By Senator Collins

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1 A bill to be entitled
2 An act relating to the Office of Insurance Regulation;
3 amending s. 48.151, F.S.; specifying that the Chief
4 Financial Officer is the agent for service of process
5 under certain circumstances for health maintenance
6 organizations; amending s. 252.63, F.S.; requiring the
7 Commissioner of Insurance Regulation to publish a
8 specified notice in the Florida Administrative
9 Register; specifying requirements for such notice;
10 amending s. 624.4085, F.S.; revising the definition of
11 the term “life and health insurer”; amending s.
12 624.422, F.S.; providing applicability; amending s.
13 624.45, F.S.; conforming a provision to changes made
14 by the act; amending s. 624.610, F.S.; deleting a
15 provision relating to the charge and collection of the
16 actual costs and expenses incurred by the office to
17 review certain requests by the insurer; requiring
18 certain applications to be accompanied by a specified
19 filing fee; deleting applicability; amending s.
20 626.9651, F.S.; requiring the Financial Services
21 Commission to adopt rules to ensure the cybersecurity
22 of consumers’ nonpublic insurance data; specifying
23 requirements for such rules; requiring the office to
24 review certain information; authorizing the office to
25 initiate an examination and investigation under
26 certain circumstances; providing that such rules may
27 require certain information to be submitted in a
28 specified form; amending s. 627.062, F.S.; authorizing
29 personal residential property insurers to submit only

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30 one “use and file” filing during a specified
31 timeframe; providing an exception; amending s.
32 627.0621, F.S.; requiring, beginning on a specified
33 date, every rate filing for residential property
34 coverage to include a rate transparency report;
35 authorizing the office to accept the report or, upon
36 certain findings, requiring the office to return the
37 report for modifications; specifying that acceptance
38 of the report does not constitute approval under a
39 certain provision; requiring insurers to provide a
40 rate transparency report in certain circumstances;
41 requiring that such report be labeled in a certain
42 manner if not approved or modified by the office;
43 providing requirements for such report; requiring the
44 office to define certain terms for a specified
45 purpose; requiring that the office establish and
46 maintain a comprehensive resource center on its
47 website for a specified purpose; specifying
48 requirements for such resource center; specifying that
49 certain rate changes and examples are not trade
50 secrets and not subject to certain public records
51 exemptions; amending s. 627.0645, F.S.; requiring a
52 full rate filing under certain circumstances; amending
53 s. 627.0651, F.S.; authorizing personal residential
54 property insurers to submit only one “use and file”
55 filing during a specified timeframe and for specified
56 purposes; amending s. 627.4554, F.S.; requiring agents
57 to make disclosures related to annuities on a form
58 similar to that posted on the department’s, rather

59 than the office’s, website; amending s. 627.642, F.S.;
60 conforming a cross-reference; amending s. 627.6475,
61 F.S.; revising the definition of the term “board”;
62 conforming provisions to changes made by the act;
63 conforming cross-references; amending s. 627.657,
64 F.S.; conforming a cross-reference; amending s.
65 627.6699, F.S.; deleting definitions; deleting
66 provisions related to the small employer health
67 reinsurance program; amending s. 627.711, F.S.;
68 requiring the office to contract with a Florida public
69 university to design, operate, upgrade, and maintain a
70 specified database; requiring that such database be
71 managed by the office for a specified purpose;
72 requiring, beginning on a specified date, that
73 insurers file, within a specified timeframe, a copy of
74 uniform mitigation inspection forms submitted by
75 policyholders or agents in such database using a
76 format prescribed by the office; requiring the
77 commission to adopt rules; amending s. 627.7152, F.S.;
78 deleting a provision that the office require insurers
79 to report claims paid under certain assignment
80 agreements; deleting a requirement that the commission
81 adopt rules; creating s. 627.9145, F.S.; requiring,
82 beginning on a specified date, certain authorized
83 insurers and surplus lines insurers to annually submit
84 a report to the office containing specified
85 information; requiring the commission to adopt by rule
86 the requirements of such report; providing
87 requirements for the report; amending s. 627.915,

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88 F.S.; requiring, beginning on a specified date,
89 insurers transacting private passenger automobile
90 insurance to submit monthly a report containing
91 specified information; requiring the commission to
92 adopt by rule the requirements of such report;
93 providing requirements for the report; deleting
94 provisions relating to liability insurance reports;
95 amending s. 628.081, F.S.; deleting a requirement that
96 incorporators execute articles of incorporation in
97 triplicate; amending s. 628.091, F.S.; deleting a
98 requirement that incorporators execute articles of
99 incorporation in triplicate; making technical changes;
100 amending s. 628.111, F.S.; deleting a requirement for
101 insurers to make a certain certificate in triplicate;
102 amending s. 628.461, F.S.; revising requirements for a
103 person acquiring voting securities of a domestic stock
104 insurer or a controlling company; amending s.
105 628.4615, F.S.; revising requirements for a person
106 acquiring securities of specialty insurers; amending
107 s. 628.717, F.S.; conforming a provision to changes
108 made by the act; amending s. 628.719, F.S.; conforming
109 provisions to changes made by the act; amending s.
110 628.910, F.S.; deleting a requirement that
111 incorporators file articles of incorporation in
112 triplicate; amending s. 629.011, F.S.; defining terms;
113 amending s. 629.071, F.S.; authorizing assessable
114 reciprocal insurers and nonassessable insurers to
115 transact insurance under certain circumstances;
116 revising the amount of surplus funds that an

117 assessable insurer must maintain; deleting a provision
118 relating to a requirement of expendable surplus;
119 amending s. 629.081, F.S.; conforming a provision to
120 changes made by the act; creating s. 629.082, F.S.;
121 specifying that the attorney in fact of a reciprocal
122 insurer is an affiliate of the reciprocal insurer;
123 creating s. 629.1015, F.S.; requiring certain
124 reciprocal insurers to provide the office
125 documentation that certain fees, commissions, or other
126 financial considerations or payments are fair and
127 reasonable; specifying requirements the office shall
128 consider to determine whether the fee, commission, or
129 other financial consideration or payment is fair and
130 reasonable; requiring domestic reciprocal insurers to
131 provide to the office certain costs, amounts charged,
132 and the dollar amounts of certain fees by a specified
133 date; requiring such insurers to make a specified
134 explanation under certain circumstances; requiring
135 such insurers to provide certain documentation for
136 certain proposed contracts; amending s. 629.121, F.S.;
137 revising the bond required by attorneys in fact of a
138 domestic reciprocal insurer; creating s. 629.162,
139 F.S.; authorizing reciprocal insurers to require
140 subscriber contributions in addition to premiums,
141 subject to approval by the office; requiring
142 reciprocal insurers to disclose required subscriber
143 contributions in a specified manner; requiring
144 reciprocal insurers to provide subscribers with a
145 specified annual report; specifying that changes to

146 subscriber contributions are subject to approval by
147 the office; creating s. 629.163, F.S.; authorizing
148 reciprocal insurers to establish subscriber savings
149 accounts; specifying that money placed in such
150 accounts is not considered a distribution; requiring
151 reciprocal insurers to inform subscribers of certain
152 limitations, restrictions, and procedures; requiring
153 certain advertisements to note certain limitations and
154 restrictions; providing that subscribers are entitled
155 to certain moneys under certain circumstances;
156 creating s. 629.164, F.S.; authorizing reciprocal
157 insurers to make distributions to subscribers from
158 certain accounts; providing that the subscribers'
159 advisory committee has the sole authority to authorize
160 distributions, subject to approval by the office;
161 requiring reciprocal insurers to renew a subscriber's
162 policy under certain circumstances and for a certain
163 timeframe; providing construction; authorizing
164 reciprocal insurers to return to subscribers any
165 unused premiums, savings, or credits; prohibiting the
166 return of such funds from unfairly discriminating
167 between classes of risks or policies or between
168 subscribers; providing that such return of funds may
169 vary as to classes of subscribers based on certain
170 factors; authorizing reciprocal insurers to pay
171 subscribers a portion of unassigned funds under
172 certain circumstances; prohibiting the payment from
173 unfairly discriminating between classes of risks or
174 policies or between subscribers; providing that such

175 return of funds may vary as to classes of subscribers
176 based on certain factors; amending s. 629.171, F.S.;
177 requiring the subscribers’ advisory committee to
178 procure specified annual statements; specifying
179 requirements for such statements; requiring the annual
180 statement filing of a reciprocal insurer to be
181 submitted by its attorney in fact; requiring that the
182 statement of the attorney in fact be submitted in a
183 specified manner; amending s. 629.181, F.S.; revising
184 the rules for determining the financial condition of a
185 reciprocal insurer; prohibiting subscriber
186 contributions from exceeding certain amounts; amending
187 s. 629.201, F.S.; requiring domestic reciprocal
188 insurers to have a subscribers’ advisory committee;
189 requiring such committees to be formed in compliance
190 with certain provisions; requiring that the rules, and
191 any amendments thereto, which subscribers adopt be
192 approved by the office before becoming effective;
193 deleting composition requirements of such committees;
194 revising the duties of such committees; specifying
195 initial appointment and composition of such
196 committees; specifying requirements for the rules
197 governing appointment of subscribers to such
198 committees; requiring the attorney in fact to provide
199 a specified platform under certain circumstances;
200 repealing s. 629.271, F.S., relating to distribution
201 of savings; amending s. 629.291, F.S.; making a
202 clarifying change; requiring that a plan to merge a
203 reciprocal insurer with another reciprocal insurer be

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204 filed with the office on forms adopted by the
205 commission, rather than by the office; amending s.
206 629.301, F.S.; specifying certain requirements for
207 reciprocal insurers whose assets are insufficient to
208 discharge their liabilities; revising requirements for
209 instances when liquidation of a reciprocal insurer is
210 ordered; repealing s. 629.401, F.S., relating to
211 insurance exchanges; repealing s. 629.520, F.S.,
212 relating to the authority of a limited reciprocal
213 insurer; creating s. 629.56, F.S.; requiring a
214 reciprocal insurer to maintain a certain unearned
215 premium reserve; amending s. 634.401, F.S.; providing
216 an exception to the requirements that certain
217 contracts be covered by a certain policy; creating s.
218 641.2012, F.S.; providing applicability; amending s.
219 641.26, F.S.; requiring health maintenance
220 organizations to file a specified annual statement and
221 quarterly statements on or before specified dates;
222 revising a requirement that health maintenance
223 organizations file quarterly unaudited financial
224 statements; revising the commission’s authorization to
225 adopt rules; creating s. 641.283, F.S.; providing
226 applicability related to administrative supervision
227 and hazardous condition; amending s. 651.011, F.S.;
228 defining terms; revising definitions; amending s.
229 651.018, F.S.; requiring the office to place a
230 facility under administrative supervision under
231 certain circumstances; amending s. 651.019, F.S.;
232 requiring a provider to provide to the office a

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233 specified outline and a specified notice relating to
234 new financing or refinancing; creating s. 651.0212,
235 F.S.; requiring the office to deny or revoke a
236 provider's authority to conduct business under certain
237 circumstances; authorizing the office to deny or
238 revoke a provider's authority to conduct business
239 under certain circumstances; requiring providers to
240 remove certain persons from their business role under
241 certain circumstances; specifying that a certain
242 action constitutes grounds for suspension or
243 revocation of the provider's certificate of authority;
244 amending s. 651.0215, F.S.; revising the timeframe
245 within which the office must examine certain
246 information and make a specified notification to the
247 applicant; deleting a requirement that the office make
248 certain other notifications to applicants; deleting
249 provisions relating to the department's review,
250 issuance, and denial of a certificate of authority;
251 amending s. 651.022, F.S.; requiring that certain
252 feasibility studies be prepared by an independent
253 consultant; deleting a requirement for the office to
254 make certain notifications to applicants; deleting
255 provisions relating to the department's review,
256 issuance, and denial of a provisional certificate of
257 authority; amending s. 651.023, F.S.; deleting a
258 requirement that the office make certain notifications
259 to providers; deleting provisions relating to the
260 department's review, issuance, and denial of a
261 certificate of authority; amending s. 651.024, F.S.;

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262 specifying that certain bondholders are subject to
263 certain provisions and are not required to make
264 certain filings; specifying what is included in the
265 meaning of the term "consent rights"; specifying that
266 certain continuing care retirement communities are
267 subject to certain provisions and are not required to
268 make certain filings; amending s. 651.0246, F.S.;
269 revising the requirements for a provider applying for
270 expansion of a certificated facility; deleting a
271 requirement that the office make certain notifications
272 to applicants; revising the timeframe within which the
273 office must review certain information and make
274 certain approvals and determinations; amending s.
275 651.026, F.S.; revising the requirements for a
276 specified annual report; requiring certain providers
277 to submit a specified forecast; specifying the manner
278 and timeframe within which such forecast must be
279 presented; specifying that photocopies of certain
280 information must be provided to the office upon its
281 request; amending s. 651.0261, F.S.; conforming a
282 cross-reference; requiring that each provider file
283 certain documents quarterly with the office; amending
284 s. 651.033, F.S.; specifying that certain agreements
285 are subject to approval by the office before their
286 execution; defining the term "emergency"; specifying
287 requirements for a provider seeking to withdraw liquid
288 reserves in the event of an emergency; revising the
289 timeframe within which the office must deny certain
290 petitions; defining the term "business days";

291 conforming cross-references; revising requirements for
292 the filing of certain statements by providers;
293 requiring an escrow agent to provide certain
294 notifications; specifying requirements for certain
295 escrow agreements; amending s. 651.034, F.S.;
296 conforming provisions to changes made by the act;
297 revising the circumstances under which the office may
298 forego taking action after impairment; amending s.
299 651.035, F.S.; specifying requirements for certain
300 reserve accounts; requiring that a provider submit a
301 specified notice within a specified timeframe to the
302 office if a debt service reserve is transferred;
303 providing requirements for such notice; requiring
304 certain escrow agreements to comply with certain
305 provisions; providing construction; revising the
306 amounts each provider must maintain in escrow;
307 specifying that the provider has a certain timeframe
308 to fund the operating reserve; requiring the provider
309 to obtain written approval from the office before
310 reducing operating reserves; deleting reserve
311 requirements for certain providers; conforming a
312 cross-reference; prohibiting a provider from
313 withdrawing certain funds until written notice is
314 provided by the office; authorizing the office to
315 order the immediate transfer of certain funds under
316 certain circumstances; amending s. 651.043, F.S.;
317 requiring management companies, as well as providers,
318 to notify the office of any change in certain
319 information; amending s. 651.071, F.S.; providing that

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320 claims against assets owned by a provider are not
321 subordinate to certain claims and must be treated with
322 a higher priority over certain claims; amending s.
323 651.085, F.S.; requiring designated resident
324 representatives to perform duties in good faith;
325 requiring that providers that own or operate more than
326 one facility ensure each facility has its own
327 designated resident representative; revising
328 requirements for notifications to designated resident
329 representatives regarding meetings related to the
330 annual budget and proposed changes in fees or
331 services; creating s. 651.087, F.S.; providing that
332 control of the organized collection and distribution
333 of certain funds for specified purposes may not be
334 controlled by a provider or management company;
335 providing requirements for providers or management
336 companies assisting in the collection or disbursement
337 of such funds; prohibiting providers or management
338 companies from borrowing or soliciting funds from
339 residents for certain purposes without office
340 approval; requiring providers or management companies
341 to comply with certain requirements before any funds
342 are eligible for distribution; prohibiting the
343 requested amount of borrowed funds from exceeding a
344 certain amount; prohibiting such funds from being used
345 for a specified purpose; requiring providers or
346 management companies to make a specified
347 acknowledgment under certain circumstances; requiring
348 that the office receive majority support from the

349 residents’ council before approving a provider’s or
350 management company’s request; requiring providers or
351 management companies to comply with certain
352 requirements after receiving approval from the office;
353 providing that failure to comply with all requirements
354 is a violation of certain provisions and the provider
355 or management company will be considered impaired;
356 requiring providers or management companies to provide
357 a specified notice and repay certain amounts under
358 certain circumstances; authorizing the commission to
359 adopt rules governing submission of certain statements
360 or filings; amending s. 651.091, F.S.; revising the
361 duties of continuing care facilities; revising the
362 required disclosures by continuing care or continuing
363 care at-home providers to residents; specifying that
364 certain providers are liable for actual damages and
365 any interest thereon, reasonable attorney fees, and
366 court costs under certain circumstances; requiring the
367 provider to refund of certain fees under certain
368 circumstances; providing applicability; prohibiting a
369 person from filing a specified action under certain
370 circumstances; providing that failure to comply with a
371 certain provision is a violation of a certain
372 provision and that the provider will be considered
373 impaired; requiring a provider to comply with certain
374 provision by a specified time; requiring certain
375 providers to submit a specified notice; specifying
376 that the repayment of any outstanding borrowed funds
377 shall be accelerated under certain circumstances;

378 creating s. 651.104, F.S.; declaring that it is
379 unlawful for a person to act as or hold himself or
380 herself out to be a management company for a
381 continuing care retirement community without a valid
382 certificate of authority; authorizing certain
383 management companies to operate without a certificate
384 of authority until a specified date; specifying
385 requirements for a management company to qualify for
386 and hold authority to act as a management company;
387 providing a civil penalty; requiring management
388 companies to file an application with the office;
389 specifying requirements for such application;
390 specifying additional information the commission or
391 office may require applicants to submit with their
392 applications; requiring applicants to make certain
393 information available for inspection; prohibiting the
394 office from issuing a certificate of authority under
395 certain circumstances; specifying that a certificate
396 of authority remains valid so long as the
397 certificateholder continues in business; requiring
398 management companies to pay a fee under certain
399 circumstances; creating s. 651.1041, F.S.; specifying
400 that an acquisition of a management company is
401 governed by certain provisions; creating s. 651.1043,
402 F.S.; requiring each authorized management company to
403 file with the office certain financial statements;
404 specifying requirements for such statements;
405 specifying when the financial statements must be
406 submitted each year within a specified timeframe;

407 requiring the submission of such other data,
408 statements, and information as the commission or
409 office may require; requiring the management company
410 to file an acquisition application for any material
411 change in its ownership; requiring management
412 companies to file quarterly unaudited financial
413 statements within a specified timeframe in a certain
414 form; authorizing the office to require additional
415 filings under certain circumstances; specifying civil
416 penalties; specifying that the management company’s
417 authority ceases until a specified time under certain
418 circumstances; prohibiting the office from collecting
419 more than a certain amount in a specified penalty;
420 requiring that moneys collected be deposited to the
421 credit of a certain trust fund; authorizing the
422 commission to require that filings be made by certain
423 electronic means; creating s. 651.1045, F.S.;
424 authorizing the office to deny an application or
425 suspend or revoke the certificate of authority of a
426 management company on certain grounds; specifying that
427 revocation of a management company’s certificate of
428 authority does not relieve a provider of certain
429 obligations; requiring such management companies to
430 continue to make certain filings and pay certain fees
431 to the office; prohibiting such management companies
432 from issuing certain contracts; authorizing the office
433 to seek certain actions in a specified court; amending
434 s. 651.105, F.S.; conforming provisions to changes
435 made by the act; deleting the prohibition against

436 examination of certain providers; requiring that
437 certain providers are subject to examination; amending
438 s. 651.1065, F.S.; conforming provisions to changes
439 made by the act; creating s. 651.1068, F.S.;
440 prohibiting certain persons who served as officers and
441 directors of a provider or a management company that
442 became insolvent within a specified timeframe from
443 serving again as officers and directors of a provider
444 or management company under certain circumstances;
445 providing an exception; amending s. 651.107, F.S.;
446 conforming provisions to changes made by the act;
447 amending s. 651.108, F.S.; conforming a provision to
448 changes made by the act; creating s. 651.113, F.S.;
449 defining the term "negative fund balance"; authorizing
450 the Commissioner of Insurance Regulation to deem
451 certain providers or facilities insolvent or in
452 imminent danger of becoming insolvent under certain
453 circumstances; requiring the provider or facility to
454 prepare a plan to address certain conditions;
455 requiring that the plan be presented to the
456 commissioner within a specified timeframe; authorizing
457 the commissioner to proceed with liquidation under
458 certain circumstances; authorizing the office to issue
459 a certain order requiring certain actions by the
460 provider or facility; authorizing the office to issue
461 a certain immediate final order; providing
462 construction; amending s. 651.114, F.S., deleting
463 provisions regarding the rights and limitations of
464 trustees and lenders in relation to continuing care

465 facilities; creating s. 651.1165, F.S.; requiring the
466 office to record a notice of lien under certain
467 circumstances for a specified purpose; specifying the
468 amount of the lien; specifying that the lien be
469 perfected by the office; specifying the contents of
470 the notice and claim of lien; authorizing release or
471 partial release of the lien under certain
472 circumstances; authorizing foreclosure of the lien by
473 civil action; specifying requirements for joining and
474 consolidation of such actions; authorizing the court
475 to allow reasonable attorney fees under certain
476 circumstances; specifying the judgment under certain
477 actions; specifying the preference of certain liens;
478 requiring the office to file a release of lien under
479 certain circumstances; authorizing the office to
480 subordinate certain liens; specifying a timeframe
481 within which certain insurers must comply with certain
482 statutory changes; providing effective dates.
483
484 Be It Enacted by the Legislature of the State of Florida:
485
486 Section 1. Subsection (3) of section 48.151, Florida
487 Statutes, is amended to read:
488 48.151 Service on statutory agents for certain persons.—
489 (3) The Chief Financial Officer is the agent for service of
490 process on all insurers applying for authority to transact
491 insurance in this state, all licensed nonresident insurance
492 agents, all nonresident disability insurance agents licensed
493 pursuant to s. 626.835, any unauthorized insurer under s.

494 626.906 or s. 626.937, domestic reciprocal insurers, fraternal
495 benefit societies under chapter 632, warranty associations under
496 chapter 634, prepaid limited health service organizations under
497 chapter 636, health maintenance organizations under chapter 641,
498 and persons required to file statements under s. 628.461. The
499 Department of Financial Services shall create a secure online
500 portal as the sole means to accept service of process on the
501 Chief Financial Officer under this section.
502 Section 2. Subsection (3) of section 252.63, Florida
503 Statutes, is amended to read:
504 252.63 Commissioner of Insurance Regulation; powers in a
505 state of emergency.—
506 (3) The commissioner shall publish in the next available
507 publication of the Florida Administrative Register a notice
508 identifying the date the emergency order was issued. The notice
509 must include a hyperlink or website address providing direct
510 access to the emergency order ~~copy of the text of any order~~
511 ~~issued under this section, together with a statement describing~~
512 ~~the modification or suspension and explaining how the~~
513 ~~modification or suspension will facilitate recovery from the~~
514 ~~emergency~~.
515 Section 3. Paragraph (g) of subsection (1) of section
516 624.4085, Florida Statutes, is amended to read:
517 624.4085 Risk-based capital requirements for insurers.—
518 (1) As used in this section, the term:
519 (g) "Life and health insurer" means an insurer authorized
520 or eligible under the Florida Insurance Code to underwrite life
521 or health insurance. The term includes a property and casualty
522 insurer that writes accident and health insurance only.

523 ~~Effective January 1, 2015,~~ The term also includes a health
524 maintenance organization that is authorized in this state ~~and~~
525 ~~one or more other states, jurisdictions, or countries~~ and a
526 prepaid limited health service organization that is authorized
527 in this state and one or more other states, jurisdictions, or
528 countries.
529 Section 4. Present subsection (3) of section 624.422,
530 Florida Statutes, is redesignated as subsection (4), and a new
531 subsection (3) is added to that section, to read:
532 624.422 Service of process; appointment of Chief Financial
533 Officer as process agent.—
534 (3) The appointment of the Chief Financial Officer under
535 this section applies to any insurer that withdraws from or
536 ceases operations in this state until the insurer has completed
537 its runoff of, or otherwise extinguished, all liabilities in
538 Florida.
539 Section 5. Subsection (2) of section 624.45, Florida
540 Statutes, is amended to read:
541 624.45 Participation of financial institutions in
542 reinsurance and in insurance exchanges.—Subject to applicable
543 laws relating to financial institutions and to any other
544 applicable provision of the Florida Insurance Code, any
545 financial institution or aggregation of such institutions may:
546 (2) Participate, directly or indirectly, as an underwriting
547 member or as an investor in an underwriting member of any
548 insurance exchange ~~authorized in accordance with s. 629.401~~,
549 which underwriting member transacts only aggregate or specific
550 excess insurance over underlying self-insurance coverage for
551 self-insurance organizations authorized under the Florida

552 Insurance Code, for multiple-employer welfare arrangements, or
553 for workers' compensation self-insurance trusts, in addition to
554 any reinsurance the underwriting member may transact.
555
556 Nothing in this section shall be deemed to prohibit a financial
557 institution from engaging in any presently authorized insurance
558 activity.
559 Section 6. Present subsection (15) of section 624.610,
560 Florida Statutes, is redesignated as subsection (16), a new
561 subsection (15) is added to that section, and paragraph (b) of
562 subsection (3), paragraph (b) of subsection (12), and present
563 subsection (16) of that section are amended, to read:
564 624.610 Reinsurance.—
565 (3)
566 (b)1. Credit must be allowed when the reinsurance is ceded
567 to an assuming insurer that is accredited as a reinsurer in this
568 state. An accredited reinsurer is one that:
569 a. Files with the office evidence of its submission to this
570 state's jurisdiction;
571 b. Submits to this state's authority to examine its books
572 and records;
573 c. Is licensed or authorized to transact insurance or
574 reinsurance in at least one state or, in the case of a United
575 States branch of an alien assuming insurer, is entered through,
576 licensed, or authorized to transact insurance or reinsurance in
577 at least one state;
578 d. Files annually with the office a copy of its annual
579 statement filed with the insurance department of its state of
580 domicile any quarterly statements if required by its state of

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581 domicile or such quarterly statements if specifically requested
582 by the office, and a copy of its most recent audited financial
583 statement; and
584 (I) Maintains a surplus as regards policyholders in an
585 amount not less than $20 million and whose accreditation has not
586 been denied by the office within 90 days after its submission;
587 or
588 (II) Maintains a surplus as regards policyholders in an
589 amount not less than $20 million and whose accreditation has
590 been approved by the office.
591 2. The office may deny or revoke an assuming insurer's
592 accreditation if the assuming insurer does not submit the
593 required documentation pursuant to subparagraph 1., if the
594 assuming insurer fails to meet all of the standards required of
595 an accredited reinsurer, or if the assuming insurer's
596 accreditation would be hazardous to the policyholders of this
597 state. In determining whether to deny or revoke accreditation,
598 the office may consider the qualifications of the assuming
599 insurer with respect to all the following subjects:
600 a. Its financial stability;
601 b. The lawfulness and quality of its investments;
602 c. The competency, character, and integrity of its
603 management;
604 d. The competency, character, and integrity of persons who
605 own or have a controlling interest in the assuming insurer; and
606 e. Whether claims under its contracts are promptly and
607 fairly adjusted and are promptly and fairly paid in accordance
608 with the law and the terms of the contracts.
609 3. Credit must not be allowed a ceding insurer if the

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610 assuming insurer’s accreditation has been revoked by the office
611 after notice and the opportunity for a hearing.
612 ~~4. The actual costs and expenses incurred by the office to~~
613 ~~review a reinsurer’s request for accreditation and subsequent~~
614 ~~reviews must be charged to and collected from the requesting~~
615 ~~reinsurer. If the reinsurer fails to pay the actual costs and~~
616 ~~expenses promptly when due, the office may refuse to accredit~~
617 ~~the reinsurer or may revoke the reinsurer’s accreditation.~~
618 (12)
619 (b) The summary statement must be signed and attested to by
620 either the chief executive officer or the chief financial
621 officer of the reporting insurer. In addition to the summary
622 statement, the office may require the filing of any supporting
623 information relating to the ceding of such risks as it deems
624 necessary. If the summary statement prepared by the ceding
625 insurer discloses that the net effect of a reinsurance treaty or
626 treaties (or series of treaties with one or more affiliated
627 reinsurers entered into for the purpose of avoiding the
628 following threshold amount) at any time results in an increase
629 of more than 25 percent to the insurer’s surplus as to
630 policyholders, then the insurer shall certify in writing to the
631 office that the relevant reinsurance treaty or treaties comply
632 with the accounting requirements contained in any rule adopted
633 by the commission under <u>subsection (16)</u> ~~subsection (15)~~. If such
634 certificate is filed after the summary statement of such
635 reinsurance treaty or treaties, the insurer shall refile the
636 summary statement with the certificate. In any event, the
637 certificate must state that a copy of the certificate was sent
638 to the reinsurer under the reinsurance treaty.

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639 (15) Any application filed with the office to review a
640 reinsurer's request to operate in this state under this section
641 must be accompanied by a filing fee equal to the application fee
642 charged under s. 624.501(1)(a).
643 ~~(16) This act shall apply to all cessions on or after~~
644 ~~January 1, 2001, under reinsurance agreements that have an~~
645 ~~inception, anniversary, or renewal date on or after January 1,~~
646 ~~2001.~~
647 Section 7. Section 626.9651, Florida Statutes, is amended
648 to read:
649 626.9651 Security of consumer data ~~Privacy~~.—
650 (1) The department and commission shall ~~must~~ each adopt
651 rules consistent with other provisions of the Florida Insurance
652 Code to govern the use of a consumer's nonpublic personal
653 financial and health information. These rules must be based on,
654 consistent with, and not more restrictive than the Privacy of
655 Consumer Financial and Health Information Regulation, adopted
656 September 26, 2000, by the National Association of Insurance
657 Commissioners; however, the rules must permit the use and
658 disclosure of nonpublic personal health information for
659 scientific, medical, or public policy research, in accordance
660 with federal law. In addition, these rules must be consistent
661 with, and not more restrictive than, the standards contained in
662 Title V of the Gramm-Leach-Bliley Act of 1999, Pub. L. No. 106-
663 102, as amended in Title LXXV of the Fixing America's Surface
664 Transportation (FAST) Act, Pub. L. No. 114-94. If the office
665 determines that a health insurer or health maintenance
666 organization is in compliance with, or is actively undertaking
667 compliance with, the consumer privacy protection rules adopted

668 by the United States Department of Health and Human Services, in
669 conformance with the Health Insurance Portability and
670 Affordability Act, that health insurer or health maintenance
671 organization is in compliance with this subsection ~~section~~.
672 (2) The commission shall adopt rules consistent with state
673 law, including the Florida Insurance Code and s. 501.171, to
674 ensure the cybersecurity of a consumer's nonpublic insurance
675 data. Such rules may not be more restrictive than the National
676 Association of Insurance Commissioners Insurance Data Security
677 Model Law, adopted in October 2017, and subsequent amendments
678 thereto if the methodology remains substantially consistent. The
679 rules must meet all of the following requirements:
680 (a) Apply to all entities acting as insurers, transacting
681 insurance, or otherwise engaging in insurance activities in this
682 state, including entities licensed under chapter 641, and any
683 entity that has been contracted to maintain, store, or process
684 personal information on behalf of a covered entity.
685 (b) Require the development and implementation of an
686 information security program as defined in the model law.
687 (c) Require investigation and notification of a
688 cybersecurity event as required under the model law.
689 (d) Require insurers to submit all or part of the required
690 information to the department or office in a computer-readable
691 format compatible with the department's or office's electronic
692 data processing system.
693 (e) Ensure that the office receives a copy of any notice
694 provided to the Department of Legal Affairs under s. 501.171.
695 (3) Upon receiving information under this section, the
696 office shall review the information and may initiate an

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697 examination and investigation under s. 624.316, s. 624.3161, or
698 s. 626.8828.
699 Section 8. Paragraph (a) of subsection (2) of section
700 627.062, Florida Statutes, is amended to read:
701 627.062 Rate standards.—
702 (2) As to all such classes of insurance:
703 (a) Insurers or rating organizations shall establish and
704 use rates, rating schedules, or rating manuals that allow the
705 insurer a reasonable rate of return on the classes of insurance
706 written in this state. A copy of rates, rating schedules, rating
707 manuals, premium credits or discount schedules, and surcharge
708 schedules, and changes thereto, must be filed with the office
709 under one of the following procedures:
710 1. If the filing is made at least 90 days before the
711 proposed effective date and is not implemented during the
712 office's review of the filing and any proceeding and judicial
713 review, such filing is considered a "file and use" filing. In
714 such case, the office shall finalize its review by issuance of a
715 notice of intent to approve or a notice of intent to disapprove
716 within 90 days after receipt of the filing. If the 90-day period
717 ends on a weekend or a holiday under s. 110.117(1)(a)-(i), it
718 must be extended until the conclusion of the next business day.
719 The notice of intent to approve and the notice of intent to
720 disapprove constitute agency action for purposes of the
721 Administrative Procedure Act. Requests for supporting
722 information, requests for mathematical or mechanical
723 corrections, or notification to the insurer by the office of its
724 preliminary findings does not toll the 90-day period during any
725 such proceedings and subsequent judicial review. The rate shall

726 be deemed approved if the office does not issue a notice of
727 intent to approve or a notice of intent to disapprove within 90
728 days after receipt of the filing.
729 2. If the filing is not made in accordance with
730 subparagraph 1., such filing must be made as soon as
731 practicable, but within 30 days after the effective date, and is
732 considered a "use and file" filing. An insurer making a "use and
733 file" filing is potentially subject to an order by the office to
734 return to policyholders those portions of rates found to be
735 excessive, as provided in paragraph (h). For the purposes of
736 this subparagraph, a personal residential property insurer may
737 submit only one "use and file" filing affecting policyholders
738 within a single policy period, unless the filing is exclusively
739 related to reinsurance.
740 3. For all property insurance filings made or submitted
741 after January 25, 2007, but before May 1, 2012, an insurer
742 seeking a rate that is greater than the rate most recently
743 approved by the office shall make a "file and use" filing. For
744 purposes of this subparagraph, motor vehicle collision and
745 comprehensive coverages are not considered property coverages.
746
747 The provisions of this subsection do not apply to workers'
748 compensation, employer's liability insurance, and motor vehicle
749 insurance.
750 Section 9. Effective upon becoming a law, subsection (2) of
751 section 627.0621, Florida Statutes, is amended, and subsection
752 (3) is added to that section, to read:
753 627.0621 Transparency in rate regulation.—
754 (2) RATE TRANSPARENCY REPORT.—

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755 (a) Beginning on October 1, 2025, every rate filing for
756 residential property coverage from a property insurer must
757 include a rate transparency report for approval or modification
758 by the office. The office may accept the rate transparency
759 report, or if it finds that the report fails to provide the
760 required information in concise and plain language that aids
761 consumers in their understanding of insurance or finds the
762 report to be misleading, it must return the report to the
763 property insurer for modification. The office's acceptance of
764 the report, including any modifications, does not constitute
765 approval under s. 627.062.
766 (b) An insurer shall provide a rate transparency report
767 with an offer of coverage and upon policy renewal to help
768 consumers understand their insurance rates. If the report has
769 not been approved or modified by the office, it must be labeled
770 as preliminary and subject to future changes.
771 (c) The rate transparency report must be compiled in a
772 uniform format prescribed by the commission and must include a
773 graphical representation identifying the percentage breakdown of
774 rating factors anticipated to impact the company, its book of
775 business, or its program affected by the filing. The report must
776 include all of the following percentages, which must total 100
777 percent, categorized by territory and at the cumulative level:
778 1. The percentage of the total rate factor associated with
779 the cost of reinsurance.
780 2. The percentage of the total rate factor associated with
781 the cost of claims.
782 3. The percentage of the total rate factor associated with
783 defense and containment costs.

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784 4. The percentage of the total rate factor associated with
785 fees and commissions.
786 5. The percentage of the rate factor associated with profit
787 and contingency of the insurer.
788 6. Any other percentages deemed necessary by the office or
789 commission.
790 (d) The rate transparency report must also include the
791 following information:
792 1. Any major adverse findings by the office for the
793 previous 3 calendar years.
794 2. Whether the insurer uses affiliated entities to perform
795 functions of the insurer.
796 3. Contact information, including a phone number, hours of
797 service, and e-mail address, for the department’s Division of
798 Consumer Services.
799 4. Contact information for the office.
800 5. The address for the website for public access to rate
801 filing and affiliate information specified in subsection (3).
802 6. Any changes in the total insured value from the last
803 policy period.
804 (e) The office shall define any terms used with the rate
805 transparency report using concise and plain language to aid
806 consumers in their understanding of insurance.
807 (3) WEBSITE FOR PUBLIC ACCESS TO RATE FILING INFORMATION.—
808 (a) The office shall establish and maintain a comprehensive
809 resource center on its website which uses concise and plain
810 language to aid consumers in their understanding of insurance.
811 The resource center must include substantive information on the
812 current and historical dynamics of the market, available data

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813 concerning the financial condition and market conduct of
814 insurance companies, and the insurance coverage choices
815 available to consumers. At a minimum, the resource center must
816 contain all of the following:
817 1. Reports, using graphical information whenever possible,
818 which outline information about the state of the insurance
819 market and adverse and positive trends affecting it.
820 2. Tools that aid consumers in finding insurers.
821 3. Tools that aid consumers in determining coverages
822 beneficial to them.
823 4. Information about mitigation credits and the My Safe
824 Florida Home program, as well as other credits insurers may
825 offer in addition to wind mitigation.
826 5. Access to the rate transparency reports, annual
827 statements, market conduct information, and other information
828 related to each insurer.
829 6. Information on the Citizens Property Insurance
830 Corporation takeout process, the clearinghouse, and general
831 information as reported by the office.
832 7. With respect to any residential property rate filing~~,~~
833 ~~the office shall provide the following information on a publicly~~
834 ~~accessible Internet website~~:
835 a.~~1.~~ The overall rate change requested by the insurer.
836 b.~~2.~~ The rate change approved by the office along with all
837 of the actuary's assumptions and recommendations forming the
838 basis of the office's decision.
839 c.~~3.~~ Certification by the office's actuary that, based on
840 the actuary's knowledge, his or her recommendations are
841 consistent with accepted actuarial principles.

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842 d. Whether the insurer uses affiliated entities to perform
843 administrative, claims handling, or other functions of the
844 insurer and, if so, the total percentage of direct written
845 premium paid to the affiliated entities by the insurer in the
846 preceding calendar year.
847 (b) For any rate filing, regardless of whether ~~or not~~ the
848 filing is subject to a public hearing, the office shall provide
849 on its website a means for any policyholder who may be affected
850 by a proposed rate change to send an e-mail regarding the
851 proposed rate change. Such e-mail must be accessible to the
852 actuary assigned to review the rate filing.
853 (c) The statewide average requested rate change and final
854 approved statewide average rate change in a filing is not a
855 trade secret as defined in s. 688.002(4) or s. 812.081 and is
856 not subject to the public records exemption for trade secrets
857 provided in s. 119.0715 or s. 624.4213.
858 (d) County rating examples submitted to the office through
859 the rate collection system for the purposes of displaying rates
860 on its website is not a trade secret as defined in s. 688.002(4)
861 or s. 812.081 and is not subject to the public records exemption
862 for trade secrets provided in s. 119.0715 or s. 624.4213.
863 Section 10. Paragraph (b) of subsection (3) of section
864 627.0645, Florida Statutes, is amended to read:
865 627.0645 Annual filings.—
866 (3) The filing requirements of this section shall be
867 satisfied by one of the following methods:
868 (b) If no rate change is proposed, a filing which consists
869 of a certification by an actuary that the existing rate level
870 produces rates which are actuarially sound and which are not

871 inadequate, as defined in s. 627.062. However, a full rate
872 filing is required after 2 consecutive years of certifications
873 under this paragraph.
874 Section 11. Paragraph (b) of subsection (1) of section
875 627.0651, Florida Statutes, is amended to read:
876 627.0651 Making and use of rates for motor vehicle
877 insurance.—
878 (1) Insurers shall establish and use rates, rating
879 schedules, or rating manuals to allow the insurer a reasonable
880 rate of return on motor vehicle insurance written in this state.
881 A copy of rates, rating schedules, and rating manuals, and
882 changes therein, shall be filed with the office under one of the
883 following procedures:
884 (b) If the filing is not made in accordance with the
885 provisions of paragraph (a), such filing must ~~shall~~ be made as
886 soon as practicable, but no later than 30 days after the
887 effective date, and must ~~shall~~ be considered a "use and file"
888 filing. An insurer making a "use and file" filing is potentially
889 subject to an order by the office to return to policyholders
890 portions of rates found to be excessive, as provided in
891 subsection (11). For purposes of this paragraph, an insurer may
892 submit only one "use and file" filing affecting policyholders
893 within a single policy period.
894 Section 12. Effective upon becoming a law, paragraph (a) of
895 subsection (5) of section 627.4554, Florida Statutes, is amended
896 to read:
897 627.4554 Suitability in annuity transactions.—
898 (5) DUTIES OF INSURERS AND AGENTS.—
899 (a) An agent, when making a recommendation of an annuity,

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900 shall act in the best interest of the consumer under the
901 circumstances known at the time the recommendation is made,
902 without placing the financial interest of the agent or insurer
903 ahead of the consumer's interest. An agent has acted in the best
904 interest of the consumer if the agent has satisfied the
905 following obligations regarding care, disclosure, conflict of
906 interest, and documentation:
907 1.a. The agent, in making a recommendation, shall exercise
908 reasonable diligence, care, and skill to:
909 (I) Know the financial situation, insurance needs, and
910 financial objectives of the customer.
911 (II) Understand the available options after making a
912 reasonable inquiry into options available to the agent.
913 (III) Have a reasonable basis to believe the recommended
914 option effectively addresses the consumer's financial situation,
915 insurance needs, and financial objectives over the life of the
916 product, as evaluated in light of the consumer profile
917 information.
918 (IV) Communicate the reason or reasons for the
919 recommendation.
920 b. The requirements of sub-subparagraph a. include:
921 (I) Making reasonable efforts to obtain consumer profile
922 information from the consumer before the recommendation of an
923 annuity.
924 (II) Requiring an agent to consider the types of products
925 the agent is authorized and licensed to recommend or sell which
926 address the consumer's financial situation, insurance needs, and
927 financial objectives. This does not require analysis or
928 consideration of any products outside the authority and license

929 of the agent or other possible alternative products or
930 strategies available in the market at the time of the
931 recommendation. Agents shall be held to standards applicable to
932 agents with similar authority and licensure.
933 (III) Having a reasonable basis to believe the consumer
934 would benefit from certain features of the annuity, such as
935 annuitization, death or living benefit, or other insurance-
936 related features.
937 c. The requirements of this subsection do not create a
938 fiduciary obligation or relationship and only create a
939 regulatory obligation as provided in this section.
940 d. The consumer profile information; characteristics of the
941 insurer; and product costs, rates, benefits, and features are
942 those factors generally relevant in making a determination
943 whether an annuity effectively addresses the consumer's
944 financial situation, insurance needs, and financial objectives,
945 but the level of importance of each factor under the care
946 obligation of this paragraph may vary depending on the facts and
947 circumstances of a particular case. However, each factor may not
948 be considered in isolation.
949 e. The requirements under sub-subparagraph a. apply to the
950 particular annuity as a whole and the underlying subaccounts to
951 which funds are allocated at the time of purchase or exchange of
952 an annuity, and riders and similar product enhancements, if any.
953 f. Sub-subparagraph a. does not require that the annuity
954 with the lowest one-time occurrence compensation structure or
955 multiple occurrence compensation structure shall necessarily be
956 recommended.
957 g. Sub-subparagraph a. does not require the agent to have

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958 ongoing monitoring obligations under the care obligation,
959 although such an obligation may be separately owed under the
960 terms of a fiduciary, consulting, investment, advising, or
961 financial planning agreement between the consumer and the agent.
962 h. In the case of an exchange or replacement of an annuity,
963 the agent shall consider the whole transaction, which includes
964 taking into consideration whether:
965 (I) The consumer will incur a surrender charge; be subject
966 to the commencement of a new surrender period; lose existing
967 benefits, such as death, living, or other contractual benefits;
968 or be subject to increased fees, investment advisory fees, or
969 charges for riders and similar product enhancements.
970 (II) The replacing product would substantially benefit the
971 consumer in comparison to the replaced product over the life of
972 the product.
973 (III) The consumer has had another annuity exchange or
974 replacement and, in particular, an exchange or replacement
975 within the preceding 60 months.
976 i. This section does not require an agent to obtain any
977 license other than an agent license with the appropriate line of
978 authority to sell, solicit, or negotiate insurance in this
979 state, including, but not limited to, any securities license, in
980 order to fulfill the duties and obligations contained in this
981 section; provided, the agent does not give advice or provide
982 services that are otherwise subject to securities laws or engage
983 in any other activity requiring other professional licenses.
984 2.a. Before the recommendation or sale of an annuity, the
985 agent shall prominently disclose to the consumer, on a form
986 substantially similar to that posted on the department ~~office~~

987 website as Appendix A, related to an insurance agent disclosure
988 for annuities:
989 (I) A description of the scope and terms of the
990 relationship with the consumer and the role of the agent in the
991 transaction.
992 (II) An affirmative statement on whether the agent is
993 licensed and authorized to sell the following products:
994 (A) Fixed annuities.
995 (B) Fixed indexed annuities.
996 (C) Variable annuities.
997 (D) Life insurance.
998 (E) Mutual funds.
999 (F) Stocks and bonds.
1000 (G) Certificates of deposit.
1001 (III) An affirmative statement describing the insurers for
1002 which the agent is authorized, contracted, or appointed, or
1003 otherwise able to sell insurance products, using the following
1004 descriptions:
1005 (A) From one insurer;
1006 (B) From two or more insurers; or
1007 (C) From two or more insurers, although primarily
1008 contracted with one insurer.
1009 (IV) A description of the sources and types of cash
1010 compensation and noncash compensation to be received by the
1011 agent, including whether the agent is to be compensated for the
1012 sale of a recommended annuity by commission as part of premium
1013 or other remuneration received from the insurer, intermediary,
1014 or other agent, or by fee as a result of a contract for advice
1015 or consulting services.

1016 (V) A notice of the consumer’s right to request additional
1017 information regarding cash compensation described in sub-
1018 subparagraph b.
1019 b. Upon request of the consumer or the consumer’s
1020 designated representative, the agent shall disclose:
1021 (I) A reasonable estimate of the amount of cash
1022 compensation to be received by the agent, which may be stated as
1023 a range of amounts or percentages.
1024 (II) Whether the cash compensation is a one-time or
1025 multiple occurrence amount; and if a multiple occurrence amount,
1026 the frequency and amount of the occurrence, which may be stated
1027 as a range of amounts or percentages.
1028 c. Before or at the time of the recommendation or sale of
1029 an annuity, the agent shall have a reasonable basis to believe
1030 the consumer has been informed of various features of the
1031 annuity, such as the potential surrender period and surrender
1032 charge; potential tax penalty if the consumer sells, exchanges,
1033 surrenders, or annuitizes the annuity; mortality and expense
1034 fees; any annual fees; investment advisory fees; potential
1035 charges for and features of riders or other options of the
1036 annuity; limitations on interest returns; potential changes in
1037 nonguaranteed elements of the annuity; insurance and investment
1038 components; and market risk.
1039 3. An agent shall identify and avoid or reasonably manage
1040 and disclose material conflicts of interest, including material
1041 conflicts of interest related to an ownership interest.
1042 4. An agent shall at the time of the recommendation or
1043 sale:
1044 a. Make a written record of any recommendation and the

1045 basis for the recommendation, subject to this section.
1046 b. Obtain a consumer-signed statement on a form
1047 substantially similar to that posted on the office website as
1048 Appendix B, related to a consumer's refusal to provide
1049 information, documenting:
1050 (I) A customer's refusal to provide the consumer profile
1051 information, if any.
1052 (II) A customer's understanding of the ramifications of not
1053 providing his or her consumer profile information or providing
1054 insufficient consumer profile information.
1055 c. Obtain a consumer-signed statement on a form
1056 substantially similar to that posted on the office website as
1057 Appendix C, related to a consumer's decision to purchase an
1058 annuity not based on a recommendation, acknowledging the annuity
1059 transaction is not recommended if a customer decides to enter
1060 into an annuity transaction that is not based on the agent's
1061 recommendation.
1062 5. Any requirement applicable to an agent under this
1063 subsection applies to every agent who has exercised material
1064 control or influence in the making of a recommendation and has
1065 received direct compensation as a result of the recommendation
1066 or sale, regardless of whether the agent has had any direct
1067 contact with the consumer. Activities such as providing or
1068 delivering marketing or education materials, product wholesaling
1069 or other back office product support, and general supervision of
1070 an agent do not, in and of themselves, constitute material
1071 control or influence.
1072 Section 13. Subsection (3) of section 627.642, Florida
1073 Statutes, is amended to read:

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1074 627.642 Outline of coverage.—
1075 (3) In addition to the outline of coverage, a policy as
1076 specified in s. 627.6699(3)(j) ~~s. 627.6699(3)(k)~~ must be
1077 accompanied by an identification card that contains, at a
1078 minimum:
1079 (a) The name of the organization issuing the policy or the
1080 name of the organization administering the policy, whichever
1081 applies.
1082 (b) The name of the contract holder.
1083 (c) The type of plan only if the plan is filed in the
1084 state, an indication that the plan is self-funded, or the name
1085 of the network.
1086 (d) The member identification number, contract number, and
1087 policy or group number, if applicable.
1088 (e) A contact phone number or electronic address for
1089 authorizations and admission certifications.
1090 (f) A phone number or electronic address whereby the
1091 covered person or hospital, physician, or other person rendering
1092 services covered by the policy may obtain benefits verification
1093 and information in order to estimate patient financial
1094 responsibility, in compliance with privacy rules under the
1095 Health Insurance Portability and Accountability Act.
1096 (g) The national plan identifier, in accordance with the
1097 compliance date set forth by the federal Department of Health
1098 and Human Services.
1099
1100 The identification card must present the information in a
1101 readily identifiable manner or, alternatively, the information
1102 may be embedded on the card and available through magnetic

1103 stripe or smart card. The information may also be provided
1104 through other electronic technology.
1105 Section 14. Present paragraphs (b) through (e) of
1106 subsection (2) of section 627.6475, Florida Statutes, are
1107 redesignated as paragraphs (c) through (f), respectively, a new
1108 paragraph (b) is added to that subsection, and paragraph (a) of
1109 subsection (2), paragraphs (a), (e), and (g) of subsection (7)
1110 and paragraph (a) of subsection (8) are amended, to read:
1111 627.6475 Individual reinsurance pool.—
1112 (2) DEFINITIONS.—As used in this section:
1113 (a) “Board~~,~~” means the board of directors of the individual
1114 health reinsurance program.
1115 (b) “Carrier~~,~~” and “health benefit plan” have the same
1116 meaning ascribed in s. 627.6699(3).
1117 (7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.—
1118 (a) The individual health reinsurance program shall operate
1119 subject to the supervision and control of the board ~~of the small~~
1120 ~~employer health reinsurance program established pursuant to s.~~
1121 ~~627.6699(11)~~. The board shall establish a separate, segregated
1122 account for eligible individuals reinsured pursuant to this
1123 section~~, which account may not be commingled with the small~~
1124 ~~employer health reinsurance account~~.
1125 (e)1. Before March 1 of each calendar year, the board shall
1126 determine and report to the office the program net loss in the
1127 individual account for the previous year, including
1128 administrative expenses for that year and the incurred losses
1129 for that year, taking into account investment income and other
1130 appropriate gains and losses.
1131 2. Any net loss in the individual account for the year

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1132 shall be recouped by assessing the carriers as follows:
1133 a. The operating losses of the program shall be assessed in
1134 the following order subject to the specified limitations. The
1135 first tier of assessments shall be made against reinsuring
1136 carriers in an amount that may not exceed 5 percent of each
1137 reinsuring carrier’s premiums for individual health insurance.
1138 If such assessments have been collected and additional moneys
1139 are needed, the board shall make a second tier of assessments in
1140 an amount that may not exceed 0.5 percent of each carrier’s
1141 health benefit plan premiums.
1142 b. Except as provided in paragraph (f), risk-assuming
1143 carriers are exempt from all assessments authorized pursuant to
1144 this section. The amount paid by a reinsuring carrier for the
1145 first tier of assessments shall be credited against any
1146 additional assessments made.
1147 c. The board shall equitably assess reinsuring carriers for
1148 operating losses of the individual account based on market
1149 share. The board shall annually assess each carrier a portion of
1150 the operating losses of the individual account. The first tier
1151 of assessments shall be determined by multiplying the operating
1152 losses by a fraction, the numerator of which equals the
1153 reinsuring carrier’s earned premium pertaining to direct
1154 writings of individual health insurance in the state during the
1155 calendar year for which the assessment is levied, and the
1156 denominator of which equals the total of all such premiums
1157 earned by reinsuring carriers in the state during that calendar
1158 year. The second tier of assessments shall be based on the
1159 premiums that all carriers, except risk-assuming carriers,
1160 earned on all health benefit plans written in this state. The

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1161 board may levy interim assessments against reinsuring carriers
1162 to ensure the financial ability of the plan to cover claims
1163 expenses and administrative expenses paid or estimated to be
1164 paid in the operation of the plan for the calendar year prior to
1165 the association's anticipated receipt of annual assessments for
1166 that calendar year. Any interim assessment is due and payable
1167 within 30 days after receipt by a carrier of the interim
1168 assessment notice. Interim assessment payments shall be credited
1169 against the carrier's annual assessment. Health benefit plan
1170 premiums and benefits paid by a carrier that are less than an
1171 amount determined by the board to justify the cost of collection
1172 may not be considered for purposes of determining assessments.
1173 d. Subject to the approval of the office, the board shall
1174 adjust the assessment formula for reinsuring carriers that are
1175 approved as federally qualified health maintenance organizations
1176 by the Secretary of Health and Human Services pursuant to 42
1177 U.S.C. s. 300e(c)(2)(A) to the extent, if any, that restrictions
1178 are placed on them which are not imposed on other carriers.
1179 3. Before March 1 of each year, the board shall determine
1180 and file with the office an estimate of the assessments needed
1181 to fund the losses incurred by the program in the individual
1182 account for the previous calendar year.
1183 4. If the board determines that the assessments needed to
1184 fund the losses incurred by the program in the individual
1185 account for the previous calendar year will exceed the amount
1186 specified in subparagraph 2., the board shall evaluate the
1187 operation of the program and report its findings and
1188 recommendations to the office in a ~~the~~ format established by the
1189 office ~~in s. 627.6699(11) for the comparable report for the~~

1190 ~~small employer reinsurance program~~.
1191 (g) Except as otherwise provided in this section, the board
1192 and the office shall have all powers, duties, and
1193 responsibilities with respect to carriers that issue and
1194 reinsure individual health insurance~~, as specified for the board~~
1195 ~~and the office in s. 627.6699(11) with respect to small employer~~
1196 ~~carriers~~, including, but not limited to, the provisions of s.
1197 627.6699(11) relating to:
1198 1. Use of assessments that exceed the amount of actual
1199 losses and expenses.
1200 2. The annual determination of each carrier's proportion of
1201 the assessment.
1202 3. Interest for late payment of assessments.
1203 4. Authority for the office to approve deferment of an
1204 assessment against a carrier.
1205 5. Limited immunity from legal actions or carriers.
1206 6. Development of standards for compensation to be paid to
1207 agents. Such standards shall be limited to those specifically
1208 enumerated in <u>s. 627.6699(11)(d)</u> ~~s. 627.6699(12)(d)~~.
1209 7. Monitoring compliance by carriers with this section.
1210 (8) STANDARDS TO ASSURE FAIR MARKETING.—
1211 (a) Each health insurance issuer that offers individual
1212 health insurance shall actively market coverage to eligible
1213 individuals in the state. The provisions of <u>s. 627.6699(11)</u> ~~s.~~
1214 ~~627.6699(12)~~ that apply to small employer carriers that market
1215 policies to small employers shall also apply to health insurance
1216 issuers that offer individual health insurance with respect to
1217 marketing policies to individuals.
1218 Section 15. Subsection (2) of section 627.657, Florida

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1219 Statutes, is amended to read:
1220 627.657 Provisions of group health insurance policies.—
1221 (2) The medical policy as specified in s. 627.6699(3)(j) ~~s.~~
1222 ~~627.6699(3)(k)~~ must be accompanied by an identification card
1223 that contains, at a minimum:
1224 (a) The name of the organization issuing the policy or name
1225 of the organization administering the policy, whichever applies.
1226 (b) The name of the certificateholder.
1227 (c) The type of plan only if the plan is filed in the
1228 state, an indication that the plan is self-funded, or the name
1229 of the network.
1230 (d) The member identification number, contract number, and
1231 policy or group number, if applicable.
1232 (e) A contact phone number or electronic address for
1233 authorizations and admission certifications.
1234 (f) A phone number or electronic address whereby the
1235 covered person or hospital, physician, or other person rendering
1236 services covered by the policy may obtain benefits verification
1237 and information in order to estimate patient financial
1238 responsibility, in compliance with privacy rules under the
1239 Health Insurance Portability and Accountability Act.
1240 (g) The national plan identifier, in accordance with the
1241 compliance date set forth by the federal Department of Health
1242 and Human Services.
1243
1244 The identification card must present the information in a
1245 readily identifiable manner or, alternatively, the information
1246 may be embedded on the card and available through magnetic
1247 stripe or smart card. The information may also be provided

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1248 through other electronic technology.

1249 Section 16. Paragraphs (b), (p), (q), and (s) of subsection
1250 (3), paragraph (d) of subsection (9), paragraphs (b) and (c) of
1251 subsection (10) and subsection (11) of section 627.6699, Florida
1252 Statutes, are amended to read:

1253 627.6699 Employee Health Care Access Act.—

1254 (3) DEFINITIONS.—As used in this section, the term:

1255 ~~(b) "Board" means the board of directors of the program.~~

1256 ~~(p) "Plan of operation" means the plan of operation of the~~
1257 ~~program, including articles, bylaws, and operating rules,~~
1258 ~~adopted by the board under subsection (11).~~

1259 ~~(q) "Program" means the Florida Small Employer Carrier~~
1260 ~~Reinsurance Program created under subsection (11).~~

1261 ~~(s) "Reinsuring carrier" means a small employer carrier~~
1262 ~~that elects to comply with the requirements set forth in~~
1263 ~~subsection (11).~~

1264 (9) SMALL EMPLOYER CARRIER'S ELECTION TO BECOME A RISK-
1265 ASSUMING CARRIER OR A REINSURING CARRIER.—

1266 ~~(d) A small employer carrier that elects to cease~~
1267 ~~participating as a reinsuring carrier and to become a risk-~~
1268 ~~assuming carrier is prohibited from reinsuring or continuing to~~
1269 ~~reinsure any small employer health benefits plan under~~
1270 ~~subsection (11) as soon as the carrier becomes a risk-assuming~~
1271 ~~carrier and must pay a prorated assessment based upon business~~
1272 ~~issued as a reinsuring carrier for any portion of the year that~~
1273 ~~the business was reinsured. A small employer carrier that elects~~
1274 ~~to cease participating as a risk-assuming carrier and to become~~
1275 ~~a reinsuring carrier is permitted to reinsure small employer~~
1276 ~~health benefit plans under the terms set forth in subsection~~

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1277 ~~(11) and must pay a prorated assessment based upon business~~
1278 ~~issued as a reinsuring carrier for any portion of the year that~~
1279 ~~the business was reinsured.~~
1280 (10) ELECTION PROCESS TO BECOME A RISK-ASSUMING CARRIER.—
1281 (b) In determining whether to approve an application by a
1282 small employer carrier to become a risk-assuming carrier, the
1283 office shall consider:
1284 1. The carrier's financial ability to support the
1285 assumption of the risk of small employer groups.
1286 2. The carrier's history of rating and underwriting small
1287 employer groups.
1288 3. The carrier's commitment to market fairly to all small
1289 employers in the state or its service area, as applicable.
1290 ~~4. The carrier's ability to assume and manage the risk of~~
1291 ~~enrolling small employer groups without the protection of the~~
1292 ~~reinsurance program provided in subsection (11).~~
1293 ~~(c) A small employer carrier that becomes a risk-assuming~~
1294 ~~carrier pursuant to this subsection is not subject to the~~
1295 ~~assessment provisions of subsection (11).~~
1296 ~~(11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.—~~
1297 ~~(a) There is created a nonprofit entity to be known as the~~
1298 ~~"Florida Small Employer Health Reinsurance Program."~~
1299 ~~(b)1. The program shall operate subject to the supervision~~
1300 ~~and control of the board.~~
1301 ~~2. Effective upon this act becoming a law, the board shall~~
1302 ~~consist of the director of the office or his or her designee,~~
1303 ~~who shall serve as the chairperson, and 13 additional members~~
1304 ~~who are representatives of carriers and insurance agents and are~~
1305 ~~appointed by the director of the office and serve as follows:~~

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1306 ~~a. Five members shall be representatives of health insurers~~
1307 ~~licensed under chapter 624 or chapter 641. Two members shall be~~
1308 ~~agents who are actively engaged in the sale of health insurance.~~
1309 ~~Four members shall be employers or representatives of employers.~~
1310 ~~One member shall be a person covered under an individual health~~
1311 ~~insurance policy issued by a licensed insurer in this state. One~~
1312 ~~member shall represent the Agency for Health Care Administration~~
1313 ~~and shall be recommended by the Secretary of Health Care~~
1314 ~~Administration.~~
1315 ~~b. A member appointed under this subparagraph shall serve a~~
1316 ~~term of 4 years and shall continue in office until the member's~~
1317 ~~successor takes office, except that, in order to provide for~~
1318 ~~staggered terms, the director of the office shall designate two~~
1319 ~~of the initial appointees under this subparagraph to serve terms~~
1320 ~~of 2 years and shall designate three of the initial appointees~~
1321 ~~under this subparagraph to serve terms of 3 years.~~
1322 ~~3. The director of the office may remove a member for~~
1323 ~~cause.~~
1324 ~~4. Vacancies on the board shall be filled in the same~~
1325 ~~manner as the original appointment for the unexpired portion of~~
1326 ~~the term.~~
1327 ~~(c)1. The board shall submit to the office a plan of~~
1328 ~~operation to assure the fair, reasonable, and equitable~~
1329 ~~administration of the program. The board may at any time submit~~
1330 ~~to the office any amendments to the plan that the board finds to~~
1331 ~~be necessary or suitable.~~
1332 ~~2. The office shall, after notice and hearing, approve the~~
1333 ~~plan of operation if it determines that the plan submitted by~~
1334 ~~the board is suitable to assure the fair, reasonable, and~~

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1335 ~~equitable administration of the program and provides for the~~
1336 ~~sharing of program gains and losses equitably and~~
1337 ~~proportionately in accordance with paragraph (j).~~
1338 ~~3. The plan of operation, or any amendment thereto, becomes~~
1339 ~~effective upon written approval of the office.~~
1340 ~~(d) The plan of operation must, among other things:~~
1341 ~~1. Establish procedures for handling and accounting for~~
1342 ~~program assets and moneys and for an annual fiscal reporting to~~
1343 ~~the office.~~
1344 ~~2. Establish procedures for selecting an administering~~
1345 ~~carrier and set forth the powers and duties of the administering~~
1346 ~~carrier.~~
1347 ~~3. Establish procedures for reinsuring risks.~~
1348 ~~4. Establish procedures for collecting assessments from~~
1349 ~~participating carriers to provide for claims reinsured by the~~
1350 ~~program and for administrative expenses, other than amounts~~
1351 ~~payable to the administrative carrier, incurred or estimated to~~
1352 ~~be incurred during the period for which the assessment is made.~~
1353 ~~5. Provide for any additional matters at the discretion of~~
1354 ~~the board.~~
1355 ~~(e) The board shall recommend to the office market conduct~~
1356 ~~requirements and other requirements for carriers and agents,~~
1357 ~~including requirements relating to:~~
1358 ~~1. Registration by each carrier with the office of its~~
1359 ~~intention to be a small employer carrier under this section;~~
1360 ~~2. Publication by the office of a list of all small~~
1361 ~~employer carriers, including a requirement applicable to agents~~
1362 ~~and carriers that a health benefit plan may not be sold by a~~
1363 ~~carrier that is not identified as a small employer carrier;~~

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1364 ~~3. The availability of a broadly publicized, toll-free~~
1365 ~~telephone number for access by small employers to information~~
1366 ~~concerning this section;~~
1367 ~~4. Periodic reports by carriers and agents concerning~~
1368 ~~health benefit plans issued; and~~
1369 ~~5. Methods concerning periodic demonstration by small~~
1370 ~~employer carriers and agents that they are marketing or issuing~~
1371 ~~health benefit plans to small employers.~~
1372 ~~(f) The program has the general powers and authority~~
1373 ~~granted under the laws of this state to insurance companies and~~
1374 ~~health maintenance organizations licensed to transact business,~~
1375 ~~except the power to issue health benefit plans directly to~~
1376 ~~groups or individuals. In addition thereto, the program has~~
1377 ~~specific authority to:~~
1378 ~~1. Enter into contracts as necessary or proper to carry out~~
1379 ~~the provisions and purposes of this act, including the authority~~
1380 ~~to enter into contracts with similar programs of other states~~
1381 ~~for the joint performance of common functions or with persons or~~
1382 ~~other organizations for the performance of administrative~~
1383 ~~functions.~~
1384 ~~2. Sue or be sued, including taking any legal action~~
1385 ~~necessary or proper for recovering any assessments and penalties~~
1386 ~~for, on behalf of, or against the program or any carrier.~~
1387 ~~3. Take any legal action necessary to avoid the payment of~~
1388 ~~improper claims against the program.~~
1389 ~~4. Issue reinsurance policies, in accordance with the~~
1390 ~~requirements of this act.~~
1391 ~~5. Establish rules, conditions, and procedures for~~
1392 ~~reinsurance risks under the program participation.~~

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1393 ~~6. Establish actuarial functions as appropriate for the~~
1394 ~~operation of the program.~~
1395 ~~7. Assess participating carriers in accordance with~~
1396 ~~paragraph (j), and make advance interim assessments as may be~~
1397 ~~reasonable and necessary for organizational and interim~~
1398 ~~operating expenses. Interim assessments shall be credited as~~
1399 ~~offsets against any regular assessments due following the close~~
1400 ~~of the calendar year.~~
1401 ~~8. Appoint appropriate legal, actuarial, and other~~
1402 ~~committees as necessary to provide technical assistance in the~~
1403 ~~operation of the program, and in any other function within the~~
1404 ~~authority of the program.~~
1405 ~~9. Borrow money to effect the purposes of the program. Any~~
1406 ~~notes or other evidences of indebtedness of the program which~~
1407 ~~are not in default constitute legal investments for carriers and~~
1408 ~~may be carried as admitted assets.~~
1409 ~~10. To the extent necessary, increase the $5,000 deductible~~
1410 ~~reinsurance requirement to adjust for the effects of inflation.~~
1411 ~~(g) A reinsuring carrier may reinsure with the program~~
1412 ~~coverage of an eligible employee of a small employer, or any~~
1413 ~~dependent of such an employee, subject to each of the following~~
1414 ~~provisions:~~
1415 ~~1. Except in the case of a late enrollee, a reinsuring~~
1416 ~~carrier may reinsure an eligible employee or dependent within 60~~
1417 ~~days after the commencement of the coverage of the small~~
1418 ~~employer. A newly employed eligible employee or dependent of a~~
1419 ~~small employer may be reinsured within 60 days after the~~
1420 ~~commencement of his or her coverage.~~
1421 ~~2. A small employer carrier may reinsure an entire employer~~

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1422 ~~group within 60 days after the commencement of the group's~~
1423 ~~coverage under the plan.~~
1424 ~~3. The program may not reimburse a participating carrier~~
1425 ~~with respect to the claims of a reinsured employee or dependent~~
1426 ~~until the carrier has paid incurred claims of at least $5,000 in~~
1427 ~~a calendar year for benefits covered by the program. In~~
1428 ~~addition, the reinsuring carrier shall be responsible for 10~~
1429 ~~percent of the next $50,000 and 5 percent of the next $100,000~~
1430 ~~of incurred claims during a calendar year and the program shall~~
1431 ~~reinsure the remainder.~~
1432 ~~4. The board annually shall adjust the initial level of~~
1433 ~~claims and the maximum limit to be retained by the carrier to~~
1434 ~~reflect increases in costs and utilization within the standard~~
1435 ~~market for health benefit plans within the state. The adjustment~~
1436 ~~shall not be less than the annual change in the medical~~
1437 ~~component of the "Consumer Price Index for All Urban Consumers"~~
1438 ~~of the Bureau of Labor Statistics of the Department of Labor,~~
1439 ~~unless the board proposes and the office approves a lower~~
1440 ~~adjustment factor.~~
1441 ~~5. A small employer carrier may terminate reinsurance for~~
1442 ~~all reinsured employees or dependents on any plan anniversary.~~
1443 ~~6. The premium rate charged for reinsurance by the program~~
1444 ~~to a health maintenance organization that is approved by the~~
1445 ~~Secretary of Health and Human Services as a federally qualified~~
1446 ~~health maintenance organization pursuant to 42 U.S.C. s.~~
1447 ~~300e(c)(2)(A) and that, as such, is subject to requirements that~~
1448 ~~limit the amount of risk that may be ceded to the program, which~~
1449 ~~requirements are more restrictive than subparagraph 3., shall be~~
1450 ~~reduced by an amount equal to that portion of the risk, if any,~~

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1451 ~~which exceeds the amount set forth in subparagraph 3. which may~~
1452 ~~not be ceded to the program.~~
1453 ~~7. The board may consider adjustments to the premium rates~~
1454 ~~charged for reinsurance by the program for carriers that use~~
1455 ~~effective cost containment measures, including high-cost case~~
1456 ~~management, as defined by the board.~~
1457 ~~8. A reinsuring carrier shall apply its case-management and~~
1458 ~~claims-handling techniques, including, but not limited to,~~
1459 ~~utilization review, individual case management, preferred~~
1460 ~~provider provisions, other managed care provisions or methods of~~
1461 ~~operation, consistently with both reinsured business and~~
1462 ~~nonreinsured business.~~
1463 ~~(h)1. The board, as part of the plan of operation, shall~~
1464 ~~establish a methodology for determining premium rates to be~~
1465 ~~charged by the program for reinsuring small employers and~~
1466 ~~individuals pursuant to this section. The methodology shall~~
1467 ~~include a system for classification of small employers that~~
1468 ~~reflects the types of case characteristics commonly used by~~
1469 ~~small employer carriers in the state. The methodology shall~~
1470 ~~provide for the development of basic reinsurance premium rates,~~
1471 ~~which shall be multiplied by the factors set for them in this~~
1472 ~~paragraph to determine the premium rates for the program. The~~
1473 ~~basic reinsurance premium rates shall be established by the~~
1474 ~~board, subject to the approval of the office. The premium rates~~
1475 ~~set by the board may vary by geographical area, as determined~~
1476 ~~under this section, to reflect differences in cost. The~~
1477 ~~multiplying factors must be established as follows:~~
1478 ~~a. The entire group may be reinsured for a rate that is 1.5~~
1479 ~~times the rate established by the board.~~

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1480 ~~b. An eligible employee or dependent may be reinsured for a~~
1481 ~~rate that is 5 times the rate established by the board.~~
1482 ~~2. The board periodically shall review the methodology~~
1483 ~~established, including the system of classification and any~~
1484 ~~rating factors, to assure that it reasonably reflects the claims~~
1485 ~~experience of the program. The board may propose changes to the~~
1486 ~~rates which shall be subject to the approval of the office.~~
1487 ~~(i) If a health benefit plan for a small employer issued in~~
1488 ~~accordance with this subsection is entirely or partially~~
1489 ~~reinsured with the program, the premium charged to the small~~
1490 ~~employer for any rating period for the coverage issued must be~~
1491 ~~consistent with the requirements relating to premium rates set~~
1492 ~~forth in this section.~~
1493 ~~(j)1. Before July 1 of each calendar year, the board shall~~
1494 ~~determine and report to the office the program net loss for the~~
1495 ~~previous year, including administrative expenses for that year,~~
1496 ~~and the incurred losses for the year, taking into account~~
1497 ~~investment income and other appropriate gains and losses.~~
1498 ~~2. Any net loss for the year shall be recouped by~~
1499 ~~assessment of the carriers, as follows:~~
1500 ~~a. The operating losses of the program shall be assessed in~~
1501 ~~the following order subject to the specified limitations. The~~
1502 ~~first tier of assessments shall be made against reinsuring~~
1503 ~~carriers in an amount which shall not exceed 5 percent of each~~
1504 ~~reinsuring carrier’s premiums from health benefit plans covering~~
1505 ~~small employers. If such assessments have been collected and~~
1506 ~~additional moneys are needed, the board shall make a second tier~~
1507 ~~of assessments in an amount which shall not exceed 0.5 percent~~
1508 ~~of each carrier’s health benefit plan premiums. Except as~~

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1509 ~~provided in paragraph (m), risk-assuming carriers are exempt~~
1510 ~~from all assessments authorized pursuant to this section. The~~
1511 ~~amount paid by a reinsuring carrier for the first tier of~~
1512 ~~assessments shall be credited against any additional assessments~~
1513 ~~made.~~
1514 ~~b. The board shall equitably assess carriers for operating~~
1515 ~~losses of the plan based on market share. The board shall~~
1516 ~~annually assess each carrier a portion of the operating losses~~
1517 ~~of the plan. The first tier of assessments shall be determined~~
1518 ~~by multiplying the operating losses by a fraction, the numerator~~
1519 ~~of which equals the reinsuring carrier's earned premium~~
1520 ~~pertaining to direct writings of small employer health benefit~~
1521 ~~plans in the state during the calendar year for which the~~
1522 ~~assessment is levied, and the denominator of which equals the~~
1523 ~~total of all such premiums earned by reinsuring carriers in the~~
1524 ~~state during that calendar year. The second tier of assessments~~
1525 ~~shall be based on the premiums that all carriers, except risk-~~
1526 ~~assuming carriers, earned on all health benefit plans written in~~
1527 ~~this state. The board may levy interim assessments against~~
1528 ~~carriers to ensure the financial ability of the plan to cover~~
1529 ~~claims expenses and administrative expenses paid or estimated to~~
1530 ~~be paid in the operation of the plan for the calendar year prior~~
1531 ~~to the association's anticipated receipt of annual assessments~~
1532 ~~for that calendar year. Any interim assessment is due and~~
1533 ~~payable within 30 days after receipt by a carrier of the interim~~
1534 ~~assessment notice. Interim assessment payments shall be credited~~
1535 ~~against the carrier's annual assessment. Health benefit plan~~
1536 ~~premiums and benefits paid by a carrier that are less than an~~
1537 ~~amount determined by the board to justify the cost of collection~~

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1538 ~~may not be considered for purposes of determining assessments.~~
1539 ~~c. Subject to the approval of the office, the board shall~~
1540 ~~make an adjustment to the assessment formula for reinsuring~~
1541 ~~carriers that are approved as federally qualified health~~
1542 ~~maintenance organizations by the Secretary of Health and Human~~
1543 ~~Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent,~~
1544 ~~if any, that restrictions are placed on them that are not~~
1545 ~~imposed on other small employer carriers.~~
1546 ~~3. Before July 1 of each year, the board shall determine~~
1547 ~~and file with the office an estimate of the assessments needed~~
1548 ~~to fund the losses incurred by the program in the previous~~
1549 ~~calendar year.~~
1550 ~~4. If the board determines that the assessments needed to~~
1551 ~~fund the losses incurred by the program in the previous calendar~~
1552 ~~year will exceed the amount specified in subparagraph 2., the~~
1553 ~~board shall evaluate the operation of the program and report its~~
1554 ~~findings, including any recommendations for changes to the plan~~
1555 ~~of operation, to the office within 180 days following the end of~~
1556 ~~the calendar year in which the losses were incurred. The~~
1557 ~~evaluation shall include an estimate of future assessments, the~~
1558 ~~administrative costs of the program, the appropriateness of the~~
1559 ~~premiums charged and the level of carrier retention under the~~
1560 ~~program, and the costs of coverage for small employers. If the~~
1561 ~~board fails to file a report with the office within 180 days~~
1562 ~~following the end of the applicable calendar year, the office~~
1563 ~~may evaluate the operations of the program and implement such~~
1564 ~~amendments to the plan of operation the office deems necessary~~
1565 ~~to reduce future losses and assessments.~~
1566 ~~5. If assessments exceed the amount of the actual losses~~

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1567 ~~and administrative expenses of the program, the excess shall be~~
1568 ~~held as interest and used by the board to offset future losses~~
1569 ~~or to reduce program premiums. As used in this paragraph, the~~
1570 ~~term "future losses" includes reserves for incurred but not~~
1571 ~~reported claims.~~
1572 ~~6. Each carrier's proportion of the assessment shall be~~
1573 ~~determined annually by the board, based on annual statements and~~
1574 ~~other reports considered necessary by the board and filed by the~~
1575 ~~carriers with the board.~~
1576 ~~7. Provision shall be made in the plan of operation for the~~
1577 ~~imposition of an interest penalty for late payment of an~~
1578 ~~assessment.~~
1579 ~~8. A carrier may seek, from the office, a deferment, in~~
1580 ~~whole or in part, from any assessment made by the board. The~~
1581 ~~office may defer, in whole or in part, the assessment of a~~
1582 ~~carrier if, in the opinion of the office, the payment of the~~
1583 ~~assessment would place the carrier in a financially impaired~~
1584 ~~condition. If an assessment against a carrier is deferred, in~~
1585 ~~whole or in part, the amount by which the assessment is deferred~~
1586 ~~may be assessed against the other carriers in a manner~~
1587 ~~consistent with the basis for assessment set forth in this~~
1588 ~~section. The carrier receiving such deferment remains liable to~~
1589 ~~the program for the amount deferred and is prohibited from~~
1590 ~~reinsuring any individuals or groups in the program if it fails~~
1591 ~~to pay assessments.~~
1592 ~~(k) Neither the participation in the program as reinsuring~~
1593 ~~carriers, the establishment of rates, forms, or procedures, nor~~
1594 ~~any other joint or collective action required by this act, may~~
1595 ~~be the basis of any legal action, criminal or civil liability,~~

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1596 ~~or penalty against the program or any of its carriers either~~
1597 ~~jointly or separately.~~
1598 ~~(l) The board shall monitor compliance with this section,~~
1599 ~~including the market conduct of small employer carriers, and~~
1600 ~~shall report to the office any unfair trade practices and~~
1601 ~~misleading or unfair conduct by a small employer carrier that~~
1602 ~~has been reported to the board by agents, consumers, or any~~
1603 ~~other person. The office shall investigate all reports and, upon~~
1604 ~~a finding of noncompliance with this section or of unfair or~~
1605 ~~misleading practices, shall take action against the small~~
1606 ~~employer carrier as permitted under the insurance code or~~
1607 ~~chapter 641. The board is not given investigatory or regulatory~~
1608 ~~powers, but must forward all reports of cases or abuse or~~
1609 ~~misrepresentation to the office.~~
1610 ~~(m) Notwithstanding paragraph (j), the administrative~~
1611 ~~expenses of the program shall be recouped by assessment of risk-~~
1612 ~~assuming carriers and reinsuring carriers and such amounts shall~~
1613 ~~not be considered part of the operating losses of the plan for~~
1614 ~~the purposes of this paragraph. Each carrier's portion of such~~
1615 ~~administrative expenses shall be determined by multiplying the~~
1616 ~~total of such administrative expenses by a fraction, the~~
1617 ~~numerator of which equals the carrier's earned premium~~
1618 ~~pertaining to direct writing of small employer health benefit~~
1619 ~~plans in the state during the calendar year for which the~~
1620 ~~assessment is levied, and the denominator of which equals the~~
1621 ~~total of such premiums earned by all carriers in the state~~
1622 ~~during such calendar year.~~
1623 ~~(n) The board shall advise the office, the Agency for~~
1624 ~~Health Care Administration, the department, other executive~~

1625 ~~departments, and the Legislature on health insurance issues.~~
1626 ~~Specifically, the board shall:~~
1627 ~~1. Provide a forum for stakeholders, consisting of~~
1628 ~~insurers, employers, agents, consumers, and regulators, in the~~
1629 ~~private health insurance market in this state.~~
1630 ~~2. Review and recommend strategies to improve the~~
1631 ~~functioning of the health insurance markets in this state with a~~
1632 ~~specific focus on market stability, access, and pricing.~~
1633 ~~3. Make recommendations to the office for legislation~~
1634 ~~addressing health insurance market issues and provide comments~~
1635 ~~on health insurance legislation proposed by the office.~~
1636 ~~4. Meet at least three times each year. One meeting shall~~
1637 ~~be held to hear reports and to secure public comment on the~~
1638 ~~health insurance market, to develop any legislation needed to~~
1639 ~~address health insurance market issues, and to provide comments~~
1640 ~~on health insurance legislation proposed by the office.~~
1641 ~~5. Issue a report to the office on the state of the health~~
1642 ~~insurance market by September 1 each year. The report shall~~
1643 ~~include recommendations for changes in the health insurance~~
1644 ~~market, results from implementation of previous recommendations,~~
1645 ~~and information on health insurance markets.~~
1646 Section 17. Paragraphs (c) and (d) are added to subsection
1647 (2) of section 627.711, Florida Statutes, to read:
1648 627.711 Notice of premium discounts for hurricane loss
1649 mitigation; uniform mitigation verification inspection form.—
1650 (2)
1651 (c) The office shall contract with a Florida public
1652 university to design, operate, upgrade, and maintain a statewide
1653 database for uniform mitigation verification inspection forms.

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1654 This database must be managed by the office to collect and
1655 evaluate mitigation features of residential properties within
1656 the state.
1657 (d) Beginning on January 1, 2026, each insurer shall
1658 electronically file a copy of uniform mitigation inspection
1659 forms submitted by a policyholder in the database created
1660 pursuant to paragraph (c) within 15 business days after receipt
1661 from the policyholder or the agent, using the electronic format
1662 prescribed by the office. The commission shall adopt rules to
1663 implement this paragraph and paragraph (c).
1664 Section 18. Effective upon becoming a law, subsection (12)
1665 of section 627.7152, Florida Statutes, is amended to read:
1666 627.7152 Assignment agreements.—
1667 ~~(12) The office shall require each insurer to report by~~
1668 ~~January 30, 2022, and each year thereafter data on each~~
1669 ~~residential and commercial property insurance claim paid in the~~
1670 ~~prior calendar year under an assignment agreement. The Financial~~
1671 ~~Services Commission shall adopt by rule a list of the data~~
1672 ~~required, which must include specific data about claims~~
1673 ~~adjustment and settlement timeframes and trends, grouped by~~
1674 ~~whether litigated or not litigated and by loss adjustment~~
1675 ~~expenses.~~
1676 Section 19. Section 627.9145, Florida Statutes, is created
1677 to read:
1678 627.9145 Reports by residential property insurers.—
1679 (1) Beginning on March 1, 2026, each authorized insurer and
1680 surplus lines insurer transacting residential property insurance
1681 in this state shall report the information specified in this
1682 section annually to the office.

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1683 (2) The commission shall adopt by rule the required
1684 information to be reported and the required format. The report
1685 must address all of the following areas:
1686 (a) Policy types, perils covered, statuses, and premiums.
1687 (b) Location and limits of writings in this state.
1688 (c) Coverages, deductibles, and exclusions.
1689 (d) Mitigation discounts.
1690 (e) Claims reporting requirements.
1691 (f) Any other information deemed necessary by the
1692 commission to provide the office with the ability to track
1693 mitigation and resiliency trends occurring in the residential
1694 property market.
1695 Section 20. Subsections (2) and (5) of section 627.915,
1696 Florida Statutes, are amended to read:
1697 627.915 Insurer experience reporting.—
1698 (2) By January 1, 2026, each insurer transacting private
1699 passenger automobile insurance in this state shall report the
1700 information specified in this subsection monthly to the office.
1701 The commission shall adopt by rule the required information to
1702 be reported and the required format. The report must address the
1703 following areas:
1704 (a) Policy coverage categories, including policies in force
1705 and total direct premiums earned and written.
1706 (b) Type, location, and limits of writings in this state.
1707 (c) Claims reporting requirements.
1708 (d) Any other information deemed necessary by the
1709 commission to provide the office with the ability to track
1710 trends occurring in the private passenger automobile insurance
1711 market. ~~Each insurer transacting fire, homeowner’s multiple~~

1712 ~~peril, commercial multiple peril, medical malpractice, products~~
1713 ~~liability, workers' compensation, private passenger automobile~~
1714 ~~liability, commercial automobile liability, private passenger~~
1715 ~~automobile physical damage, commercial automobile physical~~
1716 ~~damage, officers' and directors' liability insurance, or other~~
1717 ~~liability insurance shall report, for each such line of~~
1718 ~~insurance, the information specified in this subsection to the~~
1719 ~~office. The information shall be reported for direct Florida~~
1720 ~~business only and shall be reported on a calendar-year basis~~
1721 ~~annually by April 1 for the preceding calendar year:~~
1722 ~~(a) Direct premiums written.~~
1723 ~~(b) Direct premiums earned.~~
1724 ~~(c) Loss reserves for all known claims:~~
1725 ~~1. At beginning of the year.~~
1726 ~~2. At end of the year.~~
1727 ~~(d) Reserves for losses incurred but not reported:~~
1728 ~~1. At beginning of the year.~~
1729 ~~2. At end of the year.~~
1730 ~~(e) Allocated loss adjustment expense:~~
1731 ~~1. Reserve at beginning of the year.~~
1732 ~~2. Reserve at end of the year.~~
1733 ~~3. Paid during the year.~~
1734 ~~(f) Unallocated loss adjustment expense:~~
1735 ~~1. Reserve at beginning of the year.~~
1736 ~~2. Reserve at end of the year.~~
1737 ~~3. Paid during the year.~~
1738 ~~(g) Direct losses paid.~~
1739 ~~(h) Underwriting income or loss.~~
1740 ~~(i) Commissions and brokerage fees.~~

1741 ~~(j) Taxes, licenses, and fees.~~
1742 ~~(k) Other acquisition costs.~~
1743 ~~(l) General expenses.~~
1744 ~~(m) Policyholder dividends.~~
1745 ~~(n) Net investment gain or loss and other income gain or~~
1746 ~~loss allocated pro rata by earned premium to Florida business~~
1747 ~~utilizing the investment allocation formula contained in the~~
1748 ~~National Association of Insurance Commissioner's Profitability~~
1749 ~~Report by line by state.~~
1750 ~~(5) Any insurer or insurer group which does not write at~~
1751 ~~least 0.5 percent of the Florida market based on premiums~~
1752 ~~written shall not have to file any report required by subsection~~
1753 ~~(2) other than a report indicating its percentage of the market~~
1754 ~~share. That percentage shall be calculated by dividing the~~
1755 ~~current premiums written by the preceding year's total premiums~~
1756 ~~written in the state for that line of insurance.~~
1757 Section 21. Effective upon becoming a law, subsection (2)
1758 of section 628.081, Florida Statutes, is amended to read:
1759 628.081 Incorporation of domestic insurer.—
1760 (2) The incorporators shall execute articles of
1761 incorporation ~~in triplicate~~. At least three of them shall
1762 acknowledge execution before an officer authorized to take
1763 acknowledgments.
1764 Section 22. Effective upon becoming a law, subsections (2),
1765 (3), and (4) of section 628.091, Florida Statutes, are amended
1766 to read:
1767 628.091 Filing, approval of articles of incorporation.—
1768 (2) The incorporators shall file the ~~triplicate originals~~
1769 ~~of the~~ articles of incorporation with the office, accompanied by

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1770 the filing fee specified in s. 624.501.
1771 (3) The office shall promptly examine the articles of
1772 incorporation. If it finds that the articles of incorporation
1773 conform to law, and that a permit has been or will be issued, it
1774 must ~~shall~~ endorse its approval ~~on each of the triplicate~~
1775 ~~originals~~ of the articles of incorporation~~, retain one copy for~~
1776 ~~its files,~~ and return the articles of incorporation ~~the~~
1777 ~~remaining copies~~ to the incorporators for filing with the
1778 Department of State.
1779 (4) If the office does not so find, it shall refuse to
1780 approve the articles of incorporation ~~and shall return the~~
1781 ~~originals~~.
1782 Section 23. Effective upon becoming a law, subsections (2)
1783 and (3) of section 628.111, Florida Statutes, are amended to
1784 read:
1785 628.111 Amendment of articles of incorporation; mutual
1786 insurer.—
1787 (2)(a) Upon adoption of the amendment, the insurer shall
1788 make ~~in triplicate under its corporate seal~~ a certificate
1789 thereof, setting forth the amendment and the date and manner of
1790 the adoption thereof, which certificate shall be executed by the
1791 insurer's president or vice president and secretary or assistant
1792 secretary and acknowledged before an officer authorized to take
1793 acknowledgments. The insurer shall deliver ~~the triplicate~~
1794 ~~originals of~~ the certificate to the office, together with the
1795 filing fee specified in s. 624.501.
1796 (b) The office shall promptly examine the certificate of
1797 amendment~~;~~ and, if it finds that the certificate and the
1798 amendment comply with law, must ~~it shall~~ endorse its approval on

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1799 the certificate of amendment ~~upon each of the triplicate~~
1800 ~~originals, place one on file in its office, and return the~~
1801 ~~remaining sets to the insurer~~. The insurer shall forthwith file
1802 such endorsed certificates of amendment with the Department of
1803 State. The amendment is ~~shall be~~ effective when filed with and
1804 approved by the Department of State.
1805 (3) If the office finds that the proposed amendment or
1806 certificate does not comply with the law, it may ~~shall~~ not
1807 approve the same, and must ~~shall~~ return the ~~triplicate~~
1808 certificate of amendment to the insurer.
1809 Section 24. Paragraph (a) of subsection (1) and paragraph
1810 (b) of subsection (4) of section 628.461, Florida Statutes, are
1811 amended to read:
1812 628.461 Acquisition of controlling stock.—
1813 (1) A person may not, individually or in conjunction with
1814 any affiliated person of such person, acquire directly or
1815 indirectly, conclude a tender offer or exchange offer for, enter
1816 into any agreement to exchange securities for, or otherwise
1817 finally acquire 10 percent or more of the outstanding voting
1818 securities of a domestic stock insurer or of a controlling
1819 company, unless:
1820 (a) The person or affiliated person has filed with the
1821 office and sent by registered mail to the principal office of
1822 the insurer and controlling company a letter of notification
1823 regarding the transaction or proposed transaction within 5 days
1824 after any form of tender offer or exchange offer is proposed, or
1825 within 5 days after the acquisition of the securities if no
1826 tender offer or exchange offer is involved. The notification
1827 must be provided on forms prescribed by the commission

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1828 containing information determined necessary to understand the
1829 transaction and identify all purchasers and owners involved;
1830
1831 A filing required under this subsection must be made for any
1832 acquisition that equals or exceeds 10 percent of the outstanding
1833 voting securities.
1834 (4)
1835 (b) Any corporation, association, or trust filing the
1836 statement required by this section shall give all required
1837 information that is within the knowledge of the directors,
1838 officers, or trustees, (or others performing functions similar
1839 to those of a director, officer, or trustee,) of the
1840 corporation, association, or trust making the filing and of any
1841 person controlling either directly or indirectly such
1842 corporation, association, or trust. A copy of the statement and
1843 any amendments to the statement must shall be sent by registered
1844 mail to the insurer at its principal office within the state and
1845 to any controlling company at its principal office. If any
1846 material change occurs in the facts set forth in the statement
1847 filed with the office and sent to such insurer or controlling
1848 company pursuant to this section, an amendment setting forth
1849 such changes must shall be filed immediately with the office and
1850 sent immediately to such insurer and controlling company.
1851 Section 25. Paragraph (b) of subsection (5) of section
1852 628.4615, Florida Statutes, is amended to read:
1853 628.4615 Specialty insurers; acquisition of controlling
1854 stock, ownership interest, assets, or control; merger or
1855 consolidation.—
1856 (5)

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1857 (b) Any person filing the statement required by this
1858 section shall give all required information that is within the
1859 knowledge of:
1860 1. The directors, officers, or trustees, if a corporation,
1861 or
1862 2. The partners, owners, managers, or joint venturers, or
1863 others performing functions similar to those of a director,
1864 officer, or trustee, if not a corporation,
1865
1866 of the person making the filing and of any person controlling
1867 either directly or indirectly such person. If any material
1868 change occurs in the facts set forth in the application filed
1869 with the office pursuant to this section, an amendment setting
1870 forth such changes shall be filed immediately with the office,
1871 and a copy of the amendment shall be sent ~~by registered mail~~ to
1872 the principal office of the specialty insurer and to the
1873 principal office of the controlling company.
1874 Section 26. Effective upon becoming a law, subsection (2)
1875 of section 628.717, Florida Statutes, is amended to read:
1876 628.717 Filing of articles of incorporation.—
1877 (2) The office shall promptly examine the articles of
1878 incorporation~~;~~ and, if it finds that the articles of
1879 incorporation comply with law, must ~~the office shall~~ endorse its
1880 approval on the certificate of amendment ~~upon each of the~~
1881 ~~originals, place one on file in its office, and return the~~
1882 ~~remaining sets to the incorporators~~. The incorporators shall
1883 promptly file such endorsed articles of incorporation with the
1884 Department of State. The articles of incorporation are ~~shall be~~
1885 effective when filed with and approved by the Department of

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1886 State.
1887 Section 27. Effective upon becoming a law, subsection (2)
1888 of section 628.719, Florida Statutes, is amended to read:
1889 628.719 Amendment of articles of incorporation.—
1890 (2)(a) Upon adoption of an amendment, the mutual insurance
1891 holding company shall make ~~under its corporate seal~~ a
1892 certificate thereof, setting forth the amendment and the date
1893 and manner of the adoption thereof, which certificate shall be
1894 executed by the mutual insurance holding company's president or
1895 vice president and secretary or assistant secretary and
1896 acknowledged before an officer authorized to take
1897 acknowledgments. The mutual insurance holding company shall
1898 deliver ~~the originals of~~ the certificate to the office.
1899 (b) The office shall promptly examine the certificate of
1900 amendment~~,~~ and, if the office finds that the certificate and the
1901 amendment comply with law, the office shall endorse its approval
1902 on the certificate of amendment ~~upon each of the originals,~~
1903 ~~place one on file in its office, and return the remaining sets~~
1904 ~~to the mutual insurance holding company~~. The mutual insurance
1905 holding company shall promptly file such endorsed certificate
1906 ~~certificates~~ of amendment with the Department of State. The
1907 amendment shall be effective when filed with and approved by the
1908 Department of State.
1909 Section 28. Effective upon becoming a law, subsection (4)
1910 of section 628.910, Florida Statutes, is amended to read:
1911 628.910 Incorporation options and requirements.—
1912 (4) In the case of a captive insurance company formed as a
1913 corporation or a nonprofit corporation, before the articles of
1914 incorporation are transmitted to the Secretary of State, the

1915 incorporators shall file the articles of incorporation ~~in~~
1916 ~~triplicate~~ with the office. The office shall promptly examine
1917 the articles of incorporation. If it finds that the articles of
1918 incorporation conform to law, it shall endorse its approval on
1919 ~~each of the triplicate originals of~~ the articles of
1920 incorporation, ~~retain one copy for its files,~~ and return the
1921 articles of incorporation ~~remaining copies~~ to the incorporators
1922 for filing with the Department of State.
1923 Section 29. Subsection (5) of section 629.011, Florida
1924 Statutes, is amended, and subsections (6), (7), and (8) are
1925 added to that section, to read:
1926 629.011 Definitions.—As used in this part, the term:
1927 (5) "Reciprocal insurer" means an unincorporated
1928 aggregation of subscribers operating individually and
1929 collectively through an attorney in fact to provide reciprocal
1930 insurance among themselves.
1931 (a) An "assessable reciprocal insurer" is a reciprocal
1932 insurer that is able to levy an assessment on its subscribers to
1933 make up any shortfall in capital and surplus to cover claims and
1934 expenses as specified in s. 629.231.
1935 (b) A "nonassessable reciprocal insurer" is a reciprocal
1936 insurer authorized under s. 629.091(3) or s. 629.291(5) to issue
1937 policies when there is no recourse against subscribers for any
1938 shortfall in capital and surplus to cover claims and expenses.
1939 (6) "Subscribers' advisory committee" is the governing
1940 committee of a domestic reciprocal insurer which is formed in
1941 compliance with s. 629.201 and represents the interests of the
1942 subscribers.
1943 (7) "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.

(8) “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.

Section 30. Section 629.071, Florida Statutes, is amended to read:

629.071 Surplus funds required.—

(1) An assessable ~~A domestic~~ reciprocal insurer ~~hereunder formed~~, 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 ~~$250,000~~.

(2) A nonassessable 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 a surplus as to policyholders which is equal to that required under s. 624.408 for a domestic stock insurer authorized to transact like kinds of insurance ~~In addition to the surplus required to be maintained under subsection (1), the insurer shall have, when first so authorized, an expendable surplus of not less than $750,000~~.

Section 31. Effective upon becoming a law, subsection (3) of section 629.081, Florida Statutes, is amended to read:

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1973 629.081 Organization of reciprocal insurer.—
1974 (3) The filing must be accompanied by the application fee
1975 ~~required by s. 624.501(1)(a)~~.
1976 Section 32. Section 629.082, Florida Statutes, is created
1977 to read:
1978 629.082 Reciprocal affiliates.—The attorney in fact of a
1979 reciprocal insurer is an affiliate of the reciprocal insurer, as
1980 defined in s. 624.10.
1981 Section 33. Section 629.1015, Florida Statutes, is created
1982 to read:
1983 629.1015 Affiliate fees.—
1984 (1) Each reciprocal insurer doing business in this state
1985 which pays a fee, commission, or other financial consideration
1986 or payment to any affiliate directly or indirectly must provide
1987 to the office documentation that such fee, commission, or other
1988 financial consideration or payment is fair and reasonable for
1989 each service being provided by contract. In determining whether
1990 the fee, commission, or other financial consideration or payment
1991 is fair and reasonable, the office shall consider all of the
1992 following:
1993 (a) The actual cost of each service provided by an
1994 affiliate.
1995 (b) The relative financial condition of the reciprocal
1996 insurer and of the attorney in fact.
1997 (c) The level of debt and how such debt is serviced.
1998 (d) The amount of dividends paid by the attorney in fact
1999 and its affiliates and for what purpose.
2000 (e) Whether the terms of the written contract benefit the
2001 reciprocal insurer and are in the best interest of the

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2002 subscribers.

2003 (f) Any other such information as the office reasonably
2004 requires in making the determination.

2005 (2) For each agreement with an affiliate in force on July
2006 1, 2025, each domestic reciprocal insurer shall provide to the
2007 office no later than October 1, 2025, the cost incurred by the
2008 affiliate to provide each service, the amount charged to the
2009 domestic reciprocal insurer for each service, and the dollar
2010 amount of fees forgiven, waived, or reimbursed by the affiliate
2011 for the 2 most recent preceding years. If the total dollar
2012 amount charged to the domestic reciprocal insurer was greater
2013 than the total cost to provide services for either year, the
2014 domestic reciprocal insurer must explain how it determined the
2015 fee was fair and reasonable. For any proposed contract with an
2016 affiliate effective after July 1, 2025, a domestic reciprocal
2017 insurer must provide documentation to support that the fee,
2018 commission, or other financial consideration or payment to the
2019 affiliate is fair and reasonable.

2020 Section 34. Section 629.121, Florida Statutes, is amended
2021 to read:

2022 629.121 Attorney's bond.—

2023 (1) Concurrently with the filing of the declaration
2024 provided for in s. 629.081, the attorney in fact of a domestic
2025 reciprocal insurer shall file with the office a bond in favor of
2026 this state for the benefit of all persons damaged as a result of
2027 breach by the attorney in fact of the conditions of his or her
2028 bond as set forth in subsection (2). The bond must ~~shall~~ be
2029 executed by the attorney in fact and by an authorized corporate
2030 surety and is ~~shall be~~ subject to the approval of the office.

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2031 (2) The bond must ~~shall~~ be in the sum of $300,000 ~~$100,000~~,
2032 aggregate in form, the bond conditioned that the attorney in
2033 fact will faithfully account for all moneys and other property
2034 of the insurer coming into his or her hands, and that he or she
2035 will not withdraw or appropriate to his or her own use from the
2036 funds of the insurer any moneys or property to which he or she
2037 is not entitled under the power of attorney.
2038 (3) The bond must ~~shall~~ provide that it is not subject to
2039 cancellation unless 30 days' advance notice in writing of
2040 cancellation is given both the attorney in fact and the office.
2041 Section 35. Section 629.162, Florida Statutes, is created
2042 to read:
2043 629.162 Subscriber contributions.—
2044 (1) Reciprocal insurers may, subject to prior approval by
2045 the office, require contributions from subscribers in addition
2046 to premiums approved by the office.
2047 (2) A reciprocal insurer shall clearly disclose required
2048 subscriber contributions on the declaration page of any policy
2049 issued by the reciprocal insurer, separate from any cost
2050 associated with the premium.
2051 (3) Reciprocal insurers must provide subscribers with an
2052 annual report detailing how each dollar of subscriber
2053 contributions was allocated or spent.
2054 (4) Changes to subscriber contributions are subject to
2055 prior approval by the office.
2056 Section 36. Section 629.163, Florida Statutes, is created
2057 to read:
2058 629.163 Subscriber savings accounts.—
2059 (1) Reciprocal insurers are authorized to establish

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2060 subscriber savings accounts.
2061 (2) Money placed in subscriber savings accounts is not
2062 considered a distribution under s. 629.164.
2063 (3)(a) Reciprocal insurers must inform each subscriber, in
2064 writing, of the limitations and restrictions imposed upon the
2065 use or possession of moneys held in the subscriber savings
2066 account.
2067 (b) Reciprocal insurers must inform each subscriber, in
2068 writing, of the procedures used to distribute money to
2069 subscriber savings accounts and any calculations used to
2070 determine the amount of money to be distributed to subscriber
2071 savings accounts.
2072 (c) Advertisements marketing the benefits of subscriber
2073 savings accounts must note the limitations and restrictions
2074 imposed upon the use or possession of moneys held in the
2075 subscriber's savings account.
2076 (d) Upon cancellation or nonrenewal of a subscriber's
2077 policy, the subscriber shall be entitled to all moneys held in
2078 the subscriber savings account, except when such moneys are
2079 otherwise allocated by law or contract, or when such
2080 distribution is prohibited by order of the office.
2081 Section 37. Section 629.164, Florida Statutes, is created
2082 to read:
2083 629.164 Subscriber distributions.—
2084 (1) Reciprocal insurers are authorized to make
2085 distributions to subscribers from their subscriber savings
2086 accounts.
2087 (2) The subscribers' advisory committee has the sole
2088 authority to authorize distributions, subject to prior written

2089 approval by the office.
2090 (3) Any reciprocal insurer that otherwise authorizes
2091 distributions but prohibits subscribers from receiving
2092 distributions for a specified period of time, including after
2093 initial subscription, must renew the subscriber's policy for
2094 that period of time plus 1 additional policy year. This
2095 subsection does not prohibit the cancellation or nonrenewal of a
2096 policy under s. 629.1015 or by order of the office.
2097 (4) A reciprocal insurer may return to its subscribers any
2098 unused premiums, savings, or credits accruing to their accounts.
2099 Such return may not unfairly discriminate between classes of
2100 risks or policies, or between subscribers, but may vary as to
2101 classes of subscribers based on the experience of the classes.
2102 (5) In addition to the option provided in subsection (4), a
2103 domestic reciprocal insurer may, upon the prior written approval
2104 of the office, pay to its subscribers a portion of unassigned
2105 funds of up to 10 percent of surplus, with distribution limited
2106 to 50 percent of net income from the previous calendar year.
2107 Such payment may not unfairly discriminate between classes of
2108 risks or policies, or between subscribers, but may vary as to
2109 classes of subscribers based on the experience of the classes.
2110 Section 38. Section 629.171, Florida Statutes, is amended
2111 to read:
2112 629.171 Annual statement.—
2113 (1) The subscribers' advisory committee shall procure an
2114 audited annual statement of the accounts and records of the
2115 insurer and the attorney in fact. The statement of the insurer
2116 must be prepared by an independent auditor at the expense of the
2117 reciprocal insurer and must be available for inspection by any

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2118 subscriber. The statement of the attorney in fact must be
2119 prepared by an independent auditor at the expense of the
2120 attorney in fact.
2121 (2) The annual statement filing of a reciprocal insurer
2122 must be submitted ~~shall be made and filed~~ by its attorney in
2123 fact.
2124 (3)~~(2)~~ The audited statement of the attorney in fact must
2125 ~~shall~~ be submitted with the annual statement filing of the
2126 reciprocal insurer as required under s. 624.424, and
2127 supplemented by such information as may be required by the
2128 office relative to the affairs and transactions of the attorney
2129 in fact relating ~~insofar as they relate~~ to the reciprocal
2130 insurer.
2131 Section 39. Subsection (1) of section 629.181, Florida
2132 Statutes, is amended to read:
2133 629.181 Financial condition; method of determining.—In
2134 determining the financial condition of a reciprocal insurer, the
2135 office shall apply the following rules:
2136 (1) Subscriber contributions are ~~The surplus deposits of~~
2137 ~~subscribers shall be~~ allowed as assets, except that any premium
2138 deposits delinquent for 90 days must ~~shall~~ first be charged
2139 against such subscriber contributions. Subscriber contributions
2140 may not exceed 2 percent of each individual subscriber's policy
2141 premium for a nonassessable reciprocal insurer and 10 percent of
2142 each individual subscriber's policy premium for an assessable
2143 reciprocal insurer ~~surplus deposit~~.
2144 Section 40. Section 629.201, Florida Statutes, is amended
2145 to read:
2146 629.201 Subscribers' advisory committee.—Each domestic

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2147 reciprocal insurer must have a subscribers’ advisory committee
2148 representing the interests of the subscribers.
2149 (1) The subscribers’ advisory committee of a domestic
2150 reciprocal insurer exercising the subscribers’ rights must ~~shall~~
2151 be formed in compliance with this section and ~~selected~~ under
2152 such rules as the subscribers adopt. Such rules, along with any
2153 amendments, must be approved by the office before becoming
2154 effective.
2155 (2) ~~Not less than two-thirds of such committee shall be~~
2156 ~~subscribers other than the attorney, or any person employed by,~~
2157 ~~representing, or having a financial interest in the attorney.~~
2158 ~~(3)~~ The subscribers’ advisory committee shall perform all
2159 of the following duties:
2160 (a) Supervise the finances of the insurer.~~;~~
2161 (b) Supervise the insurer’s operations to such extent as to
2162 assure conformity with the subscribers’ agreement, ~~and~~ power of
2163 attorney, and other governing documents.~~;~~
2164 (c) Hire independent auditors, counsel, and other experts
2165 at the expense of the insurer as necessary to fulfill the
2166 committee’s duties ~~Procure the audit of the accounts and records~~
2167 ~~of the insurer and of the attorney at the expense of the~~
2168 ~~insurer~~; and
2169 (d) Exercise any ~~Have such~~ additional powers and functions
2170 as may be conferred by the subscribers’ agreement.
2171 (3) The initial subscriber’s advisory committee must be
2172 appointed by either the original subscribers or the attorney in
2173 fact. Within 6 months after the reciprocal insurer is authorized
2174 to transact insurance, at least two-thirds of the committee
2175 members must be appointed as provided for in subsections (4) and

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2176 (5).
2177 (4) The subscribers' advisory committee shall consist of
2178 subscribers of the reciprocal insurer. At least two-thirds of
2179 the subscribers' advisory committee must consist of subscribers
2180 who are independent of, not employed by, not representing, not
2181 selected by, and without any financial interest in the attorney
2182 in fact. The independent subscribers must be elected by the
2183 subscribers of the reciprocal insurer.
2184 (5) Any rules governing the appointment of subscribers to
2185 the subscribers' advisory committee require all of the
2186 following:
2187 (a) A subscribers' advisory committee composed exclusively
2188 of subscribers of the reciprocal insurer.
2189 (b) Terms of not more than 5 years.
2190 (c) A process that allows subscribers to nominate other
2191 subscribers for appointment to the subscribers' advisory
2192 committee.
2193 (6) If a reciprocal insurer has more than 50 subscribers,
2194 the attorney in fact must provide a platform by which
2195 subscribers are able to communicate with each other regarding
2196 the subscribers' advisory committee appointment process.
2197 Section 41. Section 629.271, Florida Statutes, is repealed.
2198 Section 42. Effective upon becoming a law, subsections (1)
2199 and (2) of section 629.291, Florida Statutes, are amended to
2200 read:
2201 629.291 Merger or conversion.—
2202 (1) A reciprocal insurer, upon affirmative vote of not less
2203 than two-thirds of its subscribers who vote on such merger or
2204 conversion pursuant to due notice, and subject to approval by

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2205 the office of the terms therefor, may merge with another
2206 reciprocal insurer or be converted to a stock or mutual insurer,
2207 to be thereafter governed by the applicable sections of the
2208 Florida Insurance Code. However, a domestic stock insurer may
2209 not convert to a reciprocal insurer.
2210 (2) A plan to merge a reciprocal insurer with another
2211 reciprocal insurer or for conversion of the reciprocal insurer
2212 to a stock or mutual insurer must be filed with the office on
2213 forms adopted by the commission ~~office~~ and must contain such
2214 information as the office reasonably requires to evaluate the
2215 transaction.
2216 Section 43. Section 629.301, Florida Statutes, is amended
2217 to read:
2218 629.301 Impaired reciprocal insurers.—
2219 (1) If the assets of a ~~domestic~~ reciprocal insurer are at
2220 any time insufficient to discharge its liabilities, other than
2221 any liability on account of funds contributed by the attorney in
2222 fact or others, and to maintain the required surplus, its
2223 attorney in fact shall immediately ~~forthwith~~ make up the
2224 deficiency or levy an assessment upon the subscribers for the
2225 amount needed to make up the deficiency, but subject to the
2226 limitation set forth in the power of attorney or policy.
2227 (2) If the attorney in fact fails to make up such
2228 deficiency or to make the assessment within 30 days after the
2229 office orders it ~~him or her~~ to do so, or if the deficiency is
2230 not fully made up within 60 days after the date the assessment
2231 was made, the insurer shall be deemed insolvent and shall be
2232 proceeded against in the same manner as any other insurer under
2233 chapter 631 and the insurance ~~as authorized by this~~ code.

(3) If liquidation of a reciprocal ~~such an~~ insurer is ordered, the receiver shall levy ~~an assessment shall be levied~~ 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~~,~~ ~~subject to limits as provided by this chapter, as the office determines to be necessary to discharge all liabilities of the insurer,~~ exclusive of any funds contributed by the attorney in fact or other persons, but inclusive of ~~including~~ the reasonable cost of the liquidation. The assessment is subject to any limits set forth in the power of attorney, the policy, or this chapter.

Section 44. Section 629.401, Florida Statutes, is repealed.

Section 45. Section 629.520, Florida Statutes, is repealed.

Section 46. Section 629.56, Florida Statutes, is created to read:

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

Section 47. Subsection (13) of section 634.401, Florida Statutes, is amended to read:

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

(13) “Service warranty” means any warranty, guaranty, extended warranty or extended guaranty, maintenance service contract equal to or greater than 1 year in length or which does not meet the exemption in paragraph (a), contract agreement, or other written promise for a specific duration to perform the repair, replacement, or maintenance of a consumer product, or for indemnification for repair, replacement, or maintenance, for operational or structural failure due to a defect in materials

2263 or workmanship, normal wear and tear, power surge, or accidental
2264 damage from handling in return for the payment of a segregated
2265 charge by the consumer; however:
2266 (a) Maintenance service contracts written for less than 1
2267 year which do not contain provisions for indemnification and
2268 which do not provide a discount to the consumer for any
2269 combination of parts and labor in excess of 20 percent during
2270 the effective period of such contract, motor vehicle service
2271 agreements, transactions exempt under s. 624.125, and home
2272 warranties subject to regulation under part II of this chapter
2273 are excluded from this definition;
2274 (b) The term “service warranty” does not include service
2275 contracts between consumers and condominium associations; and
2276 (c) All contracts that include coverage for accidental
2277 damage from handling must be covered by the contractual
2278 liability policy referred to in s. 634.406(3), unless issued by
2279 an association not required to establish an unearned premium
2280 reserve or maintain contractual liability insurance under s.
2281 634.406(7).
2282 Section 48. Section 641.2012, Florida Statutes, is created
2283 to read:
2284 641.2012 Service of process.—Sections 624.422 and 624.423
2285 apply to health maintenance organizations.
2286 Section 49. Subsections (1) and (3), paragraph (a) of
2287 subsection (5), and subsection (6) of section 641.26, Florida
2288 Statutes, are amended to read:
2289 641.26 Annual and quarterly reports.—
2290 (1) Every health maintenance organization shall file an
2291 annual statement covering the preceding calendar year on or

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2292 before March 1, and quarterly statements covering the periods
2293 ending on March 31, June 30, and September 30 must be filed
2294 within 45 days after each such date, ~~annually within 3 months~~
2295 ~~after the end of its fiscal year, or within an extension of time~~
2296 ~~therefor as the office, for good cause, may grant, in a form~~
2297 ~~prescribed by the commission, file a report with the office,~~
2298 verified by the oath of two officers of the organization or, if
2299 not a corporation, of two persons who are principal managing
2300 directors of the affairs of the organization, properly
2301 notarized, showing its condition on the last day of the
2302 immediately preceding reporting period. Such report must ~~shall~~
2303 include:
2304 (a) A financial statement of the health maintenance
2305 organization filed by electronic means in a computer-readable
2306 form using a format acceptable to the office.
2307 (b) A financial statement of the health maintenance
2308 organization filed on forms acceptable to the office.
2309 (c) An audited financial statement of the health
2310 maintenance organization, including its balance sheet and a
2311 statement of operations for the preceding year certified by an
2312 independent certified public accountant, prepared in accordance
2313 with statutory accounting principles.
2314 (d) The number of health maintenance contracts issued and
2315 outstanding and the number of health maintenance contracts
2316 terminated.
2317 (e) The number and amount of damage claims for medical
2318 injury initiated against the health maintenance organization and
2319 any of the providers engaged by it during the reporting year,
2320 broken down into claims with and without formal legal process,

2321 and the disposition, if any, of each such claim.
2322 (f) An actuarial certification that:
2323 1. The health maintenance organization is actuarially
2324 sound, which certification shall consider the rates, benefits,
2325 and expenses of, and any other funds available for the payment
2326 of obligations of, the organization.
2327 2. The rates being charged or to be charged are actuarially
2328 adequate to the end of the period for which rates have been
2329 guaranteed.
2330 3. Incurred but not reported claims and claims reported but
2331 not fully paid have been adequately provided for.
2332 4. The health maintenance organization has adequately
2333 provided for all obligations required by s. 641.35(3)(a).
2334 (g) A report prepared by the certified public accountant
2335 and filed with the office describing material weaknesses in the
2336 health maintenance organization's internal control structure as
2337 noted by the certified public accountant during the audit. The
2338 report must be filed with the annual audited financial report as
2339 required in paragraph (c). The health maintenance organization
2340 shall provide a description of remedial actions taken or
2341 proposed to correct material weaknesses, if the actions are not
2342 described in the independent certified public accountant's
2343 report.
2344 (h) Such other information relating to the performance of
2345 health maintenance organizations as is required by the
2346 commission or office.
2347 (3) Every health maintenance organization shall file
2348 quarterly, for the first three calendar quarters of each year,
2349 an unaudited financial statement of the organization as

2350 described in paragraphs (1)(a) and (b). ~~The statement for the~~
2351 ~~quarter ending March 31 shall be filed on or before May 15, the~~
2352 ~~statement for the quarter ending June 30 shall be filed on or~~
2353 ~~before August 15, and the statement for the quarter ending~~
2354 ~~September 30 shall be filed on or before November 15.~~ The
2355 quarterly report shall be verified by the oath of two officers
2356 of the organization, properly notarized.
2357 (5) Each authorized health maintenance organization shall
2358 retain an independent certified public accountant, referred to
2359 in this section as "CPA," who agrees by written contract with
2360 the health maintenance organization to comply with the
2361 provisions of this part.
2362 (a) The CPA shall provide to the HMO audited financial
2363 statements consistent with this part and s. 624.424.
2364 (6) To facilitate uniformity in financial statements and to
2365 facilitate office analysis, the commission may by rule adopt the
2366 form for financial statements of a health maintenance
2367 organization, requiring the financial statement to comply with
2368 the provisions of s. 624.424 ~~including supplements as approved~~
2369 ~~by the National Association of Insurance Commissioners in 1995,~~
2370 ~~and may adopt subsequent amendments thereto if the methodology~~
2371 ~~remains substantially consistent~~, and may by rule require each
2372 health maintenance organization to submit to the office all or
2373 part of the information contained in the annual statement in a
2374 computer-readable form compatible with the electronic data
2375 processing system specified by the office.
2376 Section 50. Section 641.283, Florida Statutes, is created
2377 to read:
2378 641.283 Administrative supervision and hazardous

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2379 condition.—Sections 624.80-624.87 apply to health maintenance
2380 organizations.
2381 Section 51. Present subsections (5) through (15) and (16)
2382 through (29) of section 651.011, Florida Statutes, are
2383 redesignated as subsections (7) through (17) and (19) through
2384 (32), respectively, new subsections (5), (6), and (18) are added
2385 to that section, and present subsections (8), (19), and (26) of
2386 that section are amended, to read:
2387 651.011 Definitions.—As used in this chapter, the term:
2388 (5) “Affiliate” means an entity that exercises control over
2389 or is directly or indirectly controlled by the insurer provider
2390 through any of the following:
2391 (a) Equity ownership of voting securities.
2392 (b) Common managerial control.
2393 (c) Collusive participation by the management of the
2394 insurer and affiliate in the management of the insurer or the
2395 affiliate.
2396 (6) “Affiliated person” of another person includes any of
2397 the following:
2398 (a) The spouse of the other person.
2399 (b) The parents of the other person and their lineal
2400 descendants, or the parents of the other person’s spouse and
2401 their lineal descendants.
2402 (c) A person who directly or indirectly owns or controls,
2403 or holds with the power to vote, 10 percent or more of the
2404 outstanding voting securities of the other person.
2405 (d) A person, 10 percent or more of whose outstanding
2406 voting securities are directly or indirectly owned or
2407 controlled, or held with power to vote, by the other person.

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2408 (e) A person or group of persons who directly or indirectly
2409 control, are controlled by, or are under common control with the
2410 other person.
2411 (f) An officer, director, partner, copartner, or employee
2412 of the other person.
2413 (g) If the other person is an investment company, an
2414 investment adviser of such company, or a member of an advisory
2415 board of such company.
2416 (h) If the other person is an unincorporated investment
2417 company not having a board of directors, the depositor of such
2418 company.
2419 (i) A person who has entered into a written or unwritten
2420 agreement to act in concert with the other person in acquiring
2421 or limiting the disposition of securities of a domestic stock
2422 insurer provider or controlling company.
2423 (10)~~(8)~~ "Control," including the terms "controlling,"
2424 "controlled by," "under common control with," and "controlling,"
2425 ~~"Controlling company"~~ means any corporation, trust, or
2426 association that directly or indirectly owns 10 ~~25~~ percent or
2427 more of either of the following:
2428 (a) The direct or indirect possession of the power to
2429 direct or cause the direction of the management and policies of
2430 a person, whether through the ownership of voting securities, by
2431 contract other than a commercial contract for goods or
2432 nonmanagement services, or otherwise. Control is presumed to
2433 exist if a person, directly or indirectly, owns, controls, holds
2434 with the power to vote, or holds proxies representing 10 percent
2435 or more of the voting securities of another person. ~~The voting~~
2436 ~~securities of one or more providers that are stock corporations;~~

2437 ~~or~~
2438 (b) A management company exercising control through a
2439 management agreement whereby the management company is
2440 responsible for the day-to-day business operations of the
2441 provider or the day-to-day decisionmaking on behalf of the
2442 provider ~~The ownership interest of one or more providers that~~
2443 ~~are not stock corporations~~.
2444 (18) “Governing body” or “full governing body” means a
2445 board of directors, a management company, or a body of a
2446 provider or obligated group whose members are elected or
2447 appointed to set strategy; oversee management or operations of a
2448 provider, facility, or obligated group; and protect the
2449 interests of the provider, facility, or group.
2450 (22)~~(19)~~ “Manager,” “management,” or “management company”
2451 means a person who administers the day-to-day business
2452 operations of a facility for a provider, is part of a committee
2453 that supervises the activities of a business that provides
2454 continuing care or a member of the full governing body of a
2455 business that provides continuing care, or is subject to the
2456 policies, directives, and oversight of the provider or governing
2457 body.
2458 (29)~~(26)~~ “Regulatory action level event” means that any two
2459 of the following have occurred:
2460 (a) The provider’s debt service coverage ratio is less than
2461 the greater of the minimum ratio specified in the provider’s
2462 bond covenants or lending agreement for long-term financing or
2463 1.20:1 as of the most recent annual report filed with the office
2464 pursuant to s. 651.026 or s. 651.0261, or, if the provider does
2465 not have a debt service coverage ratio required by its lending

2466 institution, the provider's debt service coverage ratio is less
2467 than 1.20:1 as of the most recent ~~annual~~ report filed with the
2468 office pursuant to s. 651.026 <u>or s. 651.0261</u>. If the provider is
2469 a member of an obligated group having cross-collateralized debt,
2470 the obligated group's debt service coverage ratio must be used
2471 as the provider's debt service coverage ratio.
2472 (b) The provider's days cash on hand is less than the
2473 greater of the minimum number of days cash on hand specified in
2474 the provider's bond covenants or lending agreement for long-term
2475 financing or 100 days. If the provider does not have a days cash
2476 on hand required by its lending institution, the days cash on
2477 hand may not be less than 100 as of the most recent ~~annual~~
2478 report filed with the office pursuant to s. 651.026 <u>or s.</u>
2479 <u>651.0261</u>. If the provider is a member of an obligated group
2480 having cross-collateralized debt, the days cash on hand of the
2481 obligated group must be used as the provider's days cash on
2482 hand.
2483 (c) The occupancy of the provider's facility is less than
2484 80 percent averaged over the 12-month period immediately
2485 preceding the annual report filed with the office pursuant to s.
2486 651.026.
2487 Section 52. Section 651.018, Florida Statutes, is amended
2488 to read:
2489 651.018 Administrative supervision.—
2490 <u>(1)</u> The office may place a facility in administrative
2491 supervision pursuant to part VI of chapter 624.
2492 <u>(2) If the office finds that any of the following</u>
2493 <u>conditions exist, the office shall place a facility in</u>
2494 <u>administrative supervision until such time as the condition is</u>

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2495 resolved to the satisfaction of the office.
2496 (a) The facility is insolvent or impaired.
2497 (b) The facility is at regulatory action level, pursuant to
2498 s. 651.034.
2499 (c) The facility reports a negative debt service reserve.
2500 (d) The facility has failed to file a monthly, quarterly,
2501 or annual financial statement or audited financial statements as
2502 required by this chapter.
2503 (e) The facility was issued a financial statement with a
2504 going concern issue by an independent certified public
2505 accountant.
2506 (f) The facility is found to be in a hazardous financial
2507 condition, pursuant to s. 651.113.
2508 (g) The facility has entered into a forbearance agreement
2509 with a lender.
2510 Section 53. Paragraph (a) of subsection (1) of section
2511 651.019, Florida Statutes, is amended to read:
2512 651.019 New financing, additional financing, or
2513 refinancing.—
2514 (1)(a) A provider shall provide a written general outline
2515 of the amount and the anticipated terms of any new financing or
2516 refinancing, and the intended use of proceeds, to the office and
2517 residents' council at least 30 days before the closing date of
2518 the financing or refinancing transaction. If there is a material
2519 change in the noticed information, a provider shall provide an
2520 updated notice to the office and the residents' council within
2521 10 business days after the provider becomes aware of such
2522 change.
2523 Section 54. Section 651.0212, Florida Statutes, is created

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2524 to read:
2525 651.0212 General eligibility requirements to operate in
2526 this state.—
2527 (1) The office must deny or revoke a provider's authority
2528 to conduct business relating to continuing care in this state,
2529 including, but not limited to, the authority to enter into
2530 contracts, provide continuing care or continuing care at home,
2531 or construct facilities for the purpose of providing continuing
2532 care in this state, if it determines that any of the following
2533 applies to the provider's management, officers, or directors:
2534 (a) They are incompetent or untrustworthy.
2535 (b) They lack sufficient experience in continuing care
2536 management, posing a risk to contract holders.
2537 (c) They lack the experience, ability, or reputation
2538 necessary to ensure a reasonable likelihood of successful
2539 operation.
2540 (d) They are affiliated, directly or indirectly, with
2541 individuals or entities whose business practices have harmed
2542 residents, stockholders, investors, creditors, or the public
2543 through asset manipulation, fraudulent accounting, or bad faith
2544 actions.
2545 (2) The office must deny or revoke a provider's authority
2546 to conduct business relating to continuing care in this state,
2547 including, but not limited to, the authority to enter into
2548 contracts, provide continuing care or continuing care at home,
2549 or construct facilities for the purpose of providing continuing
2550 care in this state, if it determines that any general partner,
2551 subscriber, stockholder, or incorporator who exercises or has
2552 the ability to exercise effective control of the provider, or

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2553 who influences or has the ability to influence the transaction
2554 of the business of the provider, lacks the financial standing
2555 and business experience necessary for the provider's successful
2556 operation.
2557 (3) The office may deny, suspend, or revoke a provider's
2558 authority to conduct business relating to continuing care in
2559 this state, including, but not limited to, the authority to
2560 enter into contracts, provide continuing care or continuing care
2561 at home, or construct facilities for the purpose of providing
2562 continuing care, if it determines that any subscriber,
2563 stockholder, or incorporator who exercises or has the ability to
2564 exercise effective control of the provider, or who influences or
2565 has the ability to influence its business transactions, has been
2566 found guilty of, or has pleaded guilty or nolo contendere to,
2567 any felony or crime punishable by imprisonment of 1 year or more
2568 under the laws of the United States, any state, or any other
2569 country, if the crime involves moral turpitude, regardless of
2570 whether a judgment of conviction has been entered by the court.
2571 However, if a provider operates under a valid certificate of
2572 authority, it must immediately remove any such person from his
2573 or her role in the business upon discovery of the conditions set
2574 forth in this subsection or remove such person upon order of the
2575 office. Failure to do so constitutes grounds for suspension or
2576 revocation of the provider's certificate of authority.
2577 (4) The office may deny, suspend, or revoke a provider's
2578 authority to conduct business relating to continuing care in
2579 this state, including, but not limited to, the authority to
2580 enter into contracts, provide continuing care or continuing care
2581 at home, or construct facilities for providing continuing care,

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2582 if it determines that any general partner, subscriber,
2583 stockholder, or incorporator who exercises or has the ability to
2584 exercise effective control of the provider, or who influences or
2585 has the ability to influence its business transactions, is now
2586 or was previously affiliated, directly or indirectly, through
2587 ownership of 10 percent or more, with any business, corporation,
2588 or entity that has been found guilty of, or has pleaded guilty
2589 or nolo contendere to, any felony or crime punishable by
2590 imprisonment for 1 year or more under the laws of the United
2591 States, any state, or any other country. However, if a provider
2592 operates under a valid certificate of authority, it must
2593 immediately remove any such person from his or her role in the
2594 business or notify the office upon discovery of the conditions
2595 set forth in this subsection. Failure to remove the person,
2596 provide notice to the office, or comply with an order from the
2597 office to remove the person from his or her role constitutes
2598 grounds for suspension or revocation of the provider’s
2599 certificate of authority.
2600 Section 55. Subsections (4) and (5) of section 651.0215,
2601 Florida Statutes, are amended to read:
2602 651.0215 Consolidated application for a provisional
2603 certificate of authority and a certificate of authority;
2604 required restrictions on use of entrance fees.—
2605 (4) Within 30 ~~45~~ days after receipt of the information
2606 required under subsection (2), the office shall examine the
2607 information and notify the applicant in writing, specifically
2608 requesting any additional information that the office is
2609 authorized to require. An application is deemed complete when
2610 the office receives all requested information and the applicant

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2611 corrects any error or omission of which the applicant was timely
2612 notified or when the time for such notification has expired.
2613 ~~Within 15 days after receipt of all of the requested additional~~
2614 ~~information, the office shall notify the applicant in writing~~
2615 ~~that all of the requested information has been received and that~~
2616 ~~the application is deemed complete as of the date of the notice.~~
2617 ~~Failure to notify the applicant in writing within the 15-day~~
2618 ~~period constitutes acknowledgment by the office that it has~~
2619 ~~received all requested additional information, and the~~
2620 ~~application is deemed complete for purposes of review on the~~
2621 ~~date the applicant files all of the required additional~~
2622 ~~information.~~
2623 ~~(5) Within 45 days after an application is deemed complete~~
2624 ~~as set forth in subsection (4) and upon completion of the~~
2625 ~~remaining requirements of this section, the office shall~~
2626 ~~complete its review and issue or deny a certificate of authority~~
2627 ~~to the applicant. If a certificate of authority is denied, the~~
2628 ~~office shall notify the applicant in writing, citing the~~
2629 ~~specific failures to satisfy this chapter, and the applicant is~~
2630 ~~entitled to an administrative hearing pursuant to chapter 120.~~
2631 Section 56. Subsections (3), (5), and (6) of section
2632 651.022, Florida Statutes, are amended to read:
2633 651.022 Provisional certificate of authority; application.—
2634 (3) In addition to the information required in subsection
2635 (2), an applicant for a provisional certificate of authority
2636 shall submit a feasibility study<u>, prepared by an independent</u>
2637 <u>consultant,</u> with appropriate financial, marketing, and actuarial
2638 assumptions for the first 5 years of operations. The feasibility
2639 study must include at least the following information:

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2640 (a) A description of the proposed facility, including the
2641 location, size, anticipated completion date, and the proposed
2642 construction program.
2643 (b) An identification and evaluation of the primary and, if
2644 appropriate, the secondary market areas of the facility and the
2645 projected unit sales per month.
2646 (c) Projected revenues, including anticipated entrance
2647 fees; monthly service fees; nursing care revenues, if
2648 applicable; and all other sources of revenue.
2649 (d) Projected expenses, including staffing requirements and
2650 salaries; cost of property, plant, and equipment, including
2651 depreciation expense; interest expense; marketing expense; and
2652 other operating expenses.
2653 (e) A projected balance sheet.
2654 (f) Expectations of the financial condition of the project,
2655 including the projected cash flow, and an estimate of the funds
2656 anticipated to be necessary to cover startup losses.
2657 (g) The inflation factor, if any, assumed in the
2658 feasibility study for the proposed facility and how and where it
2659 is applied.
2660 (h) Project costs and the total amount of debt financing
2661 required, marketing projections, resident fees and charges, the
2662 competition, resident contract provisions, and other factors
2663 that affect the feasibility of the facility.
2664 (i) Appropriate population projections, including morbidity
2665 and mortality assumptions.
2666 (j) The name of the person who prepared the feasibility
2667 study and the experience of such person in preparing similar
2668 studies or otherwise consulting in the field of continuing care.

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2669 The preparer of the feasibility study may be the provider or a
2670 contracted third party.
2671 (k) Any other information that the applicant deems relevant
2672 and appropriate to enable the office to make a more informed
2673 determination.
2674 (5)~~(a)~~ Within 30 days after receipt of an application for a
2675 provisional certificate of authority, the office shall examine
2676 the application and shall notify the applicant in writing,
2677 specifically setting forth and specifically requesting any
2678 additional information the office is permitted by law to
2679 require. If the application submitted is determined by the
2680 office to be substantially incomplete so as to require
2681 substantial additional information, including biographical
2682 information, the office may return the application to the
2683 applicant with a written notice that the application as received
2684 is substantially incomplete and, therefore, unacceptable for
2685 filing without further action required by the office. Any filing
2686 fee received shall be refunded to the applicant.
2687 ~~(b) Within 15 days after receipt of all of the requested~~
2688 ~~additional information, the office shall notify the applicant in~~
2689 ~~writing that all of the requested information has been received~~
2690 ~~and the application is deemed to be complete as of the date of~~
2691 ~~the notice. Failure to so notify the applicant in writing within~~
2692 ~~the 15-day period shall constitute acknowledgment by the office~~
2693 ~~that it has received all requested additional information, and~~
2694 ~~the application shall be deemed to be complete for purposes of~~
2695 ~~review upon the date of the filing of all of the requested~~
2696 ~~additional information.~~
2697 ~~(6) Within 45 days after the date an application is deemed~~

2698 ~~complete as set forth in paragraph (5)(b), the office shall~~
2699 ~~complete its review and issue a provisional certificate of~~
2700 ~~authority to the applicant based upon its review and a~~
2701 ~~determination that the application meets all requirements of~~
2702 ~~law, that the feasibility study was based on sufficient data and~~
2703 ~~reasonable assumptions, and that the applicant will be able to~~
2704 ~~provide continuing care or continuing care at-home as proposed~~
2705 ~~and meet all financial and contractual obligations related to~~
2706 ~~its operations, including the financial requirements of this~~
2707 ~~chapter. If the application is denied, the office shall notify~~
2708 ~~the applicant in writing, citing the specific failures to meet~~
2709 ~~the provisions of this chapter. Such denial entitles the~~
2710 ~~applicant to a hearing pursuant to chapter 120.~~
2711 Section 57. Paragraphs (c) and (h) of subsection (1) and
2712 subsections (2), (3), and (7) of section 651.023, Florida
2713 Statutes, are amended to read:
2714 651.023 Certificate of authority; application.—
2715 (1) After issuance of a provisional certificate of
2716 authority, the office shall issue to the holder of such
2717 provisional certificate a certificate of authority if the holder
2718 of the provisional certificate provides the office with the
2719 following information:
2720 (c) Subject to <u>subsection (3)</u> ~~subsection (4)~~, a provider
2721 may submit an application for a certificate of authority and any
2722 required exhibits upon submission of documents evidencing that
2723 the project has a minimum of 30 percent of the units reserved
2724 for which the provider is charging an entrance fee.
2725 (h) Documents evidencing that the applicant has complied
2726 with the escrow requirements of <u>subsection (4)</u> ~~subsection (5)~~ or

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2727 subsection (6) ~~subsection (7)~~ and will be able to comply with s.
2728 651.035.
2729
2730 If any material change occurs in the facts set forth in an
2731 application filed with the office pursuant to this subsection,
2732 an amendment setting forth such change must be filed with the
2733 office within 10 business days after the applicant becomes aware
2734 of such change, and a copy of the amendment must be sent by
2735 registered mail to the principal office of the facility and to
2736 the principal office of the controlling company.
2737 (2) Within 30 days after receipt of the information
2738 required under subsection (1), the office shall examine such
2739 information and notify the provider in writing, specifically
2740 requesting any additional information the office is permitted by
2741 law to require. ~~Within 15 days after receipt of all of the~~
2742 ~~requested additional information, the office shall notify the~~
2743 ~~provider in writing that all of the requested information has~~
2744 ~~been received and the application is deemed to be complete as of~~
2745 ~~the date of the notice. Failure to notify the applicant in~~
2746 ~~writing within the 15-day period constitutes acknowledgment by~~
2747 ~~the office that it has received all requested additional~~
2748 ~~information, and the application shall be deemed complete for~~
2749 ~~purposes of review on the date of filing all of the required~~
2750 ~~additional information.~~
2751 ~~(3) Within 45 days after an application is deemed complete~~
2752 ~~as set forth in subsection (2), and upon completion of the~~
2753 ~~remaining requirements of this section, the office shall~~
2754 ~~complete its review and issue or deny a certificate of authority~~
2755 ~~to the holder of a provisional certificate of authority. If a~~

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2756 ~~certificate of authority is denied, the office must notify the~~
2757 ~~holder of the provisional certificate in writing, citing the~~
2758 ~~specific failures to satisfy the provisions of this chapter. If~~
2759 ~~denied, the holder of the provisional certificate is entitled to~~
2760 ~~an administrative hearing pursuant to chapter 120.~~
2761 (6) ~~(7)~~ In lieu of the provider fulfilling the requirements
2762 imposed under in subsection (4) ~~subsection (5)~~ and paragraphs
2763 (5)(b) and (c) ~~paragraphs (6)(b) and (c)~~, the office may
2764 authorize the release of escrowed funds to retire all
2765 outstanding debts on the facility and equipment upon application
2766 of the provider and upon the provider's showing that the
2767 provider will grant to the residents a first mortgage on the
2768 land, buildings, and equipment that constitute the facility, and
2769 that the provider has satisfied paragraphs (5)(a) and (d)
2770 ~~paragraphs (6)(a) and (d)~~. Such mortgage shall secure the refund
2771 of the entrance fee in the amount required by this chapter. The
2772 granting of such mortgage is subject to the following:
2773 (a) The first mortgage is granted to an independent trust
2774 that is beneficially held by the residents. The document
2775 creating the trust must include a provision that agrees to an
2776 annual audit and will furnish to the office all information the
2777 office may reasonably require. The mortgage may secure payment
2778 on bonds issued to the residents or trustee. Such bonds are
2779 redeemable after termination of the residency contract in the
2780 amount and manner required by this chapter for the refund of an
2781 entrance fee.
2782 (b) Before granting a first mortgage to the residents, all
2783 construction must be substantially completed and substantially
2784 all equipment must be purchased. No part of the entrance fees

2785 may be pledged as security for a construction loan or otherwise
2786 used for construction expenses before the completion of
2787 construction.
2788 (c) If the provider is leasing the land or buildings used
2789 by the facility, the leasehold interest must be for a term of at
2790 least 30 years.
2791 Section 58. Present subsection (3) of section 651.024,
2792 Florida Statutes, is redesignated as subsection (5), and new
2793 subsections (3) and (4) are added to that section, to read:
2794 651.024 Acquisition.—
2795 (3) A bondholder that obtains consent rights from a
2796 provider which allow the bondholder to have oversight or
2797 decisionmaking authority over a facility or in the financial
2798 decisions of the facility is subject to s. 628.4615 and is not
2799 required to make filings pursuant to s. 651.022, s. 651.023, or
2800 s. 651.0245. For the purposes of this subsection, the term
2801 "consent rights" includes, but is not limited to, all of the
2802 following:
2803 (a) Approving or initiating the sale of a facility.
2804 (b) Approving or entering into an affiliation arrangement
2805 on behalf of the facility.
2806 (c) Approving or executing new or amended financing for the
2807 facility.
2808 (d) Approving or entering into a forbearance agreement for
2809 the facility.
2810 (4) A continuing care retirement community that enters into
2811 an affiliation agreement with another entity, resulting in a
2812 change of officers, directors, or effective control, is subject
2813 to s. 628.4615 and is not required to file pursuant to s.

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2814 651.022, s. 651.023, or s. 651.0245.

2815 Section 59. Paragraph (a) of subsection (2), paragraph (a)
2816 of subsection (5), and subsection (6) of section 651.0246,
2817 Florida Statutes, are amended to read:

2818 651.0246 Expansions.—

2819 (2) A provider applying for expansion of a certificated
2820 facility must submit all of the following:

2821 (a) A feasibility study prepared by an independent
2822 certified public accountant. The feasibility study must include
2823 at least the following information:

2824 1. A description of the facility and proposed expansion,
2825 including the location, the size, the anticipated completion
2826 date, and the proposed construction program.

2827 2. An identification and evaluation of the primary and, if
2828 applicable, secondary market areas of the facility and the
2829 projected unit sales per month.

2830 3. Projected revenues, including anticipated entrance fees;
2831 monthly service fees; nursing care revenues, if applicable; and
2832 all other sources of revenue.

2833 4. Projected expenses, including for staffing requirements
2834 and salaries; the cost of property, plant, and equipment,
2835 including depreciation expense; interest expense; marketing
2836 expense; and other operating expenses.

2837 5. A projected balance sheet of the applicant.

2838 6. The expectations for the financial condition of the
2839 project, including the projected cash flow and an estimate of
2840 the funds anticipated to be necessary to cover startup losses.

2841 7. The inflation factor, if any, assumed in the study for
2842 the proposed expansion and how and where it is applied.

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2843 8. Project costs; the total amount of debt financing
2844 required; marketing projections; resident rates, fees, and
2845 charges; the competition; resident contract provisions; and
2846 other factors that affect the feasibility of the facility.
2847 9. Appropriate population projections, including morbidity
2848 and mortality assumptions.
2849 10. The name of the person who prepared the feasibility
2850 study and his or her experience in preparing similar studies or
2851 otherwise consulting in the field of continuing care.
2852 11. Financial forecasts or projections prepared in
2853 accordance with standards adopted by the American Institute of
2854 Certified Public Accountants or in accordance with standards for
2855 feasibility studies for continuing care retirement communities
2856 adopted by the Actuarial Standards Board.
2857 12. An independent evaluation and examination opinion for
2858 the first 5 years of operations, or a comparable opinion
2859 acceptable to the office, by the certified public accountant who
2860 prepared the study, of the underlying assumptions used as a
2861 basis for the forecasts or projections in the study and that the
2862 assumptions are reasonable and proper and the project as
2863 proposed is feasible.
2864 13. A plan for the ongoing operations of existing
2865 facilities.
2866 14. Any other information that the provider deems relevant
2867 and appropriate to provide to enable the office to make a more
2868 informed determination.
2869
2870 If any material change occurs in the facts set forth in an
2871 application filed with the office pursuant to this section, an

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2872 amendment setting forth such change must be filed with the
2873 office within 10 business days after the applicant becomes aware
2874 of such change, and a copy of the amendment must be sent by
2875 registered mail to the principal office of the facility and to
2876 the principal office of the controlling company.
2877 (5)(a) Within 30 days after receipt of an application for
2878 expansion, the office shall examine the application and shall
2879 notify the applicant in writing, specifically requesting any
2880 additional information that the office is authorized to require.
2881 ~~Within 15 days after the office receives all the requested~~
2882 ~~additional information, the office shall notify the applicant in~~
2883 ~~writing that the requested information has been received and~~
2884 ~~that the application is deemed complete as of the date of the~~
2885 ~~notice. Failure to notify the applicant in writing within the~~
2886 ~~15-day period constitutes acknowledgment by the office that it~~
2887 ~~has received all requested additional information, and the~~
2888 ~~application is deemed complete for purposes of review on the~~
2889 ~~date the applicant files all of the required additional~~
2890 ~~information.~~ If the application submitted is determined by the
2891 office to be substantially incomplete so as to require
2892 substantial additional information, including biographical
2893 information, the office may return the application to the
2894 applicant with a written notice stating that the application as
2895 received is substantially incomplete and, therefore, is
2896 unacceptable for filing without further action required by the
2897 office. Any filing fee received must be refunded to the
2898 applicant.
2899 (6) Within 45 ~~30~~ days after the date on which an
2900 application is deemed complete as provided in paragraph (5)(b),

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2901 the office shall complete its review and, based upon its review,
2902 approve an expansion by the applicant and issue a determination
2903 that the application meets all requirements of law, that the
2904 feasibility study was based on sufficient data and reasonable
2905 assumptions, and that the applicant will be able to provide
2906 continuing care or continuing care at-home as proposed and meet
2907 all financial and contractual obligations related to its
2908 operations, including the financial requirements of this
2909 chapter. If the application is denied, the office must notify
2910 the applicant in writing, citing the specific failures to meet
2911 the requirements of this chapter. The denial entitles the
2912 applicant to a hearing pursuant to chapter 120.
2913 Section 60. Present paragraph (f) of subsection (2) of
2914 section 651.026, Florida Statutes, is redesignated as paragraph
2915 (i), present subsections (3) through (10) of that section are
2916 redesignated as subsections (4) through (11), respectively, a
2917 new paragraph (f) and paragraphs (g) and (h) are added to
2918 subsection (2) of that section, a new subsection (3) is added to
2919 that section, and subsection (1) and present subsection (6) of
2920 that section are amended, to read:
2921 651.026 Annual reports.—
2922 (1) Annually, on or before May 1, the provider shall file
2923 an annual report and such other information and data showing its
2924 condition as of the last day of the preceding calendar year,
2925 except as provided in subsection (6) ~~(5)~~. If the office does not
2926 receive the required information on or before May 1, a late fee
2927 may be charged pursuant to s. 651.015(2)(c). The office may
2928 approve an extension of up to 30 days.
2929 (2) The annual report shall be in such form as the

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2930 commission prescribes and shall contain at least the following:
2931 (f) Each facility shall file with the office quarterly,
2932 together with the quarterly report required by this section, all
2933 escrow bank statements for the last quarter of the reporting
2934 period which support the funds held in each of the minimum
2935 liquid reserves bank accounts, including, but not limited to,
2936 the debt service reserve, the operating reserve, and the renewal
2937 and replacement reserve.
2938 (g) Each facility shall file with the office quarterly,
2939 together with the quarterly report required by this section, an
2940 accounts payable aging schedule that lists all outstanding debt
2941 obligations and the corresponding amounts owed to each vendor.
2942 (h) Each facility shall file with the office annually,
2943 together with the annual report required by the section, details
2944 on any debt that has been forgiven or deferred during the
2945 period. Such details must include, but are not limited to, the
2946 entity the debt is due to, the amount forgiven or deferred, an
2947 explanation as to why the debt was forgiven or deferred, and
2948 whether the debt has been assumed by another party on behalf of
2949 the facility.
2950 (3) Any provider that has been placed in administrative
2951 supervision under s. 651.018 shall provide a compiled 2-year
2952 forecast, submitted on a form prescribed by the office, as long
2953 as the provider is operating under administrative supervision.
2954 The compiled data in the 2-year forecast must be presented on a
2955 monthly basis.
2956 (7)~~(6)~~ The workpapers, account analyses, descriptions of
2957 basic assumptions, and other information necessary for a full
2958 understanding of the annual statement of a provider as filed

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2959 with the office shall be made available for visual inspection by
2960 the office at the facility or, if the office requests, at
2961 another agreed-upon site. Photocopies must be provided to the
2962 office upon request ~~may not be made unless consented to by the~~
2963 ~~provider~~.
2964 Section 61. Present subsections (2), (3), and (4) of
2965 section 651.0261, Florida Statutes, are redesignated as
2966 subsections (5), (6), and (7), respectively, new subsections
2967 (2), (3), and (4) are added to that section, and subsection (1)
2968 and present subsection (3) are amended, to read:
2969 651.0261 Quarterly and monthly statements.—
2970 (1) Within 45 days after the end of each fiscal quarter,
2971 each provider shall file a quarterly unaudited financial
2972 statement of the provider or of the facility in the form
2973 prescribed by commission rule and days cash on hand, occupancy,
2974 debt service coverage ratio, and a detailed listing of the
2975 assets maintained in the liquid reserve as required under s.
2976 651.035. The last quarterly statement for a fiscal year is not
2977 required if a provider does not have pending a regulatory action
2978 level event, impairment, or a corrective action plan. If a
2979 provider falls below two or more of the thresholds set forth in
2980 s.651.011(29) ~~s. 651.011(26)~~ at the end of any fiscal quarter,
2981 the provider shall submit to the office, at the same time as the
2982 quarterly statement, an explanation of the circumstances and a
2983 description of the actions it will take to meet the
2984 requirements.
2985 (2) Each provider shall file with the office quarterly,
2986 together with the quarterly report required by this section, all
2987 escrow bank statements for each quarter which support the funds

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2988 held in each of the minimum liquid reserves bank accounts,
2989 including, but not limited to, the debt service reserve, the
2990 operating reserve, and the renewal and replacement reserve.
2991 (3) Each provider shall file with the office quarterly,
2992 together with the quarterly report required by this section, an
2993 accounts payable aging schedule that lists all outstanding debt
2994 obligations and the corresponding amounts owed to vendors.
2995 (4) Each provider shall file with the office quarterly,
2996 together with the quarterly report required by this section,
2997 details on any debt that has been forgiven or deferred during
2998 the period. Such details must include, but are not limited to,
2999 the entity the debt is due to, the amount forgiven or deferred,
3000 an explanation as to why the debt was forgiven or deferred, and
3001 whether the debt has been assumed by another party on behalf of
3002 the provider. If a provider is required to file monthly
3003 financial statements with the office, the facility is required
3004 to include details on forgiven or deferred debt with the monthly
3005 filing.
3006 (6)~~(3)~~ A filing under subsection (5) ~~(2)~~ may be required if
3007 any of the following applies:
3008 (a) The provider is:
3009 1. Subject to administrative supervision proceedings;
3010 2. Subject to a corrective action plan resulting from a
3011 regulatory action level event and for up to 2 years after the
3012 factors that caused the regulatory action level event have been
3013 corrected; or
3014 3. Subject to delinquency or receivership proceedings or
3015 has filed for bankruptcy.
3016 (b) The provider or facility displays a declining financial

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3017 position.
3018 (c) A change of ownership of the provider or facility has
3019 occurred within the previous 2 years.
3020 (d) The provider is found to be impaired.
3021 Section 62. Paragraph (c) of subsection (1), subsection
3022 (2), paragraph (a) of subsection (3), and paragraph (c) of
3023 subsection (5) of section 651.033, Florida Statutes, are
3024 amended, and subsection (7) is added to that section, to read:
3025 651.033 Escrow accounts.—
3026 (1) When funds are required to be deposited in an escrow
3027 account pursuant to s. 651.0215, s. 651.022, s. 651.023, s.
3028 651.0246, s. 651.035, or s. 651.055:
3029 (c) Any agreement establishing an escrow account required
3030 under this chapter is subject to approval by the office before
3031 execution. The agreement must be in writing and contain, in
3032 addition to any other provisions required by law, a provision
3033 whereby the escrow agent agrees to abide by the duties imposed
3034 by paragraphs (b) and (e), (3)(a) and (b), (5)(a), and
3035 subsection (6).
3036 (2)(a) For the purpose of this subsection, the term
3037 "emergency" means conditions that exist beyond the control of
3038 the provider, such as severe damage to the provider's physical
3039 premises caused by a natural or man-made disaster or another
3040 event of comparable gravity and severity.
3041 (b) Notwithstanding s. 651.035(7), in the event of an
3042 emergency and upon written petition by the provider to the
3043 office on a form prescribed by the office, the office may allow
3044 a withdrawal of up to 10 percent of the required minimum liquid
3045 reserve, consistent with the requirements governing how funds

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3046 can be used under s. 651.035. Before submitting the petition to
3047 the office, the provider shall meet with the office to review
3048 the emergency petition. In the meeting, the provider must
3049 address the details of the emergency, the circumstances leading
3050 to the need for an emergency petition, the provider's plan to
3051 mitigate the emergency, the amount being requested, and the
3052 provider's plan and timeline to restore the minimum liquid
3053 reserves back into compliance with s. 651.035. The office shall
3054 have 10 business ~~3 working~~ days to deny the petition for the
3055 emergency 10-percent withdrawal. If the office fails to deny the
3056 petition within 10 business ~~3 working~~ days, the petition is
3057 deemed to have been granted by the office. For purposes of this
3058 section, the term "business days ~~working day~~" means each day
3059 that is not a Saturday, Sunday, or legal holiday as defined by
3060 Florida law. Also, for purposes of this section, the day the
3061 petition is received by the office is not counted as one of the
3062 10 ~~3~~ days.
3063 (3) When entrance fees are required to be deposited in an
3064 escrow account pursuant to s. 651.0215, s. 651.022, s. 651.023,
3065 s. 651.0246, or s. 651.055:
3066 (a) The provider shall deliver to the resident a written
3067 receipt. The receipt must show the payor's name and address, the
3068 date, the price of the care contract, and the amount of money
3069 paid. A copy of each receipt, together with the funds, must be
3070 deposited with the escrow agent or as provided in paragraph (c).
3071 The escrow agent must release such funds to the provider 7 days
3072 after the date of receipt of the funds by the escrow agent if
3073 the provider, operating under a certificate of authority issued
3074 by the office, has met the requirements of s. 651.0215(7) ~~s.~~

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3075 ~~651.0215(8)~~, s. 651.023 (5) ~~s. 651.023(6)~~, or s. 651.0246.
3076 However, if the resident rescinds the contract within the 7-day
3077 period, the escrow agent must release the escrowed fees to the
3078 resident.
3079 (5) When funds are required to be deposited in an escrow
3080 account pursuant to s. 651.0215, s. 651.022, s. 651.023, s.
3081 651.0246, or s. 651.035, the following apply:
3082 (c) In accordance with the annual and quarterly filing
3083 deadlines set forth in ss. 651.026 and 651.0261 ~~On or before the~~
3084 ~~20th day of the month following the quarter for which the~~
3085 ~~statement is due~~, the provider shall file with the office a copy
3086 of the escrow agent's statement or, if the provider has not
3087 received the escrow agent's statement, a copy of the written
3088 request to the escrow agent for the statement.
3089 (7) The escrow agent is required to provide prompt written
3090 notification to the office upon withdrawal of any funds from an
3091 account required under s. 651.035. Any escrow agreement
3092 established to comply with the requirements of s. 651.035 must
3093 include the provisions required by that section.
3094 Section 63. Subsection (2) of section 651.034, Florida
3095 Statutes, is amended to read:
3096 651.034 Financial and operating requirements for
3097 providers.—
3098 (2) ~~Except when the office's remedial rights are suspended~~
3099 ~~pursuant to s. 651.114(11)(a),~~ The office must take action
3100 necessary to place an impaired provider under regulatory
3101 control, including administrative supervision or any remedy
3102 available under part I of chapter 631. ~~An impairment is~~
3103 ~~sufficient grounds for the department to be appointed as~~

3104 ~~receiver as provided in chapter 631, except when the office's~~
3105 ~~remedial rights are suspended pursuant to s. 651.114(11)(a). If~~
3106 ~~the office's remedial rights are suspended pursuant to s.~~
3107 ~~651.114(11)(a), the impaired provider must make available to the~~
3108 ~~office copies of any corrective action plan approved by the~~
3109 ~~third-party lender or trustee to cure the impairment and any~~
3110 ~~related required report.~~ For purposes of s. 631.051, the term
3111 "impaired" has the same meaning as in ~~impairment of a provider~~
3112 ~~is defined according to the term "impaired" under~~ s. 651.011.
3113 The office may forego taking action for up to 90 ~~180~~ days after
3114 the impairment if the office finds there is a reasonable
3115 expectation that the impairment may be eliminated within the 90-
3116 day ~~180-day~~ period.
3117 Section 64. Subsections (1) and (3), paragraph (b) of
3118 subsection (7), and subsection (8) of section 651.035, Florida
3119 Statutes, are amended to read:
3120 651.035 Minimum liquid reserve requirements.—
3121 (1) A provider shall maintain in escrow a minimum liquid
3122 reserve consisting of the following reserves, as applicable.
3123 Each established account must be separate and unique to a
3124 facility, unencumbered, and not commingled with any other funds
3125 from any other account, facility, affiliate, or obligated group.
3126 Funds held in escrow under paragraphs (a), (c), and (d) must be
3127 held completely separate from any funds held by a trustee under
3128 paragraph (b), meaning the debt service, operating, and renewal
3129 and replacement reserves must have their own distinct account
3130 number.~~:~~
3131 (a) Each provider shall maintain in escrow as a debt
3132 service reserve the aggregate amount of all principal and

3133 interest payments due during the fiscal year on any mortgage
3134 loan or other long-term financing of the facility, including
3135 property taxes as recorded in the audited financial report
3136 required under s. 651.026. The amount must include any leasehold
3137 payments and all costs related to such payments. If principal
3138 payments are not due during the fiscal year, the provider must
3139 maintain in escrow as a minimum liquid reserve an amount equal
3140 to interest payments due during the next 12 months on any
3141 mortgage loan or other long-term financing of the facility,
3142 including property taxes. If a provider does not have a mortgage
3143 loan or other financing on the facility, the provider must
3144 deposit monthly in escrow as a minimum liquid reserve an amount
3145 equal to one-twelfth of the annual property tax liability as
3146 indicated in the most recent tax notice provided pursuant to s.
3147 197.322(3), and must annually pay property taxes out of such
3148 escrow.
3149 (b) A provider that has outstanding indebtedness that
3150 requires a debt service reserve to be held in escrow pursuant to
3151 a trust indenture or mortgage lien on the facility and for which
3152 the debt service reserve may only be used to pay principal and
3153 interest payments on the debt that the debtor is obligated to
3154 pay, and which may include property taxes and insurance, may
3155 include such debt service reserve in computing the minimum
3156 liquid reserve needed to satisfy this subsection if the provider
3157 furnishes to the office a copy of the agreement under which such
3158 debt service reserve is held, together with a statement of the
3159 amount being held in escrow for the debt service reserve,
3160 certified by the lender or trustee and the provider to be
3161 correct. The trustee shall provide the office with any

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3162 information concerning the debt service reserve account upon
3163 request of the provider or the office. In addition, the trust
3164 indenture, loan agreement, or escrow agreement must provide that
3165 the provider, trustee, lender, escrow agent, or a person
3166 designated to act in its place shall notify the office in
3167 writing at least 10 days before the withdrawal of any portion of
3168 the debt service reserve funds required to be held in escrow as
3169 described in this paragraph. The notice must include an
3170 affidavit sworn to by the provider, the trustee, or a person
3171 designated to act in its place which includes the amount of the
3172 scheduled debt service payment, the payment due date, the amount
3173 of the withdrawal, the accounts from which the withdrawal will
3174 be made, and a plan with a schedule for replenishing the
3175 withdrawn funds. If the plan is revised by a consultant that is
3176 retained as prescribed in the provider's financing documents,
3177 the revised plan must be submitted to the office within 10 days
3178 after the approval by the lender or trustee. If a debt service
3179 reserve is transferred from one financial institution or lender
3180 to another, the provider must provide notice to the office at
3181 least 10 days before the transfer takes place. The notice must
3182 include an affidavit sworn to by the provider and include the
3183 name of the institution where the debt service reserve is being
3184 transferred, the date of transfer, the amount being transferred,
3185 a copy of the agreement requiring the transfer to the new
3186 financial institution, and the contact information for the
3187 escrow agent of the new account. The new escrow agreement must
3188 comply with the requirements of s. 651.033. Any funds held
3189 pursuant to this section do not negate the requirement to
3190 maintain an escrow account as required in paragraph (a). Any

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3191 such separate debt service reserves are not subject to the
3192 transfer provisions set forth in subsection (8).
3193 (c) Each provider shall maintain in escrow an operating
3194 reserve equal to or in excess of the following amounts:
3195 1. Thirty ~~30~~ percent of the total operating expenses
3196 projected in the feasibility study required by s. 651.023 for
3197 the first 12 months of operation. ~~Thereafter,~~
3198 2. After the first 12 months of operations, 30 percent of
3199 the total operating reserve in the annual report filed pursuant
3200 to s. 651.026.
3201 3. Once a provider maintains an occupancy level in excess
3202 of 80 percent for at least 12 months and has represented in its
3203 most recent annual report that it has reached stabilized
3204 occupancy, 15 percent of the total operating reserve upon
3205 approval of the office.
3206 4. If the provider has been found to meet any of the
3207 following conditions, 50 percent of the total operating reserve:
3208 a. Is insolvent or financially impaired.
3209 b. At regulatory action level under s. 651.034.
3210 c. Placed under administrative supervision.
3211 d. In hazardous financial condition under s. 651.113.
3212 e. Entered into a forbearance agreement with a lender.
3213 f. Filed or has notified the office of its intent to file
3214 for bankruptcy.
3215 g. Failed to maintain the minimum liquid reserve
3216 requirements under subsections (10) and (11).
3217 h. Borrowed funds from residents pursuant to s. 651.087.
3218
3219 Upon notice from the office that a condition identified in this

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3220 paragraph exists, the provider has 10 days within which to fund
3221 the operating reserve at 50 percent and provide evidence of the
3222 funding to the office.
3223 (d) Before reducing the operating reserve required under
3224 paragraph (c), the provider must obtain written approval from
3225 the office ~~each provider shall maintain in escrow an operating~~
3226 ~~reserve equal to 15 percent of the total operating expenses in~~
3227 ~~the annual report filed pursuant to s. 651.026~~.
3228 (e) If a provider has been in operation for more than 12
3229 months, the total annual operating expenses must be determined
3230 by averaging the total annual operating expenses reported to the
3231 office by the number of annual reports filed with the office
3232 within the preceding 3-year period subject to adjustment if
3233 there is a change in the number of facilities owned. For
3234 purposes of this subsection, total annual operating expenses
3235 include all expenses of the facility except depreciation and
3236 amortization; interest and property taxes included in paragraph
3237 (a); extraordinary expenses that are adequately explained and
3238 documented in accordance with generally accepted accounting
3239 principles; liability insurance premiums in excess of those paid
3240 in calendar year 1999; and changes in the obligation to provide
3241 future services to current residents. For providers initially
3242 licensed during or after calendar year 1999, liability insurance
3243 must be included in the total operating expenses in an amount
3244 not to exceed the premium paid during the first 12 months of
3245 facility operation. The operating reserves required under this
3246 subsection must be in an unencumbered account held in escrow for
3247 the benefit of the residents. Such funds may not be encumbered
3248 or subject to any liens or charges by the escrow agent or

3249 judgments, garnishments, or creditors' claims against the
3250 provider or facility. However, if a facility had a lien,
3251 mortgage, trust indenture, or similar debt instrument in place
3252 before January 1, 1993, which encumbered all or any part of the
3253 reserves required by this subsection and such funds were used to
3254 meet the requirements of this subsection, then such arrangement
3255 may be continued, unless a refinancing or acquisition has
3256 occurred, and the provider is in compliance with this
3257 subsection.

3258 (f) ~~(d)~~ Each provider shall maintain in escrow a renewal and
3259 replacement reserve equal to 15 percent of the total accumulated
3260 depreciation based on the audited financial statement required
3261 to be filed pursuant to s. 651.026, not to exceed 15 percent of
3262 the facility's average operating expenses for the past 3 fiscal
3263 years based on the audited financial statements for each of
3264 those years. For a provider who is an operator of a facility but
3265 is not the owner and depreciation is not included as part of the
3266 provider's financial statement, the renewal and replacement
3267 reserve required by this paragraph must equal 15 percent of the
3268 total operating expenses of the provider, as described in this
3269 section. ~~Each provider licensed before October 1, 1983, shall~~
3270 ~~fully fund the renewal and replacement reserve by October 1,~~
3271 ~~2003, by multiplying the difference between the former escrow~~
3272 ~~requirement and the present escrow requirement by the number of~~
3273 ~~years the facility has been in operation after October 1, 1983.~~

3274 (3) If principal and interest payments are paid to a trust
3275 that is beneficially held by the residents as described in s.
3276 651.023(6) ~~s. 651.023(7)~~, the office may waive all or any
3277 portion of the escrow requirements for mortgage principal and

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3278 interest contained in subsection (1) if the office finds that
3279 such waiver is not inconsistent with the security protections
3280 intended by this chapter.
3281 (7)
3282 (b)1. For all other proposed withdrawals, in order to
3283 receive the consent of the office, the provider must file
3284 documentation showing why the withdrawal is necessary for the
3285 continued operation of the facility and such additional
3286 information as the office reasonably requires.
3287 2. The office shall notify the provider when the filing is
3288 deemed complete. If the provider has complied with all prior
3289 requests for information, the filing is deemed complete after 30
3290 days without communication from the office.
3291 3. Within 30 days after the date a file is deemed complete,
3292 the office shall provide the provider with written notice of its
3293 approval or disapproval of the request. The provider may not
3294 withdraw funds until the office provides such written notice.
3295 The office may disapprove any request to withdraw such funds if
3296 it determines that the withdrawal is not in the best interest of
3297 the residents.
3298 (8) The office may order the immediate transfer of up to
3299 100 percent of the funds held in the minimum liquid reserve to
3300 the custody of the department pursuant to part III of chapter
3301 625 if the office finds that the provider is impaired or
3302 insolvent, or if the facility fails to fund the minimum liquid
3303 reserve required by subsection (10) or subsection (11). The
3304 office may order such a transfer regardless of whether the
3305 office has suspended or revoked, or intends to suspend or
3306 revoke, the certificate of authority of the provider.

3307 Section 65. Subsection (2) of section 651.043, Florida
3308 Statutes, is amended to read:
3309 651.043 Approval of change in management.—
3310 (2) A provider or management company shall notify the
3311 office, in writing or electronically, of any change in the
3312 information required by s. 651.022(2) ~~management~~ within 10
3313 business days. For each new management company or manager not
3314 employed by a management company, the provider shall submit to
3315 the office the information required by s. 651.022(2) and a copy
3316 of the written management contract~~, if applicable~~.
3317 Section 66. Subsection (1) of section 651.071, Florida
3318 Statutes, is amended to read:
3319 651.071 Contracts as preferred claims on liquidation or
3320 receivership.—
3321 (1) In the event of receivership or liquidation proceedings
3322 against a provider, all continuing care and continuing care at-
3323 home contracts executed by a provider are deemed preferred
3324 claims against all assets owned by the provider; ~~however,~~ such
3325 claims are not subordinate to any secured claim and must be
3326 treated with higher priority over all other claims, except Class
3327 1 claims. For purposes of s. 631.271, such contracts are deemed
3328 Class 2 claims.
3329 Section 67. Subsections (2) and (3) of section 651.085,
3330 Florida Statutes, are amended to read:
3331 651.085 Quarterly meetings between residents and the
3332 governing body of the provider; resident representation before
3333 the governing body of the provider.—
3334 (2) A residents' council formed pursuant to s. 651.081,
3335 members of which are elected by the residents, shall nominate

3336 and elect a designated resident representative to represent them
3337 before the governing body of the provider on matters specified
3338 in subsection (3). The initial designated resident
3339 representative elected under this section shall be elected to
3340 serve at least 12 months. The designated resident representative
3341 does not have to be a current member of the residents' council;
3342 however, such individual must be a resident, as defined in s.
3343 651.011. Designated resident representatives shall perform their
3344 duties in good faith. For providers that own or operate more
3345 than one facility in this state, each facility must have its own
3346 designated resident representative.
3347 (3) The designated resident representative shall be
3348 notified in writing or electronically by a representative of the
3349 provider at least 14 days in advance of any meeting of the full
3350 governing body at which the annual budget and proposed changes
3351 or increases in resident fees or services are on the agenda or
3352 will be discussed before presenting such increases in resident
3353 fees or services to all residents. The designated resident
3354 representative shall be invited to attend and participate in
3355 that portion of the meeting designated for the discussion of
3356 such changes. Designated resident representatives shall perform
3357 their duties in good faith. For providers that own or operate
3358 more than one facility in the state, each facility must have its
3359 own designated resident representative.
3360 Section 68. Section 651.087, Florida Statutes, is created
3361 to read:
3362 651.087 Resident funds for charitable or operational
3363 purposes.—
3364 (1) The organized collection and distribution of funds by

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3365 residents for charitable or benevolent purposes may not be
3366 controlled by a provider or management company. Any provider or
3367 management company assisting in the collection or disbursement
3368 of funds from its residents for the purpose of creating a
3369 benevolence or charitable fund that is outside the approved
3370 operational fees is subject to the following requirements:
3371 (a) The provider or management company shall notify the
3372 office and the residents' council that a fund is being
3373 established.
3374 (b) The provider or management company, under the direction
3375 and approval of the residents' council, shall establish written
3376 policies that govern the funds. The written policies must
3377 include, in detail, how the entity will be governed, how funds
3378 will be collected, and the criteria to be used for the
3379 distribution of funds. Any changes to the written policy must be
3380 agreed upon by the residents' council.
3381 (c) Within 60 days after the fund is established, the
3382 provider or management company shall provide the written policy
3383 to the office and current residents and post in a prominent
3384 position in the facility which is accessible to all residents
3385 and the general public. Additionally, the written policy must be
3386 given to all prospective residents.
3387 (d) The provider or management company shall include in
3388 with its annual and quarterly reports a statement detailing the
3389 financial position of the fund as of the annual or quarter
3390 period end date and a summary breakdown of how any funds were
3391 used during that reporting period, excluding any personal
3392 identifiable information.
3393 (2) A provider or management company may not borrow or

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3394 solicit funds from residents for operational purposes without
3395 prior written approval from the office.
3396 (a) Before any funds are eligible for distribution to the
3397 provider or management company, the provider or management
3398 company must comply with the following:
3399 1. Submit a request to borrow funds to the office, with
3400 notice to the residents' council, which must include the
3401 requested amount, a detailed summary of the intended use of the
3402 funds, and any additional information that supports the
3403 provider's need to borrow the funds. The requested amount may
3404 not exceed 10 percent of the funds available from residents and
3405 shall must be restricted to use only for operational expenses,
3406 which must solely benefit the residents of the facility. Funds
3407 may not be used for the benefit of management, the board of
3408 directors, or the general partner.
3409 2. Complete an anticipated repayment schedule for the
3410 borrowed funds. Within 30 days after receipt of the borrowed
3411 funds, the provider or management company shall begin repayment
3412 to the fund in equal monthly payments that allow for a complete
3413 refunding of the borrowed funds within 12 months. Full repayment
3414 must be completed within 12 months after the distribution.
3415 3. Obtain a board resolution and sworn affidavit signed by
3416 two officers or a general partner of the provider or management
3417 company which indicates support for the request to borrow funds
3418 and the repayment plan.
3419 (b) The provider or management company shall acknowledge
3420 that it is required to repay the full amount borrowed before the
3421 office can approve additional funds to be borrowed from
3422 residents.

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3423 (c) The office must receive written majority support from
3424 the residents' council before approving the provider's or
3425 management company's request.
3426 (3) Upon receipt of approval from the office, the provider
3427 or management company is required to comply with the following:
3428 (a) Maintain a 50 percent operating reserve pursuant to s.
3429 651.035(1)(c)4. for the duration of the repayment period.
3430 Following the repayment period, the provider or management
3431 company must obtain the office's prior written approval to
3432 reduce the operating reserve amount.
3433 (b) Within 5 days after receiving the office's approval,
3434 submit supporting documentation to the office as evidence that
3435 the operating reserve has been increased in compliance with this
3436 section.
3437 (c) In order to protect the residents' investment,
3438 immediately transfer up to 100 percent of the funds held in the
3439 minimum liquid reserve operating reserve account to the custody
3440 of the department pursuant to part III of chapter 625. The
3441 provider or management company shall fund the account with the
3442 department within 15 days after receiving the office's approval.
3443 The office may not approve the provider's request unless it has
3444 confirmation that the provider has established the account with
3445 the department.
3446
3447 Failure to comply with this section is a violation of s.
3448 651.035, and therefore, the provider or management company will
3449 be considered impaired as defined in s. 651.011.
3450 (4) By October 1, 2025, any provider or management company
3451 that already has benevolent or charitable funds established

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3452 shall fully comply with this section.
3453 (5) By August 1, 2025, any provider or management company
3454 that has borrowed funds from residents must provide notice to
3455 the office. Notice must include the date the funds were
3456 borrowed, the amount borrowed, and any documentation supporting
3457 the request and approval of the borrowed funds.
3458 (6) In the event that a provider or management company
3459 triggers an impairment or insolvency or enters into a
3460 forbearance agreement with a lender, the repayment of any
3461 outstanding borrowed funds must be accelerated. Within 5 days
3462 after a provider or management company becomes aware of an
3463 impairment or insolvency or the need to enter into a forbearance
3464 agreement with a lender, the provider or management company must
3465 provide notice of the triggering event to the residents' council
3466 and repay any outstanding amounts due under a repayment plan.
3467 Notice must also be given to the office within the same 5 days.
3468 (7) The commission may adopt rules that require all or part
3469 of the statements or filings required under this section to be
3470 submitted by electronic means in a computer-readable form
3471 compatible with the electronic data format specified by the
3472 commission.
3473 Section 69. Present paragraphs (h) through (n) of
3474 subsection (2) of section 651.091, Florida Statutes, are
3475 redesignated as paragraphs (i) through (o), respectively, a new
3476 paragraph (h) and paragraph (p) are added to that subsection,
3477 subsection (5) is added to that section, and present paragraph
3478 (h) of subsection (2) and paragraph (d) of subsection (3) of
3479 that section are amended, to read:
3480 651.091 Availability, distribution, and posting of reports

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3481 and records; requirement of full disclosure.—

3482 (2) Every continuing care facility shall:

3483 (h) Post a notice of any bankruptcy proceedings in a
3484 prominent location within the facility which is accessible by
3485 all residents and the general public. Such notice must include a
3486 summary of the bankruptcy proceedings and specify where the full
3487 legal record of the bankruptcy proceedings can be inspected
3488 within the facility. The facility shall also designate and make
3489 available a management representative to discuss the bankruptcy
3490 proceedings and address questions from residents. The notice
3491 required under this paragraph must also include a listing of all
3492 court documents related to the bankruptcy proceedings and the
3493 designated representative's contact information.

3494 (i) ~~(h)~~ Deliver the information described in s. 651.085(4)
3495 in writing or electronically to the president or chair of the
3496 residents' council and make supporting documentation available
3497 upon request.

3498 (p) Maintain records showing compliance with the
3499 requirements of this subsection, including information as to
3500 how, where, and when the required information was provided.

3501 (3) Before entering into a contract to furnish continuing
3502 care or continuing care at-home, the provider undertaking to
3503 furnish the care, or the agent of the provider, shall make full
3504 disclosure, obtain written acknowledgment of receipt, and
3505 provide copies of the disclosure documents to the prospective
3506 resident or his or her legal representative, of the following
3507 information:

3508 (d) In keeping with the intent of this subsection relating
3509 to disclosure, the provider shall make available for review:

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1. Master plans approved by the provider’s board or governing body;

2. Any proposed or approved ~~and any~~ plans for expansion or phased development within the next 3 years; and

3. Any known legal impediments to the plans disclosed in this paragraph 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~~, to the extent that the availability of such plans does not put at risk real estate, financing, acquisition, negotiations, or other implementation of operational plans and thus jeopardize the success of negotiations, operations, and development~~.

(5)(a) 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 shall refund fees paid to the contracting party. However, the provider shall 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.

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

(c) A person may not file or maintain an action under this section if, before filing the action, the person received a written offer citing this section for a refund of all amounts

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3539 paid the provider, plus interest at the prime rate, less the
3540 contractual value of care and lodging provided before receipt of
3541 the offer, and failed to accept it within 30 days after actual
3542 receipt.
3543 Section 70. Section 651.104, Florida Statutes, is created
3544 to read:
3545 651.104 Certificate of authority to act as a management
3546 company.—
3547 (1) It is unlawful for any person to act as or hold himself
3548 or herself out to be a management company for a continuing care
3549 retirement community in this state without a valid certificate
3550 of authority issued by the office pursuant to this section. A
3551 management company that was operating in this state as of June
3552 30, 2025, may continue to operate until January 1, 2026, as a
3553 management company without a certificate of authority and is not
3554 in violation of the requirement to possess a valid certificate
3555 of authority as a management company during that period of time.
3556 To qualify for and hold authority to act as a management company
3557 in this state, a management company must otherwise be in
3558 compliance with pursuant to this section and with its
3559 organizational agreement. A person who, on or after January 1,
3560 2026, does not hold a certificate of authority to act as a
3561 management company while operating as a management company is
3562 subject to a fine of $10,000 per violation per day.
3563 (2) A management company shall file with the office an
3564 application for a certificate of authority on a form adopted by
3565 the commission and furnished by the office. The application must
3566 include or have attached all of the following information and
3567 documents:

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3568 (a) All basic organizational documents of the management
3569 company, such as the articles of incorporation, articles of
3570 association, partnership agreement, trade name certificate,
3571 trust agreement, shareholder agreement, and other applicable
3572 documents, and all amendments to those documents.
3573 (b) The bylaws, rules, and regulations or similar documents
3574 regulating the conduct or the internal affairs of the management
3575 company.
3576 (c) For a corporation, the names, addresses, official
3577 positions, and professional qualifications of the individuals
3578 employed or retained by the management company who are
3579 responsible for the conduct of the affairs of the management
3580 company, including all members of the board of directors, board
3581 of trustees, executive committee, or other governing board or
3582 committee, and the principal officers, or equivalent, or for a
3583 partnership or association of the management company, the
3584 partners or members.
3585 (d) Audited annual financial statements, prepared in
3586 accordance with generally accepted accounting principles, for
3587 the 2 most recent fiscal years, which prove that the applicant
3588 has a positive net worth in both fiscal years. If the applicant
3589 has been in existence for less than 2 fiscal years, the
3590 application must include financial statements or reports,
3591 certified by an officer of the applicant and prepared in
3592 accordance with generally accepted accounting principles, for
3593 any completed fiscal years and for any month during the current
3594 fiscal year for which such financial statements or reports have
3595 been completed. If an applicant reports net losses for either of
3596 the 2 most recent fiscal years, the applicant is required to

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3597 provide pro forma financial statements up to the period of time
3598 that the applicant demonstrates 2 consecutive years of
3599 profitability. Pro forma financial statements must include the
3600 balance sheet, income statement, and cash flow statement. An
3601 audited financial statement or report prepared on a consolidated
3602 basis must include a columnar consolidating or combining
3603 worksheet that must be filed with the report and comply with the
3604 following:
3605 1. Amounts shown on the consolidated audited financial
3606 report must be shown on the worksheet;
3607 2. Amounts for each entity must be stated separately; and
3608 3. Explanations of consolidating and eliminating entries
3609 must be included.
3610 (e) Any information as the office may require in order to
3611 review the current financial condition of the applicant.
3612 (f) A statement describing the business plan, including
3613 information on staffing levels and activities proposed, or
3614 ongoing, in this state and nationwide. The plan must provide
3615 details setting forth the applicant's capability of providing a
3616 sufficient number of experienced and qualified personnel in the
3617 areas of issuing continuing care life contracts, managing
3618 continuing care retirement communities or similar communities,
3619 compliance with statutory requirements, and claims processing,
3620 recordkeeping, and underwriting.
3621 (g) If the applicant is not currently acting as a
3622 management company, a statement of the amounts and sources of
3623 the funds available for organizational expenses and the proposed
3624 arrangements for reimbursement and compensation of incorporators
3625 or other principals.

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3626 (h) Such other data, financial statements, and pertinent
3627 information as the commission or office may reasonably require
3628 with respect to the management company, its directors, or its
3629 trustees, or with respect to any parent, subsidiary, or
3630 affiliate, if the management company relies on a contractual or
3631 financial relationship with such parent, subsidiary, or
3632 affiliate in order to meet the financial requirements of this
3633 chapter, to determine the financial status of the management
3634 company and the management capabilities of its managers and
3635 owners.
3636 (3) An applicant must also submit all of the following for
3637 all individuals referenced in paragraph (2)(c):
3638 (a) A complete biographical statement on a form prescribed
3639 by the commission.
3640 (b) An independent background report as prescribed by the
3641 commission.
3642 (c) A full set of fingerprints of all of the individuals to
3643 the office or to a vendor, entity, or agency authorized by s.
3644 943.053(13). The office, vendor, entity, or agency, as
3645 applicable, shall forward the fingerprints to the Department of
3646 Law Enforcement for state processing, and the Department of Law
3647 Enforcement shall forward the fingerprints to the Federal Bureau
3648 of Investigation for national processing in accordance with s.
3649 943.053 and 28 C.F.R. s. 20.
3650 (d) A self-disclosure of any administrative, civil, or
3651 criminal complaints, settlements, or discipline of the
3652 applicant, or any of the applicant's affiliates, which relate to
3653 a violation of the insurance laws or continuing care retirement
3654 community laws, in any state.

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3655 (4)(a) The applicant shall make available for inspection by
3656 the office copies of all contracts and contract templates
3657 relating to services provided by the management company to
3658 providers or other persons using the services of the management
3659 company.
3660 (b) The applicant shall also make available for inspection
3661 by the office copies of all contracts and contract templates
3662 with any provider.
3663 (5) The office may not issue a certificate of authority if
3664 it determines that the management company or any individual
3665 specified in paragraph (2)(c) is not competent, trustworthy,
3666 financially responsible, or of good personal and business
3667 reputation.
3668 (6) A certificate of authority issued under this section
3669 remains valid, unless suspended or revoked by the office, so
3670 long as the certificateholder continues in business in this
3671 state.
3672 Section 71. Section 651.1041, Florida Statutes, is created
3673 to read:
3674 651.1041 Acquisition of a management company.—An
3675 acquisition of a management company is governed by s. 628.4615,
3676 as if it was a specialty insurer.
3677 Section 72. Section 651.1043, Florida Statutes, is created
3678 to read:
3679 651.1043 Management company annual and quarterly financial
3680 statement and filing fee; notice of change of ownership.—
3681 (1) Each authorized management company shall annually file
3682 with the office a full and true statement of its financial
3683 condition, transactions, and affairs within 3 months after the

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3684 end of the management company's fiscal year or within such
3685 extension of time as the office may grant for good cause. The
3686 statement must be for the preceding fiscal year and must be in
3687 such form and contain such matters as the commission prescribes
3688 and must be verified by at least two officers of the management
3689 company.
3690 (2) Each authorized management company shall also annually
3691 file an audited financial statement prepared in accordance with
3692 generally accepted accounting principles by an independent
3693 certified public accountant. The audited financial statement
3694 must be filed with the office within 3 months after the end of
3695 the management company's fiscal year and be for the preceding
3696 fiscal year. An audited financial statement prepared on a
3697 consolidated basis must include a columnar consolidating or
3698 combining worksheet that must be filed with the statement and
3699 must comply with all of the following:
3700 (a) Amounts shown on the consolidated audited financial
3701 statement must be shown on the worksheet.
3702 (b) Amounts for each entity must be stated separately.
3703 (c) Explanations of consolidating and eliminating entries
3704 must be included.
3705 (3) The management company must submit such other data,
3706 financial statements, and pertinent information as the
3707 commission or office may reasonably require with respect to the
3708 management company, its directors, or its trustees, or with
3709 respect to any parent, subsidiary, or affiliate, if the
3710 management company relies on a contractual or financial
3711 relationship with such parent, subsidiary, or affiliate in order
3712 to meet the financial requirements of this chapter; to determine

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3713 the financial status of the management company and the
3714 management capabilities of its managers and owners.
3715 (4) For any material change in its ownership, a management
3716 company shall file an acquisition application as required by s.
3717 651.024.
3718 (5) Within 45 days after the end of each fiscal quarter,
3719 each management company shall file a quarterly unaudited
3720 financial statement in the form prescribed by commission rule.
3721 (6) If the office finds that such information is needed to
3722 properly monitor the financial condition of a management company
3723 or is otherwise needed to protect the public interest, the
3724 office may require the management company to file:
3725 (a) Within 25 days after the end of each month, a monthly
3726 unaudited financial statement of the management company in the
3727 form prescribed by the commission by rule.
3728 (b) Such other data, financial statements, and pertinent
3729 information as the office may reasonably require with respect to
3730 the management company, its directors, or its trustees, or with
3731 respect to any parent, subsidiary, or affiliate, if the
3732 management company relies on a contractual or financial
3733 relationship with such parent, subsidiary, or affiliate in order
3734 to meet the financial requirements of this chapter; to determine
3735 the financial status of the management company and the
3736 management capabilities of its managers and owners.
3737 (7) Any management company that fails to file an annual
3738 financial report or quarterly financial report in the form and
3739 within the time required by this section shall forfeit to the
3740 office an amount set by order of the office which does not
3741 exceed $1,000 for each of the first 10 days of noncompliance and

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3742 does not exceed $2,000 for each subsequent day of noncompliance.
3743 Upon notice by the office that the management company is not in
3744 compliance with this section, the management company’s authority
3745 to perform in the capacity of a management company for any
3746 provider or facility in this state ceases until the office
3747 determines the management company to be in compliance. The
3748 office may not collect more than $100,000 under this subsection
3749 with respect to any particular report.
3750 (8) All moneys collected by the office under this section
3751 must be deposited to the credit of the Insurance Regulatory
3752 Trust Fund.
3753 (9) The commission may by rule require all or part of the
3754 statements or filings required under this section to be
3755 submitted by electronic means in a computer-readable form
3756 compatible with the electronic data format specified by the
3757 commission.
3758 Section 73. Section 651.1045, Florida Statutes, is created
3759 to read:
3760 651.1045 Management company grounds for discretionary
3761 denial, suspension, or revocation of certificate of authority.—
3762 (1) The office may deny an application or suspend or revoke
3763 the certificate of authority of any applicant or management
3764 company if it finds that any one or more of the following
3765 grounds applicable to the applicant or management company exist:
3766 (a) Failing to continue to meet the requirements for the
3767 certificate of authority originally granted.
3768 (b) Failing to meet one or more of the qualifications for
3769 the certificate of authority under this chapter.
3770 (c) Making a material misstatement or misrepresentation, or

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3771 committing fraud in obtaining, or attempting to obtain, a
3772 certificate of authority.
3773 (d) Demonstrating a lack of fitness or trustworthiness.
3774 (e) Engaging in fraudulent or dishonest practices of
3775 management in the conduct of business.
3776 (f) Misappropriating, converting, or withholding moneys.
3777 (g) Failing to comply with, or a violation of, any lawful
3778 order or rule issued by the office or commission, or violating
3779 any provision of this chapter.
3780 (h) Becoming insolvent, financially impaired, or conducting
3781 business in a manner that poses a risk to the public.
3782 (i) Refusing to be examined or to produce accounts,
3783 records, and files for examination, or refusing to give
3784 information with respect to its affairs or to perform any other
3785 legal obligation under this chapter when required by the office.
3786 (j) Failing to comply with the requirements of s. 651.1043.
3787 (k) Failing to maintain full compliance with escrow
3788 accounts or funds as required by this chapter, if responsible
3789 for the day-to-day operations of the provider.
3790 (l) Failing to meet the requirements of this chapter for
3791 disclosure of information to residents concerning the facility,
3792 its ownership, its management, its development, or its financial
3793 condition or failure to honor its continuing care or continuing
3794 care at-home contracts, if responsible for the day-to-day
3795 operations of the provider.
3796 (m) Having any cause for which issuance of the license
3797 could have been denied had it then existed and been known to the
3798 office.
3799 (n) Having its owners, managers, officers, or directors

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3800 found guilty of, or having pleaded guilty or nolo contendere to,
3801 a felony in this state or any other state, without regard to
3802 whether a judgment or conviction was entered by the court having
3803 jurisdiction of such cases.
3804 (o) Engaging in unfair methods of competition or in unfair
3805 or deceptive acts or practices prohibited under part IX of
3806 chapter 626.
3807 (p) Demonstrating a pattern of bankrupt enterprises.
3808 (q) Including in ownership, control, or management any
3809 person who:
3810 1. Is not reputable and of responsible character;
3811 2. Is so lacking in management expertise as to make the
3812 operation of the provider hazardous to potential and existing
3813 residents;
3814 3. Is so lacking in management experience, ability, and
3815 standing as to jeopardize the reasonable promise of successful
3816 operation;
3817 4. Is affiliated, directly or indirectly, through ownership
3818 or control, with any person or persons whose business operations
3819 are or have been marked by business practices or conduct that is
3820 detrimental to the public, contract holders, investors, or
3821 creditors, or by manipulation of assets, finances, or accounts
3822 or by bad faith; or
3823 5. Has business operations marked by business practices or
3824 conduct that is detrimental to the public, contract holders,
3825 investors, or creditors, or by manipulation of assets, finances,
3826 or accounts or by bad faith.
3827 (r) Failing to file a notice of change in management,
3828 failing to remove a disapproved manager, or persisting in

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3829 appointing disapproved managers.
3830 (2) Revocation of a management company's certificate of
3831 authority under this section does not relieve a provider of the
3832 provider's obligation to residents under the terms and
3833 conditions of any continuing care or continuing care at-home
3834 contract between the provider and residents or this chapter. The
3835 management company shall continue to file its annual statement
3836 and pay license fees to the office as required under this
3837 chapter as if the certificate of authority had continued in full
3838 force, but the management company may not issue any new
3839 contracts on behalf of a provider.
3840 (3) The office may seek an action in the circuit court of
3841 the Second Judicial Circuit, in and for Leon County, to enforce
3842 the office's order and the provisions of this section.
3843 Section 74. Subsections (1), (4), (5), and (6) of section
3844 651.105, Florida Statutes, are amended to read:
3845 651.105 Examination.—
3846 (1) The office may at any time, and shall at least once
3847 every 3 years, examine the business of any applicant for a
3848 certificate of authority and any provider or management company
3849 engaged in the execution of care contracts or engaged in the
3850 performance of obligations under such contracts, in the same
3851 manner as is provided for the examination of insurance companies
3852 pursuant to ss. 624.316 and 624.318. For a provider as deemed
3853 accredited under s. 651.028, such examinations must take place
3854 at least once every 5 years. An examination covering the
3855 preceding 3 or 5 fiscal years of the provider or management
3856 company, as applicable, must be commenced within 12 months after
3857 the end of the most recent fiscal year covered by the

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3858 examination. Such examination may include events subsequent to
3859 the end of the most recent fiscal year and the events of any
3860 prior period which relate to possible violations of this chapter
3861 or which affect the present financial condition of the provider
3862 or management company. At least once every 3 or 5 fiscal years,
3863 as applicable, the office shall conduct an interview in person,
3864 telephonically, or through electronic communication with the
3865 current president or chair of the residents' council, or another
3866 designated officer of the council if the president or chair is
3867 not available, as part of the examination process. The
3868 examinations must be made by a representative or examiner
3869 designated by the office whose compensation will be fixed by the
3870 office pursuant to s. 624.320. Routine examinations may be made
3871 by having the necessary documents submitted to the office; and,
3872 for this purpose, financial documents and records conforming to
3873 commonly accepted accounting principles and practices, as
3874 required under s. 651.026, are deemed adequate. The final
3875 written report of each examination must be filed with the office
3876 and, when so filed, constitutes a public record. Any provider or
3877 management company being examined shall, upon request, give
3878 reasonable and timely access to all of its records. The
3879 representative or examiner designated by the office may at any
3880 time examine the records and affairs and inspect the physical
3881 property of any provider or management company, whether or not
3882 in connection with a formal examination or not.
3883 (4) The office shall notify the provider or management
3884 company and the executive officer of the governing body of the
3885 provider or management company in writing of all deficiencies in
3886 its compliance with the provisions of this chapter and the rules

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3887 adopted pursuant to this chapter and shall set a reasonable
3888 length of time for compliance by the provider or management
3889 company. In addition, the office shall require corrective action
3890 or request a corrective action plan from the provider or
3891 management company which plan demonstrates a good faith attempt
3892 to remedy the deficiencies by a specified date. If the provider
3893 or management company fails to comply within the established
3894 length of time, the office may initiate action against the
3895 provider or management company in accordance with ~~the provisions~~
3896 ~~of~~ this chapter.
3897 (5) A provider or management company shall respond to
3898 written correspondence from the office and provide data,
3899 financial statements, and pertinent information as requested by
3900 the office. The office has standing to petition a circuit court
3901 for mandatory injunctive relief to compel access to and require
3902 the provider or management company to produce the documents,
3903 data, records, and other information requested by the office.
3904 The office may petition the circuit court in the county in which
3905 the facility is situated or the Circuit Court of Leon County to
3906 enforce this section.
3907 (6) ~~Unless a provider is impaired or subject to a~~
3908 ~~regulatory action level event, any parent, subsidiary, or~~
3909 ~~affiliate is not subject to examination by the office as part of~~
3910 ~~a routine examination. However,~~ If a provider, management
3911 company, or facility relies on a contractual or financial
3912 relationship with a parent, a subsidiary, or an affiliate in
3913 order to meet the financial requirements of this chapter, the
3914 office may examine any parent, subsidiary, or affiliate that has
3915 a contractual or financial relationship with the provider,

3916 management company, or facility to the extent necessary to
3917 ascertain the financial condition of the provider or management
3918 company. For any provider that has been placed in administrative
3919 supervision under s. 651.018, any parent, subsidiary, or
3920 affiliate is subject to examination by the office.
3921 Section 75. Section 651.1065, Florida Statutes, is amended
3922 to read:
3923 651.1065 Soliciting or accepting new continuing care
3924 contracts by impaired or insolvent facilities or providers.—
3925 (1) Regardless of whether delinquency proceedings as to a
3926 continuing care facility have been or are to be initiated, a
3927 proprietor, a general partner, a member, an officer, a director,
3928 a trustee, or a manager, or a management company of a continuing
3929 care facility may not actively solicit, approve the solicitation
3930 or acceptance of, or accept new continuing care contracts in
3931 this state after the proprietor, general partner, member,
3932 officer, director, trustee, or manager, or management company
3933 knew, or reasonably should have known, that the continuing care
3934 facility was impaired or insolvent except with the written
3935 permission of the office. If the facility has declared
3936 bankruptcy, the bankruptcy court or trustee appointed by the
3937 court has jurisdiction over such matters. The office must
3938 approve or disapprove the continued marketing of new contracts
3939 within 15 days after receiving a request from a provider.
3940 (2) A proprietor, a general partner, a member, an officer,
3941 a director, a trustee, or a manager, or a management company
3942 that who violates this section commits a felony of the third
3943 degree, punishable as provided in s. 775.082, s. 775.083, or s.
3944 775.084.

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3945 Section 76. Section 651.1068, Florida Statutes, is created
3946 to read:
3947 651.1068 Officers and directors of insolvent providers or
3948 management companies.—Any person who was an officer or director
3949 of a provider or management company doing business in this state
3950 and who served in that capacity within the 2-year period before
3951 the date the provider or management company became insolvent,
3952 for any insolvency that occurs on or after July 1, 2025, may not
3953 thereafter serve as an officer or director of an provider or
3954 management company authorized in this state or have direct or
3955 indirect control over the selection or appointment of an officer
3956 or director through contract, trust, or by operation of law,
3957 unless the officer or director demonstrates that his or her
3958 personal actions or omissions were not a significant
3959 contributing cause to the insolvency.
3960 Section 77. Subsections (2) and (3) of section 651.107,
3961 Florida Statutes, are amended to read:
3962 651.107 Duration of suspension; obligations during
3963 suspension period; reinstatement.—
3964 (2) During the period of suspension, the provider or
3965 management company shall file its annual statement and pay
3966 license fees and taxes as required under this chapter as if the
3967 certificate had continued in full force; but the provider shall
3968 issue no new contracts.
3969 (3) Upon expiration of the suspension period, if within
3970 such period the certificate of authority has not otherwise
3971 terminated, the provider's or management company's certificate
3972 of authority shall automatically be reinstated unless the office
3973 finds that the causes for the suspension have not been removed

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3974 or that the provider or management company is otherwise not in
3975 compliance with the requirements of this chapter. If not so
3976 automatically reinstated, the certificate of authority shall be
3977 deemed to be revoked as of the end of the suspension period or
3978 upon failure of the provider or management company to continue
3979 the certificate during the suspension period, whichever event
3980 first occurs.
3981 Section 78. Subsection (2) of section 651.108, Florida
3982 Statutes, is amended to read:
3983 651.108 Administrative fines.—
3984 (2) If it is found that the provider or management company
3985 has knowingly and willfully violated a lawful order of the
3986 office or a provision of this chapter, the office may impose a
3987 fine in an amount not to exceed $10,000 for each such violation.
3988 Section 79. Section 651.113, Florida Statutes, is created
3989 to read:
3990 651.113 Hazardous facility or provider standards; office's
3991 evaluation and enforcement authority; immediate final order.—
3992 (1) In this subsection, the term "negative fund balance"
3993 means a financial position of a provider or facility in which
3994 the assets of a provider or facility do not exceed its
3995 liabilities, as required under generally accepted accounting
3996 principles. The Commissioner of Insurance Regulation may deem a
3997 provider or facility that has a negative fund balance to be
3998 insolvent or in imminent danger of becoming insolvent if any of
3999 the following hazardous financial condition standards or factors
4000 are applicable or present:
4001 (a) The provider's or facility's financial statements
4002 contain findings or conditions that the commissioner considers

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4003 detrimental to its financial stability.

4004 (b) An independent auditor has identified significant
4005 financial risks or issued a going concern opinion.

4006 (c) The provider's or facility's current or projected ratio
4007 of total assets, including required reserves, to total
4008 liabilities indicates financial impairment or deterioration; or
4009 trends suggest a potential decline in operations, working
4010 capital, or equity.

4011 (d) The provider's or facility's current or projected ratio
4012 of current assets to current liabilities indicates financial
4013 impairment or deterioration; or trends suggest a potential
4014 decline in operations, working capital, or equity.

4015 (e) The provider or facility is unable to carry out normal
4016 daily activities and meet its obligations as they become due,
4017 based on its current or projected cash flow and liquidity
4018 position.

4019 (f) The provider's or facility's past-year operating losses
4020 or projected operating losses are significant enough to
4021 jeopardize daily operations or long-term viability.

4022 (g) The insolvency of an affiliated provider or facility or
4023 other affiliated person results in legal liability of the
4024 provider or facility for payments and expenses of such magnitude
4025 as to jeopardize the provider's or facility's ability to meet
4026 its obligations as they become due, without substantial
4027 disposition of assets outside the ordinary course of business,
4028 any restructuring of debt, or externally forced revisions of its
4029 operations.

4030 (h) The provider or facility has receivables that are more
4031 than 90 days past due.

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4032 (i) The insolvency is not temporary and the provider or
4033 facility cannot demonstrate a significant reduction or
4034 resolution of the financial shortfall.
4035 (j) The provider or facility faces financial difficulties
4036 due to reporting entrance fees as deferred revenue, factoring in
4037 generally accepted accounting principles and the overall impact
4038 on net income.
4039 (k) A start-up provider, a facility undergoing plant
4040 expansion, or an entity refinancing its debt has developed a
4041 financial condition that could seriously jeopardize current or
4042 future operation.
4043 (2) The provider or facility shall prepare a plan to
4044 address and correct any condition that has led to a
4045 determination of insolvency or imminent danger of insolvency by
4046 the Commissioner of Insurance Regulation. The plan must be
4047 presented to the commissioner within 30 days after the date of
4048 the insolvency determination. If the plan to correct the
4049 condition is disapproved by the commissioner, the plan does not
4050 correct the condition leading to the commissioner's
4051 determination of insolvency, or the provider's or facility's
4052 hazardous condition is such that it cannot be significantly
4053 corrected or eliminated, the commissioner may then proceed with
4054 liquidation under chapter 631.
4055 (3) If the office determines that the continued operations
4056 of a provider or facility authorized to transact business in
4057 this state may be hazardous to its residents or to the general
4058 public, the office may issue an order requiring the provider or
4059 facility to do any of the following:
4060 (a) Obtain additional financing or revenues to maintain

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4061 solvency.
4062 (b) Reduce expenses by specified methods or amounts.
4063 (c) Increase the operating reserve.
4064 (d) File reports in a form acceptable to the office
4065 concerning the market value of the provider’s or facilities’
4066 assets.
4067 (e) Limit or withdraw from certain investments or
4068 discontinue certain investment practices to the extent the
4069 office deems necessary.
4070 (f) Document the adequacy of income and operating reserves
4071 in relation to expenses.
4072 (g) File, in addition to regular annual statements, interim
4073 financial reports on a form prescribed by the commission.
4074 (h) Correct corporate governance practice deficiencies and
4075 adopt and use governance practices acceptable to the office.
4076 (i) Provide a business plan acceptable to the office in
4077 order to continue to transact business in this state.
4078 (j) Notwithstanding any other law limiting the frequency or
4079 amount of rate adjustments, adjust rates for any non-life
4080 insurance product written by the insurer which the office
4081 considers necessary to improve the financial condition of the
4082 insurer.
4083 (4) The office may, pursuant to ss. 120.569 and 120.57, in
4084 its discretion and without advance notice or hearing, issue an
4085 immediate final order to any insurer requiring the actions
4086 specified in subsection (3).
4087 (5) This section may not be interpreted to limit the powers
4088 granted to the office by any laws of this state, nor may it be
4089 interpreted to supersede any laws of this state.

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4090 Section 80. Subsection (11) of section 651.114, Florida
4091 Statutes, is amended to read:
4092 651.114 Delinquency proceedings; remedial rights.—
4093 ~~(11)(a) The rights of the office described in this section~~
4094 ~~are subordinate to the rights of a trustee or lender pursuant to~~
4095 ~~the terms of a resolution, ordinance, loan agreement, indenture~~
4096 ~~of trust, mortgage, lease, security agreement, or other~~
4097 ~~instrument creating or securing bonds or notes issued to finance~~
4098 ~~a facility, and the office, subject to paragraph (c), may not~~
4099 ~~exercise its remedial rights provided under this section and ss.~~
4100 ~~651.018, 651.106, 651.108, and 651.116 with respect to a~~
4101 ~~facility that is subject to a lien, mortgage, lease, or other~~
4102 ~~encumbrance or trust indenture securing bonds or notes issued in~~
4103 ~~connection with the financing of the facility, if the trustee or~~
4104 ~~lender, by inclusion or by amendment to the loan documents or by~~
4105 ~~a separate contract with the office, agrees that the rights of~~
4106 ~~residents under a continuing care or continuing care at-home~~
4107 ~~contract will be honored and will not be disturbed by a~~
4108 ~~foreclosure or conveyance in lieu thereof as long as the~~
4109 ~~resident:~~
4110 ~~1. Is current in the payment of all monetary obligations~~
4111 ~~required by the contract;~~
4112 ~~2. Is in compliance and continues to comply with all~~
4113 ~~provisions of the contract; and~~
4114 ~~3. Has asserted no claim inconsistent with the rights of~~
4115 ~~the trustee or lender.~~
4116 ~~(b) This subsection does not require a trustee or lender~~
4117 ~~to:~~
4118 ~~1. Continue to engage in the marketing or resale of new~~

4119 ~~continuing care or continuing care at-home contracts;~~
4120 ~~2. Pay any rebate of entrance fees as may be required by a~~
4121 ~~resident's continuing care or continuing care at-home contract~~
4122 ~~as of the date of acquisition of the facility by the trustee or~~
4123 ~~lender and until expiration of the period described in paragraph~~
4124 ~~(d);~~
4125 ~~3. Be responsible for any act or omission of any owner or~~
4126 ~~operator of the facility arising before the acquisition of the~~
4127 ~~facility by the trustee or lender; or~~
4128 ~~4. Provide services to the residents to the extent that the~~
4129 ~~trustee or lender would be required to advance or expend funds~~
4130 ~~that have not been designated or set aside for such purposes.~~
4131 ~~(c) If the office determines, at any time during the~~
4132 ~~suspension of its remedial rights as provided in paragraph (a),~~
4133 ~~that:~~
4134 ~~1. The trustee or lender is not in compliance with~~
4135 ~~paragraph (a);~~
4136 ~~2. A lender or trustee has assigned or has agreed to assign~~
4137 ~~all or a portion of a delinquent or defaulted loan to a third~~
4138 ~~party without the office's written consent;~~
4139 ~~3. The provider engaged in the misappropriation,~~
4140 ~~conversion, or illegal commitment or withdrawal of minimum~~
4141 ~~liquid reserve or escrowed funds required under this chapter;~~
4142 ~~4. The provider refused to be examined by the office~~
4143 ~~pursuant to s. 651.105(1); or~~
4144 ~~5. The provider refused to produce any relevant accounts,~~
4145 ~~records, and files requested as part of an examination,~~
4146
4147 ~~the office shall notify the trustee or lender in writing of its~~

4148 ~~determination, setting forth the reasons giving rise to the~~
4149 ~~determination and specifying those remedial rights afforded to~~
4150 ~~the office which the office shall then reinstate.~~
4151 ~~(d) Upon acquisition of a facility by a trustee or lender~~
4152 ~~and evidence satisfactory to the office that the requirements of~~
4153 ~~paragraph (a) have been met, the office shall issue a 90-day~~
4154 ~~temporary certificate of authority granting the trustee or~~
4155 ~~lender the authority to engage in the business of providing~~
4156 ~~continuing care or continuing care at-home and to issue~~
4157 ~~continuing care or continuing care at-home contracts subject to~~
4158 ~~the office's right to immediately suspend or revoke the~~
4159 ~~temporary certificate of authority if the office determines that~~
4160 ~~any of the grounds described in s. 651.106 apply to the trustee~~
4161 ~~or lender or that the terms of the contract used as the basis~~
4162 ~~for the issuance of the temporary certificate of authority by~~
4163 ~~the office have not been or are not being met by the trustee or~~
4164 ~~lender since the date of acquisition.~~
4165 Section 81. Section 651.1165, Florida Statutes, is created
4166 to read:
4167 651.1165 Recording of lien by the office.—
4168 (1) The office shall, as a condition to granting a
4169 provisional certificate of authority to an applicant, record
4170 with the county recorder of any county a notice of lien against
4171 the facility's properties on behalf of all residents and
4172 contract holders who enter into life care contracts with the
4173 applicant to secure performance of the provider's obligations to
4174 residents and contract holders pursuant to life care contracts.
4175 (2) From the time of such recording there exists a lien for
4176 an amount equal to the reasonable value of services to be

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4177 performed under a life care contract in favor of each resident
4178 and contract holder on the land and improvements of the
4179 facility’s properties owned by the provider, not exempt from
4180 execution, which are listed in the notice of lien filed pursuant
4181 to subsection (3) and which are located in the county in which
4182 the notice of lien is recorded.
4183 (3) The lien shall be perfected by the office by executing
4184 by affidavit the notice and claim of lien, which shall contain:
4185 (a) The legal description of the lands and improvements to
4186 be charged with a lien.
4187 (b) The name of the owner of the property affected.
4188 (c) A statement that the lien has been filed by the office
4189 pursuant to this section.
4190 (4) The lien may be released or partially released at the
4191 request of the applicant if, in the judgment of the director,
4192 such release or partial release inures to the benefit of the
4193 residents and contract holders and the performance of the
4194 provider’s obligations to the residents and contract holders.
4195 (5) The lien may be foreclosed by civil action. Any number
4196 of persons claiming liens against the same property pursuant to
4197 this section may join in the same action. If separate actions
4198 are commenced, the court may consolidate such actions. The court
4199 shall, as part of the costs, allow reasonable attorney fees for
4200 each claimant who is a party to the action.
4201 (6) In a civil action filed pursuant to this section, the
4202 judgment must be entered in favor of each resident and contract
4203 holder having a lien who has joined in the foreclosure action
4204 for the amount equal to the reasonable value of services to be
4205 performed under a life care contract in favor of each resident

4206 and contract holder. The court shall order the sheriff to sell
4207 any property subject to the lien at the time judgment is given,
4208 in the same manner as real and personal property is sold on
4209 execution. The lien for the reasonable value of services to be
4210 performed under a life care contract must be on equal footing
4211 with claims of other residents and contract holders. If a sale
4212 is ordered and the property is sold and the proceeds of the sale
4213 are not sufficient to discharge all liens of residents and
4214 contract holders against the property, the proceeds must be
4215 prorated among the respective residents and contract holders.
4216 (7) The liens provided for in this section are preferred to
4217 all liens, mortgages, or other encumbrances upon the property
4218 attaching subsequently to the time the lien is recorded and are
4219 preferred to all unrecorded liens, mortgages, and other
4220 encumbrances. The amount secured by any lien having priority to
4221 the lien filed pursuant to this section may not be increased
4222 without prior approval of the office.
4223 (8) The office shall file a release of the lien upon proof
4224 of complete performance of all obligations to residents and
4225 contract holders pursuant to life care contracts.
4226 (9) The office may subordinate any lien filed pursuant to
4227 this section to the lien of a first mortgage or other long-term
4228 financing obtained by the provider, regardless of the time at
4229 which the subsequent lien attaches.
4230 Section 82. Reciprocal insurers licensed before July 1,
4231 2025, have until July 1, 2026, to comply with the changes made
4232 to subscriber advisory committees in s. 629.201, Florida
4233 Statutes. Reciprocal insurers licensed before July 1, 2025, have
4234 until July 1, 2027, to comply with the changes made to unearned

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4235 premium reserve requirements imposed under s. 629.56, Florida
4236 Statutes.
4237 Section 83. Except as otherwise expressly provided in this
4238 act and except for this section, which shall take effect upon
4239 this act becoming a law, this act shall take effect July 1,
4240 2025.