last date each such report must be filed with the Securities and Exchange Commission, the National Association of Security Dealers Automated Quotation system, or other recognized stock exchange.[98]
- If the net worth of a parent corporation is used to satisfy the net worth requirements, the following provisions must be met:
    - The parent corporation must guarantee all service warranty obligations of the association, wherever written; and
    - The association must maintain net assets of at least $750,000.[99]

Health Maintenance Organizations

The OIR regulates health maintenance organization (HMO) finances, contracting, and marketing activities under part I of ch. 641, F.S., while the Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a COA from the OIR, an HMO must receive a Health Care Provider Certificate from the AHCA.[100] Any entity that is issued a Health Care Provider Certificate and that is otherwise in compliance with all other licensure provisions, may enter into contracts in Florida to provide an agreed-upon set of comprehensive health care services to subscribers in exchange for a prepaid per capita sum or prepaid aggregate fixed sum.[101]

Each HMO must file annually within three months after the end of its fiscal year a report with the OIR showing its condition on the last day of the immediately preceding reporting period. The report must include:
- A financial statement of the HMO filed by electronic means in a computer-readable form using a format acceptable to the OIR.
- A financial statement of the HMO filed on forms acceptable to the OIR.
- An audited financial statement of the HMO, including its balance sheet and a statement of operations for the preceding year certified by an independent certified public accountant, prepared in accordance with statutory accounting principles.
- The number of health maintenance contracts issued and outstanding and the number of health maintenance contracts terminated.
- The number and amount of damage claims for medical injury initiated against the HMO and any of the providers engaged by it during the reporting year, broken down into claims with and without formal legal process, and the disposition, if any, of each such claim.
- An actuarial certification that:

[98] Section 634.406(7)(a), F.S.
[99] Section 634.406(7)(b), F.S.
[100] Section 641.21(1), F.S.
[101] Section 641.31(1), F.S.

  - The HMO is actuarially sound, which certification considers the rates, benefits, and expenses of, and any other funds available for payment of obligation of the organization;
  - The rates being charged or to be charged are actuarially adequate to the end of the period for which rates have been guaranteed;
  - Incurred but not reported claims and claims reported but not fully paid have been adequately provided for; and
  - The HMO has adequately provided for all obligations required by s. 641.35(3)(a), F.S.
- A report prepared by the certified public accountant and filed with the OIR describing material weaknesses in the HMO's internal control structure as noted by the certified public accountant during the audit. The HMO must provide a description of remedial actions taken or proposed to correct material weaknesses, if the actions are not described in the independent certified public accountant's report.
- Such other information relating to the performance of HMOs as is required by the Commission or the OIR.[102]

Every HMO must file quarterly, for the first three calendar quarters of each year, an unaudited financial statement of the organization as described in paragraphs (1)(a) and (b). The statement for the quarter ending March 31 must be filed on or before May 15, the statement for the quarter ending June 30 must be filed on or before August 15, and the statement for the quarter ending September 30 must be filed on or before November 15. The quarterly report must be verified by the oath of two officers of the organization, properly notarized.[103]

The Commission may adopt the form for financial statements of a HMO, including supplements as approved by the National Association of Insurance Commissioners in 1995, and may adopt subsequent amendments to the form if the methodology remains substantially consistent, and may require each HMO submit all or part of the information contained in the annual statement in a computer-readable form compatible with the electronic data processing system specified by the OIR.[104]

Continuing Care Retirement Communities

A provider[105] or a continuing care retirement community (CCRC) offers shelter and nursing care or personal services upon the payment of an entrance fee.[106] The CCRCs offer a transitional approach to the aging process, accommodating residents' changing level of care. A CCRC can include an independent living apartment or a house, as well as an assisted living facility or a nursing home. The CCRCs may also offer at-home programs that provide residents CCRC services while continuing to live in their own homes until they are ready to move to the CCRC.[107] A CCRC enters into contracts with seniors (residents) to provide housing and medical care in exchange for an entrance fee and monthly fees. Entrance fees are a significant

[102] Section 641.26(1), F.S.
[103] Section 641.26(3), F.S.
[104] Section 641.26(6), F.S.
[105] Section 651.011(24), F.S., defines a provider as an owner or operator that provides continuing care.
[106] Section 651.011(14), F.S.
[107] Sections 651.057 and 651.118, F.S.

commitment by the resident as entrance fees range from around $100,000 to over one million dollars.[108]

In Florida, regulatory oversight responsibility of CCRCs is shared between the Agency for Health Care Administration (AHCA) and the OIR.[109] The AHCA regulates aspects of CCRCs related to the provision of health care, such as nursing facilities, assisted living facilities, home health agencies, quality of care, and medical facilities. There are currently 98 licensed continuing care retirement communities in Florida.[110] The OIR has primary responsibility to license, regulate, and monitor the operation of CCRCs and to determine facilities' financial condition and the management capabilities of their managers and owners.[111]

Certificate of Authority

In order to operate a CCRC in Florida, a provider must obtain from the OIR a COA predicated upon first receiving a provisional COA.[112] A provisional COA is issued once a provider meets the requirements prescribed in s. 651.023, F.S. The application process for a provisional COA and a COA involves submitting audited financial reports, feasibility studies, copies of contracts, and other information.[113] Further, the applicant must provide evidence that the applicant is reputable and of responsible character.[114]

The issuance of a provisional COA allows the applicant to collect entrance fees and reservation deposits from prospective residents.[115] A minimum of 75 percent of entrance fees and reservation deposits must be placed in an escrow account or on deposit with the DFS.[116] The required feasibility study must show projections for the first five years of operations.[117]

A COA may not be issued until documentation evidencing the project has a minimum of 50 percent of the units reserved for which the provider is charging an entrance fee is provided to the OIR.[118] In order for a unit to be considered reserved, the provider must collect a minimum deposit of the lesser of $40,000 or 10 percent of the entrance fee.[119]

Acquisition

A person who seeks to assume the role of general partner of a provider or to otherwise assume ownership or possession of, or control over, 10 percent or more of a provider, a controlling company of the provider, or a provider's assets is subject to s. 628.4615, F.S., and is not required

[108] Office of Insurance Regulation, *Senate Bill 622 Agency Legislative Analysis* (Feb. 15, 2023) (on file with Senate Committee on Banking and Insurance).
[109] Chapter 651, F.S., and s. 20.121, F.S.
[110] Office of Insurance Regulation, *Company Directory: Search Results* https://companysearch.myfloridacfo.gov/ *(*last visited March 13, 2025).
[111] *See* ss. 651.021, 651.22, and 651.023, F.S.
[112] Section 651.022, F.S.
[113] See ss. 651.021-651.023, F.S.
[114] Section 651.022(2)(c), F.S.
[115] Section 651.022(7), F.S.
[116] Section 651.023(5), F.S.
[117] Sections 651.022(3) and 651.023(1)(b)2., F.S.
[118] Section 651.023(4)(a), F.S.
[119] Section 651.023(4)(b), F.S.

to make filings pursuant to ss. 651.022, 651.023, or 651.0245, F.S.[120] Section 628.4615, F.S., provides that such person must:

- File with the OIR and send to the principal office of the provider a letter of notification regarding the transaction or proposed transaction no later than five days after any form of tender offer or exchange offer is proposed, or no later than five days after the acquisition of the securities or ownership interest if no tender offer or exchange offer is involved;
- File with the OIR an application signed under oath that contains any required information within 30 days after any form of tender offer or exchange offer is proposed, or after the acquisition of the securities if no tender offer or exchange offer is involved; and
- Receive approval from the OIR for the tender offer or exchange offer, or acquisition if no tender offer or exchange offer is involved.

Expansion

Section 651.0246, F.S., specifies the application process and information required to obtain approval from the OIR for expansion. If the provider has exceeded the current statewide median for days cash on hand, debt service coverage ratio, and total facility occupancy for the most recent two consecutive annual reporting periods, automatic approval is granted for expansions up to 35 percent of the existing units upon submitting a letter to the OIR indicating the total number of planned units in the expansion, the proposed sources and uses of funds, and an attestation that the provider understands and pledges to comply with all minimum liquid reserve and escrow account requirements.[121]

A feasibility study, prepared by an independent certified public accountant, is required to be submitted as part of an expansion application.[122] The study must include an independent evaluation and examination opinion for the first five years of operations of the underlying assumptions used as a basis for the forecasts or projections in the study and that the assumptions are reasonable and proper and the project as proposed is feasible.[123] A minimum of 75 percent of the moneys paid for all or any part of an initial entrance fee or reservation deposit collected for units in the expansion and 50 percent of the moneys paid for all or any part of an initial fee collected for continuing care at-home contracts in the expansion must be placed in an escrow account or on deposit with the DFS.[124]

Within 30 days after receipt of an application for expansion, the OIR must request from the applicant any additional information required.[125] Within 15 days after the OIR receives all the requested additional information, the OIR must notify the applicant that the is deemed complete.[126] Failure to notify the applicant in writing within the 15-day period constitutes acknowledgment by the OIR that it has received all requested information and the application is deemed complete.[127]

[120] Section 651.024(1), F.S.
[121] Section 651.0246(1)(a), F.S.
[122] Section 651.0246(2)(a), F.S.
[123] Section 651.0246(2)(a)12., F.S.
[124] Section 651.0246(3), F.S.
[125] Section 651.0246(5)(a), F.S.
[126] *Id.*
[127] *Id.*

Financial Reporting

Section 651.026, F.S., requires the provider to annually submit the management's calculation of the provider's debt service coverage ratio, occupancy, and days cash on hand. The OIR is required to publish, on its website by August 1 of each year, an industry report for the preceding calendar year that contains, for all providers, the median days cash on hand, median debt service coverage ratio, and median occupancy rate by setting, including independent living, assisted living, skilled nursing, and the entire facility.[128]

Each provider must submit a quarterly unaudited financial statement of the provider or of the facility, days cash on hand, occupancy, debt service coverage ratio, and a detailed listing of the assets maintained in the liquid reserves within 45 days after the end of each fiscal quarter.[129] If a CCRC falls below the thresholds set for two or more of the key indicators (days cash on hand, debt service coverage ratio, or occupancy) at the time of the quarterly report, the CCRC must submit to the OIR an explanation of the circumstances and a description of the actions the CCRC will take to meet the requirements.[130]

The OIR may require monthly reporting of certain information if it finds such information is needed to properly monitor the financial condition of a provider or facility.[131] The section also specifies certain circumstances under which monthly filings may be required, such as a provider being subject to delinquency, receivership, or bankruptcy proceedings.[132]

Escrow Requirements

Section 651.033, F.S., contains requirements for a provider's escrow account and the duties that apply to escrow agents. In the event of an emergency, the OIR may allow a withdrawal of up to 10 percent of the required minimum liquid reserve.[133] When funds are required to be deposited in an escrow account, the following apply:

- The escrow agreement must require that the escrow agent furnish the provider with a quarterly statement indicating the amount of any disbursements or deposits and the condition of the account during the period covered by the statement.
- If the escrow agent does not provide the quarterly statement to the provider on or before the 10th day of the month following the quarter for which the statement is due, the provider must, on or before the 15th day of the month following the quarter for which the statement is due, send a written request for the statement to the escrow agent by certified mail return receipt requested.
- On or before the 20th day of the month following the quarter for which the statement is due, the provider must file with the OIR a copy of the escrow agent's statement or, if the provider has not received the escrow agent's statement, a copy of the written request to the escrow agent for the statement.
- The OIR may levy a fine against the provider not to exceed $25 a day for each day the provider fails to comply with these provisions.

[128] Section 651.026(1), F.S.
[129] Section 651.0261(1), F.S.
[130] *Id.*
[131] Section 651.0261(2), F.S.
[132] Section 651.0261(3), F.S.
[133] Section 651.033(2), F.S.

- Funds held on deposit with the DFS are exempt from the reporting requirements.[134]

Financial and Operating Requirements

Section 651.034, F.S., provides a framework of required actions if a provider falls below specified levels of three key indicators at the time of the annual report: occupancy, days cash on hand[135], and the debt service coverage ratio[136]. If the provider's performance falls below the specified levels on two of the three key indicators at the time of the annual report, it is considered a "regulatory action level event."[137]

A provider is considered "impaired" if either of the following has occurred:
- A provider has failed to maintain its required minimum liquid reserve.
- A provider:
  - With mortgage financing from a third-party lender or a public bond issue, the provider's debt service coverage ratio is less than 1.00:1 and the provider's days cash on hand is less than 90; or
  - Without mortgage financing from a third-party lender or public bond issue, the provider's days cash on hand is less than 90.[138]

The OIR must place an impaired provider under regulatory control.[139] An impairment is sufficient grounds for the DFS to be appointed as receiver.[140] The OIR may forego taking action for up to 180 days after the impairment if the OIR finds there is a reasonable expectation that the impairment may be eliminated within the 180-day period.[141]

Reserve Requirements

Each provider is required to maintain in escrow:
- As a debt service reserve the aggregate amount of all principal and interest payments due during the fiscal year on any mortgage loan or other long-term financing of the facility, including property taxes.[142]
- An operating reserve equal to 30 percent of the total operating expenses projected in the feasibility study required by s. 651.023, F.S., for the first 12 months of operation and

[134] Section 651.033(5), F.S.
[135] "Days cash on hand" is an accounting term to account for the number of days an organization can continue to pay operating expenses, given the amount of cash available. Accounting Tools, *What Is Days Cash on Hand?* https://www.accountingtools.com/articles/days-cash-on-hand (last visited March 13, 2025).
[136] Debt service ratio applies to corporate, government and personal finance. In relation to corporate finance, the debt-service coverage ratio (DSCR) is a measurement of the firm's available cash flow to pay current debt obligations. The DSCR shows investors whether a company has enough income to pay its debts. Investopedia, Jason Fernando, *Debt-Service Coverage Ratio (DSCR): How to Use and Calculate It*, https://www.investopedia.com/terms/d/dscr.asp (last visited March 13, 2025).
[137] Section 651.011(26), F.S.
[138] Section 651.011(16), F.S.
[139] Section 651.034(2), F.S.
[140] *Id.*
[141] *Id.*
[142] Section 651.035(1)(a), F.S. If principal payments are not due during the fiscal year, the provider must maintain in escrow an amount equal to interest payments due during the next 12 months on any mortgage loan or other long-term financing of the facility, including property taxes. If a provider does not have a mortgage loan or other financing on the facility, the provider must deposit monthly in escrow an amount equal to one-twelfth of the annual property tax liability and must annually pay property taxes out of such escrow.

thereafter, maintain in escrow an operating reserve equal to 15 percent of the total operating expenses in the annual report.[143]

- A renewal and replacement reserve equal to 15 percent of the total accumulated depreciation based on the audited financial statement, not to exceed 15 percent of the facility's average operating expenses for the past three fiscal years based on the audited financial statements for each of those years.[144]

Each fiscal year and with approval from the OIR, a provider may withdraw up to 33 percent of the total renewal and replacement reserve available to be used for capital items or major repairs.[145] A provider may withdraw funds held in escrow without the approval of the OIR if:

- The amount held in escrow exceeds the requirements of this section and if the withdrawal will not affect compliance with this section; or
- The withdrawal is from a debt service reserve required to be held in escrow pursuant to a trust indenture or mortgage lien on the facility as described in paragraph (1)(b) and will be used to pay principal or interest payments, which may include property taxes and insurance, that the debtor is obligated to pay when sufficient funds are not available on the next principal or interest payment due date.[146]

Contracts as Preferred Claims

In the event of receivership or liquidation proceedings against a provider, all continuing care and continuing care at-home contracts executed by a provider are deemed preferred claims against all assets owned by the provider, except such claims are subordinate to any secured claim.[147] All other claims are to be considered as general creditors' claims.[148]

Requirement of Full Disclosure

Each continuing care facility is required to maintain for five years records all cost and inspection reports pertaining to that facility that have been filed with or issued by any governmental agency.[149] Each facility must also maintain as public information, and make available upon request, all annual statements that have been filed with the OIR.[150] The following disclosures must be made to prospective residents: a notice of the issuance of any examination reports; a notice of the initiation of any legal or administrative proceedings by the OIR or the DFS; notice that, if the resident does not exercise the right to rescind a continuing care contract within seven days after executing the contract, the resident's funds held in escrow will be released to the provider; a statement that distribution of the provider's assets or income may occur or a statement that such distribution will not occur; and a disclosure of any holding company system or obligated group of which the provider is a member.[151]

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[143] Section 651.035(1)(c), F.S.
[144] Section 651.035(1)(d), F.S.
[145] Section 651.035(6), F.S. The replacement reserve available is the market value of the invested reserves at the end of the provider's prior fiscal year.
[146] Section 651.035(7)(a), F.S.
[147] Section 651.071(1), F.S.
[148] Section 651.071(2), F.S.
[149] Section 651.091(1), F.S.
[150] *Id.*
[151] Section 651.091, F.S.

Examinations of Providers

Section 651.105, F.S., requires the OIR to examine at least once every three years any applicant for a COA and any provider engaged in the execution of care contracts or engaged in the performance of obligations under such contracts, for a provider accredited under s. 651.028, F.S., at least once every five years.[152] The OIR must notify the provider of all deficiencies in its compliance, require corrective action or request a corrective action plan from the provider, and set a reasonable length of time for compliance by the provider.[153]

Delinquency Proceedings

If the financial condition of a continuing care provider is impaired or its continued operation would result in insolvency, the OIR may direct the provider to formulate and file with the OIR a corrective action plan.[154] The provider must submit a monthly progress report in a manner prescribed by the OIR.[155] If the OIR finds that sufficient grounds exist for rehabilitation, liquidation, conservation, reorganization, seizure, or summary proceedings, the DFS may petition for court order or may pursue such other relief as is afforded in part I of chapter 631, F.S.[156] In the event an order of conservation, rehabilitation, liquidation, or seizure has been entered against a provider, the DFS and the OIR are vested with all of the powers and duties they have under part I of ch. 631, F.S., in regard to delinquency proceedings of insurance companies.[157]

III. Effect of Proposed Changes:

Service of Process on Insurers

Section 1 amends s. 48.151, F.S., to add HMOs to the list of insurers that the CFO is the agent for service of process.

Section 4 amends s. 624.422, F.S., to provide that the appointment of the CFO as agent for service of process applies to any insurer that withdraws from or ceases operations in this state until the insurer has completed its runoff of, or otherwise extinguished, all liabilities in Florida.

Section 48 creates s. 641.2012, F.S., to provide that the service of process provisions in ss. 624.422 and 624.423, F.S., apply to HMOs.

Emergency Orders

Section 2 amends s. 252.63, F.S., to require the Commissioner to publish in the next available publication of the Florida Administrative Register a notice identifying the date an emergency order was issued. The notice must include a hyperlink or website address providing direct access to the emergency order.

[152] Section 651.105(1), F.S.
[153] Section 651.105(4), F.S.
[154] Section 651.114(4), F.S.
[155] Section 651.114(5), F.S.
[156] Section 651.114(6), F.S.
[157] Section 651.114(8), F.S.

Risk-Based Capital Requirements for Insurers

Section 3 amends s. 624.4085, F.S., to remove an obsolete date and provide that the definition of "life and health insurer" includes all HMOs authorized in Florida, not just those that are also authorized in one or more other states, jurisdictions, or countries.

Insurance Exchange

Section 5 amends s. 624.45, F.S., to remove a cross-reference to an insurance exchange created pursuant to s. 629.401, F.S., as that statute is being repealed in this bill.

Reinsurance

Section 6 amends s. 624.610, F.S., to delete the requirement that a requesting insurer be charged the actual costs and expenses incurred by the OIR to review a reinsurer's request for accreditation and that subsequent reviews be charged to the requesting reinsurer, as well. Instead, the bill provides that the requesting reinsurer must pay a $1,500 filing fee equal to the application fee charged under s. 624.501(1)(a), F.S.

Privacy

Section 7 amends s. 626.9651, F.S., to require the Commission to adopt rules to ensure the cybersecurity of a consumer's nonpublic insurance information. Such rules may not be more restrictive than the National Association of Insurance Commissioners Insurance (NAIC) Data Security Model Law, adopted in October 2017, and must:

- Apply to all entities acting as insurers, transacting insurance, or otherwise engaging in insurance activities in this state, including entities licensed under ch. 641, F.S. (health care service programs), and any entity that has been contracted to maintain, store, or process personal information on behalf of a covered entity.
- Require the development and implementation of an information security program as defined in the model law.
- Require investigation and notification of a cybersecurity event as required under the model law.
- Require insurers to submit all or part of the required information to the DFS or the OIR in a compatible computer-readable format.
- Ensure that the OIR receives a copy of any notice provided to the Department of Legal Affairs under s. 501.171, F.S.

Upon receiving such information, the OIR is required to review the information and may initiate an examination and investigation under ss. 624.316, 624.3161, or 626.8828, F.S.

Regulation of Insurance Rates

Section 8 amends s. 627.062, F.S., to provide that a personal residential property insurer may submit only one "use and file" filing affecting policyholders within a single policy period, unless the filing is exclusively related to reinsurance.

Section 10 amends s. 627.0645, F.S., regarding the requirement for insurers to make a base rate filing at least once every twelve months, which insurers may meet by certifying that the insurer's existing base rate level produces actuarially sound rates that are not inadequate. The bill requires insurers to make a full rate filing after two consecutive years of certifications.

Section 11 amends s. 627.0651, F.S., to provide that a motor vehicle insurer may submit only one "use and file" filing affecting policyholders within a single policy period.

Insurer Reporting of Property Insurance Data

Section 9 amends s. 627.0621, F.S., that beginning on October 1, 2025, every rate filing for residential property coverage from a property insurer must include a rate transparency report. The OIR may accept the rate transparency report, or if it finds that the report fails to provide the required information in concise and plain language that aids consumers in their understanding of insurance or finds the report to be misleading, the OIR must return the report to the property insurer for modification. The report must be included with any offer of coverage and upon policy renewal. The report must include all of the following percentages, which must total 100 percent, categorized by territory and at the cumulative level:

- The percentage of the total rate factor associated with the cost of reinsurance.
- The percentage of the total rate factor associated with the cost of claims.
- The percentage of the total rate factor associated with defense and containment costs.
- The percentage of the total rate factor associated with fees and commissions.
- The percentage of the rate factor associated with profit and contingency of the insurer.
- Any other percentages deemed necessary by the OIR or the Financial Services Commission.

The rate transparency report must also include the following information:

- Any major adverse findings by the OIR for the previous three calendar years.
- Whether the insurer uses affiliated entities to perform functions of the insurer.
- Contact information, including a phone number, hours of service, and e-mail address, for the DFS's Division of Consumer Services.
- Contact information for the OIR.
- The address for the website for public access to rate filing and affiliate information specified in subsection (3).
- Any changes in the total insured value from the last policy period.

The bill revises requirements for the OIR website for public access to rate filing information. The bill provides that the OIR must establish and maintain a comprehensive resource center on the website which uses concise and plain language to aid consumers in their understanding of insurance. The resource center must include substantive information on the current and historical dynamics of the market, available data concerning the financial condition and market conduct of insurance companies, and the insurance coverage choices available to consumers. At a minimum, the resource center must contain the following:

- Reports, using graphical information whenever possible, outlining information about the state of the insurance market and adverse and positive trends affecting it.
- Tools that aid consumers in finding insurers.

- Tools that aid consumers in determining coverages beneficial to them.
- Information about mitigation credits and the My Safe Florida Home program, as well as other credits insurers may offer in addition to wind mitigation.
- Access to the rate transparency reports, annual statements, market conduct information, and other information related to each insurer.
- Information on the Citizens Property Insurance Corporation takeout process, the clearinghouse, and general information as reported by the OIR.
- With respect to any residential property rate filing, the OIR must provide the following information on a publicly accessible Internet website:
  - The overall rate change requested by the insurer.
  - The rate change approved by the OIR along with all of the actuary's assumptions and recommendations forming the basis of the OIR's decision.
  - Certification by the OIR's actuary that, based on the actuary's knowledge, his or her recommendations are consistent with accepted actuarial principles.
  - Whether the insurer uses affiliated entities to perform administrative, claims handling, or other functions of the insurer and, if so, the total percentage of direct written premium paid to the affiliated entities by the insurer in the preceding calendar year.

The bill provides that the statewide average requested rate change and final approved statewide average rate change in a filing is not a trade secret as defined in s. 688.002(4), F.S., or s. 812.081, F.S., and is not subject to the public records exemption for trade secrets provided in s. 119.0715, F.S., or s. 624.4213, F.S.

The bill provides that the county rating examples submitted to the OIR through the rate collection system for the purpose of displaying rates on its website is not a trade secret as defined in s. 688.002(4), F.S., or s. 812.081, F.S., and is not subject to the public records exemption for trade secrets provided in s. 119.0715, F.S., or s. 624.4213, F.S.

Duties of Insurers and Agents

Suitability in Annuity Transactions

Section 12 amends s. 627.4554, F.S., to provide that an agent, before the recommendation or sale of an annuity, must prominently disclose to the consumer, on a form substantially similar to that posted on the DFS website, instead of the OIR website, as Appendix A, related to an insurance agent disclosure for annuities.

Outline of Coverage

Section 13 amends s. 627.642, F.S., to correct a cross-reference to s. 627.6699, F.S., necessitated due to changes made in this bill.

Small Employer Health Reinsurance Program

Section 14 amends s. 627.6475, F.S., to revise the Individual Reinsurance Pool definition of "board" due to the repeal by this bill of the Small Employer Health Reinsurance Program, remove reference to the repealed program, and conform cross-references.

Section 15 amends s. 627.657, F.S., to conform a cross-reference due to the repeal by this bill of the Small Employer Health Reinsurance Program.

Section 16 amends s. 627.6699, F.S., to repeal the Small Employer Health Reinsurance Program.

Residential Property Insurance Mitigation Credits, Discounts, or Other Rate Differentials

Section 17 amends s. 627.711, F.S., to require the OIR to contract with a Florida public university to design, operate, upgrade, and maintain a statewide database for uniform mitigation verification inspection forms to be managed by the OIR to collect and evaluate mitigation features of residential properties within the state. Beginning on January 1, 2026, each insurer must electronically file a copy of uniform mitigation inspection forms submitted by a policyholder in the database within 15 business days after receipt from the policyholder or the agent, using the electronic format prescribed by the OIR.

Assignment Agreements

Section 18 amends s. 627.7152, F.S., to repeal the requirement that each insurer report data on each residential and commercial property insurance claim paid in the prior calendar year under an assignment agreement. Assignment agreements are no longer allowed by law.

Insurer Experience Reporting

Section 19 creates s. 627.9145, F.S., to require that, beginning on March 1, 2026, each authorized insurer and surplus lines insurer transacting residential property insurance in Florida must report annually to the OIR the following information:
- Policy types, perils covered, statuses, and premiums.
- Location and limits of writings in this state.
- Coverages, deductibles, and exclusions.
- Mitigation discounts.
- Claims reporting requirements.
- Any other information deemed necessary by the Commission to provide the OIR with the ability to track mitigation and resiliency trends occurring in the residential property market.

Section 20 amends s. 627.915, F.S., to require each insurer transacting private passenger automobile insurance in Florida report monthly to the OIR the following information:
- Policy coverage categories, including policies in force and total direct premiums earned and written.
- Type, location, and limits of writings in Florida.
- Claims reporting requirements.
- Any other information deemed necessary by the Commission to provide the OIR with the ability to track trends occurring in the private passenger automobile insurance market.

The bill deletes a requirement that insurers in various lines of liability insurance annually report to the office specified information on premiums, reserves, expenses, losses, income, fees, acquisition costs, general expenses, dividends, and investments.

Insurer Organization and Procedure

Sections 21, 22, 23, 26, 27, and 28 amend ss. 628.081, 628.091, 628.111, 628.717, 628.719, and 628.910, to remove requirements to file certain documents in triplicate.

Section 24 amends s. 628.461, F.S., to require that a person seeking to acquire 10 percent or more of the outstanding voting securities of a domestic stock insurer or of a controlling company must send by registered mail to the principal office of the insurer and controlling company a letter of notification regarding the transaction or proposed transaction within five days after any form of tender offer or exchange offer is proposed, or within five days after the acquisition of the securities if no tender offer or exchange offer is involved.

Section 25 amends s. 628.4615, F.S. to remove the registered mail requirement that, if any material change occurs in the facts set forth in the acquisition application filed with the OIR, an amendment setting forth such changes must be filed immediately with the OIR, and a copy of the amendment be sent by registered mail to the principal office of the specialty insurer and to the principal office of the controlling company.

Reciprocal Insurers

Definitions

Section 29 amends s. 629.011, F.S., to provide definitions for certain terms, as follows:

- An "assessable reciprocal insurer" is a reciprocal insurer that can assess its subscribers to make up any shortfall in capital and surplus to cover claims and expenses as specified in s. 629.231, F.S.
- A "nonassessable reciprocal insurer" is a reciprocal insurer authorized under ss. 629.091(3) or 629.291(5), F.S., to issue policies when there is no recourse against subscribers for any shortfall in capital and surplus to cover claims and expenses.
- "Subscribers' advisory committee" is the governing committee of a domestic reciprocal insurer which is formed in compliance with s. 629.201, F.S., and represents the interests of the subscribers.
- "Subscriber contribution" means any transfer of money by a subscriber of a reciprocal insurer to a reciprocal insurer, which transfer is in excess of the premium approved by the office, when such money is counted as surplus for the reciprocal insurer or used to pay surplus notes.
- "Subscriber savings account" is any account in which a reciprocal insurer allocates money to be held in whole or in part for the benefit of an individual subscriber, other than accounts holding money for the payment of a specific claim by or settlement of a specific legal dispute with that individual subscriber.

Surplus Funds Required

Section 30 amends s. 629.071, F.S., to provide that an assessable reciprocal insurer, if it has otherwise complied with the applicable provisions of this code, may be authorized to transact insurance if it has and thereafter maintains surplus funds of not less than $3 million (up from $250,000).

This section further provides that a nonassessable reciprocal insurer, if it has otherwise complied with the applicable provisions of the Florida Insurance Code, may be authorized to transact insurance if it has and thereafter maintains a surplus as to policyholders which is equal to that required under s. 624.408, F.S., for a domestic stock insurer authorized to transact like kinds of insurance.

Organization

Section 31 amends s. 629.081, F.S., to remove language that requires the filing be accompanied by the application fee required by s. 624.501(1)(a), F.S.

Reciprocal Affiliates

Section 32 creates s. 629.082, F.S., to provide that the attorney in fact of a reciprocal insurer is an affiliate of the reciprocal insurer, as defined in s. 624.10, F.S. This will have the effect of applying to an attorney in fact any applicable state laws relating to affiliates, including Section 33 of the bill.

Section 33 creates s. 629.1015, F.S., to provide that each reciprocal insurer doing business in Florida that pays a fee, commission, or other financial consideration or payment to any affiliate directly or indirectly must provide to the OIR documentation that such fee, commission, or other financial consideration or payment is fair and reasonable for each service being provided by contract. In determining whether the fee, commission, or other financial consideration or payment is fair and reasonable, the OIR shall consider all of the following:

- The actual cost of each service provided by an affiliate.
- The relative financial condition of the reciprocal insurer and of the attorney in fact.
- The level of debt and how such debt is serviced.
- The amount of dividends paid by the attorney in fact and its affiliates and for what purpose.
- Whether the terms of the written contract benefit the reciprocal insurer and are in the best interest of the subscribers.
- Any other such information as the OIR reasonably requires in making the determination.

For each agreement with an affiliate in force on July 1, 2025, each domestic reciprocal insurer must provide to the OIR no later than October 1, 2025, the cost incurred by the affiliate to provide each service, the amount charged to the domestic reciprocal insurer for each service, and the dollar amount of fees forgiven, waived, or reimbursed by the affiliate for the two most recent preceding years. If the total dollar amount charged to the domestic reciprocal insurer was greater than the total cost to provide services for either year, the domestic reciprocal insurer must explain how it determined the fee was fair and reasonable. For any proposed contract with an affiliate effective after July 1, 2025, a domestic reciprocal insurer must provide documentation to support that the fee, commission, or other financial consideration or payment to the affiliate is fair and reasonable.

Attorney's Bond

Section 34 amends s. 629.121, F.S., to provide that the required attorney's bond be in the sum of $300,000, rather than $100,000.

Subscriber Contributions

Section 35 creates s. 629.162, F.S., to provide that:

- Reciprocal insurers may, subject to prior approval by the OIR, require contributions from subscribers in addition to premiums approved by the OIR.
- A reciprocal insurer must clearly disclose required subscriber contributions on the declaration page of any policy issued by the reciprocal insurer, separate from any cost associated with the premium.
- Reciprocal insurers must provide subscribers with an annual report detailing how each dollar of subscriber contributions was allocated or spent.
- Changes to subscriber contributions are subject to prior approval by the OIR.

Subscriber Savings Accounts

Section 36 creates s. 629.163, F.S., to provide that reciprocal insurers may establish subscriber savings accounts. Money placed in subscriber savings accounts is not considered a distribution under s. 629.164, F.S., and:

- Reciprocal insurers must inform each subscriber, in writing, of the limitations and restrictions imposed upon the use or possession of moneys held in the subscriber savings account.
- Reciprocal insurers must inform each subscriber, in writing, of the procedures used to distribute money to subscriber savings accounts and any calculations used to determine the amount of money to be distributed to subscriber savings accounts.
- Advertisements marketing the benefits of subscriber savings accounts must note the limitations and restrictions imposed upon the use or possession of moneys held in the subscriber's savings account.
- Upon cancellation or nonrenewal of a subscriber's policy, the subscriber must be entitled to all moneys held in the subscriber savings account, except when such moneys are otherwise allocated by law or contract, or when such distribution is prohibited by order of the OIR.

Subscriber Distributions

Section 37 creates s. 629.164, F.S., to authorize reciprocal insurers to make distributions to subscribers from their subscriber savings accounts. The subscribers' advisory committee has the sole authority to authorize distributions, subject to prior written approval by the OIR. Any reciprocal insurer that otherwise authorizes distributions but prohibits subscribers from receiving distributions for a specified period of time, including after initial subscription, must renew the subscriber's policy for that period of time plus 1 additional policy year.

A reciprocal insurer may return to its subscribers any unused premiums, savings, or credits accruing to their accounts. Such a return may not unfairly discriminate between classes of risks or policies, or between subscribers, but may vary as to classes of subscribers based on the experience of the classes.

A domestic reciprocal insurer may, upon the prior written approval of the OIR, pay to its subscribers a portion of unassigned funds of up to 10 percent of surplus, with distribution limited to 50 percent of net income from the previous calendar year. Such payment may not unfairly discriminate between classes of risks or policies, or between subscribers, but may vary as to classes of subscribers based on the experience of the classes.

Section 41 repeals s. 629.271, relating to distribution of savings.

Annual Statement

Section 38 amends s. 629.171, F.S., to require the subscribers' advisory committee to procure an audited annual statement of the accounts and records of the insurer and the attorney in fact. The statement of the insurer must be prepared by an independent auditor at the expense of the reciprocal insurer and must be available for inspection by any subscriber. The statement of the attorney in fact must be prepared by an independent auditor at the expense of the attorney in fact.

Financial Condition

Section 39 amends s. 629.181, F.S., to provide that subscriber contributions are allowed as assets, except that any premium deposits delinquent for 90 days must first be charged against such subscriber contributions. Subscriber contributions may not exceed two percent of each individual subscriber's policy premium for a nonassessable reciprocal insurer and 10 percent of each individual subscriber's policy premium for an assessable reciprocal insurer.

Subscribers' Advisory Committee

Section 40 amends s. 629.201, F.S., to require that each domestic reciprocal insurer have a subscribers' advisory committee representing the interests of the subscribers. The subscribers' advisory committee must perform the following duties:

- Supervise the finances of the insurer.
- Supervise the insurer's operations to such extent to assure conformity with the subscribers' agreement, power of attorney, and other governing documents.
- Hire independent auditors, counsel, and other experts at the expense of the insurer as necessary to fulfill the committee's duties.
- Exercise any additional powers and functions as may be conferred by the subscribers' agreement.

The initial subscribers' advisory committee must be appointed by either the original subscribers or the attorney in fact. Within six months after the reciprocal insurer is authorized to transact insurance, at least two-thirds of the subscribers' advisory committee must consist of subscribers who are independent of, not employed by, not representing, not selected by, and without any financial interest in the attorney in fact. The independent subscribers must be elected by the subscribers of the reciprocal insurer. Any rules governing the appointment of subscribers to the subscribers' advisory committee require must all of the following:

- A subscribers' advisory committee composed exclusively of subscribers of the reciprocal insurer.
- Terms of not more than five years.
- A process that allows subscribers to nominate other subscribers for appointment to the subscribers' advisory committee.

If a reciprocal insurer has more than 50 subscribers, the attorney in fact must provide a platform by which subscribers are able to communicate with each other regarding the subscribers' advisory committee appointment process.

Merger or Conversion

Section 42 amends s. 629.291, F.S., to add "conversion" to the provision that a reciprocal insurer, upon affirmative vote of not less than two-thirds of its subscribers who vote, may merge with another reciprocal insurer or be converted to a stock or mutual insurer, to be thereafter governed by the applicable sections of the Florida Insurance Code. This section also provides that the applicable forms are to be adopted by the Financial Services Commission, not by the OIR.

Impaired Reciprocal Insurers

Section 43 amends s. 629.301, F.S., to provide that if liquidation of a reciprocal insurer is ordered, the receiver must levy upon the subscribers an assessment for such an amount as the receiver determines to be necessary to discharge all liabilities of the insurer. The liabilities must be exclusive of any funds contributed by the attorney in fact or other persons, but inclusive of the reasonable cost of the liquidation. The assessment is subject to any limits set forth in the power of attorney, the policy, or ch. 629, F.S.

Insurance Exchanges

Section 44 repeals s. 629.401, F.S., relating to insurance exchanges. This section is obsolete, as there are no longer any reciprocal insurance exchanges.

Limited Reciprocal Insurers

Section 45 repeals s. 629.520, F.S., relating to authority of a limited reciprocal insurer. This section is obsolete, as there are no longer any limited reciprocal insurers.

Unearned Premium Reserves

Section 46 creates s. 629.56, F.S., to provide that a reciprocal insurer must at all times maintain an unearned premium reserve as required under s. 625.051, F.S.

Compliance Dates for Existing Reciprocal Insurers

Section 82 provides that reciprocal insurers licensed before July 1, 2025, have until July 1, 2026, to comply with the changes made to subscribers' advisory committees in s. 629.201, F.S., and have until July 1, 2027, to comply with the changes made to unearned premium reserve requirements imposed under s. 629.56, F.S.

Service Warranty Associations

Section 47 amends s. 634.401, F.S., to require that all contracts that include coverage for accidental damage from handling must be covered by the contractual liability policy referred to in s. 634.406(3), F.S., unless issued by an association not required to establish an unearned premium reserve or maintain contractual liability insurance under s. 634.406(7), F.S.

Health Maintenance Organizations

Section 49 amends s. 641.26, F.S., to provide that every HMO must file an annual statement covering the preceding calendar year on or before March 1, and that quarterly statements covering the periods ending on March 31, June 30, and September 30 must be filed within 45 days after each such date. The Commission may by rule adopt the form for financial statements of a HMO, requiring the financial statement to comply with the provisions of s. 624.424, F.S.

Section 50 creates s. 641.283, F.S., to provide that the administrative supervision and hazardous insurer standard provisions of ss. 624.80-624.87, F.S., apply to HMOs.

Continuing Care Retirement Communities

Definitions

Section 51 amends s. 651.011, F.S., to provide definitions for certain terms, as follows:

- "Affiliate" means an entity that exercises control over or is directly or indirectly controlled by the insurer provider through any of the following:
  - Equity ownership of voting securities.
  - Common managerial control.
  - Collusive participation by the management of the insurer and affiliate in the management of the insurer or the affiliate.
- "Affiliated person" of another person includes any of the following:
  - The spouse of the other person.
  - The parents of the other person and their lineal descendants, or the parents of the other person's spouse and their lineal descendants.
  - A person who directly or indirectly owns or controls, or holds with the power to vote, 10 percent or more of the outstanding voting securities of the other person.
  - A person, 10 percent or more of whose outstanding voting securities are directly or indirectly owned or controlled, or held with power to vote, by the other person.
  - A person or group of persons who directly or indirectly control, are controlled by, or are under common control with the other person.
  - An officer, director, partner, copartner, or employee of the other person.
  - If the other person is an investment company, an investment adviser of such company, or a member of an advisory board of such company.
  - If the other person is an unincorporated investment company not having a board of directors, the depositor of such company.
  - A person who has entered into a written or unwritten agreement to act in concert with the other person in acquiring or limiting the disposition of securities of a domestic stock insurer provider or controlling company.
- "Control," including the terms "controlling," "controlled by," "under common control with," and "controlling," means any corporation, trust, or association that directly or indirectly owns 10 percent or more of either of the following:
  - The direct or indirect possession of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise. Control is presumed to exist if a person, directly or indirectly, owns, controls,

holds with the power to vote, or holds proxies representing 10 percent or more of the voting securities of another person.
    - A management company exercising control through a management agreement whereby the management company is responsible for the day-to-day business operations of the provider or the day-to-day decisionmaking on behalf of the provider.
- "Governing body" or "full governing body" means a board of directors, a management company, or a body of a provider or obligated group whose members are elected or appointed to set strategy; oversee management or operations of a provider, facility, or obligated group; and protect the interests of the provider, facility, or group.

The definition of "manager," "management," or "management company" is revised to mean a person who administers the day-to-day business operations of a facility for a provider, is part of a committee that supervises the activities of a business that provides continuing care or a member of the full governing body of a business that provides continuing care, or is subject to the policies, directives, and oversight of the provider or governing body.

Administrative Supervision

Section 52 amends s. 651.018, F.S., to provide that the OIR must place a facility in administrative supervision until such time as the condition is resolved to the satisfaction of the OIR if any of the following conditions exist:
- The facility is insolvent or impaired.
- The facility is at regulatory action level, pursuant to s. 651.034, F.S.
- The facility reports a negative debt service reserve.
- The facility has failed to file a monthly, quarterly, or annual financial statement or audited financial statements as required by ch. 651, F.S.
- The facility was issued a financial statement with a going concern issue by an independent certified public accountant.
- The facility is found to be in a hazardous financial condition, pursuant to s. 651.113, F.S.

New Financing

Section 53 amends s. 651.019, F.S., to require a provider to submit a written general outline of the amount and the anticipated terms of any new financing or refinancing, and the intended use of the proceeds, to the OIR, as well as the residents' council at least 30 days before the closing date of the financing or refinancing transaction. If there is a material change in the noticed information, the provider must provide an updated notice to the OIR, as well as to the residents' council within 10 business days after the provider becomes aware of such change.

Eligibility Requirements

Section 54 creates s. 651.0212, F.S., to provide general eligibility requirements in order to operate a CCRC in Florida. The OIR must deny or revoke a provider's authority to conduct business if it determines that any of the following applies to the provider's management, officers, or directors:
- They are incompetent or untrustworthy.
- They lack sufficient experience in continuing care management, posing a risk to contract holders.

- They lack the experience, ability, or reputation necessary to ensure a reasonable likelihood of successful operation.
- They are affiliated, directly or indirectly, with individuals or entities whose business practices have harmed residents, stockholders, investors, creditors, or the public through asset manipulation, fraudulent accounting, or bad faith actions.

The OIR must deny or revoke a provider's authority to conduct business if it determines that any general partner, subscriber, stockholder, or incorporator who exercises or has the ability to exercise effective control of the provider, or who influences or has the ability to influence the transaction of the business of the provider, lacks the financial standing and business experience necessary for the provider's successful operation.

The OIR may deny, suspend, or revoke a provider's authority to conduct business if it determines that any subscriber, stockholder, or incorporator who exercises or has the ability to exercise effective control of the provider, or who influences or has the ability to influence its business transactions, has been found guilty of, or has pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment of one year or more under the laws of the United States, any state, or any other country, if the crime involves moral turpitude, regardless of whether a judgment of conviction has been entered by the court. A provider operating under a valid COA must immediately remove any such person from his or her role in the business upon discovery of the conditions set forth in this subsection or remove such person upon order of the OIR.

The OIR may deny, suspend, or revoke a provider's authority to conduct business if it determines that any general partner, subscriber, stockholder, or incorporator who exercises or has the ability to exercise effective control of the provider, or who influences or has the ability to influence its business transactions, is now or was previously affiliated, directly or indirectly, through ownership of 10 percent or more, with any business, corporation, or entity that has been found guilty of, or has pleaded guilty or nolo contendere to, any felony or crime punishable by imprisonment for 1 year or more under the laws of the United States, any state, or any other country. A provider operating under a valid COA must immediately remove any such person from his or her role in the business or notify the OIR upon discovery of the conditions set forth in this subsection.

Section 55 amends s. 651.0215, F.S., to require the OIR to notify an applicant for a COA within 30 days, rather than 45 days, if it needs further information. This section removes the requirements that:

- Within 15 days after receipt of all of the requested additional information, the OIR notify the applicant in writing that all of the requested information has been received and that the application is deemed complete as of the date of the notice. Failure to notify the applicant in writing within the 15-day period constitutes acknowledgment by the OIR that it has received all requested additional information, and the application is deemed complete for purposes of review on the date the applicant files all of the required additional information.
- Within 45 days after an application is deemed complete and upon completion of the remaining requirements of this section, the OIR complete its review and issue or deny a COA to the applicant.

Section 56 amends s. 651.022, F.S., to require that the feasibility study required for a provisional COA be prepared by an independent consultant. This section removes requirements that:

- Within 15 days after receipt of all of the requested additional information, the OIR notify the applicant in writing that all of the requested information has been received and the application is deemed to be complete as of the date of the notice. Failure to so notify the applicant in writing within the 15-day period shall constitute acknowledgment by the OIR that it has received all requested additional information, and the application shall be deemed to be complete for purposes of review upon the date of the filing of all of the requested additional information.
- Within 45 days after the date an application is deemed complete as set forth in paragraph (5)(b), the OIR complete its review and issue a provisional COA to the applicant based upon its review and a determination that the application meets all requirements of law, that the feasibility study was based on sufficient data and reasonable assumptions, and that the applicant will be able to provide continuing care or continuing care at-home as proposed and meet all financial and contractual obligations related to its operations, including the financial requirements of this chapter.

Section 57 amends s. 651.023, F.S., to remove the requirements that:

- Within 15 days after receipt of all of the requested additional information, the OIR notify the provider in writing that all of the requested information has been received and the application is deemed to be complete as of the date of the notice. Failure to notify the applicant in writing within the 15-day period constitutes acknowledgment by the OIR that it has received all requested additional information, and the application shall be deemed complete for purposes of review on the date of filing all of the required additional information.
- Within 45 days after an application is deemed complete as set forth in subsection (2), and upon completion of the remaining requirements of this section, the OIR complete its review and issue or deny a COA to the holder of a provisional COA. If a COA is denied, the OIR must notify the holder of the provisional certificate in writing, citing the specific failures to satisfy the provisions of this chapter.

Acquisition

Section 58 amends s. 651.024, F.S. to provide that a bondholder that obtains consent rights from a provider that allow the bondholder to have oversight or decisionmaking authority over a facility or in the financial decisions of the facility is subject to s. 628.4615, F.S., and is not required to make filings pursuant to ss. 651.022, 651.023, or 651.0245, F.S.

A continuing care retirement community that enters into an affiliation agreement with another entity, resulting in a change of officers, directors, or effective control, is subject to s. 628.4615, F.S., and is not required to file pursuant to ss. 651.022, 651.023, or 651.0245, F.S.

Expansions

Section 59 amends s. 651.0246, F.S., to require that the feasibility study required to be submitted by a provider applying for expansion of a certificated facility must include a plan for the ongoing operations of existing facilities. This section requires the OIR to notify an applicant for such expansion to complete its review with 45 days, rather than 30 days, after the date on which the application is deemed complete.

This section removes the requirements that, within 15 days after the OIR receives all the requested additional information it notify the applicant in writing that the requested information has been received and that the application is deemed complete as of the date of the notice and that failure to notify the applicant in writing within the 15-day period constitutes acknowledgment by the OIR that it has received all requested additional information, and the application is deemed complete for purposes of review on the date the applicant files all of the required additional information.

Annual Reports

Section 60 amends s. 651.026, F.S., to require that each facility file with the OIR:

- Together with the quarterly report, all escrow bank statements for the last quarter of the reporting period which support the funds held in each of the minimum liquid reserves bank accounts, including, but not limited to, the debt service reserve, the operating reserve, and the renewal and replacement reserve.
- Together with the quarterly report, an accounts payable aging schedule that lists all outstanding debt obligations and the corresponding amounts owed to each vendor.
- Together with the annual report, details on any debt that has been forgiven or deferred during the period. Such details must include, but are not limited to, the entity the debt is due to, the amount forgiven or deferred, an explanation as to why the debt was forgiven or deferred, and whether the debt has been assumed by another party on behalf of the facility.

Any provider that has been placed in administrative supervision under s. 651.018, F.S., must provide on a monthly basis a compiled two-year forecast so long as the provider is operating under administrative supervision.

This section provides that photocopies of the workpapers, account analyses, descriptions of basic assumptions, and other information necessary for a full understanding of the annual statement of a provider as filed must be provided upon request of the OIR.

Quarterly and Monthly Statements

Section 61 amends s. 651.0261, F.S., to require each provider to file with the quarterly report:

- All escrow bank statements for each quarter which support the funds held in each of the minimum liquid reserves bank accounts, including, but not limited to, the debt service reserve, the operating reserve, and the renewal and replacement reserve.
- An accounts payable aging schedule that lists all outstanding debt obligations and the corresponding amounts owed to vendors.
- Details on any debt that has been forgiven or deferred during the period. Such details must include, but are not limited to, the entity the debt is due to, the amount forgiven or deferred, an explanation as to why the debt was forgiven or deferred, and whether the debt has been assumed by another party on behalf of the provider. If a provider is required to file monthly financial statements with the office, the facility is required to include details on forgiven or deferred debt with the monthly filing.

Escrow Accounts

Section 62 amends s. 651.033, F.S., to provide that in the event of an emergency, before submitting a petition to the OIR for permission to withdraw funds from an escrow account, the provider must meet with the OIR to review the emergency petition. In the meeting, the provider must address the details of the emergency, the circumstances leading to the need for an emergency petition, the provider's plan to mitigate the emergency, the amount being requested, and the provider's plan and timeline to restore the minimum liquid reserves back into compliance with s. 651.035, F.S. The OIR shall have 10 business working days to deny the petition for the emergency 10 percent withdrawal. The escrow agent is required to provide prompt written notification to the OIR upon withdrawal of any funds from an account required under s. 651.035, F.S.

Financial and Operating Requirements for Providers

Section 63 amends s. 651.034, F.S, to remove language that provides that an impairment is sufficient grounds for the DFS to be appointed as receiver as provided in ch. 631, F.S., except when the OIR's remedial rights are suspended pursuant to s. 651.114(11)(a), F.S., and that if the OIR's remedial rights are suspended, the impaired provider must make available to the OIR copies of any corrective action plan approved by the third-party lender or trustee to cure the impairment and any related required report.

Section 64 amends s. 651.035, F.S., to require that each account established to maintain in escrow a minimum liquid reserve must be separate and unique to a facility, unencumbered, and not commingled with any other funds from any other account, facility, affiliate, or obligated group. Funds held in escrow under paragraphs (a), (c), and (d) must be held completely separate from any funds held by a trustee under paragraph (b), meaning the debt service, operating, and renewal and replacement reserves must have their own distinct account number.

If a debt service reserve is transferred from one financial institution or lender to another, the provider must provide notice to the OIR at least 10 days before the transfer takes place. The notice must include an affidavit sworn to by the provider and include the name of the institution where the debt service reserve is being transferred, the date of transfer, the amount being transferred, a copy of the agreement requiring the transfer to the new financial institution, and the contact information for the escrow agent of the new account. The new escrow agreement must comply with the requirements of s. 651.033, F.S. Any funds held pursuant to this section do not negate the requirement to maintain an escrow account as required in paragraph (a).

Each provider must maintain in escrow an operating reserve equal to or in excess of the following amounts:

- Thirty percent of the total operating expenses projected in the feasibility study required by s. 651.023, F.S., for the first 12 months of operation.
- After the first 12 months of operations, 30 percent of the total operating reserve in the annual report filed pursuant to s. 651.026, F.S.
- Once a provider maintains an occupancy level in excess of 80 percent for at least 12 months and has represented in its most recent annual report that it has reached stabilized occupancy, 15 percent of the total operating reserve upon approval of the OIR.

- If the provider has been found to meet any of the following conditions, 50 percent of the total operating reserve:
  - Is insolvent or financially impaired.
  - At regulatory action level under s. 651.034, F.S.
  - Placed under administrative supervision.
  - In hazardous financial condition under s. 651.113, F.S.
  - Entered into a forbearance agreement with a lender.
  - Filed or has notified the OIR of its intent to file for bankruptcy.
  - Failed to maintain the minimum liquid reserve requirements under subsections (10) and (11).

Upon notice from the OIR that a condition identified in this paragraph exists, the provider has 10 days within which to fund the operating reserve at 50 percent and provide evidence of the funding to the office. Before reducing the operating reserve required under paragraph (c), the provider must obtain written approval from the OIR.

This section removes a provision that requires each provider licensed before October 1, 1983, fully fund the renewal and replacement reserve by October 1, 2003, by multiplying the difference between the former escrow requirement and the present escrow requirement by the number of years the facility has been in operation after October 1, 1983.

Approval of Change in Management

Section 65 amends s. 651.943, F.S., to include managements companies in the requirement to notify the OIR of any change of management within 10 business days.

Contracts as Preferred Claims on Liquidations or Receivership

Section 66 amends s. 651.071, F.S., to provide that in the event of receivership or liquidation proceedings against a provider, all continuing care and continuing care at-home contracts executed by a provider are deemed preferred claims against all assets owned by the provider and such claims are not subordinate to any secured claim and must be treated with higher priority over all other claims, except Class 1 claims.

Quarterly Meetings Between Residents and the Provider

Section 67 amends s. 651.085, F.S., to provide that the representatives designated to represent the residents before the governing body of the provider on matters specified in subsection (3), must perform their duties in good faith and that providers that own or operate more than one facility, each facility must have its own designated resident representative.

Resident Funds for Charitable or Operational Purposes

Section 68 creates s. 651.087, F.S., to provide that the organized collection and distribution of funds by residents for charitable or benevolent purposes may not be controlled by a provider or management company. Any provider or management company assisting in the collection or disbursement of such funds that is outside the approved operational fees is subject to the following requirements:

- The provider or management company shall notify the OIR and the residents' council that a fund is being established.
- The provider or management company, under the direction and approval of the residents' council, must establish written policies that govern the funds.
- Within 60 days after the fund is established, the provider or management company must provide the written policy to the OIR and current residents and post in a prominent position in the facility which is accessible to all residents and the general public. Additionally, the written policy must be given to all prospective residents.
- The provider or management company must include with its annual and quarterly reports a statement detailing the financial position of the fund as of the annual or quarter period end date and a summary breakdown of how any funds were used during that reporting period, excluding any personal identifiable information.

A provider or management company may not borrow or solicit funds from residents for operational purposes without prior written approval from the OIR. Before any funds are eligible for distribution to the provider or management company, the provider or management company must comply with the following:

- Submit a request to borrow funds to the OIR, with notice to the residents' council, which must include the requested amount, a detailed summary of the intended use of the funds, and any additional information that supports the provider's need to borrow the funds. The requested amount may not exceed 10 percent of the funds available from residents and must be restricted to use only for operational expenses, which must solely benefit the residents of the facility. Funds may not be used for the benefit of management, the board of directors, or the general partner.
- Complete an anticipated repayment schedule for the borrowed funds. Within 30 days after receipt of the borrowed funds, the provider or management company shall begin repayment to the fund in equal monthly payments that allow for a complete refunding of the borrowed funds within 12 months. Full repayment must be completed within 12 months after the distribution.
- Obtain a board resolution and sworn affidavit signed by two officers or a general partner of the provider or management company which indicates support for the request to borrow funds and the repayment plan.

Upon receipt of approval from the OIR, the provider or management company is required to comply with the following:

- Maintain a 50 percent operating reserve pursuant to s. 651.035(1)(c)4., F.S., for the duration of the repayment period. Following the repayment period, the provider or management company must obtain the OIR's prior written approval to reduce the operating reserve amount.
- Within five days after receiving the OIR's approval, submit supporting documentation to the OIR as evidence that the operating reserve has been increased in compliance with this section.
- In order to protect the residents' investment, immediately transfer up to 100 percent of the funds held in the minimum liquid reserve operating reserve account to the custody of the DFS pursuant to part III of ch. 625, F.S. The provider or management company must fund the account with the DFS within 15 days after receiving the OIR's approval. The OIR may

not approve the provider's request unless it has confirmation that the provider has established the account with the DFS.

By October 1, 2025, any provider or management company that already has benevolent or charitable funds established must comply with this section. By August 1, 2025, any provider or management company that has borrowed funds from residents must provide notice to the OIR. In the event that a provider or management company triggers an impairment or insolvency or enters into a forbearance agreement with a lender, the repayment of any outstanding borrowed funds must be accelerated.

Requirement of Full Disclosure

Section 69 amends s. 615.091, F.S., to require every continuing care facility to:

- Post a notice of any bankruptcy proceedings in a prominent location within the facility which is accessible by all residents and the general public. Such notice must include a summary of the bankruptcy proceedings and specify where the full legal record of the bankruptcy proceedings can be inspected within the facility. The facility must also designate and make available a management representative to discuss the bankruptcy proceedings and address questions from residents. The notice required under this paragraph must also include a listing of all court documents related to the bankruptcy proceedings and the designated representative's contact information.
- Maintain records showing compliance with the requirements of this subsection, including information as to how, where, and when the required information was provided.

Before entering into a contract to furnish continuing care or continuing care at-home, the provider must make full disclosure to the prospective resident of the following information:

- Any proposed or approved plans for expansion or phased development within the next three years; and
- Any known legal impediments to the plans disclosed including, but not limited to, pending legal action to stop or modify the plans, the denial of building permits, or a failure to secure financing.

A provider who enters into a contract for continuing care at a facility without first delivering a true and complete copy of the full disclosure document to the contracting party, or who enters into a contract based on a disclosure document that omits a material fact required to be stated or necessary to prevent misleading statements, is liable for actual damages and any interest thereon, reasonable attorney fees, and court costs and must refund fees paid to the contracting party. However, the provider may deduct the reasonable value of care and lodging provided before the violation, misstatement, or omission was discovered or should have reasonably been discovered from the fees to be refunded to the contracting party.

Management Companies

Section 70 creates s. 651.104, F.S., to provide requirements for CCRC management companies to obtain a COA. In order to obtain a COA, the management company application must include:

- All basic organizational documents of the management company, such as the articles of incorporation, articles of association, partnership agreement, trade name certificate, trust

agreement, shareholder agreement, and other applicable documents, and all amendments to those documents.

- The bylaws, rules, and regulations or similar documents regulating the conduct or the internal affairs of the management company.
- For a corporation, the names, addresses, official positions, and professional qualifications of the individuals employed or retained by the management company who are responsible for the conduct of the affairs of the management company, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, and the principal officers, or equivalent, or for a partnership or association of the management company, the partners or members.
- Audited annual financial statements, prepared in accordance with generally accepted accounting principles, for the two most recent fiscal years, which prove that the applicant has a positive net worth in both fiscal years. If the applicant has been in existence for less than two fiscal years, the application must include financial statements or reports, certified by an officer of the applicant and prepared in accordance with generally accepted accounting principles, for any completed fiscal years and for any month during the current fiscal year for which such financial statements or reports have been completed. If an applicant reports net losses for either of the two most recent fiscal years, the applicant is required to provide pro forma financial statements up to the period of time that the applicant demonstrates two consecutive years of profitability. Pro forma financial statements must include the balance sheet, income statement, and cash flow statement. An audited financial statement or report prepared on a consolidated basis must include a columnar consolidating or combining worksheet that must be filed with the report and comply with the following:
  - Amounts shown on the consolidated audited financial report must be shown on the worksheet;
  - Amounts for each entity must be stated separately; and
  - Explanations of consolidating and eliminating entries must be included.
- Any information as the OIR may require in order to review the current financial condition of the applicant.
- A statement describing the business plan, including information on staffing levels and activities proposed, or ongoing, in this state and nationwide. The plan must provide details setting forth the applicant's capability of providing a sufficient number of experienced and qualified personnel in the areas of issuing continuing care life contracts, managing continuing care retirement communities or similar communities, compliance with statutory requirements, and claims processing, recordkeeping, and underwriting.
- If the applicant is not currently acting as a management company, a statement of the amounts and sources of the funds available for organizational expenses and the proposed arrangements for reimbursement and compensation of incorporators or other principals.
- Such other data, financial statements, and pertinent information as the Commission or the OIR may reasonably require with respect to the management company, its directors, or its trustees, or with respect to any parent, subsidiary, or affiliate, if the management company relies on a contractual or financial relationship with such parent, subsidiary, or affiliate in order to meet the financial requirements of this chapter, to determine the financial status of the management company and the management capabilities of its managers and owners.

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

- A complete biographical statement.
- An independent background report.
- A full set of fingerprints of all of the individuals.
- A self-disclosure of any administrative, civil, or criminal complaints, settlements, or discipline of the applicant, or any of the applicant's affiliates, which relate to a violation of the insurance laws or continuing care retirement community laws, in any state.

The applicant must make available for inspection copies of all contracts and contract templates relating to services provided by the management company to providers or other persons using the services of the management company. The OIR may not issue a COA if it determines that the management company or any individual specified in paragraph (2)(c) is not competent, trustworthy, financially responsible, or of good personal and business reputation.

Section 71 creates s. 651.1041, F.S., to provide that acquisition of a CCRC management company is governed by s. 628.4615, F.S., as if it was a specialty insurer.

Section 72 creates s. 651.1043, F.S., to require each authorized CCRC management company to annually file with the OIR a full and true statement of its financial condition, transactions, and affairs within three months after the end of the management company's fiscal year or within such extension of time as the OIR may grant for good cause. The statement must be for the preceding fiscal year and must be verified by at least two officers of the management company. Each authorized management company must annually file an audited financial statement prepared in accordance with generally accepted accounting principles by an independent certified public accountant. The audited financial statement must be filed with the OIR within three months after the end of the management company's fiscal year and be for the preceding fiscal year. An audited financial statement prepared on a consolidated basis must include a columnar consolidating or combining worksheet that must be filed with the statement and must comply with all of the following:

- Amounts shown on the consolidated audited financial statement must be shown on the worksheet.
- Amounts for each entity must be stated separately.
- Explanations of consolidating and eliminating entries must be included.

The management company must submit such other data, financial statements, and pertinent information as the Commission or the OIR may reasonably require with respect to the management company, its directors, or its trustees, or with respect to any parent, subsidiary, or affiliate, if the management company relies on a contractual or financial relationship with such parent, subsidiary, or affiliate in order to meet the financial requirements of this chapter; to determine the financial status of the management company and the management capabilities of its managers and owners. For any material change in its ownership, a management company must file an acquisition application as required by s. 651.024, F.S. Within 45 days after the end of each fiscal quarter, each management company shall file a quarterly unaudited financial statement.

If the OIR finds that such information is needed to properly monitor the financial condition of a management company or is otherwise needed to protect the public interest, the OIR may require the management company to file:

- Within 25 days after the end of each month, a monthly unaudited financial statement of the management company.
- Such other data, financial statements, and pertinent information as the OIR may reasonably require with respect to the management company, its directors, or its trustees, or with respect to any parent, subsidiary, or affiliate, if the management company relies on a contractual or financial relationship with such parent, subsidiary, or affiliate in order to meet the financial requirements of this chapter; to determine the financial status of the management company and the management capabilities of its managers and owners.

Any management company that fails to file an annual financial report or quarterly financial report as required shall forfeit to the OIR an amount set by order of the OIR which does not exceed $1,000 for each of the first 10 days of noncompliance and does not exceed $2,000 for each subsequent day of noncompliance. Upon notice by the OIR that the management company is not in compliance with this section, the management company's authority as a management company ceases until the OIR determines the management company to be in compliance. The OIR may not collect more than $100,000 under this subsection with respect to any particular report.

Section 73 creates s. 651.1045, F.S., to provide that the OIR may deny an application or suspend or revoke the COA of any applicant or management company if it finds any of the following:

- Failing to continue to meet the requirements for the COA originally granted.
- Failing to meet one or more of the qualifications for the COA.
- Making a material misstatement or misrepresentation, or committing fraud in obtaining, or attempting to obtain, a COA.
- Demonstrating a lack of fitness or trustworthiness.
- Engaging in fraudulent or dishonest practices of management in the conduct of business.
- Misappropriating, converting, or withholding moneys.
- Failing to comply with, or a violation of, any lawful order or rule or violating any provision of ch. 651, F.S.
- Becoming insolvent, financially impaired, or conducting business in a manner that poses a risk to the public.
- Refusing to be examined or to produce accounts, records, and files for examination, or refusing to give information with respect to its affairs or to perform any other legal obligation.
- Failing to comply with the requirements of s. 651.1043, F.S.
- Failing to maintain full compliance with escrow accounts or funds as required, if responsible for the day-to-day operations of the provider.
- Failing to meet the requirements for disclosure of information to residents concerning the facility, its ownership, its management, its development, or its financial condition or failure to honor its continuing care or continuing care at-home contracts, if responsible for the day-to-day operations of the provider.
- Having any cause for which issuance of the license could have been denied had it then existed and been known to the OIR.

- Having its owners, managers, officers, or directors found guilty of, or having pleaded guilty or nolo contendere to, a felony in this state or any other state, without regard to whether a judgment or conviction was entered by the court having jurisdiction of such cases.
- Engaging in unfair methods of competition or in unfair or deceptive acts or practices prohibited under part IX of ch. 626, F.S.
- Demonstrating a pattern of bankrupt enterprises.
- Including in ownership, control, or management any person who:
  - Is not reputable and of responsible character;
  - Is so lacking in management expertise as to make the operation of the provider hazardous to potential and existing residents;
  - Is so lacking in management experience, ability, and standing as to jeopardize the reasonable promise of successful operation;
  - Is affiliated, directly or indirectly, through ownership or control, with any person or persons whose business operations are or have been marked by business practices or conduct that is detrimental to the public, contract holders, investors, or creditors, or by manipulation of assets, finances, or accounts or by bad faith; or
  - Has business operations marked by business practices or conduct that is detrimental to the public, contract holders, investors, or creditors, or by manipulation of assets, finances, or accounts or by bad faith.
- Failing to file a notice of change in management, failing to remove a disapproved manager, or persisting in appointing disapproved managers.

Revocation of a management company's COA does not relieve a provider of the provider's obligation to residents under the terms and conditions of any contract between the provider and residents or ch. 651, F.S. The management company must continue to file its annual statement and pay license fees as if the COA had continued in full force, but the management company may not issue any new contracts on behalf of a provider. The OIR may seek an action in the circuit court of the Second Judicial Circuit, in and for Leon County, to enforce its order and the provisions of this section.

Section 74 amends s. 651.105, F.S., to include CCRC management companies within the OIR's authority to examine.

Section 75 amends s. 651.1065, F.S., to include CCRC management companies within the prohibition against actively soliciting, approving the solicitation or acceptance of, or accepting new continuing care contracts after the management company knew, or reasonably should have known, that the continuing care facility was impaired or insolvent unless it has been given permission by the OIR. A violation of this prohibition is a felony of the third degree.

Section 78 amends s. 651.108, F.S., to include CCRC management companies within OIR's authority to issue an administrative fine not to exceed $10,000 for each violation if it is found that the management company has knowingly and willfully violated a lawful order of the OIR or a provision of ch. 651, F.S.

Insolvent Providers and Management Companies

Section 76 creates s. 651.1068, F.S., to provide that any person who was an officer or director of a provider or management company doing business in Florida and who served in that capacity within the two-year period before the date the provider or management company became insolvent, for any insolvency that occurs on or after July 1, 2025, may not thereafter serve as an officer or director of an provider or management company in Florida or have direct or indirect control over the selection or appointment of an officer or director through contract, trust, or by operation of law, unless the officer or director demonstrates that his or her personal actions or omissions were not a significant contributing cause to the insolvency.

Section 77 amends s. 651.107, F.S., to include CCRC management companies within the requirement that, during the period of a suspension, the management company must file its annual statement and pay license fees and taxes as if the certificate had continued in full force; but the provider may not issue any new contracts. Upon expiration of the suspension period, if within such period the COA has not otherwise terminated, the management company's COA shall automatically be reinstated unless the OIR finds that the causes for the suspension have not been removed or that the management company is otherwise not in compliance with the requirements of ch. 651, F.S. If not so automatically reinstated, the COA is deemed revoked as of the end of the suspension period or upon failure of the management company to continue the certificate during the suspension period, whichever event first occurs.

Section 79 creates s. 651.113, F.S., to provide that the Commissioner may deem a provider or facility that has a negative fund balance to be insolvent or in imminent danger of becoming insolvent if:

- The provider's or facility's financial statements contain findings or conditions that the Commissioner considers detrimental to its financial stability.
- An independent auditor has identified significant financial risks or issued a going concern opinion.
- The provider's or facility's current or projected ratio of total assets, including required reserves, to total liabilities indicates financial impairment or deterioration; or trends suggest a potential decline in operations, working capital, or equity.
- The provider's or facility's current or projected ratio of current assets to current liabilities indicates financial impairment or deterioration; or trends suggest a potential decline in operations, working capital, or equity.
- The provider or facility is unable to carry out normal daily activities and meet its obligations as they become due, based on its current or projected cash flow and liquidity position.
- The provider's or facility's past-year operating losses or projected operating losses are significant enough to jeopardize daily operations or long-term viability.
- The insolvency of an affiliated provider or facility or other affiliated person results in legal liability of the provider or facility for payments and expenses of such magnitude as to jeopardize the provider's or facility's ability to meet its obligations as they become due, without substantial disposition of assets outside the ordinary course of business, any restructuring of debt, or externally forced revisions of its operations.
- The provider or facility has receivables that are more than 90 days past due.
- The insolvency is not temporary and the provider or facility cannot demonstrate a significant reduction or resolution of the financial shortfall.

- The provider or facility faces financial difficulties due to reporting entrance fees as deferred revenue, factoring in generally accepted accounting principles and the overall impact on net income.
- A start-up provider, a facility undergoing plant expansion, or an entity refinancing its debt has developed a financial condition that could seriously jeopardize current or future operation.

The provider or facility must prepare a plan to address and correct any condition that has led to a determination of insolvency or imminent danger of insolvency by the Commissioner. The plan must be presented to the Commissioner within 30 days after the date of the insolvency determination. If the plan to correct the condition is disapproved by the Commissioner, the plan does not correct the condition leading to the Commissioner's determination of insolvency, or the provider's or facility's hazardous condition is such that it cannot be significantly corrected or eliminated, the Commissioner may then proceed with liquidation under chapter 631, F.S.

If the OIR determines that the continued operations of a provider or facility authorized to transact business in this state may be hazardous to its residents or to the general public, the OIR may issue an order requiring the provider or facility to do any of the following:
- Obtain additional financing or revenues to maintain solvency.
- Reduce expenses by specified methods or amounts.
- Increase the operating reserve.
- File reports concerning the market value of the provider's or facilities' assets.
- Limit or withdraw from certain investments or discontinue certain investment practices to the extent the OIR deems necessary.
- Document the adequacy of income and operating reserves in relation to expenses.
- File, in addition to regular annual statements, interim financial reports.
- Correct corporate governance practice deficiencies and adopt and use governance practices acceptable to the OIR.
- Provide a business plan.
- Adjust rates for any non-life insurance product written by the insurer which the OIR considers necessary to improve the financial condition of the insurer.

The OIR may issue an immediate final order to any insurer requiring the actions specified in subsection (3). This section may not be interpreted to limit the powers granted to the OIR by any laws of this state, nor may it be interpreted to supersede any laws of this state.

Section 80 amends s. 651.114, F.S., to delete language that provides that the rights of the OIR related to delinquency proceedings and remedial rights are subordinate to the rights of a trustee or lender pursuant to the terms of a resolution, ordinance, loan agreement, indenture of trust, mortgage, lease, security agreement, or other instrument creating or securing bonds or notes issued to finance a facility, and that the OIR may not exercise its remedial rights with respect to a facility that is subject to a lien, mortgage, lease, or other encumbrance or trust indenture securing bonds or notes issued in connection with the financing of the facility, if the trustee or lender agrees that the rights of residents will be honored and will not be disturbed by a foreclosure so long as the resident:
- Is current in the payment of all monetary obligations required by the contract;

- Is in compliance and continues to comply with all provisions of the contract; and
- Has asserted no claim inconsistent with the rights of the trustee or lender.

This section also deletes language that provides that this section does not require a trustee or lender to:

- Continue to engage in the marketing or resale of new continuing care or continuing care at-home contracts;
- Pay any rebate of entrance fees as may be required by a resident's contract as of the date of acquisition of the facility by the trustee or lender and until expiration of the period described in paragraph (d);
- Be responsible for any act or omission of any owner or operator of the facility arising before the acquisition of the facility by the trustee or lender; or
- Provide services to the residents to the extent that the trustee or lender would be required to advance or expend funds that have not been designated or set aside for such purposes.

This section also deletes language that provides that the OIR must notify the trustee or lender setting forth the reasons and specifying those remedial rights afforded to the OIR, if the OIR determines, at any time during the suspension of its remedial rights as provided in paragraph (a), that:

- The trustee or lender is not in compliance with paragraph (a);
- A lender or trustee has assigned or has agreed to assign all or a portion of a delinquent or defaulted loan to a third party without the office's written consent;
- The provider engaged in the misappropriation, conversion, or illegal commitment or withdrawal of minimum liquid reserve or escrowed funds required under this chapter;
- The provider refused to be examined by the OIR pursuant to s. 651.105(1); or
- The provider refused to produce any relevant accounts, records, and files requested as part of an examination,

This section also deletes language that provides that, upon acquisition of a facility by a trustee or lender and evidence that the requirements of paragraph (a) have been met, the OIR must issue a 90-day temporary COA granting the trustee or lender the authority to engage in the business of providing continuing care subject to the OIR's right to immediately suspend or revoke the temporary COA if it determines that any of the grounds described in s. 651.106, F.S., apply to the trustee or lender or that the terms of the contract used as the basis for the issuance of the temporary COA have not been or are not being met by the trustee or lender since the date of acquisition.

Recording of Lien by OIR

Section 81 creates s. 651.1165, F.S., to provide that as a condition to granting a provisional COA, the OIR shall record a notice of lien against the facility's properties on behalf of all residents and contract holders to secure performance of the provider's obligations to residents and contract holders. Once it is recorded, there exists a lien for an amount equal to the reasonable value of services to be performed under a life care contract in favor of each resident and contract holder on the land and improvements of the facility's properties owned by the provider, not exempt from execution, which are listed in the notice of lien. The lien may be released or partially released at the request of the applicant if, in the judgment of the director, such release

inures to the benefit of the residents and contract holders and the performance of the provider's obligations. Such liens are preferred to all liens, mortgages, or other encumbrances upon the property attaching subsequently to the time the lien is recorded and are preferred to all unrecorded liens, mortgages, and other encumbrances.

Effective Date

Section 83 provides that. except as expressly provided elsewhere in the bill, the bill becomes effective on July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Policyholders may benefit from the transparency report information, the mitigation inspection database, as well as the cybersecurity portion of the bill should such an event occur.

Insurers will be limited in the amount of "use and file" rate filings. Insurers will incur the costs of uploading uniform mitigation verification inspection forms into the statewide database, once created.

Reciprocal insurers and continuing care retirement communities will incur expenses associated with heightened regulation if they do not currently meet any of the new requirements.

C. Government Sector Impact:

The bill has an indeterminate impact to state revenues and expenditures. The bill makes numerous changes that will require systems and process changes in the OIR.

The OIR will see a reduction in costs of publishing the full text of emergency orders.

The OIR will incur the expense of contracting with a Florida public university to design, operate, upgrade, and maintain a statewide database for uniform mitigation verification inspection forms.

VI. Technical Deficiencies:

None.

VII. Related Issues:

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

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 48.151, 252.63, 624.4085, 624.422, 624.45, 624.610, 626.9651, 627.062, 627.0621, 627.0645, 627.0651, 627.4554, 627.642, 627.6475, 627.657, 627.6699, 627.711, 627.7152, 627.915, 628.081, 628.091, 628.111, 628.461, 628.4615, 628.717, 628.719, 628.910, 629.011, 629.071, 629.081, 629.121, 629.171, 629.181, 629.201, 629.291, 629.301, 634.401, 641.26, 651.011, 651.018, 651.019, 651.0215, 651.022, 651.023, 651.024, 651.0246, 651.026, 651.0261, 651.033, 651.034, 651.035, 651.043, 651.071, 651.085, 651.091, 651.105, 651.1065, 651.107, 651.108, and 651.114.

This bill creates the following sections of the Florida Statutes: 627.9145, 629.082, 629.1015, 629.162, 629.163, 629.164, 629.56, 641.2012, 641.283, 651.0212, 651.087, 651.104, 651.1041, 651.1043, 651.1045, 651.1068, 651.113, and 651.1165.

This bill repeals the following sections of the Florida Statutes: 629.271, 629.401, and 629.520.

IX. Additional Information:

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

None.

B. Amendments:

None.