

Tab 1 SB 280 by Bean; (Identical to H 00793) Telehealth						
856092	D	S	RCS	BI, Bean	Delete everything after	01/16 06:25 PM
773864	AA	S	RCS	BI, Bean	Delete L.69:	01/16 06:25 PM

Tab 2 SB 396 by Hukill (CO-INTRODUCERS) Young, Hutson; (Identical to H 00811) Motor Vehicle Insurance Coverage for Windshield Glass						
144400	A	S	RCS	BI, Steube	Delete L.24:	01/16 06:25 PM
408714	AA	S	RCS	BI, Bradley	Delete L.9 - 11:	01/16 06:25 PM

Tab 3 SB 416 by Thurston; (Similar to CS/CS/H 00455) Governance of Banks and Trust Companies						
945032	D	S	RCS	BI, Thurston	Delete everything after	01/16 06:25 PM

Tab 4 SB 438 by Lee; (Compare to H 00783) Continuing Care Contracts						
872234	D	S	RCS	BI, Lee	Delete everything after	01/16 06:25 PM

Tab 5 SB 492 by Garcia; (Similar to CS/H 00289) Provision of Pharmaceutical Services						
---	--	--	--	--	--	--

Tab 6 SB 518 by Bean; (Similar to CS/CS/H 00329) Motor Vehicle Insurance Coverage Exclusions						
710292	A	S		BI, Thurston	Delete L.16 - 42:	01/10 08:50 AM
565706	A	S		BI, Bean	Delete L.18 - 37:	01/12 03:43 PM

Tab 7 SB 640 by Rouson; (Similar to H 00747) Consumer Finance Loans						
--	--	--	--	--	--	--

Tab 8 SB 756 by Grimsley; (Similar to CS/H 00533) Unfair Insurance Trade Practices						
---	--	--	--	--	--	--

Tab 9 SB 920 by Bradley (CO-INTRODUCERS) Braynon; (Identical to H 00857) Deferred Presentment Transactions						
---	--	--	--	--	--	--

Tab 10 SB 1168 by Steube; (Compare to H 07015) Insurance						
804018	D	S		BI, Broxson	Delete everything after	01/16 10:04 AM
178904	A	S		BI, Steube	btw L.103 - 104:	01/12 03:44 PM
382922	A	S		BI, Steube	Delete L.134:	01/12 03:48 PM
202936	A	S		BI, Steube	Delete L.150 - 167:	01/12 03:44 PM
313360	A	S		BI, Steube	Delete L.186 - 194:	01/12 03:56 PM
606060	A	S		BI, Steube	Delete L.118 - 122:	01/16 10:33 AM

The Florida Senate
COMMITTEE MEETING EXPANDED AGENDA

BANKING AND INSURANCE
Senator Flores, Chair
Senator Steube, Vice Chair

MEETING DATE: Tuesday, January 16, 2018

TIME: 4:00—6:00 p.m.

PLACE: Toni Jennings Committee Room, 110 Senate Office Building

MEMBERS: Senator Flores, Chair; Senator Steube, Vice Chair; Senators Bracy, Bradley, Braynon, Broxson, Gainer, Garcia, Grimsley, Taddeo, and Thurston

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	SB 280 Bean (Identical H 793)	Telehealth; Encouraging the state group health insurance program to offer health insurance plans that include telehealth coverage for state employees; establishing the standard of care for telehealth providers; encouraging insurers offering certain rating plans for workers' compensation and employer's liability insurance, which are approved by the Office of Insurance Regulation, to include in the plans services provided through telehealth, etc. BI 01/16/2018 Fav/CS HP AHS AP	Fav/CS Yeas 11 Nays 0
2	SB 396 Hukill (Identical H 811)	Motor Vehicle Insurance Coverage for Windshield Glass; Authorizing a motor vehicle insurance policy providing comprehensive or combined additional coverage to require an inspection of the damaged windshield of a covered motor vehicle before the windshield repair or replacement is authorized by the insurer, etc. BI 12/05/2017 Not Considered BI 01/10/2018 Not Considered BI 01/16/2018 Fav/CS CM RC	Fav/CS Yeas 11 Nays 0
3	SB 416 Thurston (Similar CS/CS/H 455)	Governance of Banks and Trust Companies; Revising requirements relating to the financial institution experience of certain proposed directors and officers of a proposed bank or trust company; revising applicability of the residency requirement for directors of a bank or trust company, etc. BI 01/10/2018 Not Considered BI 01/16/2018 Fav/CS CM RC	Fav/CS Yeas 11 Nays 0

COMMITTEE MEETING EXPANDED AGENDA

Banking and Insurance

Tuesday, January 16, 2018, 4:00—6:00 p.m.

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	SB 438 Lee (Compare H 783)	Continuing Care Contracts; Revising applicability of specified provisions of the Florida Insurance Code as to the Office of Insurance Regulation's authority to regulate providers of continuing care and continuing care at-home; prohibiting a person, without the office's prior written approval, from acquiring a facility operating under a subsisting certificate of authority and engaging in the business of providing continuing care; providing that violations of certain provisions constitute an immediate danger to the public health, safety, or welfare, etc. BI 01/16/2018 Fav/CS AGG AP RC	Fav/CS Yeas 9 Nays 0
5	SB 492 Garcia (Similar CS/H 289)	Provision of Pharmaceutical Services; Prohibiting certain health insurance policies and health maintenance contracts from requiring insureds and subscribers to obtain certain prescription drugs exclusively from mail order pharmacies for the treatment of specified chronic illnesses; requiring certain health maintenance organizations to include specified disclosures in their outlines of coverage regarding such prescription drugs, etc. BI 01/16/2018 Favorable HP AP	Favorable Yeas 10 Nays 1
6	SB 518 Bean (Similar CS/CS/H 329)	Motor Vehicle Insurance Coverage Exclusions; Providing that private passenger motor vehicle policies may exclude certain identified individuals from specified coverages under certain circumstances; providing that such policies may not exclude coverage under certain circumstances, etc. BI 01/10/2018 Not Considered BI 01/16/2018 Temporarily Postponed CM RC	Temporarily Postponed
7	SB 640 Rouson (Similar H 747, Compare CS/H 239, CS/S 386)	Consumer Finance Loans; Establishing the Access to Responsible Credit Pilot Program within the Office of Financial Regulation; prohibiting a person from certain actions relating to program loans unless the person obtains a pilot program license from the office; providing that only one pilot program license is required for a person to make program loans, etc. BI 01/16/2018 Favorable CM RC	Favorable Yeas 10 Nays 0

COMMITTEE MEETING EXPANDED AGENDA

Banking and Insurance

Tuesday, January 16, 2018, 4:00—6:00 p.m.

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
8	SB 756 Grimsley (Similar CS/H 533)	Unfair Insurance Trade Practices; Authorizing insurers to refuse to insure or refuse to continue to insure an applicant or insured for failing to purchase certain noninsurance motor vehicle services, etc. BI 01/16/2018 Favorable CM RC	Favorable Yeas 10 Nays 0
9	SB 920 Bradley (Identical H 857)	Deferred Presentment Transactions; Specifying the maximum face amount of checks which may be taken for deferred presentment installment transactions, exclusive of fees; providing an exception to a prohibition against a deferred presentment provider's or its affiliate's presentment of a drawer's check before the end of the deferment period, etc. BI 01/16/2018 Favorable CM RC	Favorable Yeas 9 Nays 2
10	SB 1168 Steube (Compare H 7015, S 62, S 256, S 258)	Insurance; Providing that certain attorney fees and costs paid by property insurers may not be included in the property insurer's rate base and may not be used to justify a rate increase or rate change; providing that personal lines residential and commercial residential property insurance policies may not restrict the assignment of post-loss benefits; providing that an agreement to assign post-loss benefits of a residential homeowner's property insurance is not valid unless specified conditions are met, etc. BI 01/16/2018 Not Considered JU RC	Not Considered

Other Related Meeting Documents

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: CS/SB 280

INTRODUCER: Banking and Insurance Committee and Senator Bean

SUBJECT: Telehealth

DATE: January 22, 2018

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	Fav/CS
2.			HP	
3.			AHS	
4.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 280 establishes practice standards for telehealth health care services, addresses the prescribing of controlled substances and ordering of medical marijuana through telehealth, and prescribes recordkeeping and patient consent. Telehealth is the delivery of health care services using telecommunication technologies, which allows licensed practitioners in one location to diagnose and treat patients at a different location. The bill will remove regulatory ambiguity regarding the provision of health care services using this technology because it is not currently addressed in Florida Statutes.

Expanding the use of telehealth could help Florida address a significant health care provider shortage. This shortage is evidenced by the fact there are 647 federally designated Health Professional Shortage Areas (HPSA) within the state for primary care, dental care and mental health. It is estimated that an additional 1,609 primary care, 1,169 dental care and 158 mental health practitioners are needed to eliminate these shortage areas in Florida.

Telehealth technology is currently being utilized to provide health care services nationally and in Florida. Telehealth technology can enable real-time communication between patients and health care practitioners (or between multiple practitioners) using live video conferencing; can securely store-and-forward clinical data to offsite locations for evaluation by health care practitioners; and can support remote monitoring of patients' conditions.

II. Present Situation:

Health Care Professional Shortage

There is currently a health care provider shortage in the United States (U.S.). Approximately 20 percent of the U.S. residents live in rural areas, but only 9 percent of physicians practice in these areas.¹ As of December 31, 2017,² the U.S. Department of Health and Human Services has designated 7,176 Primary Care Health Professional Shortage Areas (HPSA), 5,866 Dental HPSA and 5,042 Mental Health HPSA.³ An estimated 31,449 practitioners are needed to eliminate the shortage nationwide. Florida is experiencing a health care provider shortage. This is evidenced by the fact that there are 647 federally designated Health Professional Shortage Areas (HPSA) within the state for primary care, dental care and mental health,⁴ and it would take an estimated 2,936 practitioners to eliminate these shortage areas in Florida.

Telehealth

The term, “telehealth,” is sometimes used interchangeably with telemedicine. Telehealth, however, generally refers to a wider range of health care services that may or may not include clinical services.⁵ Telehealth often collectively defines the telecommunications equipment and technology that are used to collect and transmit the data for a telemedicine consultation or evaluation. Telemedicine may refer to clinical services that are provided remotely via telecommunication technologies. Telemedicine is not a separate medical specialty and does not change what constitutes proper medical treatment and services. There is no consensus among federal programs and health care providers on the definition of either term.

The federal Centers for Medicare & Medicaid Services (CMS) defines telehealth as:

The use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance. Telehealth includes technologies such as telephones, facsimile machines, electronic mail

¹ Health Affairs, Health Policy Brief: *Telehealth Parity Laws*, (Aug. 15, 2016) (on file with the Banking and Insurance Committee).

² See U.S. Department of Health and Human Services, Bureau of Health Workforce, Designated Health Professional Shortage Areas Statistics, *First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary* (as of Dec. 31, 2017), available at: https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Qtr_Smry_HTML&rc:Toolbar=false (last viewed Jan. 7, 2018).

³ HPSA designations are used to identify areas and population groups within the U.S. that are experiencing a shortage of health professionals. The primary factor used to determine a HPSA designation is the number of health professionals relative to the population with consideration of high need. Federal regulations stipulate that in order for an area to be considered as having a shortage of providers, an area must have a population-to-provider ratio of a certain threshold. For example, for primary medical care, the population to provider ratio must be at least 3,500 to 1 (3,000 to 1 if there are unusually high needs in the community). See <https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last viewed January 7, 2018).

⁴ *Id.*

⁵ Anita Majerowicz and Susan Tracy, “Telemedicine: Bridging Gaps in Healthcare Delivery,” *Journal of AHIMA* 81, no. 5, (May 2010): 52-53, 56. http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_047324.hcsp?dDocName=bok1_047324 (last viewed Jan. 1, 2018).

systems, and remote patient monitoring devices, which are used to collect and transmit data for monitoring and interpretation.⁶

According to the American Telemedicine Association,⁷ telemedicine is a significant and rapidly growing component of health care in the U.S. There are currently about 200 telemedicine networks, with 3,500 service sites in the U.S. Nearly one million Americans are currently using remote cardiac monitors. In 2011, the Veterans Administration delivered over 300,000 remote consultations using telemedicine. Over half of all U.S. hospitals now use some form of telemedicine. Around the world, millions of patients use telemedicine to monitor their vital signs, remain healthy and out of hospitals and emergency rooms. Consumers and physicians download health and wellness applications for use on their cell phones.

Florida Telehealth Advisory Council

In 2016, legislation⁸ was enacted that required the Agency for Health Care Administration (agency), with assistance from the Department of Health (DOH) and the Office of Insurance Regulation (OIR), to survey health care practitioners, facilities, and insurers on telehealth utilization and coverage, and submit a report on the survey findings to the Governor, Senate President and Speaker of the House of Representatives by December 31, 2016. The law also created a 15-member Telehealth Advisory Council, and required it to submit a report with recommendations based on the survey findings to the Governor, Senate President and Speaker of the House of Representatives by October 31, 2017.

Summary of the Survey Findings of the Telehealth Advisory Council⁹

The types of health care services provided via telehealth in the state. The most frequent uses of telehealth reported by licensed health care facilities in Florida include neurology (including stroke care), home health/patient monitoring, primary care, behavioral health, and radiology. About 44 percent of home health agencies responding to the agency's survey indicated using telehealth to assist with remote patient monitoring.

The extent to which telehealth is used by health care practitioners and health care facilities nationally and in the state. At the national level, an estimated 63 percent of practitioners use some type of telehealth platform to provide services. In contrast, only 6 percent of surveyed practitioners in Florida indicated they use telehealth for the provision of health care services. About 52 percent of hospitals in the U.S. use telehealth, and 45 percent of surveyed Florida hospitals stated they offer care through some form of telehealth. Major factors driving the adoption of telehealth include advancing technologies, an aging population, health practitioner shortage, and greater acceptance of innovative treatment by patients.

⁶ Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Telemedicine*, available at <https://www.medicare.gov/medicaid/benefits/telemed/index.html> (last viewed Jan. 5, 2018).

⁷ See <https://www.americantelemed.org/about/telehealth-faqs-> (last viewed Jan. 5, 2018).

⁸ Ch. 2016-240, Laws of Fla. The law designated the Secretary of the Agency for Health Care Administration as the council Chair, and designated the State Surgeon General and Secretary of the Department of Health as a member. The agency's Secretary and the Surgeon General appointed 13 council members representing specific stakeholder groups.

⁹ See Telehealth Advisory Council website available at <http://www.ahca.myflorida.com/SCHS/telehealth/> (last viewed Jan. 8, 2018).

The estimated costs and cost savings to provide health care services. Benefits reported from health care facilities and professionals offering telehealth services include improved convenience for both patients and providers, improved efficiencies, and improved patient care outcomes. Financial barriers are the most frequently reported obstacles among health care facilities and providers during both implementation and ongoing operations of telehealth programs. The American Hospital Association notes that direct return on investment for health care providers is limited; particularly when there is limited coverage and reimbursement by health plans for the services offered by telehealth. Twenty five Florida health facilities and practitioners identify costs, reimbursement, and inability to determine a Return on Investment (ROI) as challenges in providing telehealth services.

The extent of insurance coverage for providing health care services via telehealth and how such coverage compares to coverage for in-person services. Some public and private payers limit reimbursement for health services offered through telehealth technology by the type of telehealth service offered and/or by the locations where care is provided and received. Approximately 43 percent of Florida health insurers indicate that they cover some form of telehealth services. Companies who offer Medicare Advantage plans were shown as having the largest percentage of plans offering reimbursement to health care providers for service provided through telehealth technologies. Coverage typically is limited to certain delivery types and requires special coding. A majority of health insurers indicate very limited coverage.

As of December 2016, 28 states, and the District of Columbia, have parity laws, which require private payer coverage and payment for telehealth services to be equitable with coverage and reimbursements for face-to-face health services. The definition of telehealth in each of these states varies, and some state definitions may include limitations on the telehealth modalities encompassed in required coverage and payment models.

Notable differences in the state regulations include whether telehealth services must be reimbursed at the same rate as in-person services; or whether the state only requires that the same services be covered but allow for variable rates of reimbursement. Florida does not currently have any statutory requirements related to private payer parity for telehealth services. Some private payers in the state have voluntarily opted to provide coverage and reimbursement for telehealth services.

According to the survey, 18 states provide Medicaid coverage and reimbursement for telehealth services. At least 17 states have some reimbursement for remote patient monitoring; and 9 states reimburse for store and forward services under their Medicaid program.¹⁰ Within each of these reimbursement models, there are variances in the types of services, specialties, providers, and locations that are covered. The Florida Medicaid fee-for-service rules were updated in June 2016 to expand telehealth payments to a broader array of practitioners. Similar to Medicare, Medicaid coverage in Florida is limited to live video conferencing, and pays the practitioner that provides the diagnosis only. With the vast majority of Florida Medicaid beneficiaries enrolled in managed

¹⁰ See Center for Connected Health Policy, *50 State Scan of Telehealth Reimbursement Laws and Medicaid Policies-Factsheet* (Mar. 2017) (on file with Banking and Insurance Committee). In their recent state survey¹⁰ of Medicaid telehealth reimbursement laws, they noted 48 states provide reimbursement for some form of live video in Medicaid fee for service; 13 states reimburse for store and forward delivered services; 22 states reimburse for remote patient monitoring; 9 states reimburse for all three of the above services; and 31 states provide a transmission and/or facility fee.

care, Florida's Medicaid Managed Care plans are authorized to cover telehealth services with greater flexibility; however, there is no mandate for coverage. Based on survey responses by Florida health plans, coverage for telehealth is greatest for Medicaid Managed Care and Affordable Care Act Exchange Plans. Florida health care providers indicate very little reimbursement for telehealth services no matter the plan type.

Barriers to using or accessing services through telehealth. The primary issues related to telehealth often cited are financial, interoperability, and licensure. Florida providers and practitioners cited financial issues, such as inadequate reimbursement from payers, insufficient funding capital, and the inability to determine return on investment. An estimated 44 percent of the health plans surveyed noted government regulations and liability as barriers for covering telehealth services. The issue of interstate practice and reimbursement is among the legal issues health plans must consider. For example, health plans must ensure they are reimbursing health providers that are licensed appropriately in the jurisdiction where they are treating patients.⁴⁷ Florida facility and practitioner licensees who responded to the survey indicated the top three barriers to implementing telehealth involve finances: inadequate reimbursement from payers, insufficient funding capital, and the inability to determine return on investment.

Summary of the Recommendations of the Telehealth Advisory Council¹¹

The report contained the following recommendations:

1. **Create definition of telehealth and replace existing telehealth and telemedicine definitions in Florida statutes and rules.** Telehealth is defined as the mode of providing health care and public health services through synchronous and asynchronous information and communication technology by a Florida licensed health care practitioner, within the scope of his or her practice, who is located at a site other than the site where a recipient (patient or licensed health care practitioner) is located.
2. **Coverage Parity.** A health insurance policy issued, amended, or renewed on or after July 1, 2018, shall provide coverage for services (excluding Medicare plans) provided via telehealth to the same extent the services are covered, if provided in-person. An insurer shall not impose any additional conditions for coverage of services provided via telehealth.¹²
3. **Payment Parity.** For the purpose of health insurance payment (excluding Medicare plans), payment rates for services provided via telehealth shall be equivalent to the rates for comparable services provided via in-person consultation or contact contained in the participation agreement between the insurer and the health care practitioner.¹³

¹¹ See Telehealth Advisory Council, *Expanding Florida's Use and Accessibility of Telehealth* (Oct. 31, 2017), available at http://www.ahca.myflorida.com/SCHS/telehealth/docs/TAC_Report.pdf (last visited January 5, 2018).

¹² According to the report, the intent of this recommendation is to ensure appropriate insurance coverage for the use of telehealth in treating patients. Any legislative language developed should not require insurers to add additional service lines or specialties, mandate a fee-for-service arrangement, inhibit value-based payment programs, or limit health care insurers and practitioners from negotiating contractual coverage terms.

¹³ According to the report, the intent of this recommendation is to ensure appropriate insurance reimbursement for the use of telehealth in treating patients. Any legislative language developed should not require insurers to add additional service lines or specialties, mandate fee-for-service arrangements, inhibit value-based payment programs, limit health care insurers and practitioners from negotiating contractual coverage terms, or require insurers to pay for facsimiles or audio only communication.

4. **Medicaid Reimbursement.** The council recommends the agency modify the Medicaid telehealth fee-for-service rule to include coverage of store-and-forward and remote patient monitoring modalities in addition to the currently reimbursed live video conferencing modality.
5. **Medicaid Network Adequacy.** The council recommends the agency develop a model that would allow Medicaid Managed Care plans to utilize telehealth for meeting network adequacy.
6. **Interstate Licensure.** In order to ensure the best care for Florida patients and maximize available resources and access to care, the council recommends the following:
 - Maintain the requirement of Florida licensure for health practitioners providing patient care in Florida via telehealth. This recommendation requires no change to current regulations and does not inhibit the use of telehealth to treat patients.
 - The Legislature adopt laws allowing participation in health care practitioner licensure compacts that have licensure requirements that are equivalent to or more stringent than Florida Law.
7. **Standards of Care.** To ensure clarity for Florida licensed health care practitioners and stakeholders regarding the ability to use telehealth as a modality of care, the council recommends the DOH, healthcare regulatory boards and councils continue to educate and raise awareness among licensees that they may use telehealth modalities to serve patients.
8. **Patient-Practitioner Relationships and Continuity of Care.** The council offers the following language for inclusion in Florida statutes: A health care practitioner-patient relationship may be established through telehealth.
9. **Patient Consent.** The council recommends maintaining current consent laws in Florida.
10. **Telehealth and Prescribing.** The council offers the following language:

Health care practitioners, authorized by law, may prescribe medications via telehealth to treat a patient as is deemed appropriate to meet the standard of care established by his or her respective health care regulatory board or council. The prescribing of controlled substances through telehealth should be limited to the treatment of psychiatric disorders and emergency medical services. This should not prohibit an authorized health care practitioner from ordering a controlled substance for an inpatient at a facility licensed under ch. 395, F.S., or a patient of a hospice licensed under ch. 400, F.S.
11. **Technology and Health Care Facilities/Practitioners.** The council notes that technology-related barriers for practitioners will decrease as technological advances and market forces drive cost reductions. Barriers remain related to interoperability of health care information systems. The council recommends:
 - The agency identify existing resources for health information exchange to expand interoperability between telehealth technologies and integration into electronic health record (EHR) platforms.
 - The agency continue promotion of existing programs and services available to increase access to technology, access to broadband networks, and improved interoperability.
 - Medical schools, schools of allied health practitioners, and health care associations provide information and educational opportunities related to the utilization to telehealth for serving patients.

Florida Board of Medicine

Florida's Board of Medicine (board) convened a Telemedicine Workgroup in 2013 to review its rules on telemedicine, which had not been amended since 2003. The 2003 rules focused on standards for the prescribing of medicine via the Internet. On March 12, 2014, the board's new Telemedicine Rule, 64B8-9.0141, became effective for Florida-licensed physicians. The new rule defined telemedicine,¹⁴ established standards of care, prohibited the prescription of controlled substances, permitted the establishment of a doctor-patient relationship via telemedicine, and exempted emergency medical services.¹⁵

Two months after the initial rule's implementation, the board proposed the development of a rule amendment to address concerns that the prohibition on physicians ordering controlled substances may also preclude physicians from prescribing controlled substances via telemedicine for hospitalized patients. The board indicated such a prohibition was not intended.¹⁶ The amended rule took effect July 22, 2014. Additional changes followed to clarify medical record requirements and the relationship between consulting or cross-coverage physicians. On December 18, 2015, the board published another proposed rule change to allow controlled substances to be prescribed through telemedicine for the limited treatment of psychiatric disorders.¹⁷ The proposed rule amendment, Rule 64B8-9.0141-Standards for Telemedicine Practice, became effective March 7, 2016.¹⁸

Florida's Medicaid Program¹⁹

The Florida Medicaid program is a partnership between the federal and state governments. In Florida, the Agency for Health Care Administration (agency) oversees the Medicaid program.²⁰ The Statewide Medicaid Managed Care (SMMC) program is comprised of the Managed Medical Assistance (MMA) program and the Long-term Care (LTC) managed care program. The agency contracts with managed care plans to provide services to eligible enrollees.²¹ Under the Managed Medical Assistance (MMA) component of Statewide Medicaid Managed Care, managed care

¹⁴ The term, "telemedicine," is defined to mean the practice of medicine by a licensed Florida physician or physician assistant where patient care, treatment, or services are provided through the use of medical information exchanged from one site to another via electronic communications. Telemedicine shall not include the provision of health care services only through an audio only telephone, email messages, text messages, facsimile transmission, U.S. Mail or other parcel service, or any combination thereof.

¹⁵ Rule 64B15-14.0081, F.A.C., also went into effect March 12, 2014, for osteopathic physicians.

¹⁶ Florida Board of Medicine, *Latest News - Emergency Rule Related to Telemedicine*, <http://flboardofmedicine.gov/latest-news/emergency-rule-related-to-telemedicine/> (last visited Jan. 14, 2018).

¹⁷ Vol. 41/244, Fla. Admin. Weekly, Dec. 18, 2015, available at https://www.flrules.org/BigDoc/View_Section.asp?Issue=2011&Section=1 (last visited Jan. 14, 2018).

¹⁸ Florida Board of Medicine, *Latest News*, Feb. 23, 2016, available at <http://flboardofmedicine.gov/latest-news/board-revises-floridas-telemedicine-practice-rule/> (last viewed Jan. 7, 2018).

¹⁹ See Agency for Health Care Administration, *Analysis of SB 280* (Oct. 9, 2017) (on file with the Senate Banking and Insurance Committee).

²⁰ Part III of ch. 409, F.S., governs the Medicaid program.

²¹ A managed care plan that is eligible to provide services under the SMMC program must have a contract with the agency to provide services under the Medicaid program and must also be a health insurer; an exclusive provider organization or a HMO authorized under chs. 624, 627, or 641, F.S., respectively; a provider service network authorized under s. 409.912(2), F.S., or an accountable care organization authorized under federal law. Section 409.962, F.S.

plans may use telemedicine for behavioral health, dental services, and physician services.²² The AHCA may also approve other telemedicine services provided by the managed care plans if approval is sought by those plans under the MMA component.

Florida Medicaid has adopted a rule on telemedicine, which authorizes services to be delivered via telemedicine. The rule defines telemedicine as the practice of health care delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis, or treatment.²³ Further, telemedicine services must be provided by licensed practitioners operating within their scope of practice and involve the use of interactive telecommunications equipment which includes, at a minimum, audio and video equipment permitting two-way, real time, communication between the enrollee and the practitioner.²⁴ Additionally, the rule provides that Medicaid reimburses a practitioner rendering services in the fee-for-service delivery system who is providing the evaluation, diagnosis, or treatment recommendation located at a site other than where the recipient is located.

Equipment is also required to meet specific federal technical safeguards, which require implementation of procedures for protection of health information.²⁵ The safeguards include unique user identifications, automatic log-offs, encryption, authentication of users, and transmission security. Telemedicine services must also comply with all other state and federal laws regarding patient privacy.

Florida Medicaid and the federal Medicaid statute consider telemedicine to be a delivery system rather than a distinct service; as such, Florida Medicaid does not have reimbursement rates specific to the telemedicine mode of service. In the fee-for-service system, Florida Medicaid reimburses services delivered via telemedicine at the same rate and in the same manner as if the service were delivered face-to-face. Medicaid health plans can negotiate rates with providers, so they have the flexibility to pay different rates for services delivered via telemedicine.

Regulation of Insurance in Florida

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, health maintenance organizations (HMOs), and other risk-bearing entities.²⁶ The Agency for Health Care Administration (agency) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the agency.²⁷ As part of the certification process used by the agency, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.²⁸

²² Agency for Health Care Administration, *2012-2015 Medicaid Health Plan Model Agreement Attachment II - Exhibit II-A*, p. 63-64 http://ahca.myflorida.com/medicaid/statewide_mc/pdf/mma/Attachment_II_Exhibit_II-A_MMA_Model_2014-01-31.pdf, (last visited Jan. 11, 2018).

²³ See Rule 59G-1.057, F.A.C.

²⁴ *Id.*

²⁵ 45 CFR s. 164.312.

²⁶ Section 20.121(3)(a), F.S.

²⁷ Section 641.21(1), F.S.

²⁸ Section 641.495, F.S.

Federal Telemedicine Provisions

Federal laws and regulations address telemedicine from several perspectives, including prescriptions for controlled substances, hospital emergency room guidelines, and reimbursement rates for the Medicare program.

Prescribing Via the Internet

Federal law specifically prohibits the prescribing of controlled substances via the Internet without an in-person evaluation. Federal regulation 21 CFR s. 829 provides:

No controlled substance that is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act may be delivered, distributed or dispensed by means of the Internet without a valid prescription.

A valid prescription is further defined under the same regulation as one issued by a practitioner who has conducted an in-person evaluation. The in-person evaluation requires that the patient be in the physical presence of the provider without regard to the presence or conduct of other professionals.²⁹ However, the Ryan Haight Online Pharmacy Consumer Protection Act,³⁰ signed into law in October 2008, created an exception for the in-person medical evaluation for telemedicine practitioners. The practitioner is still subject to the requirement that all controlled substances be issued for a legitimate purpose by a practitioner acting in the usual course of professional practice.

The Drug Enforcement Administration (DEA) of the federal Department of Justice issued its own definition of telemedicine in April 2009, as required under the Haight Act.³¹ The federal regulatory definition of telemedicine under the DEA includes, but is not limited to, the following elements:

- The patient and practitioner are located in separate locations;
- Patient and practitioner communicate via a telecommunications system;
- The practitioner must meet other registration requirements for the dispensing of controlled substances via the Internet; and
- Certain practitioners (Department of Veterans Affairs' employees, for example) or practitioners in certain situations (public health emergencies) may be exempted from registration requirements.³²

Medicare Coverage

Specific telehealth services delivered at designated sites are covered under Medicare. Federal CMS regulations require both a distant site (location of physician delivering the service via telecommunications) and an originating site (location of the patient).

To qualify for Medicare reimbursement, the Medicare beneficiary must be located at an originating site that meets one of three qualifications. These three qualifications are:

²⁹ 21 CFR s. 829(e)(2).

³⁰ Ryan Haight Online Pharmacy Consumer Protection Act of 2008, Public Law 110-425 (H.R. 6353).

³¹ Id., at sec. 3(j).

³² 21 CFR s. 802(54).

- A rural health professional shortage area (HPSA) that is either outside a metropolitan statistical area (MSA) or in a rural census tract;
- A county outside of an MSA; or
- Participation in a federal telemedicine demonstration project approved by the Secretary of Health and Human Services as of December 31, 2000.³³

Additionally, federal requirements provide that an originating site must be one of the following location types as further defined in federal law and regulation:

- The office of a physician or practitioner;
- A hospital;
- A critical access hospital (CAH);
- A rural health clinic;
- A federally qualified health center;
- A hospital-based or CAH-based renal dialysis center (including satellite offices);
- A skilled nursing facility; or
- A community mental health center.³⁴

Under Medicare, distant site practitioners are limited, subject also to state law, to:

- Physicians;
- Nurse practitioners;
- Physician assistants;
- Nurse-midwives;
- Clinical nurse specialists;
- Certified registered nurse anesthetists;
- Clinical psychologists and clinical social workers; and
- Registered dietitians and nutrition professionals.

For 2015, Medicare added new services under telehealth:

- Annual wellness visits;
- Psychoanalysis;
- Psychotherapy; and
- Prolonged evaluation and management services.³⁵

Protection of Personal Health Information

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects personal health information (PHI). Initial privacy rules were initially issued in 2000 by the federal Department of Health and Human Services and later modified in 2002. These rules address the use and disclosure of an individual's health information and create standards for

³³ Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Telehealth Services- Rural Health Fact Sheet* (Dec. 2014), <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf> (last visited Jan. 7, 2018).

³⁴ See 42 U.S.C. sec. 1395(m)(m)(4)(C)(ii).

³⁵ Department of Health and Human Services, Centers for Medicare and Medicaid Services, *MLN Matters* (Dec. 24, 2014), <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9034.pdf> (last visited Jan. 7, 2018).

privacy rights. Additional privacy and security measures were adopted in 2009 with the Health Information Technology for Economic Clinical Health (HITECH) Act.

Only certain entities are subject to HIPAA's provisions. These "covered entities" include:

- Health plans;
- Health care providers;
- Health care clearinghouses; and
- Business associates of the entities listed above.

While not a covered entity as an individual, the patient still maintains his or her privacy and confidentiality rights regardless of the method in which a medical service is delivered. The HITECH Act specifically identified telemedicine as an area for review and consideration, and funding was provided to, in part, strengthen infrastructure and tools to promote telemedicine.³⁶

Under the provisions of HIPAA and the HITECH Act, a health care provider or other covered entity participating in telemedicine is required to meet the same technical and physical HIPAA and HITECH requirements as would be required for a physical office visit. These requirements include ensuring that the equipment and technology are HIPAA compliant.

III. Effect of Proposed Changes:

Section 1 creates s. 456.4501, F.S., which addresses the provision of healthcare services through telehealth. The section provides definitions of the terms "information and telecommunications technologies," "store and forward," "synchronous," and "telecommunications system," which are terms used in defining the technological means by which telehealth services may be provided. This section also defines the term, "telehealth," as the mode of providing health care services and public health care services by a Florida licensed practitioner, within the scope of his or her practice, through synchronous and asynchronous information and telecommunication technologies where the practitioner is located at a site other than the site where the recipient, whether a patient or another licensed practitioner, is located.

The section defines "telehealth provider" as a person providing health care services and related services through telehealth, and who is licensed under ch. 457, F.S. (acupuncture); ch. 458, F.S. (medical practice); ch. 459, F.S. (osteopathic medicine); ch. 460, F.S. (chiropractic medicine); ch. 461, F.S. (podiatric medicine); ch. 462, F.S. (naturopathy); ch. 463, F.S. (optometry); ch. 464, F.S. (nursing); ch. 465, F.S. (pharmacy); ch. 466, F.S. (dentistry); ch. 467, F.S. (midwifery); part I (speech-language pathology and audiology), part III (occupational therapy), part IV (radiological personnel), part V (respiratory therapy), part X (dietetics and nutrition practice), part XIII (athletics trainers), or part XIV (orthotics, prosthetics, and pedorthics) of ch. 468, F.S.; ch. 478, F.S. (electrolysis); ch. 480, F.S. (massage practice); parts III (clinical lab personnel) and IV (medical physicists) of ch. 483, F.S.; ch. 484, F.S. (dispensing of optical devices and hearing aids); ch. 486, F.S. (physical therapy); ch. 490, F.S. (psychological services); or ch. 491, F.S. (clinical, counseling, and psychotherapy services); or who is certified under s. 393.17, F.S., (behavior analyst) or part III of ch 401, F.S. (medical transportation services).

³⁶ Public Law 111-5, s. 3002(b)(2)(C)(iii) and s. 3011(a)(4).

The section creates practice standards for the provision of telehealth services. The standard of care for a telehealth provider is the same as that for an in-person health care provider. However, a telehealth provider is not required to research patient's medical history or conduct a physical examination if a patient evaluation conducted by telehealth is sufficient to diagnose and treat the patient. The bill specifies that the telehealth provider and the patient may be in separate locations and telehealth providers who are not physicians, and who are acting within their relevant scope of practice, are not practicing medicine without a license.

The bill specifically provides that telehealth providers who are licensed to prescribe schedule I through V controlled substances may prescribe those controlled substances through telehealth except that those controlled substances may not be prescribed through telehealth to treat chronic nonmalignant pain as defined in s. 458.3265(1)(a), F.S., and s. 459.0137(1)(a), F.S. Telehealth may not be used to issue a physician certification for marijuana pursuant to s. 381.986, F.S. This subsection does not apply when prescribing a controlled substance for an inpatient at a facility licensed under ch. 395, F.S., or a patient of a hospice licensed under ch. 400, F.S.

The Department of Health, in coordination with the relevant boards, must develop and disseminate educational materials for telehealth licensees delineated in s. 456.4501(1)(f), F.S., on using telehealth modalities to treat patients by January 1, 2019.

The section provides that a patient's medical records must be updated by a telehealth provider according to the same standards that apply to an in-person healthcare provider. Finally, the section provides that while a patient need not specifically consent to be treated via telehealth, the patient must still provide consent for treatment as provided under current law. The patient would retain the right to withhold consent for any particular procedure or treatment to be provided through telehealth.

Section 2 provides that the effective date of the bill is July 1, 2018.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

According to the Telehealth Advisory Council's report,³⁷ health practitioners indicated the need for a definition of the term, "telehealth," that would clarify the use of technological modalities as an acceptable way to treat patients within their scope of practice. Further, health plans noted the need for clarity in the allowable modes of telehealth for coverage and reimbursement purposes.

These changes may encourage the use of telehealth offers, which may result in reduced healthcare costs, increased patient access to providers, especially in medically underserved areas, improved quality and continuity of care, and faster and more convenient treatment resulting in reduction of lost work time and travel costs for patients. Preventing the unnecessary use of intensive services such as emergency department visits improves health outcomes and can reduce overall health care costs.

C. Government Sector Impact:

Department of Health. The Department of Health anticipates incurring non-recurring increase in workload and costs associated with the development and dissemination of educational materials for licensees on using telehealth modalities to treat patients. The impact is indeterminate at this time, yet it is anticipated that current resources and budget authority are adequate to absorb.³⁸

Agency for Health Care Administration. To maintain uniform naming conventions and practice standards throughout the state's policies, the agency will need to amend the Medicaid state plan, which will require federal approval.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 456.4501 of the Florida Statutes.

³⁷ See Telehealth Advisory Council, *Expanding Florida's Use and Accessibility of Telehealth* (Oct. 31, 2017), available at http://www.ahca.myflorida.com/SCHS/telehealth/docs/TAC_Report.pdf (last visited January 5, 2018).

³⁸ Department of Health, *Analysis of SB 280* (Oct. 12, 2017) (on file with Senate Banking and Insurance Committee).

IX. Additional Information:

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

CS by Banking and Insurance on January 16, 2018:

The CS eliminates telehealth provisions relating to the State Group Insurance program, Medicaid, and the Insurance Code and provides a technical change.

- B. **Amendments:**

None.



856092

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/16/2018	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause
and insert:

Section 1. Section 456.4501, Florida Statutes, is created
to read:

456.4501 Use of telehealth to provide services.-

(1) DEFINITIONS.-As used in this section, the term:

(a) "Information and telecommunications technologies" means
those secure electronic applications used by health care



856092

practitioners and health care providers to provide health care services, evaluate health care information or data, provide remote patient monitoring, or promote healthy behavior through interactions that include, but are not limited to, live video interactions, text messages, or store and forward transmissions.

(b) "Store and forward" means the type of telehealth encounter which uses still images of patient data for rendering a medical opinion or patient diagnosis. The term includes the asynchronous transmission of clinical data from one site to another site.

(c) "Synchronous" means live or two-way interactions using a telecommunications system between a provider and a person who is a patient, caregiver, or provider.

(d) "Telecommunications system" means the transfer of health care data through advanced information technology using compressed digital interactive video, audio, or other data transmission; clinical data transmission using computer image capture; and other technology that facilitates access to health care services or medical specialty expertise.

(e) "Telehealth" means the mode of providing health care services and public health services by a Florida licensed practitioner, within the scope of his or her practice, through synchronous and asynchronous information and telecommunications technologies where the practitioner is located at a site other than the site where the recipient, whether a patient or another licensed practitioner, is located.

(f) "Telehealth provider" means a person who provides health care services and related services through telehealth and who is licensed under chapter 457; chapter 458; chapter 459;



856092

chapter 460; chapter 461; chapter 462; chapter 463; chapter 464;
chapter 465; chapter 466; chapter 467; part I, part III, part
IV, part V, part X, part XIII, or part XIV of chapter 468;
chapter 478; chapter 480; parts III and IV of chapter 483;
chapter 484; chapter 486; chapter 490; or chapter 491; or who is
certified under s. 393.17 or part III of chapter 401.

(2) PRACTICE STANDARDS.—

(a) The standard of care for a telehealth provider
providing medical care to a patient is the same as the standard
of care generally accepted for a health care professional
providing in-person health care services to a patient. A
telehealth provider may use telehealth to perform a patient
evaluation. If a telehealth provider conducts a patient
evaluation sufficient to diagnose and treat the patient, the
telehealth provider is not required to research the patient's
medical history or conduct a physical examination of the patient
before using telehealth to provide services to the patient.

(b) A telehealth provider and a patient may be in separate
locations when telehealth is used to provide health care
services to the patient.

(c) A nonphysician telehealth provider using telehealth and
acting within his or her relevant scope of practice is not
deemed to be practicing medicine without a license under any
provision of law listed in paragraph (1) (f).

(d) A telehealth provider who is authorized to prescribe a
controlled substance named or described in Schedules I through V
of s. 893.03 may use telehealth to prescribe a controlled
substance, except that telehealth may not be used to prescribe a
controlled substance to treat chronic nonmalignant pain as



856092

defined in s. 458.3265(1)(a) or to issue a physician certification for marijuana pursuant to s. 381.986. This paragraph does not prohibit a physician from using telehealth to order a controlled substance for an inpatient admitted to a facility licensed under chapter 395 or a patient of a hospice licensed under chapter 400.

(e) By January 1, 2019, the department, in coordination with the applicable boards, shall develop and disseminate educational materials for the licensees listed in paragraph (1)(f) on the use of telehealth modalities to treat patients.

(3) RECORDS.—A telehealth provider shall document in the patient's medical record the health care services rendered using telehealth according to the same standard used for in-person health care services pursuant to ss. 395.3025(4) and 456.057.

(4) CONSENT.—Patients are not required to provide specific authorization for treatment through telehealth, but must authorize treatment that meets the requirements of the applicable practice acts and s. 766.103, and must be allowed to withhold consent for any specific procedure or treatment through telehealth.

Section 2. This act shall take effect July 1, 2018.

===== T I T L E A M E N D M E N T =====

And the title is amended as follows:

Delete everything before the enacting clause
and insert:

A bill to be entitled
An act relating to telehealth; creating s. 456.4501,
F.S.; defining terms; establishing the standard of



856092

care for telehealth providers; authorizing telehealth providers to use telehealth to perform patient evaluations; providing that telehealth providers, under certain circumstances, are not required to research a patient's history or conduct physical examinations before providing services through telehealth; providing that a nonphysician telehealth provider using telehealth and acting within her or her relevant scope of practice is not deemed to be practicing medicine without a license; authorizing certain telehealth providers to use telehealth to prescribe specified controlled substances; providing for construction; requiring the Department of Health to develop and disseminate certain educational materials to specified licensees by a specified date; providing recordkeeping requirements for telehealth providers; providing requirements for patient consent for telehealth treatment; providing an effective date.



773864

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/16/2018	.	
	.	
	.	
	.	

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

Senate Amendment to Amendment (856092)

Delete line 69
and insert:
defined in ss. 458.3265(1)(a) and 459.0137(1)(a) or to issue a
physician

By Senator Bean

4-00393B-18

2018280__

1 A bill to be entitled
 2 An act relating to telehealth; amending s. 110.123,
 3 F.S.; encouraging the state group health insurance
 4 program to offer health insurance plans that include
 5 telehealth coverage for state employees; amending s.
 6 409.906, F.S.; authorizing the Agency for Health Care
 7 Administration to pay for certain telehealth services
 8 as optional Medicaid services; creating s. 456.4501,
 9 F.S.; defining terms; establishing the standard of
 10 care for telehealth providers; authorizing telehealth
 11 providers to use telehealth to perform patient
 12 evaluations; providing that telehealth providers,
 13 under certain circumstances, are not required to
 14 research a patient's history or conduct physical
 15 examinations before providing services through
 16 telehealth; providing that a nonphysician telehealth
 17 provider using telehealth acting within her or her
 18 relevant scope of practice is not deemed to be
 19 practicing medicine without a license; authorizing
 20 certain telehealth providers to use telehealth to
 21 prescribe specified controlled substances; providing
 22 for construction; requiring the Department of Health
 23 to develop and disseminate certain educational
 24 materials to specified licensees by a specified date;
 25 providing requirements for recordkeeping by telehealth
 26 providers; providing requirements for patient consent
 27 for telehealth treatment; amending s. 627.0915, F.S.;
 28 encouraging insurers offering certain rating plans for
 29 workers' compensation and employer's liability

Page 1 of 7

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

4-00393B-18

2018280__

30 insurance, which are approved by the Office of
 31 Insurance Regulation, to include in the plans services
 32 provided through telehealth; providing an effective
 33 date.

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

36
 37 Section 1. Paragraph (b) of subsection (3) of section
 38 110.123, Florida Statutes, is amended to read:

39 110.123 State group insurance program.—

40 (3) STATE GROUP INSURANCE PROGRAM.—

41 (b) It is the intent of the Legislature to offer a
 42 comprehensive package of health insurance and retirement
 43 benefits and a personnel system for state employees which are
 44 provided in a cost-efficient and prudent manner, and to allow
 45 state employees the option to choose benefit plans that ~~which~~
 46 best suit their individual needs. The state group insurance
 47 program may include the state group health insurance plan or
 48 plans, health maintenance organization plans, group life
 49 insurance plans, TRICARE supplemental insurance plans, group
 50 accidental death and dismemberment plans, group disability
 51 insurance plans, other group insurance plans or coverage
 52 choices, and other benefits authorized by law. While not
 53 mandated to do so, the state group health insurance program is
 54 encouraged to offer a selection of plans that include coverage
 55 of services provided through telehealth.

56 Section 2. Subsection (28) is added to section 409.906,
 57 Florida Statutes, to read:

58 409.906 Optional Medicaid services.—Subject to specific

Page 2 of 7

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

4-00393B-18

2018280

appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(28) TELEHEALTH.—The agency may pay for live video conferencing, store and forward, as defined in s. 456.4501(1), and remote patient monitoring of a covered service delivered by or under the direction of a licensed health care practitioner.

Section 3. Section 456.4501, Florida Statutes, is created to read:

456.4501 Use of telehealth to provide services.—

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

Page 3 of 7

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

4-00393B-18

2018280

(a) "Information and telecommunications technologies" means those secure electronic applications used by health care practitioners and health care providers to provide health care services, evaluate health care information or data, provide remote patient monitoring, or promote healthy behavior through interactions that include, but are not limited to, live video interactions, text messages, or store and forward transmissions.

(b) "Store and forward" means the type of telehealth encounter which uses still images of patient data for rendering a medical opinion or patient diagnosis. The term includes the asynchronous transmission of clinical data from one site to another site.

(c) "Synchronous" means live or two-way interactions using a telecommunications system between a provider and a person who is a patient, caregiver, or provider.

(d) "Telecommunications system" means the transfer of health care data through advanced information technology using compressed digital interactive video, audio, or other data transmission; clinical data transmission using computer image capture; and other technology that facilitates access to health care services or medical specialty expertise.

(e) "Telehealth" means the mode of providing health care services and public health services by a Florida licensed practitioner, within the scope of his or her practice, through synchronous and asynchronous information and telecommunications technologies where the practitioner is located at a site other than the site where the recipient, whether a patient or another licensed practitioner, is located.

(f) "Telehealth provider" means a person who provides

Page 4 of 7

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

4-00393B-18

2018280

health care services and related services through telehealth and who is licensed under chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 462; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part III, part IV, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; parts III and IV of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491; or who is certified under s. 393.17 or part III of chapter 401.

(2) PRACTICE STANDARDS.—

(a) The standard of care for a telehealth provider providing medical care to a patient is the same as the standard of care generally accepted for a health care professional providing in-person health care services to a patient. A telehealth provider may use telehealth to perform a patient evaluation. If a telehealth provider conducts a patient evaluation sufficient to diagnose and treat the patient, the telehealth provider is not required to research the patient's medical history or conduct a physical examination of the patient before using telehealth to provide services to the patient.

(b) A telehealth provider and a patient may be in separate locations when telehealth is used to provide health care services to the patient.

(c) A nonphysician telehealth provider using telehealth and acting within his or her relevant scope of practice is not deemed to be practicing medicine without a license under any provision of law listed in paragraph (1)(f).

(d) A telehealth provider who is authorized to prescribe a controlled substance named or described in Schedules I through V of s. 893.03 may use telehealth to prescribe a controlled

4-00393B-18

2018280

substance, except that telehealth may not be used to prescribe a controlled substance to treat chronic nonmalignant pain as defined in s. 458.3265(1)(a) or to issue a physician certification for marijuana pursuant to s. 381.986. This paragraph does not prohibit a physician from using telehealth to order a controlled substance for an inpatient admitted to a facility licensed under chapter 395 or a patient of a hospice licensed under chapter 400.

(e) By January 1, 2019, the department, in coordination with the applicable boards, shall develop and disseminate educational materials for the licensees listed in paragraph (1)(f) on the use of telehealth modalities to treat patients.

(3) RECORDS.—A telehealth provider shall document in the patient's medical record the health care services rendered using telehealth according to the same standard used for in-person health care services pursuant to ss. 395.3025(4) and 456.057.

(4) CONSENT.—Patients are not required to provide specific authorization for treatment through telehealth, but must authorize treatment that meets the requirements of the applicable practice acts and s. 766.103, and must be allowed to withhold consent for any specific procedure or treatment through telehealth.

Section 4. Section 627.0915, Florida Statutes, is amended to read:

627.0915 Rate filings; workers' compensation, drug-free workplace, and safe employers; consideration of telehealth.—

(1) The office shall approve rating plans for workers' compensation and employer's liability insurance that give specific identifiable consideration in the setting of rates to

4-00393B-18

2018280

employers that either implement a drug-free workplace program pursuant to s. 440.102 and rules adopted under such section or implement a safety program pursuant to provisions of the rating plan or implement both a drug-free workplace program and a safety program. The plans must be actuarially sound and must state the savings anticipated to result from such drug-testing and safety programs.

(2) An insurer offering a rate plan approved under this section shall notify the employer at the time of the initial quote for the policy and at the time of each renewal of the policy of the availability of the premium discount where a drug-free workplace plan is used by the employer pursuant to s. 440.102 and rules adopted under such section. The Financial Services Commission may adopt rules to implement the provisions of this subsection.

(3) An insurer offering a rate plan approved under this section is encouraged to include in the plan services provided through telehealth.

Section 5. This act shall take effect July 1, 2018.



The Florida Senate

Committee Agenda Request

To: Senator Anitere Flores, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: October 12, 2017

I respectfully request that **Senate Bill #280**, relating to Telehealth, be placed on the:

- ☐ committee agenda at your earliest possible convenience.
- ☒ next committee agenda.

A handwritten signature in blue ink that reads "Aaron Bean". The signature is written in a cursive style.

Senator Aaron Bean
Florida Senate, District 4

THE FLORIDA SENATE
APPEARANCE RECORD

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

1/16/18
Meeting Date

280
Bill Number (if applicable)

Topic Telehealth

Amendment Barcode (if applicable)

Name Brewster Benis

Job Title Senior VP

Address 516 N Adams
Street

Phone 224-7173

FLH
City

FL
State

33301
Zip

Email bbenis@airt.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Associated Industries of Florida

Appearing at request of Chair: ☐ Yes ☒ No Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

THE FLORIDA SENATE

APPEARANCE RECORD

1/16/18

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

SB 280

Meeting Date

Bill Number (if applicable)

Topic Telehealth

Amendment Barcode (if applicable)

Name Brittney Hunt

Job Title Policy Director

Address 136 S. Bronough St.

Phone (850) 521-1200

Street

Tallahassee, FL 32301

City

State

Zip

Email bhunt@flchamber.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Chamber of Commerce

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/16/18

Meeting Date

280

Bill Number (if applicable)

Topic

Telehealth

Name

PAUL LAMBERT

Job Title

Address

263 Rosehill Drive North

Street

Tallahassee

City

State

FL

Zip

32312

Phone

850 8597-2696

Email

plambert@paulambertlaw.com

Speaking:

☐

For

☐

Against

☐

Information

Waive Speaking:

☒

In Support

☐

Against

(The Chair will read this information into the record.)

Representing

FLORIDA CHIROPRACTIC ASSOCIATION

Appearing at request of Chair:

☐

Yes

☒

No

Lobbyist registered with Legislature:

☒

Yes

☐

No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

THE FLORIDA SENATE
APPEARANCE RECORD

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

1/16/18

Meeting Date

(B)

280

Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Chris Nuland

Job Title _____

Address Chris Nuland
Street

Phone 904-233-3051

Jacksonville, FL 32204
City State Zip

Email nulandlaw@aol.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Chapter, American College of Physicians

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

APPEARANCE RECORD

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

Jan 16 2018
Meeting Date

SB 280
Bill Number (if applicable)

Topic Telehealth

Name Doane Barker

Job Title Associate State Director

Address 200 W. College Ave
Street

Phone 850-228-6387

Gall FL 32303
City State Zip

Email dobarker@aarpa.org

Speaking: ☒ For ☐ Against ☐ Information

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

Representing AARP Florida

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

APPEARANCE RECORD

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

1/16/18

Meeting Date

SB 280

Bill Number (if applicable)

856092

Amendment Barcode (if applicable)

Topic Telehealth

Name Joni Higgins

Job Title

Address 2985 Drew St

Street

Clearwater

City

State

Zip

Phone 727 579 1220

Email

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against

(The Chair will read this information into the record.)

Representing Bay Care Health System

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

THE FLORIDA SENATE

APPEARANCE RECORD

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

1-16-18

Meeting Date

SB 280

Bill Number (if applicable)

856092

Amendment Barcode (if applicable)

Topic Telehealth Strike all

Name Marti Coley Eubanks

Job Title Director Government Relations

Address 10140 Centurion Pkwy N.

Street

Jacksonville, FL

City

State

Zip

Phone 850-209-0069

Email marti.coley@nemours.org

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Nemours Children's Health System

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

APPEARANCE RECORD

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

1-16-18

Meeting Date

SB 280

Bill Number (if applicable)

856092

Amendment Barcode (if applicable)

Topic Telehealth Strike a 11

Name LAUREN FAISON

Job Title ADMINISTRATOR

Address 1300 Milcosukee Rd
StreetPhone 850-431-4048³Tallahassee, FL 32308
City State Zip

Email lauren.faison@tmh.org

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

Representing TALLAHASSEE MEMORIAL HEALTHCARE

Appearing at request of Chair: ☐ Yes ☒ NoLobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

THE FLORIDA SENATE
APPEARANCE RECORD

110-S63

4:00

AA

1-16-2018

Meeting Date

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

SB 280

Bill Number (if applicable)

#773864

Amendment Barcode (if applicable)

Topic TELEHEALTH

Name STEPHEN R. WINN

Job Title EXECUTIVE DIRECTOR

Address 2544 BLAIRSTONE PINES

Street

TALLAHASSEE

City

FL

State

Zip

Phone 878-7364

Email _____

Speaking: ☒ For ☐ Against ☐ Information

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

Representing FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: CS/SB 396

INTRODUCER: Banking and Insurance Committee; Senator Hukill and others

SUBJECT: Motor Vehicle Insurance Coverage for Windshield Glass

DATE: January 17, 2018

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Billmeier	Knudson	BI	Fav/CS
2.			CM	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 396 provides that an automobile insurance policy may require an inspection of a damaged windshield before the windshield repair or replacement is authorized by the insurer. The inspection must be performed by an adjuster licensed in Florida who is an employee of the insurer within 24 hours after the notice of claim. The insurer may not require an inspection where:

- Windshield damage has demonstrably impacted the structural integrity of the vehicle; or
- Continued use of the vehicle would be a violation of law prohibiting the operation of unsafe vehicles.

II. Present Situation:

Automobile Insurance

Automobile insurance consists of different types of insurance coverages. Personal injury protection or “PIP” coverage is required in Florida to cover injuries to the driver regardless of which party is at fault in an accident. Bodily injury liability coverage pays for damage that the insured causes to other drivers and passengers in an accident. Property damage liability coverage covers damage that the insured causes to the property of another individual. Collision coverage pays for damages to the insured automobile caused by a collision with another automobile. Comprehensive coverage generally pays for damages to the insured automobile, including damage to the windshield, caused by events other than a collision.

The “deductible” is the amount the insured must pay before the insurance company pays any amount. Section 627.7288, F.S. states:

The deductible provisions of any policy of motor vehicle insurance, delivered or issued in this state by an authorized insurer, providing comprehensive coverage or combined additional coverage shall not be applicable to damage to the windshield of any motor vehicle covered under such policy.^{1, 2}

Consumers who purchase the minimum coverage required by law do not have first-party coverage for windshield repair or replacement. Consumers who purchase comprehensive coverage have coverage if a windshield is damaged or broken. Lenders often require borrowers to purchase comprehensive coverage, so consumers who owe money on their vehicles will often qualify for windshield repair or replacement without a deductible.³

Windshield Replacement and Repair

Florida law does not contain insurer claim handling requirements specific to windshield claims. The claims are handled through the insurance contract. Current law does not prohibit an insurer from including an inspection requirement in policy forms.

Many Florida insurance carriers set up a network of providers that will provide windshield repair or replacement services at negotiated rates. If the insured uses one of these “in-network” providers, an insured windshield is repaired or replaced at no cost to the insured. Some glass shops do not participate in the insurer’s provider network. To claim benefits from an insured’s automobile insurer, the “out-of-network” shop often obtains an assignment of benefits from the insured. Florida law allows an insured to assign the benefits of his or her insurance policy to a third party, in this case, the out-of-network glass shop. The assignee glass shop can negotiate with the insurer and file a lawsuit against the insurance company if the two sides do not agree on the claim amount.⁴

Vehicle Safety Requirements

Section 316.2952, F.S., requires vehicles operated on highways to have a windshield. Section 316.610, F.S., prohibits any person driving a vehicle in such an unsafe condition that it endangers persons or property. A police officer is allowed to stop a vehicle if required equipment is not in proper repair.⁵ Depending on the severity of the equipment damage, a police officer may order a vehicle removed from use until repairs are made or give the driver 48 hours to make the repairs.⁶

¹ Language similar to s. 627.7288, F.S., has been part of Florida law since 1979. See Ch. 79-241, Laws of Florida.

² At least seven other states have provisions prohibiting insurers from requiring a deductible for windshield claims or allow insureds to purchase a policy with no deductible for windshield claims.

³ Florida Department of Financial Services, *Automobile Insurance A Toolkit for Consumers*, <https://www.myfloridacfo.com/division/consumers/UnderstandingCoverage/Guides/documents/AutoToolkit.pdf> (last visited December 1, 2017).

⁴ Dale Parker and Brendan McKay, *Florida Auto Glass Claims: A Cracked System*, Trial Advocate Quarterly Fall 2016 (Westlaw Citation: 35 No. 4 Trial Advoc. Q. 20).

⁵ Section 316.610(1), F.S.

⁶ Section 316.610(2), F.S.

Windshield Litigation

According to the Department of Financial Services,⁷ the number of auto glass lawsuits has increased in recent years:

Year Number of Lawsuits

Year	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017 YTD
Auto Glass	397	571	271	709	351	478	1,389	4,331	9,018	12,817	19,695	19,513

Section 627.428, F.S., allows the insured or the assignee to obtain attorney fees from the insurer if the insured or assignee obtains a judgment against an insurer.⁸ The statute does not allow an insurer that prevails in a case involving an insured or assignee to recover attorney fees.⁹ The purpose of the statute is to “discourage contesting of valid claims of insureds against insurance companies . . . and to reimburse successful insureds reasonably for their outlays for attorney’s fees when they are compelled to defend or to sue to enforce their contracts.”¹⁰

Some insurers argue that the increase in litigation is caused by the ability of some vendors to execute an assignment of benefits and recover attorney fees under s. 627.428, F.S. They allege that some vendors are obtaining an assignment of benefits from the insured and inflating the cost of the claim when they bill the insurance company.¹¹ Insurers also believe that many windshield claims brought by assignees are fraudulent.¹² In such cases, the insurer must determine whether to pay what it believes to be an inflated or fraudulent claim or pay its own attorneys to litigate the case and risk having to pay the other side’s attorney fees if it does not prevail.¹³

Some auto glass vendors argue that litigation is necessary because insurers enter into agreements with preferred vendors and will not pay the “prevailing competitive price” for windshield repair or replacement. Instead, some vendors contend, insurers will only pay the price they pay to the preferred vendors and that litigation is necessary to force the insurers to pay the “prevailing competitive price” pursuant to the insurance policy language.¹⁴

⁷ Data provided by the Department of Financial Services (on file with the Senate Committee on Banking and Insurance).

⁸ The Florida Supreme Court has recognized the right of assignees to obtain attorney fees under s. 627.428, F.S. (and its predecessor statute) since at least 1972. *See All Ways Reliable Building Maintenance, Inc. v. Moore*, 261 So.2d 131 (Fla. 1972). The First District Court of Appeal has recognized the right since at least 1961. *See Travelers Insurance Co. v. Tallahassee Bank and Trust Co.*, 133 So.2d 463 (Fla. 1st DCA 1961).

⁹ Insurers can recover attorney fees in some cases by using offers of judgment and proposals for settlements. *See* s. 768.79, F.S., and Fla.R.Civ.P. 1.442.

¹⁰ *Roberts v. Carter*, 350 So.2d 78, 79 (Fla. 1977).

¹¹ One provider offers cash rebates and restaurant gift cards to customers “with qualifying insurance” for windshield repair or replacement. *See* <http://www.auto-glassamerica.com> (last accessed November 29, 2017).

¹² *Government Employees Insurance Co. v. Clear Vision Windshield Repair, L.L.C.*, 2017 WL 1196438 (M.D. Florida March 29, 2017).

¹³ Florida Justice Reform Institute, White Paper: *Restoring Balance in Insurance Litigation* (2015)(on file with the Senate Committee on Banking and Insurance).

¹⁴ *See VIP Auto Glass, Inc. v. Geico General Insurance Co.*, 2017 WL 3712918 (M.D. Florida March 17, 2017) at p. 1. (discussing a class action lawsuit against Geico by VIP Auto Glass).

III. Effect of Proposed Changes:

The bill provides that an automobile insurance policy may require an inspection of a damaged windshield before the windshield repair or replacement is authorized by the insurer. Current law does not prohibit the inclusion of inspection requirements in an insurance policy. This bill would affirmatively allow insurers to require an inspection before authorizing a windshield repair or replacement.

An inspection required by an insurer must be performed by an adjuster licensed by the state and employed by the insurer. Section 626.862, F.S., allows licensed insurance agents to adjust claims without being licensed as an adjuster if authorized to do so by their insurer. This bill would not allow agents to adjust windshield claims. Section 626.856, F.S., allows an adjuster employed by an insurer's "parent" company to adjust claims for that insurer. This bill might require the adjuster to be employed by the actual company and not its corporate parent. The Department of Financial Services suggests that the "vast majority" of insurers have business models which do not comply with this provision of the bill.¹⁵

The bill requires that the inspection be performed within 24 hours after the notice of claim or the insurer's right to inspection is waived.

The bill provides that an inspection may not be required if windshield damage has demonstrably impacted the structural integrity of the vehicle or where continued use of the vehicle would be a violation of s. 316.610, F.S.¹⁶

The effective date is July 1, 2018.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

¹⁵ Email from the Department of Financial Services staff to Committee staff dated January 17, 2018.

¹⁶ Section 316.610, F.S., prohibits any person from driving or moving any vehicle on any highway if the vehicle is in such unsafe condition as to endanger any person or property.

B. Private Sector Impact:

The fiscal impact is not known. It is not known how many additional insurers would implement inspection requirements or what the effect of those requirements might be. In addition, it is not known how many insurers employ licensed adjusters who could conduct inspections.

C. Government Sector Impact:

The Office of Insurance Regulation does not anticipate a fiscal impact.¹⁷

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 627.7288 of the Florida Statutes.

IX. Additional Information:**A. Committee Substitute – Statement of Substantial Changes:**
(Summarizing differences between the Committee Substitute and the prior version of the bill.)**CS by Banking and Insurance on January 16, 2018:**

The CS requires the insurance company to conduct the inspection within 24 hours. The inspection must be performed by an adjuster licensed in Florida who is an employee of the insurer. The insurer may not require an inspection where:

- Windshield damage has demonstrably impacted the structural integrity of the vehicle; or
- Continued use of the vehicle would be a violation of law prohibiting the operation of unsafe vehicles.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

¹⁷ Office of Insurance Regulation, *SB 396 Agency Bill Analysis* (October 17, 2017)(on file with the Senate Committee on Banking and Insurance).



144400

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/16/2018	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete line 24
and insert:
windshield repair or replacement is authorized by the insurer.
An inspection required by an insurer must be performed by an
adjuster licensed in this state who is an employee of the
insured's insurer and must be performed within 24 hours after
the notice of claim unless the inspection will delay the
windshield repair or replacement to the detriment of the



144400

11 insured.
12
13 ===== T I T L E A M E N D M E N T =====
14 And the title is amended as follows:
15 Delete line 8
16 and insert:
17 replacement is authorized by the insurer; requiring
18 that such inspections be performed by certain
19 adjusters, and, except under certain circumstances,
20 within a specified timeframe; providing an



408714

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/16/2018	.	
	.	
	.	
	.	

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

Senate Amendment to Amendment (144400) (with title amendment)

Delete lines 9 - 11

and insert:

notice of the claim, or the right to an inspection is waived.
However, an insurer may not require an inspection in any case
where windshield damage has demonstrably impacted the structural
integrity of the vehicle or where continued use of the vehicle
would be a violation of s. 316.610.



408714

11
12 ===== T I T L E A M E N D M E N T =====
13 And the title is amended as follows:
14 Delete lines 19 - 20
15 and insert:
16 adjusters and within a specified timeframe, or the
17 right to an inspection is waived; prohibiting insurers
18 from requiring inspections under certain
19 circumstances; providing an

By Senator Hukill

14-00443-18

2018396__

A bill to be entitled

An act relating to motor vehicle insurance coverage for windshield glass; amending s. 627.7288, F.S.; authorizing a motor vehicle insurance policy providing comprehensive or combined additional coverage to require an inspection of the damaged windshield of a covered motor vehicle before the windshield repair or replacement is authorized by the insurer; providing an effective date.

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

Section 1. Section 627.7288, Florida Statutes, is amended to read:

627.7288 Comprehensive coverage; ~~deductible not to apply to~~ motor vehicle windshield glass.—

(1) The deductible provisions of any policy of motor vehicle insurance, delivered or issued in this state by an authorized insurer, providing comprehensive coverage or combined additional coverage are ~~shall~~ not be applicable to damage to the windshield of any motor vehicle covered under such policy.

(2) A policy under this section may require an inspection of the damaged windshield of a covered motor vehicle before the windshield repair or replacement is authorized by the insurer.

Section 2. This act shall take effect July 1, 2018.



THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:

Education, *Chair*
Appropriations Subcommittee on the
Environment and Natural Resources, *Vice Chair*
Regulated Industries, *Vice Chair*
Agriculture
Environmental Preservation and Conservation
Health Policy
Transportation

JOINT COMMITTEE:

Joint Committee on Public Counsel Oversight

SENATOR DOROTHY L. HUKILL

14th District

October 26, 2017

The Honorable Anitere Flores
404 Senate Office Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Re: Senate Bill 396 – Motor Vehicle Insurance Coverage for Windshield Glass

Dear Chairwoman Flores:

Senate Bill 396, relating to Motor Vehicle Insurance Coverage for Windshield Glass, has been referred to the Senate Committee on Banking and Insurance. I respectfully request that SB 396 be placed on the committee agenda at your earliest possible convenience.

Should you need any additional information, please do not hesitate to contact my office.

Thank you for your consideration.

Sincerely,

A handwritten signature in blue ink that reads "Dorothy L. Hukill".

Dorothy L. Hukill
State Senator, District 14

Cc: James Knudson, Staff Director, Senate Committee on Banking and Insurance
Sheri Green, Administrative Assistant, Senate Committee on Banking and Insurance

REPLY TO:

- ☐ 209 Dunlawton Avenue, Unit 17, Port Orange, Florida 32127 (386) 304-7630 FAX: (888) 263-3818
- ☐ 434 Delannoy Avenue, Suite 204, Cocoa, Florida 32922 (321) 634-3549
- ☐ 406 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5014

Senate's Website: www.flsenate.gov

JOE NEGRON
President of the Senate

ANITERE FLORES
President Pro Tempore

THE FLORIDA SENATE
APPEARANCE RECORD

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

1/16/18
Meeting Date

B
SB 396
Bill Number (if applicable)

Topic Windshield

Amendment Barcode (if applicable)

Name Brewster Bevis

Job Title Senior VP

Address 516 N Adams
Street

Phone 224-2173

TLH FL 3234
City State Zip

Email bevis@air.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Associated Industries of Florida

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

THE FLORIDA SENATE
APPEARANCE RECORD

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

1/14/18
Meeting Date

3914
Bill Number (if applicable)

Topic Windshield Replacement

Amendment Barcode (if applicable)

Name Cardyn Johnson

Job Title Policy Director

Address 134 S Bronough St
Street

Phone 850-521-1200

Tallahassee FL 32301
City State Zip

Email _____

Speaking: ☐ For ☐ Against ☐ Information

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

Representing FL Chamber of Commerce

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

APPEARANCE RECORD

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

1/16/17

Meeting Date

394

Bill Number (if applicable)

Topic Motor Vehicle Insurance Coverage for Windshield

Name BG Murphy

Job Title Legislative Affairs Director / DFS

Address 200 E. Gaines St.

Street

Tallahassee

Phone 850-413-2890

City

200 E. Gaines St.

State

FL

Zip

32399

Email BGM0415u@gmail.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing CFO Patronis - Department of Financial Services

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

APPEARANCE RECORD

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

1/16/18

Meeting Date

346

Bill Number (if applicable)

Topic Wmashields claims

Name Logan McFadden

Job Title

Address 215 S. Monroes
Street

Phone

City

State

Zip

Email

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Property Casualty Ins. Assoc. of America

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

THE FLORIDA SENATE
APPEARANCE RECORD

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

1.6.17

Meeting Date

396

Bill Number (if applicable)

1424000

Amendment Barcode (if applicable)

Topic auto glass

Name Ashley Kalish

Job Title lobbyist

Address 101 E. Gally Ave

Street

Tallahassee, FL

City

State

Zip

Phone 222-9075

Email akalish@capitol.com

Speaking: ☐ For ☒ Against ☐ Information

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

Representing ATA

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

THE FLORIDA SENATE

APPEARANCE RECORD

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

Meeting Date _____

396
Bill Number (if applicable)

Topic WINDSHIELD GLASS

144400
Amendment Barcode (if applicable)

Name JEFF KORTKAMP

Job Title _____

Address _____

Phone _____

Street

COLLINGSWOOD

FL

City

State

Zip

Email _____

Speaking: ☐ For ☐ Against ☐ Information

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

Representing FLORIDA JUSTICE ASSOC.

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

APPEARANCE RECORD

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

11/16/18

Meeting Date

396

Bill Number (if applicable)

144400

Amendment Barcode (if applicable)

Topic

Auto Glass

Name

Matthew Blair

Job Title

Address

112 E. SERRAVALLO ST., First Floor

Street

TALLAHASSEE

City

State

32301

Zip

Phone

813 521 0172

Email

matt@corcoranfirm.com

Speaking:

☐

For

☐

Against

☒

Information

Waive Speaking:

☐

In Support

☐

Against

(The Chair will read this information into the record.)

Representing

FLORIDA INDEPENDENT GLASS ASSOCIATION

Appearing at request of Chair:

☐

Yes

☒

No

Lobbyist registered with Legislature:

☒

Yes

☐

No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

A

APPEARANCE RECORD

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

1/16/2018

Meeting Date

396

Bill Number (if applicable)

144400

Amendment Barcode (if applicable)

Topic Windshield Coverage

Name JAN GORRIE

Job Title Lobbyist

Address 205 E. Park Ave
Street

Phone 813-334-5288

Tallahassee FL 32031
City State Zip

Email jan@ballardfl.com

Speaking: ☐ For ☒ Against ☐ Information

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

Representing CARCO

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

AA

THE FLORIDA SENATE

APPEARANCE RECORD

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

1.16.17

Meeting Date

396

Bill Number (if applicable)

408714

Amendment Barcode (if applicable)

Topic Auto glass

Name Anthony Kaulich

Job Title Lobbyist

Address 101 E College Ave # 502

Street

Tallahassee, FL

City

State

Zip

Phone 222 9075

Email akaulich@openair.net

Speaking: ☐ For ☒ Against ☐ Information

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

Representing ADA

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/16/18

Meeting Date

396

Bill Number (if applicable)

408714

Amendment Barcode (if applicable)

Topic Auto Glass

Name Leslie Kroeger

Job Title Attorney with Cohen Milstein

Address 2925 POA Blvd

Street

Palm Beach Gardens FL 33410

City

State

Zip

Phone 561-515-1400

Email LKroeger@cohenmilstein.com

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Florida Justice Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: CS/SB 416

INTRODUCER: Banking and Insurance Committee and Senator Thurston

SUBJECT: Governance of Banks and Trust Companies

DATE: January 16, 2018

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	Fav/CS
2.	_____	_____	CM	_____
3.	_____	_____	RC	_____

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 416 amends the Financial Institution Codes to expand the pool of eligible individuals who may qualify to serve as a director, president, or chief executive officer of a new or existing bank or trust company that is subject to regulation by the Office of Financial Regulation (OFR). Further, the bill clarifies and revises the limitations on corporate investments.

For existing and new state-chartered banks and trust companies, the bill extends the lookback period from 3 to 5 years for certain officers and directors to have met the minimum 1 year of direct financial institution experience. Under current law, at least two of the proposed directors, who are not also proposed officers, must have had at least 1 year of direct financial institution experience within 3 years prior to the submission of a bank or trust company application to the OFR. Likewise, for existing state-chartered banks or trust companies, the president, chief executive officer, or any other person with an equivalent rank, must have had at least 1 year of direct experience within the last 3 years.

The bill requires that at least a majority, rather than three-fifths, of the directors of a state-chartered bank or trust company must have resided in this state for at least 1 year preceding their election and must continue their residency in Florida for the duration of their time in office. This change will align the residency requirement for Florida state-chartered banks with the residency requirement for national banks.

Lastly, the bill amends current law in order to clarify an ambiguity in the interpretation of investment limitations relating to corporate obligations or corporate bonds. The bill clarifies that:

- The types of entities for which the limitation on investments in corporations applies are subsidiary corporations and affiliates.
- The limitation on investments in corporations applies to an aggregate of any combination of stocks, obligations, and other securities of subsidiary corporations and affiliates.
- The aggregate of such investments may not exceed 10 percent of the total assets of the bank.

The bill has no fiscal impact on the Office of Financial Regulation.

II. Present Situation:

Regulation of State-Chartered Financial Institutions in Florida

The Office of Financial Regulation (OFR) regulates state-chartered depository and non-depository financial institutions and financial service companies. One of the OFR's primary goals is to provide for and promote the safety and soundness of financial institutions while preserving the integrity of Florida's markets and financial service industries.¹ Florida law provides the OFR with regulatory authority over entities regulated under the Financial Institutions Codes (codes). The codes include:

- Ch. 655, F.S., relating to financial institutions generally;
- Ch. 657, F.S., relating to credit unions;
- Ch. 658, F.S., relating to banks and trust companies;
- Ch. 660, F.S., relating to trust business;
- Ch. 663, F.S., relating to international banking;
- Ch. 665, F.S., relating to associations; and
- Ch. 667, F.S., relating to savings banks.²

Qualifications of Officers and Directors

New or De Novo State-Chartered Bank or Trust Company

Section 658.19, F.S., prescribes the requirements to organize a state-chartered bank or trust company, which includes the submission of financial, business, and biographical information the Financial Services Commission or the OFR may reasonably require for each proposed director, executive officer, and, if applicable, each trust officer. The OFR must approve the application if it finds the proposed bank or trust company meets certain criteria including the qualifications of the proposed officers and directors.³

Section 658.21, F.S., requires that proposed officers and directors meet certain requirements in regards to their background and experience. Proposed officers must have sufficient financial experience, ability, standing, and reputation and the proposed directors have sufficient business experience, ability, standing and reputation to indicate reasonable promise of successful operation. Further, as a condition, none of the proposed officers and directors may not have been convicted of, or pled guilty or nolo contendere to, any violation of s. 655.50, F.S., relating to the

¹ Section 655.001, F.S.

² Section 655.005(1)(k), F.S.

³ Section 658.21, F.S.

control of money laundering and terrorist financing; and ch. 896, F.S., relating to offenses against financial institutions.

At least two of the proposed directors who are not also proposed officers must have had at least 1 year of direct experience as an executive officer, regulator, or director of a financial institution within the 3 years before the application date. However, if the applicant demonstrates that at least one of the proposed directors has very substantial experience as an executive officer, director, or regulator of a financial institution more than 3 years before the date of the application, the office may modify the requirement and allow only one director to have direct financial institution experience within the last 3 years. The proposed president or chief executive officer must have had at least 1 year of direct experience as an executive officer, director, or regulator of a financial institution within the last 3 years.⁴

Existing State-Chartered Bank or Trust Company

A state-chartered bank or trust company must have at least five directors and at least a majority of the directors must be citizens of the United States.⁵ At least three-fifths of the directors must have resided in this state for at least 1 year preceding their election and must continue their residency in Florida for the duration of their time in office.⁶

A state-chartered bank or trust company with total assets of less than \$150 million must have at least one director who is not also an officer of the bank or trust company with at least 1 year of direct experience as an executive officer, regulator, or director of a financial institution within the preceding 3 years.⁷ For a bank or trust company with total assets of more than \$150 million, at least two directors, who are not also officers of the bank or trust company, must have at least 1 year of direct experience as an executive officer, regulator, or director of a financial institution within the last 3 years. The president, chief executive officer, or other person who has equivalent rank or leads the overall operations of a bank or trust company must have at least 1 year of direct experience as an executive officer, director, or regulator of a financial institution within the last 3 years.⁸

Nationally Chartered Bank or Trust Company

The Office of the Comptroller of Currency (Comptroller) has different requirements relating to the directors or officers of a nationally chartered bank or trust company. Every director must be a citizen of the United States. At least a majority of the directors must have resided in the state, territory, or district in which the association is located, or within 100 miles of the location of the office of the association, for at least 1 year immediately preceding their election, and must be residents of such state or within 100-mile territory of the location of the association during their continuance in office. However, the Comptroller has the discretion to waive the requirement of residency, and waive the requirement of citizenship in the case of not more than a minority of the total number of directors.⁹

⁴ Section 658.21(4), F.S.

⁵ Section 658.33, F.S.

⁶ Section 658.33(2), F.S.

⁷ *Id.*

⁸ Section 658.33(5), F.S.

⁹ See 12 U.S.C. s. 72 and 12 C.F.R. s. 5.20.

Permissible Investments

A bank may invest its funds, and a trust company may invest its corporate funds, subject to the limitations of s. 658.67, F.S. Up to 25 percent of the capital accounts of the purchasing bank may be invested in corporate obligations of any one corporation that is not an affiliate or subsidiary of the bank. Further, the codes currently permit up to an aggregate of 10 percent of all the total assets of a bank to be invested in the stock, obligations, or other securities of subsidiary corporations or other corporations or entities. These investment requirements are subject to two exceptions: 1) such investments may not exceed any limitation or prohibition of federal law; and 2) during the first 3 years of existence of a bank, such investments are limited to 5 percent of the total assets.¹⁰ The Financial Services Commission by rule, or the OFR by order, may further limit any type of investment made pursuant to this subsection if it finds that such investment would constitute an unsafe or unsound practice.¹¹ In making this determination, the OFR must consider the size and condition of the financial institution, the gravity of the violation, and the prior conduct of the person or institution involved.¹²

III. Effect of Proposed Changes:

Section 1 amends s. 658.21, F.S., to require that a proposed president or chief executive officer must have at least 1 year of direct experience as an executive officer, regulator, or director of a financial institution within 5 years, rather than 3 years, of the application date for a state chartered bank or trust company.

Further, the bill provides that at least two of the proposed directors who are not also proposed officers must have at least 1 year of direct financial institution experience within the 5 years, rather than 3 years, prior to the application. However, the OFR may require only one director to have such experience if at least one of the proposed directors has very substantial experience as an executive officer, director, or regulator of a financial institution within the last 5 years rather than the last 3 years.

Section 2 amends s. 658.33, F.S., to increase the lookback period within which a president or chief executive officer and a certain number of directors must have 1 year of relevant financial institution experience in order to serve at an existing state-chartered bank or trust company. The bill expands the period to satisfy the required experience from 3 years to 5 years, as follows:

- The president or chief executive officer, or other person who has equivalent rank or leads the overall operations of a bank or trust company must have at least 1 year of direct experience as an executive officer, director, or regulator of a financial institution within the last 5 years.
- For a bank or trust company with total assets of less than \$150 million, at least one director who is not also an officer of the bank or trust company must have at least 1 year of direct experience as an executive officer, regulator, or director of a financial institution within the last 5 years.

¹⁰ Section 658.67(6), F.S.

¹¹ See s. 655.005(1), F.S. An unsafe or unsound practice is any practice or conduct found by the OFR to be contrary to generally accepted standards applicable to a financial institution, or a violation of any prior agreement in writing or order of a state or federal regulatory agency, which practice, conduct, or violation creates the likelihood of loss, insolvency, or dissipation of assets or otherwise prejudices the interest of the financial institution or its depositors or members.

¹² *Id.*

- For a bank or trust company with total assets of more than \$150 million, at least two directors who are not also officers of the bank or trust company must have at least 1 year of direct experience as an executive officer, regulator, or director of a financial institution within the last 5 years.

The bill also requires that at least a majority, rather than three-fifths, of the directors must have resided in Florida for at least 1 year preceding their election and must continue their residency in Florida for the duration of their time in office. This change will align the residency requirement for Florida state-chartered banks with the residency requirement of national banks.

Section 3 amends s. 658.67, F.S., to revise the limitations relating to corporate obligations or corporate bonds. The bill clarifies:

- The types of entities for which the limitation on investments in corporations applies are subsidiary corporations and affiliates.
- The limitation on investments in corporations applies to an aggregate of any combination of stocks, obligations, and other securities of subsidiary corporations and affiliates.
- The aggregate of such investments may not exceed 10 percent of the total assets of the bank.

Section 4 provides the act will take effect July 1, 2018.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill would expand the pool of eligible individuals who may qualify to serve as an officer or director of a proposed or existing state chartered bank or trust company.

C. Government Sector Impact:

The bill has no fiscal impact on the Office of Financial Regulation.¹³

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 658.21, 658.33, and 658.67.

IX. Additional Information:

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

CS by Banking and Insurance on January 16, 2018:

The CS clarifies investment limitations relating to corporate obligations or corporate bonds and provides technical changes.

- B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

¹³ Office of Financial Regulation, *2018 Analysis of SB 416* (Oct. 17, 2017). On file with Banking and Insurance Committee.



945032

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/16/2018	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause
and insert:

Section 1. Subsection (4) of section 658.21, Florida
Statutes, is amended to read:

658.21 Approval of application; findings required.—The
office shall approve the application if it finds that:

(4) The proposed officers have sufficient financial
institution experience, ability, standing, and reputation and



945032

the proposed directors have sufficient business experience, ability, standing, and reputation to indicate reasonable promise of successful operation, and none of the proposed officers or directors has been convicted of, or pled guilty or nolo contendere to, any violation of s. 655.50, relating to the control of money laundering and terrorist financing; chapter 896, relating to offenses related to financial institutions; or similar state or federal law. At least two of the proposed directors who are not also proposed officers must have had at least 1 year of direct experience as an executive officer, regulator, or director of a financial institution within the 5 ~~3~~ years before the date of the application. However, if the applicant demonstrates that at least one of the proposed directors has very substantial experience as an executive officer, director, or regulator of a financial institution more than 5 ~~3~~ years before the date of the application, the office may modify the requirement and allow the applicant to have only one director who has ~~to have~~ direct financial institution experience within the last 5 ~~3~~ years. The proposed president or chief executive officer must have had at least 1 year of direct experience as an executive officer, director, or regulator of a financial institution within the last 5 ~~3~~ years.

Section 2. Subsections (2) and (5) of section 658.33, Florida Statutes, are amended to read:

658.33 Directors, number, qualifications; officers.—

(2) Not less than a majority of the directors must, during their whole term of service, be citizens of the United States, and at least a majority ~~three-fifths~~ of the directors must have resided in this state for at least 1 year preceding their



945032

election and must be residents therein during their continuance in office. In the case of a bank or trust company with total assets of less than \$150 million, at least one, and in the case of a bank or trust company with total assets of \$150 million or more, two of the directors who are not also officers of the bank or trust company must have had at least 1 year of direct experience as an executive officer, regulator, or director of a financial institution within the last 5 ~~3~~ years.

(5) The president, chief executive officer, or any other person, regardless of title, who has equivalent rank or leads the overall operations of a bank or trust company must have had at least 1 year of direct experience as an executive officer, director, or regulator of a financial institution within the last 5 ~~3~~ years. This requirement may be waived by the office after considering the overall experience and expertise of the proposed officer and the condition of the bank or trust company, as reflected in the most recent regulatory examination report and other available data.

Section 3. Subsection (6) of section 658.67, Florida Statutes, is amended to read:

658.67 Investment powers and limitations.—A bank may invest its funds, and a trust company may invest its corporate funds, subject to the following definitions, restrictions, and limitations:

(6) INVESTMENTS IN CORPORATIONS AND OTHER ENTITIES.—Except as limited or prohibited by federal law, Up to an aggregate of ~~10 percent of the total assets of a bank may invest be invested~~ in the stock, obligations, and ~~or~~ other securities of subsidiary corporations and affiliates. The aggregate of such investments



945032

may not exceed 10 percent of the total assets of the bank. ~~or other corporations or entities, except as limited or prohibited by federal law, and except that~~ During the first 3 years of existence of a bank, such investments are limited to 5 percent of the total assets of the bank. The commission by rule, or the office by order, may further limit any type of investment made pursuant to this subsection if it finds that such investment would constitute an unsafe or unsound practice.

Section 4. This act shall take effect July 1, 2018.

===== T I T L E A M E N D M E N T =====

And the title is amended as follows:

Delete everything before the enacting clause
and insert:

A bill to be entitled

An act relating to governance of banks and trust companies; amending s. 658.21, F.S.; revising requirements relating to the financial institution experience of certain proposed directors and officers of a proposed bank or trust company; amending s. 658.33, F.S.; revising the residency requirement for certain directors of a bank or trust company; revising requirements relating to the financial institution experience of certain officers of a bank or trust company; amending s. 658.67, F.S.; revising instances during which a bank may not own certain stock, obligations, and other securities; providing an effective date.

By Senator Thurston

33-00614-18

2018416__

A bill to be entitled

An act relating to governance of banks and trust companies; amending s. 658.21, F.S.; revising requirements relating to the financial institution experience of certain proposed directors and officers of a proposed bank or trust company; amending s. 658.33, F.S.; revising applicability of the residency requirement for directors of a bank or trust company; revising requirements relating to the financial institution experience of certain officers of a bank or trust company; amending s. 658.67, F.S.; revising a limitation on investments by banks in corporations; providing an effective date.

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

Section 1. Subsection (4) of section 658.21, Florida Statutes, is amended to read:

658.21 Approval of application; findings required.—The office shall approve the application if it finds that:

(4) The proposed officers have sufficient financial institution experience, ability, standing, and reputation and the proposed directors have sufficient business experience, ability, standing, and reputation to indicate reasonable promise of successful operation, and none of the proposed officers or directors has been convicted of, or pled guilty or nolo contendere to, any violation of s. 655.50, relating to the control of money laundering and terrorist financing; chapter 896, relating to offenses related to financial institutions; or

Page 1 of 4

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

33-00614-18

2018416__

similar state or federal law. At least two of the proposed directors who are not also proposed officers must have had at least 1 year direct experience as an executive officer, regulator, or director of a financial institution within the 5 ~~3~~ years before the date of the application. However, if the applicant demonstrates that at least one of the proposed directors has very substantial experience as an executive officer, director, or regulator of a financial institution more than 5 ~~3~~ years before the date of the application, the office may modify the requirement and allow only one director to have direct financial institution experience within the last 5 ~~3~~ years. The proposed president or chief executive officer must have had at least 1 year of direct experience as an executive officer, director, or regulator of a financial institution within the last 5 ~~3~~ years.

Section 2. Subsections (2) and (5) of section 658.33, Florida Statutes, are amended to read:

658.33 Directors, number, qualifications; officers.—

(2) Not less than a majority of the directors must, during their whole term of service, be citizens of the United States, and at least a majority ~~three-fifths~~ of the directors must have resided in this state for at least 1 year preceding their election and must be residents therein during their continuance in office. In the case of a bank or trust company with total assets of less than \$150 million, at least one, and in the case of a bank or trust company with total assets of \$150 million or more, two of the directors who are not also officers of the bank or trust company must have had at least 1 year of direct experience as an executive officer, regulator, or director of a

Page 2 of 4

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

33-00614-18

2018416__

financial institution within the last 5 3 years.

(5) The president, chief executive officer, or any other person, regardless of title, who has equivalent rank or leads the overall operations of a bank or trust company must have had at least 1 year of direct experience as an executive officer, director, or regulator of a financial institution within the last 5 3 years. This requirement may be waived by the office after considering the overall experience and expertise of the proposed officer and the condition of the bank or trust company, as reflected in the most recent regulatory examination report and other available data.

Section 3. Subsection (6) of section 658.67, Florida Statutes, is amended to read:

658.67 Investment powers and limitations.—A bank may invest its funds, and a trust company may invest its corporate funds, subject to the following definitions, restrictions, and limitations:

(6) INVESTMENTS IN CORPORATIONS.—~~Up to an aggregate of 10 percent of the total assets of~~ A bank may not own ~~be invested in~~ the stock, obligations, or other securities issued by an individual corporation or entity which have an aggregate par value greater than 10 percent of the total assets of such bank ~~of subsidiary corporations or other corporations or entities,~~ except as limited or prohibited by federal law, and except that during the first 3 years of existence of a bank, such investments are limited to 5 percent of the total assets. The commission by rule, or the office by order, may further limit any type of investment made pursuant to this subsection if it finds that such investment would constitute an unsafe or unsound

Page 3 of 4

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

33-00614-18

2018416__

practice.

Section 4. This act shall take effect July 1, 2018.

Page 4 of 4

CODING: Words ~~stricken~~ are deletions; words underlined are additions.



The Florida Senate

Committee Agenda Request

To: Senator Anitere Flores, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: November 3, 2017

I respectfully request that **Senate Bill #416**, relating to Governance of Banks and Trust Companies, be placed on the:

- ☐ committee agenda at your earliest possible convenience.
- ☒ next committee agenda.

A handwritten signature in black ink, appearing to be "Perry E. Thurston, Jr.", written over a horizontal line.

Senator Perry E. Thurston, Jr.
Florida Senate, District 33



THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:

Appropriations Subcommittee on Transportation,
Tourism, and Economic Development
Banking and Insurance
Education
Judiciary
Regulated Industries
Rules

JOINT COMMITTEE:

Joint Legislative Auditing Committee

SENATOR PERRY E. THURSTON, JR.

Democratic Caucus Rules Chair
33rd District

November 3, 2017

The Honorable Anitere Flores
Florida Senate
404 Senate Office Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Senator Flores,

I am writing this letter because my bill, SB 416: Governance of Banks and Trust Companies has been referred to the Senate Banking and Insurance Committee. I am respectfully requesting that you place this bill on your committee's calendar for the next committee agenda.

Thank you for your consideration. Please contact me if you have any questions.

Respectfully,

A handwritten signature in cursive script that reads "Perry E. Thurston, Jr." with a stylized flourish at the end.

Perry E. Thurston, Jr.
Florida Senate, District 33

CC: Vice Chair Greg Steube

REPLY TO:

- ☐ 2151 NW 6th Street, Fort Lauderdale, Florida 33311 (954) 321-2705 FAX: (888) 284-6086
- ☐ 208 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5033

Senate's Website: www.flsenate.gov

JOE NEGRON
President of the Senate

ANITERE FLORES
President Pro Tempore

THE FLORIDA SENATE
APPEARANCE RECORD

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

1/16/2018
Meeting Date

416
Bill Number (if applicable)

Topic Governance of Banks + Trust Companies Amendment Barcode (if applicable)

Name Katie Crofoot

Job Title Asst. VP of Gov't Affairs

Address 1001 Thomasville Rd.
Street

Phone 850.224.2265

Tallahassee FL 32303
City State Zip

Email kcrofoot@floridabankers.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Bankers Association

Appearing at request of Chair: ☐ Yes ☒ No Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

THE FLORIDA SENATE
APPEARANCE RECORD

1-16-2017

Meeting Date

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

SB 416

Bill Number (if applicable)

Topic SB 416 - Governance of Banks and Trust Companies

Amendment Barcode (if applicable)

Name Jamie Mongiovi

Job Title Legislative Affairs Director - OFR

Address 200 East Gaines Street

Phone 850-410-9687

Street

Tallahassee

FL

32399

Email jamie.mongiovi@flofr.com

City

State

Zip

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Office of Financial Regulation (OFR)

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S 001 (10/14/14)

THE FLORIDA SENATE
APPEARANCE RECORD

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

1/16/2018

Meeting Date

416

Bill Number (if applicable)

945032

Amendment Barcode (if applicable)

Topic Governance of Banks + Trust Companies

Name Katie Crofoot

Job Title Asst. VP of Gov't Affairs

Address 1001 Thomasville Rd.

Street

Tallahassee

City

FL

State

32303

Zip

Phone 850.224.2265

Email Kcrofoot@floridabankers.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Bankers Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: CS/SB 438

INTRODUCER: Banking and Insurance Committee and Senator Lee

SUBJECT: Continuing Care Contracts

DATE: January 22, 2018

REVISED: _____

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Johnson	Knudson	BI	Fav/CS
2. _____	_____	AGG	_____
3. _____	_____	AP	_____
4. _____	_____	RC	_____

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 438 revises provisions within the Insurance Code governing continuing care retirement communities (CCRC) or providers, which are regulated by the Office of Insurance Regulation (OIR). Generally, the CCRCs provide lifelong housing, household assistance, and nursing care in exchange for a significant entrance fee and monthly fees. The CCRCs appeal to older Americans because they offer an independent lifestyle for as long as possible but also provide the reassurance that, as residents age or become sick or frail, they will receive the care they need. There are currently 70 licensed continuing care retirement communities in Florida.¹ About 30,000 residents live in CCRCs.²

Many of the financial accountability, solvency, and consumer protection provisions of the bill are in response to the allegations of violations of the Insurance Code by University Village, a CCRC located in Tampa, Florida. According to the OIR, unapproved owners and managers failed to cooperate with examination by the OIR and to comply with other provisions of state laws. In March 2015, within weeks of beginning an examination, the OIR and the Department of Financial Services (DFS) began the process to place University Village into receivership. The DFS has not been appointed as receiver due to ongoing litigation and the preemption of state

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

² *Id.*

authority by federal bankruptcy filings. Residents, former residents, and estates of residents are owed over \$9 million in unpaid refunds.

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

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

If the provider's performance fails to meet certain requirements, the provider is deemed to be experiencing a regulatory action level event and must submit a corrective action to the OIR. The OIR must examine the provider and issue a corrective order specifying any corrective actions that the OIR deems necessary. Effective July 1, 2019, a provider is considered impaired if it does not meet the minimum liquid reserves requirements or debt service coverage ratios, as applicable. Under current law, the intervention framework in ch. 651, F.S., is triggered after a provider becomes insolvent.

Protections and Transparency for Residents. The bill requires the provider to make additional information, notices, and reports available to the residents or residents' council. These will help residents and prospective residents to remain apprised of the status and stability of the provider and to take action to protect their interests.

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

The bill provides the OIR with additional authority to approve or disapprove management. To prevent actions that would be detrimental of the interests of the residents, the bill would also allow the OIR to revoke, suspend, or take other administrative action in the event a CCRC does not remove a manager in a timely manner by the CCRC.

Regulatory Oversight. The bill clarifies the duty of a provider to respond to written correspondence from the OIR. Further, the section provides that the OIR has standing to petition a circuit court for mandatory injunctive relief to compel access to and require a provider to produce requested records. The bill provides that, if a facility or provider relies on a contractual or financial relationship with a parent, subsidiary, or affiliate in order to demonstrate that the financial condition of the provider or facility complies with ch. 651, F.S., the OIR would be authorized to examine these entities, too. The books and records of affiliates often reflect on the financial state of the provider and may be relevant to the ability of the CCRC to provide the care promised to residents. In the University Village situation, the CCRC refused to produce records upon request and the OIR was challenged on whether or not the Office had authority to obtain books and records of affiliates.

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

II. Present Situation:

Continuing Care Retirement Communities (CCRC)

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

Regulatory oversight responsibility of CCRCs in Florida is shared primarily between the Agency for Health Care Administration (agency) and the OIR.⁶ The OIR regulates CCRC providers⁷ as specialty insurers. The agency regulates aspects of CCRCs related to the provision of health care, such as nursing facilities, assisted living facilities, home health agencies, quality of care, and medical facilities.⁸

Oversight by the Office of Insurance Regulation

Certificate of Authority

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

In order to operate a CCRC in Florida, a provider must obtain from the OIR a COA predicated upon first receiving a provisional certificate of authority.¹¹ The application process involves submitting various financial statements and information, and expectations of the financial condition of the project, and copies of contracts.¹² Further, the applicant must provide evidence

³ Section 651.011(2), F.S.

⁴ Sections 651.057 and 651.118, F.S.

⁵ AARP, *About Continuing Care Retirement Communities*, available at http://www.aarp.org/relationships/caregiving-resource-center/info-09-2010/ho_continuing_care_retirement_communities.html (last viewed Jan. 7, 2018).

⁶ Chapter 651, F.S.

⁷ Section 651.011(12), F.S., a provider means an owner or operator.

⁸ Agency for Health Care Administration reports, available at <http://www.floridahealthfinder.gov/reports-guides/nursinghomesfl.aspx> (last viewed Jan. 7, 2018) and s. 651.118, F.S.

⁹ See ss. 651.021, 651.22, and 651.023, F.S.

¹⁰ Section 651.028, F.S.

¹¹ Section 651.022, F.S.

¹² See ss. 651.021-651.023, F.S.

that the applicant is reputable and of responsible character.¹³ A certificate of authority will be issued once a provider meets the requirements prescribed in s. 651.023, F.S.¹⁴

Continuing Care Contracts

Continuing care services are governed by a contract between the facility and the resident of a CCRC. In Florida, continuing care contracts are considered an insurance product and are reviewed and approved by the OIR.¹⁵ A CCRC enters into contracts with seniors (residents) to provide housing and medical care in exchange for an entrance fee and monthly fees. Entrance fees are a significant commitment by the resident as entrance fees range from around \$100,000 to over \$1 million. The CCRCs offer different types of contracts that provide for varying amounts of monthly fees and levels of healthcare discounts.

All CCRC contracts provide for a refund of a declining portion of the entrance fee if the contract is cancelled for reasons other than the death of the resident, during the first 4 years of occupancy by the resident, in the CCRC.¹⁶ However, many contracts exceed this requirement and contain minimum refund provisions that guarantee a refund of a specified portion (typically 50 to 90 percent) of the entrance fee upon the death of the resident or termination of the contract regardless of the length of occupancy by the resident.¹⁷

Financial Requirements/Solvency

The CCRCs are required to file an annual report with the OIR, which includes an audited financial report, and other detailed financial information, such as a listing of assets maintained in the liquid reserve required under s. 651.035, F.S., and information about fees required of residents.¹⁸ Section 651.033, F.S., prescribes requirements relating to the establishment and maintenance of escrow accounts. Providers are required to maintain a minimum liquid reserve, as applicable, as prescribed in s. 651.035, F.S.

Rights of Residents in a Continuing Care Retirement Community

The OIR is also authorized to discipline a facility for violations of residents' rights.¹⁹ These rights include: a right to live in a safe and decent living environment, free from abuse and neglect; freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community; and present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without restraint, interference, coercion, discrimination, or reprisal.²⁰

¹³ Section 651.022(2)(c), F.S.

¹⁴ Section 651.023(4)(a), F.S.

¹⁵ Section 651.055(1), F.S.

¹⁶ Section 651.055, F.S.

¹⁷ See Office of Insurance Regulation, *Analysis of SB 438* (Oct. 11, 2017) (on file with the Senate Committee on Banking and Insurance).

¹⁸ Section 651.026, F.S.

¹⁹ Section 651.083, F.S.

²⁰ *Id.*

Each CCRC must establish a resident's council to provide a forum for residents' input on issues that affect the general residential quality of life, such as the facility's financial trends, and problems, as well as proposed changes in policies, programs, and services.²¹ The CCRCs are required to maintain and make available certain public information and records.²²

OIR Enforcement Authority

If a provider fails to meet the requirements of ch. 651, F.S., relating to a provisional certificate of authority or a certificate of authority, the OIR must notify the provider of any deficiencies and require the provider to make corrective action within a period determined by the OIR. If the provider does not correct the deficiencies by the expiration of such time required by the OIR, the OIR may initiate delinquency proceedings as provided in s. 651.114, F.S., or seek other relief provided under ch. 651, F.S. The OIR may deny, suspend, or revoke the provisional certificate of authority or the certificate of authority of any applicant or provider **for grounds specified in s. 651.106, F.S.**

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

Department of Financial Services

The Department of Financial Services (DFS) may become involved with a resident after a CCRC contractual agreement has been signed by both parties or during a mediation or arbitration process.²³ Typically, residents will contact the Division of Consumer Services of the Department of Financial Services, which receives and resolves complaints involving products and entities regulated by OIR or DFS.²⁴

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

III. Effect of Proposed Changes:

Section 1 amends s. 651.011, F.S., to create definitions of the following terms: actuarial opinion, actuarial study, actuary, corrective order, days cash on hand, debt service coverage ratio,

²¹ Section 651.081, F.S.

²² Section 651.091, F.S.

²³ See Rules 69O-193.062 and 69O-193.063, F.A.C.

²⁴ Section 624.307, F.S.

impaired, manager or management company, obligated group, occupancy, and regulatory action level event. The term, “impaired,” means any of the following has occurred:

- A provider has failed to maintain its minimum liquid reserve as required in s. 651.035, F.S., unless the provider has received prior written approval from the office for a withdrawal pursuant to s. 651.035(6), F.S., and is compliant with the approved payment schedule; or
- Beginning July 1, 2019:
 - For a provider with mortgage financing from a third-party lender or public bond issue, the provider’s debt service coverage ratio is less than 1.00:1 and the provider’s days cash on hand is less than 90; or
 - For a provider without mortgage financing from a third-party lender or public bond issue, the provider’s days cash on hand is less than 90.

Solvency/Financial Accountability

Sections 12 and 13 amend ss. 651.026 and 651.0261, F.S., respectively, to revise financial reporting requirements. Section 12 provides that the annual report submitted to the OIR must include the reporting of the management’s calculation of the provider’s debt service coverage ratio and days cash on hand for the current reporting period, and an opinion from an independent certified public accountant of the management’s calculations. The OIR is required to publish an annual industry benchmarking report that contains specified information about the industry’s performance.

Section 13 codifies the current discretionary monthly financial reporting rule²⁵ and revises the quarterly financial reporting requirements. The section provides the conditions that would trigger a monthly financial reporting to the OIR. The OIR may waive the quarterly reporting requirements if certain conditions are met. Further, the section requires providers to submit a detailed listing of assets in the minimum liquid reserve with the quarterly and monthly unaudited financial statement filings, if applicable, which will enable the OIR to determine whether the provider is impaired and to take action to assist providers who may fall below the impairment threshold.

Section 14 amends s. 651.028, F.S., relating to waivers of ch. 631, F.S., requirements. The section provides that if a provider or obligated group has obtained an investment grade credit rating from Moody’s Investors Services, Standard & Poor’s, or Fitch Ratings, the OIR may waive any requirements of ch. 631, F.S., if the OIR finds that such waivers are not inconsistent with the protections intended by this chapter. Currently, the OIR may waive ch. 631, F.S., requirements if a provider is accredited.

Section 15 amends s. 651.033, F.S., to clarify the terms and conditions relating to an escrow account and the duties of escrow agents. The section provides that an escrow agent must receive the OIR’s prior approval before releasing escrowed funds with some exceptions. According to the OIR, these changes are based on conversations with escrow agents who expressed confusion over their statutory responsibilities because some of the requirements are beyond those customarily undertaken by escrow agents. The section also clarifies permissible investments

²⁵ Rule 69O-193.005, F.A.C.

(e.g., cash, cash equivalents, mutual funds, equities, or investment grade bonds) of escrowed funds and removes references to part II of ch. 625, F.S.

Section 16 creates s. 651.034, F.S., to establish a financial and operating framework of required actions if a regulatory action level event or impairment occurs. A regulatory action level event occurs when a provider fails to meet minimum requirements of two of the three following key indicators: occupancy rate, days cash on hand, and debt service coverage ratios. If the provider is a member of an obligated group with an investment grade credit rating, the indicators of the obligated group may be substituted. Once a regulatory action level event is triggered, the OIR is required to examine the provider, review the provider's corrective action plan, and issue a corrective order specifying any corrective actions that the OIR deems necessary. Further, this section details the information the provider must submit to the OIR if a regulatory action level event occurs, which would include the submission of a corrective action plan within 30 days after the regulatory action level event. The OIR must approve or disapprove the corrective plan within 15 days. If an impairment occurs, OIR must take action, which could include "any remedy available under ch. 631, F.S." An impairment is sufficient grounds for the DFS to be appointed as receiver, as provided in ch. 631, F.S. The section provides that the OIR may exempt a provider from provisions relating to the regulatory action level event and impairment if certain conditions are met.

Section 17 amends s. 651.035, F.S., relating to the minimum liquid reserve requirements and reporting. Each facility must file annually with the OIR a calculation of the minimum liquid reserve along with the annual report. The section allows a provider to withdraw funds held in escrow without the approval of the OIR if the amount in escrow exceeds the requirements of this section and the withdrawal will not affect compliance with this section. For all other proposed withdrawals, the provider must file information documenting the necessity of the withdrawal. Within 30 days after the file is deemed complete, the OIR must notify the provider of its approval or disapproval of the withdrawal request. The section also requires providers that do not have a mortgage loan or other financing on the facility, to deposit monthly in escrow one-twelfth of their annual property tax liability. This change modifies the current requirement that providers hold funds equivalent to one year's property taxes in escrow as a reserve. The section authorizes the OIR to require the transfer of up to 100 percent of the funds held in the minimum liquid reserve to the custody of the Bureau of Collateral Management of the Department of Financial Services if the OIR finds that the provider is impaired or insolvent in order to ensure the safety of those assets.

Section 27 amends s. 651.114, F.S., relating to delinquency proceedings and remedial rights. A provider must develop a plan for obtaining compliance or solvency within 30 days after a request from the advisory council or the office. The OIR or advisory council is required to respond within 30 days after receipt of a plan. If the financial conditions of the provider is impaired or the provider fails to submit a plan or submits a plan that is insufficient to correct the condition, the OIR may specify a plan. However, the section clarifies that the availability of remedial rights will not delay or prevent OIR from taking regulatory measures it deems necessary.

The section requires a provider to give residents a written notice of a delinquency proceeding under ch. 631, F.S., within 3 business days of initiation. If a ch. 631, F.S., show cause order is issued, the provider must respond within 20 days after service, but no less than 15 days prior to

the hearing. Any hearing must be held within 60 days after the order to show cause. A hearing to determine whether cause exists for DFS to be appointed a receiver must be commenced within 60 days after an order directing a provider to show cause. According to the OIR, University Village successfully delayed receivership proceedings by asserting that the OIR was prohibited from further action, although a court ultimately rejected the assertion. Further, the section provides that, notwithstanding s. 631.011, F.S., impairment of a provider, for purposes of s. 631.051, F.S., is defined according to the term, “impaired” in s. 651.011, F.S.

Regulatory Oversight

Section 3 amends s. 651.013, F.S., to expand the scope of laws applicable to CCRCs. Sections 624.307, 624.308, 624.310, 624.3102, 624.311, 624.312, and 624.318, F.S., are added. These provisions provide the OIR with additional authority to take enforcement authority against licensed entities, affiliates, and unlicensed entities subject to OIR’s regulation. Further, these provisions specify that CCRCs must appoint the Chief Financial Officer for service of process; clarify the role of DFS Division of Consumer Services in resolving consumer complaints; specify requirements for the retention of records by the OIR; provide immunity from civil liability for persons providing the DFS, FSC, or the OIR with information about the condition of an insurer and clarify the authority of the OIR in regards to examinations and investigations. Section 624.318, F.S., which applies generally to insurers, provides that it is the duty of every person being examined, and its officers, attorneys, employees, agents, and representatives, to “make freely available” to the OIR the accounts, records, documents during an examination or investigation. This section also specifies, “any individual who willfully obstructs the DFS, the OIR, or the examiner in the examinations or investigations authorized by this part is guilty of a misdemeanor.” This proposal directly ties to problems the OIR encountered with University Village, which refused to produce records upon request. Finally, s. 624.312, F.S., provides that reproductions and certified copies of records are admissible as evidence. These requirements are consistent with the oversight of other licensees and consumer complaint handling subject to the Insurance Code.

Sections 5 and 7 amend ss. 651.021 and 651.022, F.S., respectively, and **Section 6** creates s. 651.0215, F.S. These sections relate to the certificate of authority and the provisional certificate of authority process.

Section 6 allows an applicant to qualify for a certificate of authority without first obtaining a provisional certificate of authority if certain conditions are met. These requirements include:

- Placement of all reservation deposits and entrance fees in escrow and not pledging initial entrance fees for construction or purchase of the facility or a security for long-term financing.
- Compliance with the requirement of s. 651.022(2), F.S.
- Submission of a feasibility study, financial forecasts or projections, an audited financial report, and quarterly unaudited financial reports.
- Evidence of compliance with lenders’ conditions.
- Documentation evidencing that aggregate amount of entrance fee received by or pledged by the applicant and other specified sources equal at 100 percent of the aggregate cost of constructing, acquiring, equipping, and furnishing the facility plus 100 percent of the anticipated losses of the facility.
- Evidence that the applicant will meet minimum liquid requirements.

Such other reasonable data and information requested by the OIR.

Section 7 clarifies that an applicant must disclose material changes that occur while a provisional certificate of authority application is pending before the OIR, which is consistent with other requirements in the Insurance Code. **Section 5** moves provisions relating to expansion to Section 11.

Section 8 amends s. 651.023, F.S., relating to the requirements for a certificate of authority application. After issuance of a provisional certificate of authority, the OIR will issue the holder a certificate of authority if the holder provides certain information. For example, an applicant must submit a feasibility study that contains specified information, such as information evidencing commitments had been made for construction financing and long-term financing or a documented plan acceptable to the OIR. Further, audited financial reports are required. The bill clarifies the deadlines for the OIR's approval or denial of completed applications.

The section provides that a certificate of authority may not be issued until documentation is submitted to the OIR evidencing the project has a minimum of 50 percent of the units reserved for which the provider is charging an entrance fee. In order for a unit to be considered reserved, the provider must collect a minimum deposit of the lesser of \$40,000 or 10 percent of then-current entrance fee for that unit, and may assess a forfeiture penalty of 2 percent of the entrance fee due to termination of the reservation contract after 30 days for any reason other than death or serious illness of the resident, the failure of the provider to meet obligations under the reservation contract, or other circumstances beyond the control of the resident.

Section 9 amends s. 651.024, F.S., relating to acquisitions, to clarify which filing or application for acquisition statutory provision applies to each type of transaction, including the new, consolidated provisions of s. 651.0245, F.S. The section clarifies that the assumption of the role of a general partner of a CCRC or the assumption of ownership, or possession of, or control over, 10 percent or more of a provider's assets requires an acquisition filing. However, this type of acquisition would not be subject to the filing requirements pursuant to s. 651.022, s. 651.023, or s. 651.0245, F.S.

According to the OIR, University Village is a limited partnership structure and in early 2014 there was a change in the limited partners. The OIR's position, which requires a person acquiring the general partnership in a CCRC to file an acquisition application, was upheld in litigation with IHM Healthcare, LLC, which was denied approval to acquire the general partnership of University Village. Codifying the ruling in statute will make this requirement clear to those seeking to acquire partnership interests in the future.

A person who seeks to acquire and become the provider for a facility would be subject to s. 651.0245, F.S., and would not be required to make filings pursuant to ss. 651.4615, 651.022, and 651.023, F.S. The section provides that a person may rebut a presumption of control by filing a disclaimer of control form with the OIR. The federal Securities and Exchange Commission (SEC) Schedule 13G form may be filed in lieu of a disclaimer of control form. This SEC filing is used to report a party's ownership of stock in a company. Insurers are able to use this filing, and some CCRCs have requested that the OIR accept such filings from them.

Section 10 creates s. 651.0245, F.S., to establish an application for the simultaneous acquisition of a facility and issuance of a certificate of authority. The section provides that a person must obtain the OIR's prior approval before acquiring a facility operating under an existing COA and engaging in the business of continuing care. Under current law, if a person applies to acquire an existing facility and become the provider, they must submit an acquisition application, a provisional certificate of authority application, and a certificate of authority application. This section streamlines the application process by creating a single application.

Section 11 creates s. 651.0246, F.S., relating to expansions, to clarify the requirements and approval process. The section establishes requirements for an expansion of a facility equivalent to the addition of at least 20 percent of the existing units or 20 percent more continuing care at-home contracts. Such expansion applications will require the submission of feasibility study to the OIR. The section prescribes the factors OIR must consider in deciding whether to approve the application. It also requires 75 percent of the initial entrance fees/reservation deposits for continuing care contracts, and 50 percent of the moneys paid for initial fees for continuing care at-home contracts be placed in escrow or on deposit with DFS. Up to 25 percent of these funds may be used for construction or financing. The escrow funds may be released once certain conditions are met. Only the provider, escrow agent, and OIR have standing under ch. 120, F.S., to seek redress regarding OIR's decision regarding the release of escrow funds. The OIR has 90 days to review and act upon complete expansion applications. If a provider has exceeded the current statewide median for certain indicators, the provider is automatically granted authority to expand the total number of existing units by up to 35 percent upon submission of specified information and an attestation to the OIR.

Section 18 creates s. 651.043, F.S., relating to changes in management. This section creates criteria for the OIR to use in determining whether management meets minimum qualification standards and allows for the disapproval and removal of unqualified management. This section requires management contracts be in writing, and requires providers to file notices of a change in management within 10 days of the appointment of new management. The OIR must approve or disapprove the filing within 15 days after the filing is deemed complete. Disapproved management must be removed within 30 days after receipt of the OIR's notice. Currently, the OIR does not have authority to disapprove unaffiliated management except by taking action against the certificate of authority (COA) of the provider.

Effective July 1, 2018, management contracts must be in writing. Currently, Rule 690-193.002(13), F.A.C., specifies that a manager or management company agrees to administer the day-to-day activities of a facility pursuant to a written contract with the provider. However, the rule does not address situations where a manager or management company does not have a written contract with the provider. This change closes a loophole that has allowed management serving under an oral contract to evade regulation by the OIR.

Section 19 amends s. 651.051, F.S., to clarify the requirements relating to the maintenance of records and assets. The section provides that the records and assets of a provider must be maintained in Florida, or, if the provider's corporate office is located in another state, they must be electronically stored in a manner that will ensure the records are accessible to the OIR. In the University Village case, documents and records were created and maintained outside of the state and the OIR was not able to gain access to them.

Section 23 amends s. 651.105, F.S., relating to examinations by the OIR. The section requires a provider to respond to written correspondence from the OIR. Further, the section provides that the OIR has standing to petition a circuit court for mandatory injunctive relief to compel access to and require a provider to produce requested records. Unless a provider or facility is impaired or subject to a regulatory level event, any parent, subsidiary, or affiliate is not subject to examination by the OIR as part of a routine examination. However, an exception is provided if a facility or provider relies on a contractual or financial relationship with a parent, subsidiary, or affiliate in order to demonstrate that the financial condition of the provider or facility is in compliance with ch. 651, F.S. The books and records of affiliates often reflect on the financial state of the provider and may be relevant to the ability of the CCRC to provide the care promised to residents. In the University Village situation, the OIR was challenged on whether or not the Office had authority to obtain books and records of affiliates.

Section 24 amends s. 651.106, F.S., to provide additional grounds for the OIR to refuse, suspend, or revoke a COA. The section provides that the OIR may deny an application, suspend, or revoke the provisional certificate of authority or certificate of authority if the provider is impaired or the owners, managers, or controlling persons are not reputable or lack sufficient management expertise or experience to operate a CCRC. Other grounds are delineated.

Section 25 creates s. 651.1065, F.S., relating to soliciting or accepting new contracts by impaired or insolvent facilities or providers. This section would prohibit an impaired or insolvent provider from soliciting or accepting new contracts after the proprietor, general partner, its member, officer, director, trustee, or manager knew, or reasonably should have known, that the CCRC is impaired or insolvent, even if a delinquency hearing had not been initiated. According to the OIR, this provision would help to protect potential residents who may be considering investing substantial funds into the purchase of a CCRC contract. The OIR would have discretion to allow the issuance of new contracts where safeguards are adequate unless the facility had declared bankruptcy. The provision provides that a violation of this section is a felony of the third degree, which is consistent with regulations for other insurance entities.

Section 28 creates s. 651.1141, F.S., to clarify that certain statutory violations are an immediate danger to the public health, safety, or welfare, which would authorize the OIR to issue an immediate final order to cease and desist. These violations are:

- Installation of a general partner of a provider or assumption of ownership or possession or control of 10 percent or more of a provider's assets in violation of s. 651.024, F.S., or s. 651.0245, F.S.;
- The removal or commitment of 10 percent or more for the required minimum liquid reserve funds in violation of s. 651.035, F.S.; or
- The assumption of control over a facility's operations in violation of s. 651.043, F.S., has occurred.

This section will allow the OIR to take more expedited action to protect the assets of the provider and the significant investments of the residents.

Section 30 amends s. 651.125, F.S., relating to criminal penalties and injunctive relief, to clarify that any person who assists in entering into, maintaining, or performing any continuing care or

continuing care at-home contract subject to ch. 651, F.S., without a valid provisional certificate of authority or certificate of authority commits a felony of the third degree.

Increased Transparency and Protections for Residents

Section 4 amends s. 651.019, F.S., provisions relating to CCRC financing. A provider must notify the residents' council of any new financing or refinancing at least 30 days before the closing date of the transaction. This will allow residents to object to financing transactions that concern them. Under current law, the residents' council receives notice of all financing documents filed with the OIR. Such documents must be submitted to the OIR within 30 days after the closing date to remove the perception that the OIR can prevent a provider from securing new financing, additional financing, or refinancing that may be hazardous to the residents. Currently, providers are required to file a general outline and intended use of proceeds with the OIR prior to the closing date of the financing.

Section 21 amends s. 651.071, F.S., to deem all continuing care and continuing care at-home contracts preferred claims or policyholder loss claims pursuant to s. 631.271(1)(b), F.S., in the event the provider is liquidated or put into receivership. The intent of this provision is to protect the claims of residents in the event of a liquidation.

Section 22 amends s. 651.091, F.S., to create additional provider reporting requirements to the residents or residents' council. These reports will help residents and prospective residents to remain apprised of the status and stability of the provider and to take action to protect their interests. The section requires the provider to furnish information to the chair of the residents' council, such as, a notice of the issuance of any examination reports, a notice of the initiation of any legal or administrative proceedings by the OIR or the DFS, and the reasons for any increase in the monthly fee that exceeds the consumer price index.

Section 26 amends s. 651.111, F.S., relating to resident complaints and inspections by the OIR to provide more guidance as to inspections or investigations by the OIR regarding the status and resolution of the complaint. The section requires the OIR to acknowledge receipt of a complaint within 15 days and issue a written closure statement to the complainant upon the final disposition of the complaint.

Section 29 amends s. 651.121, F.S., relating to the Continuing Care Advisory Council, to increase the number of residents on the council from three to four and remove the requirement that one of the 10 members is an attorney.

Sections 2 and 20 provide technical, conforming changes.

Section 31 provides the bill will take effect July 1, 2018.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

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

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

C. Government Sector Impact:

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

Office of Insurance Regulation. The OIR²⁶ indicates that it would need one additional FTE, a Reinsurance Financial Specialist, to implement the provisions of the bill.

Base Salary - \$45,043

Benefits - \$19,204

Standard Expense Package with new FTE - \$9,895

Total Salary, Benefits, and Expenses - \$74,141

VI. Technical Deficiencies:

Consumer Complaints, Examinations, Investigations, and Inspections

The handling of complaints and inspections, as provided in Section 26 of the bill, may create confusion and duplication with the existing provisions found in s. 624.307, F.S., and s. 651.105, F.S. Section 651.105, F.S., relates to OIR's authority to conduct examinations and inspections. Currently, s. 624.307(10), F.S., authorizes the Division of Consumer Services of the Department of Financial Services to receive and respond to complaints concerning products or services regulated by the DFS or the OIR, which would include CCRCs. According to the DFS, these

²⁶ Office of Insurance Regulation, *Analysis of SB 438* (Oct. 11, 2017) (on file with the Senate Banking and Insurance Committee).

types of inquiries are usually handled through coordination between the OIR and the division because the OIR lacks personnel to handle consumer inquiries but the division lacks access to financial documents as well as the technical knowledge to interpret and understand financial reports. Consumer inquiries are logged into the division's database and follow the same timelines and requirements as other entities regulated by the OIR.²⁷ Consumers may initiate contact with DFS through the DFS website or by telephone.

Section 26 of the bill amends s. 651.111, F.S., relating to complaints and inspections received by the OIR. Under current law, the OIR is required to make an inspection unless the OIR determines a complaint is without reasonable basis. The language appears to require the OIR to make an inspection if one is requested even if the OIR determines the request is without merit. The term, "inspection," is used in ss. 651.105 and 651.111, F.S.; however, the term is undefined.

Solvency

Currently, chapters 631, F.S., relating to insurer insolvency, and 651, F.S., do not define the term "impaired." However, s. 631.051, F.S., does use the term as one of the grounds for the initiation of delinquency proceedings. In addition, The Insurance Code uses the terms "impaired" and "impairment" throughout but does not define either term. Section 1 of the bill contains a definition of "impaired" and given that term is not defined in ch. 631, F.S., it is unclear how the receivership court would treat actions based on the amended definition of "impaired."²⁸

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 651.011, 651.012, 651.013, 651.019, 651.021, 651.022, 651.023, 651.024, 651.026, 651.0261, 651.028, 651.033, 651.035, 651.051, 651.057, 651.071, 651.091, 651.105, 651.106, 651.111, 651.114, 651.1151, 651.121, and 651.125.

This bill creates the following sections of the Florida Statutes: 651.0215, 651.0245, 651.0246, 651.034, 651.043, 651.1065, and 651.1141.

IX. Additional Information:

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

CS by Banking and Insurance on January 16, 2018:

The CS provides the following changes:

- Revises definitions.

²⁷ Department of Financial Services, Analysis of SB 438 (Dec. 28, 2017) (on file with Senate Banking and Insurance Committee).

²⁸ Department of Financial Services, *Analysis of SB 438* (Oct. 16, 2017) (on file with Senate Banking and Insurance Committee).

- Creates consolidated application for provisional certificate of authority and certificate of authority.
- Revises and clarifies escrow account requirements.
- Revises requirements for expansions.
- Revises annual and quarterly report requirements.
- Allows the Office of Insurance Regulation (OIR) to waive requirements of ch. 651, F.S., if a provider or obligator group has obtained an investment grade credit rating and has met certain conditions.
- Revises minimum liquid reserve requirements.
- Revises provisions relating to approval of changes in management.
- Revises maintenance of record provisions.
- Revises provisions relating to examinations and inspections.
- Revises grounds for discretionary refusal, suspension, or revocation of a certificate of authority.
- Provides technical, conforming changes.

B. Amendments:

None.



872234

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/16/2018	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause
and insert:

Section 1. Section 651.011, Florida Statutes, is amended to
read:

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

(1) "Actuarial opinion" means an opinion issued by an
actuary in accordance with Actuarial Standards of Practice No. 3
for Continuing Care Retirement Communities, Revised Edition,



872234

effective May 1, 2011, or any future amendments or replacements to this standard which may be adopted by the Actuarial Standards Board.

(2) "Actuarial study" means an analysis prepared for an individual facility, or consolidated for multiple facilities, for either a certified provider, as of a current valuation date or the most recent fiscal year, or for an applicant, as of a projected future valuation date, which includes an actuary's opinion as to whether such provider or applicant is in satisfactory actuarial balance in accordance with Actuarial Standards of Practice No. 3 for Continuing Care Retirement Communities, Revised Edition, effective May 1, 2011, or any future amendments or replacements to this standard which may be adopted by the Actuarial Standards Board.

(3) "Actuary" means an individual who is qualified to sign an actuarial opinion in accordance with the American Academy of Actuaries' qualification standards and who is a member in good standing of the American Academy of Actuaries.

~~(4)~~ (1) "Advertising" means the dissemination of written, visual, or electronic information by a provider, or any person affiliated with or controlled by a provider, to potential residents or their representatives for the purpose of inducing such persons to subscribe to or enter into a contract for continuing care or continuing care at-home.

~~(5)~~ (2) "Continuing care" or "care" means, pursuant to a contract, furnishing shelter and nursing care or personal services to a resident who resides in a facility, whether such nursing care or personal services are provided in the facility or in another setting designated in the contract for continuing



872234

care, by an individual not related by consanguinity or affinity to the resident, upon payment of an entrance fee. The terms may also be referred to as a "life plan."

(6)~~(3)~~ "Continuing Care Advisory Council" or "advisory council" means the council established in s. 651.121.

(7)~~(4)~~ "Continuing care at-home" means, pursuant to a contract other than a contract described in subsection (5) ~~(2)~~, furnishing to a resident who resides outside the facility the right to future access to shelter and nursing care or personal services, whether such services are provided in the facility or in another setting designated in the contract, by an individual not related by consanguinity or affinity to the resident, upon payment of an entrance fee. The term may also be referred to as a "life plan at-home."

(8) "Corrective order" means an order issued by the office which specifies corrective actions the office has determined are required.

(9) "Days cash on hand" means, for a facility or obligated group, the quotient obtained by dividing the value of paragraph (a) by the value of paragraph (b).

(a) The sum of unrestricted cash, unrestricted short-term and long-term investments, provider restricted funds, and the minimum liquid reserve as of the reporting period.

(b) Operating expenses less depreciation, amortization, and other noncash expenses and nonoperating losses, divided by 365. Operating expenses, depreciation, amortization, and other noncash expenses and nonoperating losses are each the sum of their respective values over the 12-month period immediately preceding the reporting date.



872234

69
70 With prior written approval of the office, a demand note or
71 other parental guarantee may be considered a short-term or long-
72 term investment for the purposes of paragraph (a). However, the
73 total of all demand notes issued by the parent may not, at any
74 time, be more than the sum of unrestricted cash and unrestricted
75 short-term and long-term investments held by the parent.

76 (10) "Debt service coverage ratio" means, for a facility or
77 obligated group, the quotient obtained by dividing the value of
78 paragraph (a) by the value of paragraph (b).

79 (a) The sum of total expenses less interest expense on the
80 facility, depreciation, amortization, and other noncash expenses
81 and nonoperating losses, subtracted from the sum of total
82 revenues and gross entrance fees received less earned entrance
83 fees and refunds paid. Expenses, interest expense on the
84 facility, depreciation, amortization, other noncash expenses and
85 nonoperating losses, revenues, noncash revenues, nonoperating
86 gains, gross entrance fees, earned entrance fees, and refunds
87 are each the sum of their respective values over the 12-month
88 period immediately preceding the reporting date.

89 (b) Total annual principal and interest expense due on the
90 facility or obligated group over the 12-month period immediately
91 preceding the reporting date. For purposes of this paragraph,
92 principal excludes any balloon principal payment amounts, and
93 interest expense due is the sum of the interest over the 12-
94 month period immediately preceding the reporting date which is
95 reflected in the provider's audit.

96 (11)-(5) "Entrance fee" means an initial or deferred payment
97 of a sum of money or property made as full or partial payment



872234

for continuing care or continuing care at-home. An accommodation fee, admission fee, member fee, or other fee of similar form and application are considered to be an entrance fee.

(12)~~(6)~~ "Facility" means a place where continuing care is furnished and may include one or more physical plants on a primary or contiguous site or an immediately accessible site. As used in this subsection, the term "immediately accessible site" means a parcel of real property separated by a reasonable distance from the facility as measured along public thoroughfares, and the term "primary or contiguous site" means the real property contemplated in the feasibility study required by this chapter.

~~(7) "Generally accepted accounting principles" means those accounting principles and practices adopted by the Financial Accounting Standards Board and the American Institute of Certified Public Accountants, including Statement of Position 90-8 with respect to any full year to which the statement applies.~~

(13) "Impaired" means that any of the following have occurred:

(a) A provider has failed to maintain its minimum liquid reserve as required in s. 651.035, unless the provider has received prior written approval from the office for a withdrawal pursuant to s. 651.035(6) and is compliant with the approved payment schedule; or

(b) Beginning July 1, 2019:

1. For a provider with mortgage financing from a third-party lender or public bond issue, the provider's debt service coverage ratio is less than 1.00:1 and the provider's days cash



872234

on hand is less than 90; or

2. For a provider without mortgage financing from a third-party lender or public bond issue, the provider's days cash on hand is less than 90.

(14)(8) "Insolvency" means the condition in which a the provider is unable to pay its obligations as they come due in the normal course of business.

(15)(9) "Licensed" means that a the provider has obtained a certificate of authority from the office department.

(16) "Manager" or "management company" means a person who administers the day-to-day business operations of a facility for a provider, subject to the policies, directives, and oversight of the provider.

(17)(10) "Nursing care" means those services or acts rendered to a resident by an individual licensed or certified pursuant to chapter 464.

(18) "Obligated group" means one or more entities that jointly agree to be bound by a financing structure containing security provisions and covenants applicable to the group. For purposes of this subsection, debt issued under such a financing structure must be a joint and several obligation of each member of the group.

(19) "Occupancy" means the total number of occupied independent living, assisted living, and skilled nursing units in a facility divided by the total number of units in that facility, excluding units that are unavailable to market or reserve, as of the most recent annual report.

(20)(11) "Personal services" has the same meaning as in s. 429.02.



872234

156 (21)~~(12)~~ "Provider" means the owner or operator, whether a
157 natural person, partnership or other unincorporated association,
158 however organized, trust, or corporation, of an institution,
159 building, residence, or other place, whether operated for profit
160 or not, which owner or operator provides continuing care or
161 continuing care at-home for a fixed or variable fee, or for any
162 other remuneration of any type, whether fixed or variable, for
163 the period of care, payable in a lump sum or lump sum and
164 monthly maintenance charges or in installments. The term does
165 not apply to an entity that has existed and continuously
166 operated a facility located on at least 63 acres in this state
167 providing residential lodging to members and their spouses for
168 at least 66 years on or before July 1, 1989, and has the
169 residential capacity of 500 persons, is directly or indirectly
170 owned or operated by a nationally recognized fraternal
171 organization, is not open to the public, and accepts only its
172 members and their spouses as residents.

173 (22)~~(13)~~ "Records" means all documents, correspondence, and
174 the permanent financial, directory, and personnel information
175 and data maintained by a provider pursuant to this chapter,
176 regardless of the physical form, characteristics, or means of
177 transmission.

178 (23) "Regulatory action level event" means that any two of
179 the following have occurred:

180 (a) The provider's debt service coverage ratio is less than
181 the minimum ratio specified in the provider's bond covenants or
182 lending agreement for long-term financing, or, if the provider
183 does not have a debt service coverage ratio required by its
184 lending institution, the provider's debt service coverage ratio



872234

is less than 1.20:1 as of the most recent annual report filed with the office. If the provider is a member of an obligated group having cross-collateralized debt and the obligated group has obtained an investment grade credit rating from a nationally recognized credit rating agency, as applicable, from Moody's Investors Service, Standard & Poor's, or Fitch Ratings, the obligated group's debt service coverage ratio will be used as the provider's debt service coverage ratio.

(b) The provider's days cash on hand is less than the minimum number of days cash on hand specified in the provider's bond covenants or lending agreement for long-term financing. If the provider does not have a days cash on hand required by its lending institution, the days cash on hand may not be less than 100 as of the most recent annual report filed with the office. If the provider is a member of an obligated group having cross-collateralized debt and the obligated group has obtained an investment grade credit rating from a nationally recognized credit rating agency, as applicable, from Moody's Investors Service, Standard & Poor's, or Fitch Ratings, the days cash on hand of the obligated group will be used as the provider's days cash on hand.

(c) The occupancy at the provider's facility is less than 80 percent, averaged over the 12-month period immediately preceding the reporting date.

~~(24)(14)~~ "Resident" means a purchaser of, a nominee of, or a subscriber to a continuing care or continuing care at-home contract. Such contract does not give the resident a part ownership of the facility in which the resident is to reside, unless expressly provided in the contract.



872234

(25)(15) "Shelter" means an independent living unit, room, apartment, cottage, villa, personal care unit, nursing bed, or other living area within a facility set aside for the exclusive use of one or more identified residents.

Section 2. Section 651.012, Florida Statutes, is amended to read:

651.012 Exempted facility; written disclosure of exemption.—Any facility exempted under ss. 632.637(1)(e) and 651.011(21) ~~651.011(12)~~ must provide written disclosure of such exemption to each person admitted to the facility ~~after October 1, 1996~~. This disclosure must be written using language likely to be understood by the person and must briefly explain the exemption.

Section 3. Subsection (2) of section 651.013, Florida Statutes, is amended to read:

651.013 Chapter exclusive; applicability of other laws.—
(2) In addition to other applicable provisions cited in this chapter, the office has the authority granted under ss. 624.302 and 624.303, 624.307-624.312, 624.318 ~~624.308-624.312,~~ 624.319(1)-(3), 624.320-624.321, 624.324, ~~and~~ 624.34, and 624.422 of the Florida Insurance Code to regulate providers of continuing care and continuing care at-home.

Section 4. Section 651.019, Florida Statutes, is amended to read:

651.019 New financing, additional financing, or refinancing.—

(1)(a) A provider shall provide notice to the residents' council of any new financing or refinancing at least 30 days before the closing date of the financing or refinancing



872234

transaction. The notice must include a general outline of the amount and terms of the financing or refinancing and the intended use of proceeds.

(b) If the facility does not have a residents' council, the facility must make available, in the same manner as other community notices, the information required by paragraph (a) ~~After issuance of a certificate of authority, the provider shall submit to the office a general outline, including intended use of proceeds, with respect to any new financing, additional financing, or refinancing at least 30 days before the closing date of such financing transaction.~~

(2) Within 30 days after the closing date of such financing or refinancing transaction, ~~The provider shall furnish any information the office may reasonably request in connection with any new financing, additional financing, or refinancing, including, but not limited to, the financing agreements and any related documents, escrow or trust agreements, and statistical or financial data.~~ the provider shall ~~also~~ submit to the office copies of executed financing documents and escrow or trust agreements prepared in support of such financing or refinancing transaction, and a copy of all documents required to be submitted to the residents' council under paragraph (1) (a) within 30 days after the closing date.

Section 5. Section 651.021, Florida Statutes, is amended to read:

651.021 Certificate of authority required.—

~~(1)~~ A ~~No~~ person may not engage in the business of providing continuing care, issuing contracts for continuing care or continuing care at-home, or constructing a facility for the



872234

purpose of providing continuing care in this state without a certificate of authority obtained from the office as provided in this chapter. This section ~~subsection~~ does not prohibit the preparation of a construction site or construction of a model residence unit for marketing purposes, or both. The office may allow the purchase of an existing building for the purpose of providing continuing care if the office determines that the purchase is not being made to circumvent the prohibitions in this section.

~~(2) Written approval must be obtained from the office before commencing construction or marketing for an expansion of a certificated facility equivalent to the addition of at least 20 percent of existing units or 20 percent or more in the number of continuing care at-home contracts. This provision does not apply to construction for which a certificate of need from the Agency for Health Care Administration is required.~~

~~(a) For providers that offer both continuing care and continuing care at-home, the 20 percent is based on the total of both existing units and existing contracts for continuing care at-home. For purposes of this subsection, an expansion includes increases in the number of constructed units or continuing care at-home contracts or a combination of both.~~

~~(b) The application for such approval shall be on forms adopted by the commission and provided by the office. The application must include the feasibility study required by s. 651.022(3) or s. 651.023(1)(b) and such other information as required by s. 651.023. If the expansion is only for continuing care at-home contracts, an actuarial study prepared by an independent actuary in accordance with standards adopted by the~~



872234

~~American Academy of Actuaries which presents the financial impact of the expansion may be substituted for the feasibility study.~~

~~(c) In determining whether an expansion should be approved, the office shall use the criteria provided in ss. 651.022(6) and 651.023(4).~~

Section 6. Section 651.0215, Florida Statutes, is created to read:

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

(1) For an applicant to qualify for a certificate of authority without first obtaining a provisional certificate of authority, the following conditions must be met:

(a) All reservation deposits and entrance fees must be placed in escrow in accordance with s. 651.033. The applicant may not use or pledge any part of an initial entrance fee for the construction or purchase of the facility or as security for long-term financing.

(b) The reservation deposit may not exceed \$5,000 upon a resident's selection of a unit and must be refundable at any time before the resident takes occupancy of the selected unit.

(c) The resident contract must state that collection of the balance of the entrance fee is to occur after the resident is notified that his or her selected unit is available for occupancy and on or before the occupancy date.

(2) The consolidated application must be on a form prescribed by the commission and must contain all of the following information:



872234

(a) All of the information required under s 651.022(2).

(b) A feasibility study prepared by an independent consultant which contains all of the information required by s. 651.022(3) and financial forecasts or projections prepared in accordance with standards adopted by the American Institute of Certified Public Accountants or in accordance with standards for feasibility studies for continuing care retirement communities adopted by the Actuarial Standards Board.

1. The feasibility study must take into account project costs, actual marketing results to date and marketing projections, resident fees and charges, competition, resident contract provisions, and other factors that affect the feasibility of operating the facility.

2. If the feasibility study is prepared by an independent certified public accountant, it must contain an examination report, or a compilation report acceptable to the office, containing a financial forecast or projections for the first 5 years of operations which take into account an actuary's mortality and morbidity assumptions as the study relates to turnover, rates, fees, and charges. If the study is prepared by an independent consulting actuary, it must contain mortality and morbidity assumptions as it relates to turnover, rates, fees, and charges and an actuary's signed opinion that the project as proposed is feasible and that the study has been prepared in accordance with Actuarial Standards of Practice No. 3 for Continuing Care Retirement Communities, Revised Edition, effective May 1, 2011.

(c) Documents evidencing that commitments have been secured for construction financing and long-term financing or that a



872234

documented plan acceptable to the office has been adopted by the applicant for long-term financing.

(d) Documents evidencing that all conditions of the lender have been satisfied to activate the commitment to disburse funds, other than the obtaining of the certificate of authority, the completion of construction, or the closing of the purchase of realty or buildings for the facility.

(e) Documents evidencing that the aggregate amount of entrance fees received by or pledged to the applicant, plus anticipated proceeds from any long-term financing commitment and funds from all other sources in the actual possession of the applicant, equal at least 100 percent of the aggregate cost of constructing or purchasing, equipping, and furnishing the facility plus 100 percent of the anticipated startup losses of the facility.

(f) A complete audited financial report of the applicant, prepared by an independent certified public accountant in accordance with generally accepted accounting principles, as of the date the applicant commenced business operations or for the fiscal year that ended immediately preceding the date of application, whichever is later, and complete unaudited quarterly financial statements attested to by the applicant after the date of the last audit.

(g) Documents evidencing that the applicant will be able to comply with s. 651.035.

(h) Such other reasonable data, financial statements, and pertinent information as the commission or office may require with respect to the applicant or the facility to determine the financial status of the facility and the management capabilities



872234

of its managers and owners.

(3) If an applicant has or proposes to have more than one facility offering continuing care or continuing care at-home, a separate certificate of authority must be obtained for each facility.

(4) Within 45 days after receipt of the information required under subsection (2), the office shall examine the information and notify the applicant in writing, specifically requesting any additional information that the office is authorized to require. An application is deemed complete when the office receives all requested information and the applicant corrects any error or omission of which the applicant was timely notified or when the time for such notification has expired. Within 15 days after receipt of all of the requested additional information, the office shall notify the applicant in writing that all of the requested information has been received and that the application is deemed to be complete as of the date of the notice. Failure to notify the applicant in writing within the 15-day period constitutes acknowledgment by the office that it has received all requested additional information, and the application is deemed complete for purposes of review on the date the applicant files all of the required additional information.

(5) Within 45 days after an application is deemed complete as set forth in subsection (4) and upon completion of the remaining requirements of this section, the office shall complete its review and issue or deny a certificate of authority to the applicant. The period for review by the office may not be tolled if the office requests additional information and the



872234

applicant provides the requested information within 5 business days. If a certificate of authority is denied, the office must notify the applicant in writing, citing the specific failures to satisfy this chapter, and the applicant is entitled to an administrative hearing pursuant to chapter 120.

(6) The office shall issue a certificate of authority upon determining that the applicant meets all requirements of law and has submitted all of the information required under this section, that all escrow requirements have been satisfied, and that the fees prescribed in s. 651.015(2) have been paid.

(7) The issuance of a certificate of authority entitles the applicant to begin construction and collect reservation deposits and entrance fees from prospective residents. The reservation contract must state the cancellation policy and the terms of the continuing care contract to be entered into. All or any part of an entrance fee or reservation deposit collected must be placed in an escrow account or on deposit with the department pursuant to s. 651.033.

(8) The provider is entitled to secure release of the moneys held in escrow within 7 days after the office receives an affidavit from the provider, along with appropriate documentation to verify, and notification is provided to the escrow agent by certified mail, that the following conditions have been satisfied:

(a) A certificate of occupancy has been issued.

(b) Payment in full has been received for at least 70 percent of the total units of a phase or of the total of the combined phases constructed. If a provider offering continuing care at-home is applying for a release of escrowed entrance



872234

fees, the same minimum requirement must be met for the continuing care and continuing care at-home contracts independently of each other.

(c) The provider has evidence of sufficient funds to meet the requirements of s. 651.035, which may include funds deposited in the initial entrance fee account.

(d) Documents evidencing the intended application of the proceeds upon release and documents evidencing that the entrance fees, when released, will be applied as represented to the office.

Notwithstanding chapter 120, a person, other than the provider, the escrow agent, and the office, may not have a substantial interest in any decision by the office regarding the release of escrow funds in any proceeding under chapter 120 or this chapter.

(9) The office may not approve any application that includes in the plan of financing any encumbrance of the operating reserves or renewal and replacement reserves required by this chapter.

(10) The office may not issue a certificate of authority to a facility that does not have a component that is to be licensed pursuant to part II of chapter 400 or part I of chapter 429, or that does not offer personal services or nursing services through written contractual agreement. A written contractual agreement must be disclosed in the contract for continuing care or continuing care at-home and is subject to s. 651.1151.

Section 7. Subsection (2) and present subsections (6) and (8) of section 651.022, Florida Statutes, are amended, present



872234

subsections (3) through (8) of that section are redesignated as subsections (4) through (9), respectively, and a new subsection (3) is added to that section, to read:

651.022 Provisional certificate of authority; application.-

(2) The application for a provisional certificate of authority must ~~shall~~ be on a form prescribed by the commission and must ~~shall~~ contain the following information:

(a) If the applicant or provider is a corporation, a copy of the articles of incorporation and bylaws; if the applicant or provider is a partnership or other unincorporated association, a copy of the partnership agreement, articles of association, or other membership agreement; and, if the applicant or provider is a trust, a copy of the trust agreement or instrument.

(b) The full names, residences, and business addresses of:

1. The proprietor, if the applicant or provider is an individual.

2. Every partner or member, if the applicant or provider is a partnership or other unincorporated association, however organized, having fewer than 50 partners or members, together with the business name and address of the partnership or other organization.

3. The principal partners or members, if the applicant or provider is a partnership or other unincorporated association, however organized, having 50 or more partners or members, together with the business name and business address of the partnership or other organization. If such unincorporated organization has officers and a board of directors, the full name and business address of each officer and director may be set forth in lieu of the full name and business address of its



872234

principal members.

4. The corporation and each officer and director thereof, if the applicant or provider is a corporation.

5. Every trustee and officer, if the applicant or provider is a trust.

6. The manager, whether an individual, corporation, partnership, or association.

7. Any stockholder holding at least a 10 percent interest in the operations of the facility in which the care is to be offered.

8. Any person whose name is required to be provided in the application under this paragraph and who owns any interest in or receives any remuneration from, directly or indirectly, any professional service firm, association, trust, partnership, or corporation providing goods, leases, or services to the facility for which the application is made, with a real or anticipated value of \$10,000 or more, and the name and address of the professional service firm, association, trust, partnership, or corporation in which such interest is held. The applicant shall describe such goods, leases, or services and the probable cost to the facility or provider and shall describe why such goods, leases, or services should not be purchased from an independent entity.

9. Any person, corporation, partnership, association, or trust owning land or property leased to the facility, along with a copy of the lease agreement.

10. Any affiliated parent or subsidiary corporation or partnership.

(c)1. Evidence that the applicant is reputable and of



872234

responsible character. If the applicant is a firm, association, organization, partnership, business trust, corporation, or company, the form must ~~shall~~ require evidence that the members or shareholders ~~are reputable and of responsible character,~~ and the person in charge of providing care under a certificate of authority are ~~shall likewise be required to produce evidence of being~~ reputable and of responsible character.

2. Evidence satisfactory to the office of the ability of the applicant to comply with ~~the provisions of~~ this chapter and with rules adopted by the commission pursuant to this chapter.

3. A statement of whether a person identified in the application for a provisional certificate of authority or the administrator or manager of the facility, if such person has been designated, or any such person living in the same location:

a. Has been convicted of a felony or has pleaded nolo contendere to a felony charge, or has been held liable or has been enjoined in a civil action by final judgment, if the felony or civil action involved fraud, embezzlement, fraudulent conversion, or misappropriation of property.

b. Is subject to a currently effective injunctive or restrictive order or federal or state administrative order relating to business activity or health care as a result of an action brought by a public agency or department, including, without limitation, an action affecting a license under chapter 400 or chapter 429.

The statement must ~~shall~~ set forth the court or agency, the date of conviction or judgment, and the penalty imposed or damages assessed, or the date, nature, and issuer of the order. Before



872234

determining whether a provisional certificate of authority is to be issued, the office may make an inquiry to determine the accuracy of the information submitted pursuant to subparagraphs 1., 2., and 3. ~~1. and 2.~~

(d) The contracts for continuing care and continuing care at-home to be entered into between the provider and residents which meet the minimum requirements of s. 651.055 or s. 651.057 and which include a statement describing the procedures required by law relating to the release of escrowed entrance fees. Such statement may be furnished through an addendum.

(e) Any advertisement or other written material proposed to be used in the solicitation of residents.

(f) Such other reasonable data, financial statements, and pertinent information as the commission or office may reasonably require with respect to the provider or the facility, including the most recent audited financial report ~~statements~~ of comparable facilities currently or previously owned, managed, or developed by the applicant or its principal, to assist in determining the financial viability of the project and the management capabilities of its managers and owners.

(g) The forms of the residency contracts, reservation contracts, escrow agreements, and wait list contracts, if applicable, which are proposed to be used by the provider in the furnishing of care. The office shall approve contracts and escrow agreements that comply with ss. 651.023(1)(c), 651.033, 651.055, and 651.057. Thereafter, no other form of contract or agreement may be used by the provider until it has been submitted to the office and approved.



872234

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

(3) In addition to the information required in subsection (2), an applicant for a provisional certificate of authority must submit a feasibility study with appropriate financial, marketing, and actuarial assumptions for the first 5 years of operations. The feasibility study must include at least the following information:

(a) A description of the proposed facility, including the location, size, anticipated completion date, and the proposed construction program.

(b) Identification and an evaluation of the primary and, if appropriate, the secondary market areas of the facility and the projected unit sales per month.

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

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

(e) A projected balance sheet of the applicant.

(f) Expectations of the financial condition of the project, including the projected cash flow, and an estimate of the funds



872234

anticipated to be necessary to cover startup losses.

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

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

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

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

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

(7) ~~(6)~~ Within 45 days after the date an application is deemed complete as set forth in paragraph (6) (b) ~~(5) (b)~~, the office shall complete its review and issue a provisional certificate of authority to the applicant based upon its review and a determination that the application meets all requirements of law, that the feasibility study was based on sufficient data and reasonable assumptions, and that the applicant will be able to provide continuing care or continuing care at-home as proposed and meet all financial and contractual obligations related to its operations, including the financial requirements of this chapter. The period for review by the office may not be



872234

tolled if the office requests additional information and the applicant provides the requested information within 5 business days. If the application is denied, the office shall notify the applicant in writing, citing the specific failures to meet the provisions of this chapter. Such denial entitles the applicant to a hearing pursuant to chapter 120.

~~(9)-(8)~~ The office may ~~shall~~ not approve any application that ~~which~~ includes in the plan of financing any encumbrance of the operating reserves or renewal and replacement reserves required by this chapter.

Section 8. Subsections (1) through (4), paragraph (b) of subsection (5), and subsections (6), (8), and (9) of section 651.023, Florida Statutes, are amended to read:

651.023 Certificate of authority; application.—

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

(a) Any material change in status with respect to the information required to be filed under s. 651.022(2) in the application for the provisional certificate.

(b) A feasibility study prepared by an independent consultant which contains all of the information required by s. 651.022(4) ~~s. 651.022(3)~~ and financial forecasts or projections prepared in accordance with standards adopted by the American Institute of Certified Public Accountants or in accordance with standards for feasibility studies or continuing care retirement communities adopted by the Actuarial Standards Board.



872234

~~1. The study must also contain an independent evaluation and examination opinion, or a comparable opinion acceptable to the office, by the consultant who prepared the study, of the underlying assumptions used as a basis for the forecasts or projections in the study and that the assumptions are reasonable and proper and the project as proposed is feasible.~~

1.2. The study must take into account project costs, actual marketing results to date and marketing projections, resident fees and charges, competition, resident contract provisions, and any other factors which affect the feasibility of operating the facility.

~~2.3.~~ If the study is prepared by an independent certified public accountant, it must contain an examination opinion, or a compilation report acceptable to the office, containing a financial forecast or projections for the first 5 3 years of operations which take into account an actuary's mortality and morbidity assumptions as the study relates to turnover, rates, fees, and charges ~~and financial projections having a compilation opinion for the next 3 years.~~ If the study is prepared by an independent consulting actuary, it must contain mortality and morbidity assumptions as the study relates to turnover, rates, fees, and charges, ~~data~~ and an actuary's signed opinion that the project as proposed is feasible and that the study has been prepared in accordance with standards adopted by the American Academy of Actuaries.

(c) Subject to subsection (4), a provider may submit an application for a certificate of authority and any required exhibits upon submission of documents evidencing ~~proof~~ that the project has a minimum of 30 percent of the units reserved for



872234

which the provider is charging an entrance fee. ~~This does not apply to an application for a certificate of authority for the acquisition of a facility for which a certificate of authority was issued before October 1, 1983, to a provider who subsequently becomes a debtor in a case under the United States Bankruptcy Code, 11 U.S.C. ss. 101 et seq., or to a provider for which the department has been appointed receiver pursuant to part II of chapter 631.~~

(d) Documents evidencing Proof that commitments have been secured for both construction financing and long-term financing or a documented plan acceptable to the office has been adopted by the applicant for long-term financing.

(e) Documents evidencing Proof that all conditions of the lender have been satisfied to activate the commitment to disburse funds other than the obtaining of the certificate of authority, the completion of construction, or the closing of the purchase of realty or buildings for the facility.

(f) Documents evidencing Proof that the aggregate amount of entrance fees received by or pledged to the applicant, plus anticipated proceeds from any long-term financing commitment, plus funds from all other sources in the actual possession of the applicant, equal at least 100 percent of the aggregate cost of constructing or purchasing, equipping, and furnishing the facility plus 100 percent of the anticipated startup losses of the facility.

(g) A complete audited financial report ~~statements~~ of the applicant, prepared by an independent certified public accountant in accordance with generally accepted accounting principles, as of the date the applicant commenced business



872234

operations or for the fiscal year that ended immediately preceding the date of application, whichever is later, and complete unaudited quarterly financial statements attested to by the applicant after the date of the last audit.

(h) Documents evidencing Proof that the applicant has complied with the escrow requirements of subsection (5) or subsection (7) and will be able to comply with s. 651.035.

(i) Such other reasonable data, financial statements, and pertinent information as the commission or office may require with respect to the applicant or the facility, to determine the financial status of the facility and the management capabilities of its managers and owners.

If any material change occurs in the facts set forth in an application filed with the office pursuant to this subsection, an amendment setting forth such change must be filed with the office within 10 business days, and a copy of the amendment must be sent by registered mail to the principal office of the facility and to the principal office of the controlling company.

(2) Within 30 days after receipt of the information required under subsection (1), the office shall examine such information and notify the provider in writing, specifically requesting any additional information the office is permitted by law to require. Within 15 days after receipt of all of the requested additional information, the office shall notify the provider in writing that all of the requested information has been received, and the application is deemed to be complete as of the date of the notice. Failure to notify the provider in writing within the 15-day period constitutes acknowledgment by



872234

the office that it has received all requested additional information, and the application is deemed complete for purposes of review on the date of filing all of the required additional information. ~~Within 15 days after receipt of all of the requested additional information, the office shall notify the provider in writing that all of the requested information has been received and the application is deemed to be complete as of the date of the notice. Failure to notify the applicant in writing within the 15-day period constitutes acknowledgment by the office that it has received all requested additional information, and the application shall be deemed complete for purposes of review on the date of filing all of the required additional information.~~

(3) Within 45 days after an application is deemed complete as set forth in subsection (2), and upon completion of the remaining requirements of this section, the office shall complete its review and issue or deny a certificate of authority to the holder of a provisional certificate of authority. If a certificate of authority is denied, the office must notify the holder of the provisional certificate in writing, citing the specific failures to satisfy the provisions of this chapter. The period for review by the office may not be tolled if the office requests additional information and the applicant provides the requested information within 5 business days. If denied, the holder of the provisional certificate is entitled to an administrative hearing pursuant to chapter 120.

(4) The office shall issue a certificate of authority upon determining that the applicant meets all requirements of law and has submitted all of the information required by this section, that all escrow requirements have been satisfied, and that the



872234

fees prescribed in s. 651.015(2) have been paid.

(a) ~~A Notwithstanding satisfaction of the 30-percent~~
~~minimum reservation requirement of paragraph (1)(c), no~~
certificate of authority may not ~~shall~~ be issued until
documentation evidencing that the project has a minimum of 50
percent of the units reserved for which the provider is charging
an entrance fee, ~~and proof~~ is provided to the office. If a
provider offering continuing care at-home is applying for a
certificate of authority ~~or approval of an expansion pursuant to~~
~~s. 651.021(2)~~, the same minimum reservation requirements must be
met for the continuing care and continuing care at-home
contracts, independently of each other.

(b) In order for a unit to be considered reserved under
this section, the provider must collect a minimum deposit of the
lesser of \$40,000 or 10 percent of the then-current entrance fee
for that unit, and may assess a forfeiture penalty of 2 percent
of the entrance fee due to termination of the reservation
contract after 30 days for any reason other than the death or
serious illness of the resident, the failure of the provider to
meet its obligations under the reservation contract, or other
circumstances beyond the control of the resident that equitably
entitle the resident to a refund of the resident's deposit. The
reservation contract must state the cancellation policy and the
terms of the continuing care or continuing care at-home contract
to be entered into.

(5) Up to 25 percent of the moneys paid for all or any part
of an initial entrance fee may be included or pledged for the
construction or purchase of the facility or as security for
long-term financing. The term "initial entrance fee" means the



872234

total entrance fee charged by the facility to the first occupant of a unit.

(b) For an expansion as provided in s. 651.0246 ~~s. 651.021(2)~~, a minimum of 75 percent of the moneys paid for all or any part of an initial entrance fee collected for continuing care and 50 percent of the moneys paid for all or any part of an initial fee collected for continuing care at-home shall be placed in an escrow account or on deposit with the department as prescribed in s. 651.033.

(6) The provider is entitled to secure release of the moneys held in escrow within 7 days after receipt by the office of an affidavit from the provider, along with appropriate copies to verify, and notification to the escrow agent by certified mail, that the following conditions have been satisfied:

(a) A certificate of occupancy has been issued.

(b) Payment in full has been received for at least 70 percent of the total units of a phase or of the total of the combined phases constructed. If a provider offering continuing care at-home is applying for a release of escrowed entrance fees, the same minimum requirement must be met for the continuing care and continuing care at-home contracts, independently of each other.

~~(c) The consultant who prepared the feasibility study required by this section or a substitute approved by the office certifies within 12 months before the date of filing for office approval that there has been no material adverse change in status with regard to the feasibility study. If a material adverse change exists at the time of submission, sufficient information acceptable to the office and the feasibility~~



872234

~~consultant must be submitted which remedies the adverse condition.~~

(c)~~(d)~~ Documents evidencing Proof that commitments have been secured or a documented plan adopted by the applicant has been approved by the office for long-term financing.

(d)~~(e)~~ Documents evidencing Proof that the provider has sufficient funds to meet the requirements of s. 651.035, which may include funds deposited in the initial entrance fee account.

(e)~~(f)~~ Documents evidencing Proof as to the intended application of the proceeds upon release and documentation ~~proof~~ that the entrance fees when released will be applied as represented to the office.

(f) If any material change occurred in the facts set forth in the application filed with the office pursuant to subsection (1), the applicant timely filed the amendment setting forth such change with the office and sent copies of the amendment to the principal office of the facility and to the principal office of the controlling company as required under that subsection.

Notwithstanding chapter 120, no person, other than the provider, the escrow agent, and the office, may have a substantial interest in any office decision regarding release of escrow funds in any proceedings under chapter 120 or this chapter regarding release of escrow funds.

~~(8) The timeframes provided under s. 651.022(5) and (6) apply to applications submitted under s. 651.021(2).~~ The office may not issue a certificate of authority to a facility that does not have a component that is to be licensed pursuant to part II of chapter 400 or to part I of chapter 429 or that does not



872234

offer personal services or nursing services through written contractual agreement. A written contractual agreement must be disclosed in the contract for continuing care or continuing care at-home and is subject to ~~the provisions of~~ s. 651.1151, relating to administrative, vendor, and management contracts.

(9) The office may not approve an application that includes in the plan of financing any encumbrance of the operating reserves or renewal and replacement reserves required by this chapter.

Section 9. Section 651.024, Florida Statutes, is amended to read:

651.024 Acquisition.—

(1) A person who seeks to assume the role of general partner of a provider or otherwise assume ownership or possession of, or control over, 10 percent or more of a provider's assets, based on the balance sheet from the most recent financial audit filed with the office, is issued a certificate of authority to operate a continuing care facility or a provisional certificate of authority shall be subject to the provisions of s. 628.4615 and is not required to make filings pursuant to s. 651.022, s. 651.023, or s. 651.0245.

(2) A person who seeks to acquire and become the provider for a facility is subject to s. 651.0245 and is not required to make filings pursuant to ss. 628.4615, 651.022, and 651.023.

(3) A person may rebut a presumption of control by filing a disclaimer of control with the office on a form prescribed by the commission. The disclaimer must fully disclose all material relationships and bases for affiliation between the person and the provider or facility, as well as the basis for disclaiming



872234

the affiliation. In lieu of such form, a person or acquiring party may file with the office a copy of a Schedule 13G filed with the Securities and Exchange Commission pursuant to Rule 13d-1(b) or (c), 17 C.F.R. s. 240.13d-1, under the Securities Exchange Act of 1934, as amended. After a disclaimer has been filed, the provider or facility is relieved of any duty to register or report under this section which may arise out of the provider's or facility's relationship with the person, unless the office disallows the disclaimer.

(4) As used in this section, the term:

(a) "Controlling company" means any corporation, trust, or association that directly or indirectly owns 25 percent or more of the voting securities of one or more facilities that are stock corporations, or 25 percent or more of the ownership interest of one or more facilities that are not stock corporations.

(b) "Natural person" means an individual.

(c) "Person" includes a natural person, corporation, association, trust, general partnership, limited partnership, joint venture, firm, proprietorship, or any other entity that may hold a license or certificate as a facility.

(5) In addition to the facility or the controlling company, the office has standing to petition a circuit court as described in s. 628.4615(9).

Section 10. Section 651.0245, Florida Statutes, is created to read:

651.0245 Application for the simultaneous acquisition of a facility and issuance of a certificate of authority.-

(1) Except with the prior written approval of the office, a



872234

person may not, individually or in conjunction with any affiliated person of such person, directly or indirectly acquire a facility operating under a subsisting certificate of authority and engage in the business of providing continuing care.

(2) An applicant seeking simultaneous acquisition of a facility and issuance of a certificate of authority must:

(a) Comply with the notice requirements of s. 628.4615(2)(a); and

(b) File an application in the form required by the office and cooperate with the office's review of the application.

(3) The commission shall adopt by rule application requirements equivalent to those described in ss. 628.4615(4) and (5), 651.022(2)(a)-(g), and 651.023(1)(b). The office shall review the application and issue an approval or disapproval of the filing in accordance with ss. 628.4615(6)(a) and (c), (7)-(10), and (14); 651.022(9); and 651.023(1)(b).

(4) As used in this section, the term:

(a) "Controlling company" means any corporation, trust, or association that directly or indirectly owns 25 percent or more of the voting securities of one or more facilities that are stock corporations, or 25 percent or more of the ownership interest of one or more facilities that are not stock corporations.

(b) "Natural person" means an individual.

(c) "Person" includes a natural person, corporation, association, trust, general partnership, limited partnership, joint venture, firm, proprietorship, or any other entity that may hold a license or certificate as a facility.

(5) In addition to the facility or the controlling company,



872234

the office has standing to petition a circuit court as described in s. 628.4615(9).

(6) A person may rebut a presumption of control by filing a disclaimer of control with the office on a form prescribed by the commission. The disclaimer must fully disclose all material relationships and bases for affiliation between the person and the provider or facility, as well as the basis for disclaiming the affiliation. In lieu of such form, a person or acquiring party may file with the office a copy of a Schedule 13G filed with the Securities and Exchange Commission pursuant to Rule 13d-1(b) or (c), 17 C.F.R. s. 240.13d-1, under the Securities Exchange Act of 1934, as amended. After a disclaimer has been filed, the provider or facility is relieved of any duty to register or report under this section which may arise out of the provider's or facility's relationship with the person, unless the office disallows the disclaimer.

(7) The commission may adopt, amend, or repeal rules as necessary to administer this section.

Section 11. Section 651.0246, Florida Statutes, is created to read:

651.0246 Expansions.—

(1)(a) A provider must obtain written approval from the office before commencing construction or marketing for an expansion of a certificated facility equivalent to the addition of at least 20 percent of existing units or 20 percent or more in the number of continuing care at-home contracts. If the provider has exceeded the current statewide median for days cash on hand, debt service coverage ratio, and total campus occupancy for two consecutive annual reporting periods, the provider is



872234

automatically granted approval to expand the total number of
existing units by up to 35 percent upon submitting a letter to
the office indicating the total number of planned units in the
expansion, the proposed sources and uses of funds, and an
attestation that the provider understands and pledges to comply
with all minimum liquid reserve and escrow account requirements.
As used in this section, the term "existing units" means the sum
of the total number of independent living units and assisted
living units identified in the most recent annual report filed
with the office pursuant to s. 651.026. For purposes of this
section, the statewide median for days cash on hand, debt
service coverage ratio, and total campus occupancy is the median
calculated in the most recent annual report submitted by the
office to the Continuing Care Advisory Council pursuant to s.
651.121(8). This section does not apply to construction for
which a certificate of need from the Agency for Health Care
Administration is required.

(b) The application for such approval must be on forms
adopted by the commission and provided by the office. The
application must include the feasibility study required by this
section and such other information as reasonably requested by
the office. If the expansion is only for continuing care at-home
contracts, an actuarial study prepared by an independent actuary
in accordance with standards adopted by the American Academy of
Actuaries which presents the financial impact of the expansion
may be substituted for the feasibility study.

(c) In determining whether an expansion should be approved,
the office shall consider:

1. Whether the application meets all requirements of law;



872234

2. Whether the feasibility study was based on sufficient data and reasonable assumptions; and

3. Whether the applicant will be able to provide continuing care or continuing care at-home as proposed and meet all financial obligations related to its operations, including the financial requirements of this chapter.

If the application is denied, the office must notify the applicant in writing, citing the specific failures to meet the provisions of this chapter. A denial entitles the applicant to a hearing pursuant to chapter 120.

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

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

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

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

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

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



872234

5. A projected balance sheet of the applicant.

6. Expectations of the financial condition of the project, including the projected cash flow and an estimate of the funds anticipated to be necessary to cover startup losses.

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

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

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

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

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

12. An independent evaluation and examination opinion for the first 5 years of operations, or a comparable opinion acceptable to the office, by the consultant who prepared the study, of the underlying assumptions used as a basis for the forecasts or projections in the study and that the assumptions are reasonable and proper and the project as proposed is feasible.

13. Any other information that the provider deems relevant and appropriate to provide to enable the office to make a more



872234

informed determination.

(b) Such other reasonable data, financial statements, and pertinent information as the commission or office may require with respect to the applicant or the facility to determine the financial status of the facility and the management capabilities of its managers and owners.

(3) A minimum of 75 percent of the moneys paid for all or any part of an initial entrance fee or reservation deposit collected for continuing care and 50 percent of the moneys paid for all or any part of an initial fee collected for continuing care at-home must be placed in an escrow account or on deposit with the department as prescribed in s. 651.033. Up to 25 percent of the moneys paid for all or any part of an initial entrance fee or reservation deposit may be included or pledged for the construction or purchase of the facility or as security for long-term financing. As used in this section, the term "initial entrance fee" means the total entrance fee charged by the facility to the first occupant of a unit.

Entrance fees and reservation deposits collected for expansions must be held pursuant to the escrow requirements of s. 651.023(5) and (6).

(4) The provider is entitled to secure release of the moneys held in escrow within 7 days after receipt by the office of an affidavit from the provider, along with appropriate copies to verify, and notification to the escrow agent by certified mail that the following conditions have been satisfied:

(a) A certificate of occupancy has been issued.

(b) Payment in full has been received for at least 50



872234

percent of the total units of a phase or of the total of the combined phases constructed. If a provider offering continuing care at-home is applying for a release of escrowed entrance fees, the same minimum requirement must be met for the continuing care and continuing care at-home contracts independently of each other.

(c) Documents evidencing that commitments have been secured or that a documented plan adopted by the applicant has been approved by the office for long-term financing.

(d) Documents evidencing that the provider has sufficient funds to meet the requirements of s. 651.035, which may include funds deposited in the initial entrance fee account.

(e) Documents evidencing the intended application of the proceeds upon release and documentation that the entrance fees, when released, will be applied as represented to the office.

Notwithstanding chapter 120, only the provider, the escrow agent, and the office have a substantial interest in any office decision regarding release of escrow funds in any proceedings under chapter 120 or this chapter.

(5) (a) Within 30 days after receipt of an application for expansion, the office shall examine the application and shall notify the applicant in writing, specifically setting forth and specifically requesting any additional information that the office is authorized to require. Within 15 days after the office receives all the requested additional information, the office shall notify the applicant in writing that the requested information has been received and that the application is deemed to be complete as of the date of the notice. If the office



872234

chooses not to notify the applicant within the 15-day period,
then the application is deemed complete for purposes of review
on the date the applicant files the additional requested
information. If the application submitted is determined by the
office to be substantially incomplete so as to require
substantial additional information, including biographical
information, the office may return the application to the
applicant with a written notice that the application as received
is substantially incomplete and therefore unacceptable for
filing without further action required by the office. Any filing
fee received must be refunded to the applicant.

(b) An application is deemed complete upon the office
receiving all requested information and the applicant correcting
any error or omission of which the applicant was timely notified
or when the time for such notification has expired. The office
shall notify the applicant in writing of the date on which the
application was deemed complete.

(6) Within 45 days after the date on which an application
is deemed complete as set forth in paragraph (5)(b), the office
shall complete its review and, based upon its review, approve an
expansion by the applicant and issue a determination that the
application meets all requirements of law, that the feasibility
study was based on sufficient data and reasonable assumptions,
and that the applicant will be able to provide continuing care
or continuing care at-home as proposed and meet all financial
and contractual obligations related to its operations, including
the financial requirements of this chapter. The period for
review by the office may not be tolled if the office requests
additional information and the applicant provides information



872234

acceptable to the office within 5 business days. If the application is denied, the office must notify the applicant in writing, citing the specific failures to meet the provisions of this chapter. The denial entitles the applicant to a hearing pursuant to chapter 120.

Section 12. Paragraph (c) of subsection (2) and subsection (3) of section 651.026, Florida Statutes, are amended, subsection (10) is added to that section, and paragraph (a) of subsection (2) of that section is republished, to read:

651.026 Annual reports.—

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

(a) Any change in status with respect to the information required to be filed under s. 651.022(2).

(c) The following financial information:

1. A detailed listing of the assets maintained in the liquid reserve as required under s. 651.035 and in accordance with part II of chapter 625;

2. A schedule giving additional information relating to property, plant, and equipment having an original cost of at least \$25,000, so as to show in reasonable detail with respect to each separate facility original costs, accumulated depreciation, net book value, appraised value or insurable value and date thereof, insurance coverage, encumbrances, and net equity of appraised or insured value over encumbrances. Any property not used in continuing care must be shown separately from property used in continuing care;

3. The level of participation in Medicare or Medicaid programs, or both;



872234

4. A statement of all fees required of residents, including, but not limited to, a statement of the entrance fee charged, the monthly service charges, the proposed application of the proceeds of the entrance fee by the provider, and the plan by which the amount of the entrance fee is determined if the entrance fee is not the same in all cases; and

5. Any change or increase in fees if the provider changes the scope of, or the rates for, care or services, regardless of whether the change involves the basic rate or only those services available at additional costs to the resident.

6. If the provider has more than one certificated facility, or has operations that are not licensed under this chapter, it shall submit a balance sheet, statement of income and expenses, statement of equity or fund balances, and statement of cash flows for each facility licensed under this chapter as supplemental information to the audited financial report ~~statements~~ required under paragraph (b).

7. The management's calculation of the provider's debt service coverage ratio and days cash on hand for the current reporting period, and an opinion from an independent certified public accountant of the management's calculations.

(3) The commission shall adopt by rule additional ~~meaningful~~ measures of assessing the financial viability of a provider. ~~The rule may include the following factors:~~

~~(a) Debt service coverage ratios.~~

~~(b) Current ratios.~~

~~(c) Adjusted current ratios.~~

~~(d) Cash flows.~~

~~(e) Occupancy rates.~~



872234

~~(f) Other measures, ratios, or trends.~~

~~(g) Other factors as may be appropriate.~~

(10) Within 90 days after the conclusion of each annual reporting period, the office shall publish an industry benchmarking report that contains all of the following:

(a) The median days cash on hand for all providers.

(b) The median debt service coverage ratio for all providers.

(c) The median occupancy rate for all providers by setting, including independent living, assisted living, skilled nursing, and the entire campus.

Section 13. Section 651.0261, Florida Statutes, is amended to read:

651.0261 Quarterly and monthly statements.—

(1) Within 45 days after the end of each fiscal quarter, each provider shall file a quarterly unaudited financial statement of the provider or of the facility in the form prescribed by rule of the commission and a detailed listing of the assets maintained in the liquid reserve as required under s. 651.035. This requirement may be waived by the office upon written request from a provider that is accredited or that has obtained an investment grade credit rating from a United States credit rating agency as authorized under s. 651.028. The last quarterly statement for a fiscal year is not required if a provider does not have pending a regulatory action level event or corrective action plan.

(2) If the office finds, pursuant to rules of the commission, that such information is needed to properly monitor the financial condition of a provider or facility or is



872234

otherwise needed to protect the public interest, the office may require the provider to file:

(a) Within 25 days after the end of each month, a monthly unaudited financial statement of the provider or of the facility in the form prescribed by the commission by rule and a detailed listing of the assets maintained in the liquid reserve as required under s. 651.035, ~~within 45 days after the end of each fiscal quarter, a quarterly unaudited financial statement of the provider or of the facility in the form prescribed by the commission by rule. The commission may by rule require all or part of the statements or filings required under this section to be submitted by electronic means in a computer-readable form compatible with the electronic data format specified by the commission.~~

(b) Such other data, financial statements, and pertinent information as the commission or office may reasonably require with respect to the provider or the facility, or its directors, trustees, members, branches, subsidiaries, or affiliates, to determine the financial status of the provider or of the facility and the management capabilities of its managers and owners.

(3) A filing under subsection (2) may be required if any of the following apply:

(a) The facility has been operational for less than 2 years.

(b) The provider is:

1. Subject to administrative supervision proceedings;

2. Subject to a corrective action plan resulting from a regulatory action level event for up to 2 years after the



872234

factors that caused the regulatory action level event have been corrected; or

3. Subject to delinquency or receivership proceedings.

(c) The provider or facility displays a declining financial position.

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

(e) The facility is deemed to be impaired.

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

Section 14. Section 651.028, Florida Statutes, is amended to read:

651.028 Accredited or certain credit-rated facilities.—If a provider or obligated group is accredited without stipulations or conditions by a process found by the office to be acceptable and substantially equivalent to the provisions of this chapter or has obtained an investment grade credit rating from a nationally recognized credit rating agency, as applicable, from Moody's Investors Service, Standard & Poor's, or Fitch Ratings, the office may, pursuant to rule of the commission, waive any requirements of this chapter with respect to the provider if the office finds that such waivers are not inconsistent with the security protections intended by this chapter.

Section 15. Paragraphs (a), (c), and (d) of subsection (1) and subsections (2) and (3) of section 651.033, Florida Statutes, are amended, and subsection (6) is added to that



872234

section, to read:

651.033 Escrow accounts.—

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

(a) The escrow account must ~~shall~~ be established in a Florida bank, Florida savings and loan association, ~~or~~ Florida trust company, or a national bank that is chartered and supervised by the Office of the Comptroller of the Currency within the United States Department of the Treasury and that has either a branch or a license to operate in this state which is acceptable to the office, or such funds must be deposited on ~~deposit~~ with the department, ~~and the funds deposited therein shall~~ be kept and maintained in an account separate and apart from the provider's business accounts.

(c) Any agreement establishing an escrow account required under ~~the provisions of this chapter is~~ shall be subject to approval by the office. The agreement must ~~shall~~ be in writing and ~~shall~~ contain, in addition to any other provisions required by law, a provision whereby the escrow agent agrees to abide by the duties imposed by paragraphs (b) and (e), (3) (a), (3) (b), and (5) (a) and subsection (6) under this section.

(d) All funds deposited in an escrow account, if invested, must ~~shall~~ be invested in cash, cash equivalents, mutual funds, equities, or investment grade bonds as set forth in part II of ~~chapter 625;~~ however, such investment may not diminish the funds held in escrow below the amount required by this chapter. Funds deposited in an escrow account are not subject to charges by the escrow agent except escrow agent fees associated with



872234

administering the accounts, or subject to any liens, judgments, garnishments, creditor's claims, or other encumbrances against the provider or facility except as provided in s. 651.035(1).

(2) Notwithstanding s. 651.035(7), ~~In addition, the escrow agreement shall provide that the escrow agent or another person designated to act in the escrow agent's place and the provider, except as otherwise provided in s. 651.035, shall notify the office in writing at least 10 days before the withdrawal of any portion of any funds required to be escrowed under the provisions of s. 651.035. However,~~ in the event of an emergency and upon petition by the provider, the office may ~~waive the 10-day notification period and~~ allow a withdrawal of up to 10 percent of the required minimum liquid reserve. The office shall have 3 working days to deny the petition for the emergency 10-percent withdrawal. If the office fails to deny the petition within 3 working days, the petition is ~~shall be~~ deemed to have been granted by the office. For purposes ~~the purpose~~ of this section, "working day" means each day that is not a Saturday, Sunday, or legal holiday as defined by Florida law. Also, for purposes ~~the purpose~~ of this section, the day the petition is received by the office is ~~shall~~ not ~~be~~ counted as one of the 3 days.

(3) ~~In addition,~~ When entrance fees are required to be deposited in an escrow account pursuant to s. 651.022, s. 651.023, or s. 651.055:

(a) The provider shall deliver to the resident a written receipt. The receipt must show the payor's name and address, the date, the price of the care contract, and the amount of money paid. A copy of each receipt, together with the funds, must



872234

~~shall~~ be deposited with the escrow agent or as provided in paragraph (c). The escrow agent must ~~shall~~ release such funds to the provider 7 days after the date of receipt of the funds by the escrow agent if the provider, operating under a certificate of authority issued by the office, has met the requirements of s. 651.023(6). However, if the resident rescinds the contract within the 7-day period, the escrow agent must ~~shall~~ release the escrowed fees to the resident.

(b) At the request of an individual resident of a facility, the escrow agent shall issue a statement indicating the status of the resident's portion of the escrow account.

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

(d) A provider may assess a nonrefundable fee, which is separate from the entrance fee, for processing a prospective resident's application for continuing care or continuing care at-home.

(6) Except as described in paragraph (3)(a), the escrow agent may not release or otherwise allow the transfer of funds without the written approval of the office, unless the withdrawal is from funds in excess of the amounts required by ss. 651.022, 651.023, 651.035, and 651.055.

Section 16. Section 651.034, Florida Statutes, is created to read:

651.034 Financial and operating requirements for



872234

providers.—

(1) (a) If a regulatory action level event occurs, the office must:

1. Require the provider to prepare and submit a corrective action plan or, if applicable, a revised corrective action plan;

2. Perform an examination pursuant to s. 651.105 or an analysis, as the office considers necessary, of the assets, liabilities, and operations of the provider, including a review of the corrective action plan or the revised corrective action plan; and

3. After the examination or analysis, issue a corrective order specifying any corrective actions that the office determines are required.

(b) In determining corrective actions, the office shall consider any factor relevant to the provider based upon the office's examination or analysis of the assets, liabilities, and operations of the provider. The provider must submit the corrective action plan or the revised corrective action plan within 30 days after the occurrence of the regulatory action level event. The office shall review and approve or disapprove the corrective action plan within 15 business days.

(c) The office may use members of the Continuing Care Advisory Council, individually or as a group, or may retain actuaries, investment experts, and other consultants to review a provider's corrective action plan or revised corrective action plan, examine or analyze the assets, liabilities, and operations of a provider, and formulate the corrective order with respect to the provider. The fees, costs, and expenses relating to consultants must be borne by the affected provider.



872234

(2) If an impairment occurs, the office must take any action necessary to place the provider under regulatory control, including any remedy available under chapter 631. An impairment is sufficient grounds for the department to be appointed as receiver as provided in chapter 631. Notwithstanding s. 631.011, impairment of a provider, for purposes of s. 631.051, is defined according to the term "impaired" under s. 651.011. The office may forego taking action for up to 180 days after the impairment if the office finds there is a reasonable expectation that the impairment may be eliminated within the 180-day period.

(3) There is no liability on the part of, and a cause of action may not arise against, the commission, department, or office, or their employees or agents, for any action they take in the performance of their powers and duties under this section.

(4) The office shall transmit any notice that may result in regulatory action by registered mail, certified mail, or any other method of transmission which includes documentation of receipt by the provider. Notice is effective when the provider receives it.

(5) This section is supplemental to the other laws of this state and does not preclude or limit any power or duty of the department or office under those laws or under the rules adopted pursuant to those laws.

(6) The office may exempt a provider from subsection (1) or subsection (2) until stabilized occupancy is reached or until the time projected to achieve stabilized occupancy as reported in the last feasibility study required by the office as part of an application filing under s. 651.023, s. 651.024, s. 651.0245,



872234

or s. 651.0246 has elapsed, but for no longer than 5 years from the date of issuance of the certificate of occupancy.

(7) The commission may adopt rules to administer this section, including, but not limited to, rules regarding corrective action plans, revised corrective action plans, corrective orders, and procedures to be followed in the event of a regulatory action level event or an impairment.

Section 17. Paragraphs (a), (b), and (c) of subsection (1) of section 651.035, Florida Statutes, are amended, and subsections (7) through (10) are added to that section, to read:

651.035 Minimum liquid reserve requirements.—

(1) A provider shall maintain in escrow a minimum liquid reserve consisting of the following reserves, as applicable:

(a) Each provider shall maintain in escrow as a debt service reserve the aggregate amount of all principal and interest payments due during the fiscal year on any mortgage loan or other long-term financing of the facility, including property taxes as recorded in the audited financial report ~~statements~~ required under s. 651.026. The amount must include any leasehold payments and all costs related to such payments. If principal payments are not due during the fiscal year, the provider must ~~shall~~ maintain in escrow as a minimum liquid reserve an amount equal to interest payments due during the next 12 months on any mortgage loan or other long-term financing of the facility, including property taxes. If a provider does not have a mortgage loan or other financing on the facility, the provider must deposit monthly in escrow as a minimum liquid reserve an amount equal to one-twelfth of the annual property tax liability as indicated in the most recent tax notice



872234

provided pursuant to s. 197.322(3).

(b) A provider that has outstanding indebtedness that requires a debt service reserve to be held in escrow pursuant to a trust indenture or mortgage lien on the facility and for which the debt service reserve may only be used to pay principal and interest payments on the debt that the debtor is obligated to pay, and which may include property taxes and insurance, may include such debt service reserve in computing the minimum liquid reserve needed to satisfy this subsection if the provider furnishes to the office a copy of the agreement under which such debt service is held, together with a statement of the amount being held in escrow for the debt service reserve, certified by the lender or trustee and the provider to be correct. The trustee shall provide the office with any information concerning the debt service reserve account upon request of the provider or the office. Such separate debt service reserves, if any, are not subject to the transfer provisions set forth in subsection (8).

(c) Each provider shall maintain in escrow an operating reserve equal to 30 percent of the total operating expenses projected in the feasibility study required by s. 651.023 for the first 12 months of operation. Thereafter, each provider shall maintain in escrow an operating reserve equal to 15 percent of the total operating expenses in the annual report filed pursuant to s. 651.026. If a provider has been in operation for more than 12 months, the total annual operating expenses must ~~shall~~ be determined by averaging the total annual operating expenses reported to the office by the number of annual reports filed with the office within the preceding 3-year period subject to adjustment if there is a change in the number



872234

of facilities owned. For purposes of this subsection, total annual operating expenses include all expenses of the facility except+ depreciation and amortization; interest and property taxes included in paragraph (a); extraordinary expenses that are adequately explained and documented in accordance with generally accepted accounting principles; liability insurance premiums in excess of those paid in calendar year 1999; and changes in the obligation to provide future services to current residents. For providers initially licensed during or after calendar year 1999, liability insurance must ~~shall~~ be included in the total operating expenses in an amount not to exceed the premium paid during the first 12 months of facility operation. ~~Beginning January 1, 1993,~~ The operating reserves required under this subsection must ~~shall~~ be in an unencumbered account held in escrow for the benefit of the residents. Such funds may not be encumbered or subject to any liens or charges by the escrow agent or judgments, garnishments, or creditors' claims against the provider or facility. However, if a facility had a lien, mortgage, trust indenture, or similar debt instrument in place before January 1, 1993, which encumbered all or any part of the reserves required by this subsection and such funds were used to meet the requirements of this subsection, then such arrangement may be continued, unless a refinancing or acquisition has occurred, and the provider is ~~shall be~~ in compliance with this subsection.

(7) (a) A provider may withdraw funds held in escrow without the approval of the office if the amount held in escrow exceeds the requirements of this section and if the withdrawal will not affect compliance with this section.



872234

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

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

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

(8) The office may order the immediate transfer of up to 100 percent of the funds held in the minimum liquid reserve to the custody of the department pursuant to part III of chapter 625 if the office finds that the provider is impaired or insolvent. The office may order such a transfer regardless of whether the office has suspended or revoked, or intends to suspend or revoke, the certificate of authority of the provider.

(9) Each facility shall file with the office annually, together with the annual report required by s. 651.026, a calculation of its minimum liquid reserve, determined in accordance with this section, on a form prescribed by the commission. The minimum liquid reserve must be maintained at the calculated level within 60 days after filing the annual report.

(10) If the balance of the minimum liquid reserve is below



872234

the required amount at the end of any month, the provider must fund the shortfall in the reserve within 10 business days after the beginning of the following month. If the balance of the minimum liquid reserve is not restored to the required amount within such time, the provider will be deemed out of compliance with this section.

Section 18. Section 651.043, Florida Statutes, is created to read:

651.043 Approval of change in management.—

(1) As used in this section, the term "management" means:

(a) A manager or management company; or

(b) A person who exercises or who has the ability to exercise effective control of the provider or organization, or who influences or has the ability to influence the transaction of the business of the provider.

(2) A contract for management entered into after July 1, 2018, must be in writing and include a provision that the contract will be canceled upon issuance of an order by the office pursuant to this section without the application of any cancellation fee or penalty. If a provider contracts with a management company, a separate written contract is not required for the individual manager employed by the management company to oversee a facility.

(3) A provider must notify the office, in writing or electronically, of any change in management within 10 business days. For each new management appointment, the provider must submit the information required by s. 651.022(2) and a copy of the written management contract, if applicable.

(4) For a provider that is deemed to be impaired or that



872234

has a regulatory action level event pending, the office may disapprove new management and order the provider to remove the new management after reviewing the information required in subsection (3).

(5) For a provider other than that specified in subsection (4), the office may disapprove new management and order the provider to remove the new management after receiving the required information in subsection (3) if the office:

(a) Finds that the new management is incompetent or untrustworthy;

(b) Finds that the new management is so lacking in relevant managerial experience as to make the proposed operation hazardous to the residents or potential residents;

(c) Finds that the new management is so lacking in relevant experience, ability, and standing as to jeopardize the reasonable promise of successful operation; or

(d) Has good reason to believe that the new management is affiliated directly or indirectly through ownership, control, or business relations with any person or persons whose business operations are or have been marked by manipulation of assets or accounts or by bad faith, to the detriment of residents, stockholders, investors, creditors, or the public.

The office shall complete its review as required under subsections (4) and (5) and, if applicable, issue notice of disapproval of the new management within 15 business days after the filing is deemed complete. A filing is deemed complete upon the office's receipt of all requested information and the provider's correction of any error or omission for which the



872234

provider was timely notified. If the office does not issue notice of disapproval of the new management within 15 business days after the filing is deemed complete, then the new management is deemed approved.

(6) Management disapproved by the office must be removed within 30 days after receipt by the provider of notice of such disapproval.

(7) The office may revoke, suspend, or take other administrative action against the certificate of authority of the provider if the provider:

(a) Fails to timely remove management disapproved by the office;

(b) Fails to timely notify the office of a change in management;

(c) Appoints new management without a written contract; or

(d) Repeatedly appoints management that was previously disapproved by the office or that is not approvable pursuant to subsection (5).

(8) The provider shall remove any management immediately upon discovery of any of the following conditions, if the conditions were not disclosed in the notice to the office required in subsection (3):

(a) That any person who exercises or has the ability to exercise effective control of the provider, or who influences or has the ability to influence the transaction of the business of the provider, has been found guilty of, or has pled guilty or no contest to, any felony or crime punishable by imprisonment of 1 year or more under the laws of the United States or any state thereof or under the laws of any other country which involves



872234

moral turpitude, without regard to whether a judgment or conviction has been entered by the court having jurisdiction in such case.

(b) That any person who exercises or has the ability to exercise effective control of the organization, or who influences or has the ability to influence the transaction of the business of the provider, is now or was in the past affiliated, directly or indirectly, through ownership interest of 10 percent or more in, or control of, any business, corporation, or other entity that has been found guilty of or has pled guilty or no contest to any felony or crime punishable by imprisonment for 1 year or more under the laws of the United States, any state, or any other country, regardless of adjudication.

The failure to remove such management is grounds for revocation or suspension of the provider's certificate of authority.

Section 19. Section 651.051, Florida Statutes, is amended to read:

651.051 Maintenance of assets and records in state.—All records and assets of a provider must be maintained in this state, or, if the provider's corporate office is located in another state, must be electronically stored in a manner that will ensure that the records are readily accessible to the office. No records or assets may be removed from this state by a provider unless the office consents to such removal in writing before such removal. Such consent must ~~shall~~ be based upon the provider's submitting satisfactory evidence that the removal will facilitate and make more economical the operations of the



872234

provider and will not diminish the service or protection thereafter to be given the provider's residents in this state. Before ~~Prior to~~ such removal, the provider shall give notice to the president or chair of the facility's residents' council. If such removal is part of a cash management system which has been approved by the office, disclosure of the system must ~~shall~~ meet the notification requirements. The electronic storage of records on a web-based, secured storage platform by contract with a third party is acceptable if the records are readily accessible to the office.

Section 20. Subsection (2) of section 651.057, Florida Statutes, is amended to read:

651.057 Continuing care at-home contracts.—

(2) A provider that holds a certificate of authority and wishes to offer continuing care at-home must also:

(a) Submit a business plan to the office with the following information:

1. A description of the continuing care at-home services that will be provided, the market to be served, and the fees to be charged;

2. A copy of the proposed continuing care at-home contract;

3. An actuarial study prepared by an independent actuary in accordance with the standards adopted by the American Academy of Actuaries which presents the impact of providing continuing care at-home on the overall operation of the facility; and

4. A market feasibility study that meets the requirements of s. 651.022(4) ~~s. 651.022(3)~~ and documents that there is sufficient interest in continuing care at-home contracts to support such a program;



872234

(b) Demonstrate to the office that the proposal to offer continuing care at-home contracts to individuals who do not immediately move into the facility will not place the provider in an unsound financial condition;

(c) Comply with the requirements of s. 651.0246(1) ~~s. 651.021(2)~~, except that an actuarial study may be substituted for the feasibility study; and

(d) Comply with the requirements of this chapter.

Section 21. Subsection (1) of section 651.071, Florida Statutes, is amended to read:

651.071 Contracts as preferred claims on liquidation or receivership.—

(1) In the event of receivership or liquidation proceedings against a provider, all continuing care and continuing care at-home contracts executed by a provider are ~~shall be~~ deemed preferred claims or policyholder loss preferred claims pursuant to s. 631.271(1)(b) against all assets owned by the provider; however, such claims are subordinate to any secured claim.

Section 22. Subsection (2) and present paragraph (g) of subsection (3) of section 651.091, Florida Statutes, are amended, present paragraphs (h) and (i) of subsection (3) of that section are redesignated as paragraphs (g) and (h), respectively, a new paragraph (i) and paragraphs (j), (k), and (l) are added to that subsection, and paragraph (d) of subsection (3) and subsection (4) of that section are republished, to read:

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

(2) Every continuing care facility shall:



872234

(a) Display the certificate of authority in a conspicuous place inside the facility.

(b) Post in a prominent position in the facility which is accessible to all residents and the general public a concise summary of the last examination report issued by the office, with references to the page numbers of the full report noting any deficiencies found by the office, and the actions taken by the provider to rectify such deficiencies, indicating in such summary where the full report may be inspected in the facility.

(c) Provide notice to the president or chair of the residents' council within 10 business days after issuance of a final examination report or the initiation of any legal or administrative proceeding by the office or the department and include a copy of such document.

(d)~~(e)~~ Post in a prominent position in the facility which is accessible to all residents and the general public a summary of the latest annual statement, indicating in the summary where the full annual statement may be inspected in the facility. A listing of any proposed changes in policies, programs, and services must also be posted.

(e)~~(d)~~ Distribute a copy of the full annual statement and a copy of the most recent third-party ~~third-party~~ financial audit filed with the annual report to the president or chair of the residents' council within 30 days after filing the annual report with the office, and designate a staff person to provide explanation thereof.

(f)~~(e)~~ Deliver the information described in s. 651.085(4) in writing to the president or chair of the residents' council and make supporting documentation available upon request ~~Notify~~



872234

~~the residents' council of any plans filed with the office to obtain new financing, additional financing, or refinancing for the facility and of any applications to the office for any expansion of the facility.~~

(g)~~(f)~~ Deliver to the president or chair of the residents' council a summary of entrance fees collected and refunds made during the time period covered in the annual report and the refund balances due at the end of the report period.

(h)~~(g)~~ Deliver to the president or chair of the residents' council a copy of each quarterly statement within 30 days after the quarterly statement is filed with the office if the facility is required to file quarterly.

(i)~~(h)~~ Upon request, deliver to the president or chair of the residents' council a copy of any newly approved continuing care or continuing care at-home contract within 30 days after approval by the office.

(j) Provide to the president or chair of the residents' council a copy of any notice filed with the office relating to any change in ownership within 10 business days after such filing by the provider.

(k) Make the information available to prospective residents pursuant to paragraph (3) (d) available to current residents and provide notice of changes to that information to the president or chair of the residents' council within 3 business days.

(3) Before entering into a contract to furnish continuing care or continuing care at-home, the provider undertaking to furnish the care, or the agent of the provider, shall make full disclosure, and provide copies of the disclosure documents to the prospective resident or his or her legal representative, of



872234

the following information:

(d) In keeping with the intent of this subsection relating to disclosure, the provider shall make available for review master plans approved by the provider's governing board and any plans for expansion or phased development, 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.

~~(g) The amount and location of any reserve funds required by this chapter, and the name of the person or entity having a claim to such funds in the event of a bankruptcy, foreclosure, or rehabilitation proceeding.~~

(i) Notice of the issuance of a final examination report or the initiation of any legal or administrative proceeding by the office or the department, including where the report or filing may be inspected in the facility, and that upon request, an electronic copy or specific website address will be provided where the document can be downloaded at no cost.

(j) Notice that the entrance fee is the property of the provider after the expiration of the 7-day escrow requirement under s. 651.055(2).

(k) If the provider operates multiple facilities, a disclosure of any distribution of assets or income between facilities that may occur and the manner in which such distributions would be made, or a statement that such distributions will not occur.

(l) Notice of any holding company system or obligated group of which the provider is a member.



872234

(4) A true and complete copy of the full disclosure document to be used must be filed with the office before use. A resident or prospective resident or his or her legal representative may inspect the full reports referred to in paragraph (2)(b); the charter or other agreement or instrument required to be filed with the office pursuant to s. 651.022(2), together with all amendments thereto; and the bylaws of the corporation or association, if any. Upon request, copies of the reports and information shall be provided to the individual requesting them if the individual agrees to pay a reasonable charge to cover copying costs.

Section 23. Subsections (1) and (5) of section 651.105, Florida Statutes, are amended, and subsections (7) and (8) are added to that section, to read:

651.105 Examination and inspections.—

(1) The office may at any time, and shall at least once every 3 years, examine the business of any applicant for a certificate of authority and any provider engaged in the execution of care contracts or engaged in the performance of obligations under such contracts, in the same manner as is provided for the examination of insurance companies pursuant to ss. 624.316 and 624.318 ~~s. 624.316~~. For a provider as described ~~defined~~ in s. 651.028, such examinations must ~~shall~~ take place at least once every 5 years. Such examinations must ~~shall~~ be made by a representative or examiner designated by the office whose compensation will be fixed by the office pursuant to s. 624.320. Routine examinations may be made by having the necessary documents submitted to the office; and, for this purpose, financial documents and records conforming to commonly



872234

accepted accounting principles and practices, as required under s. 651.026, are deemed adequate. The final written report of each examination must be filed with the office and, when so filed, constitutes a public record. Any provider being examined shall, upon request, give reasonable and timely access to all of its records. The representative or examiner designated by the office may at any time examine the records and affairs and inspect the physical property of any provider, whether in connection with a formal examination or not.

(5) A provider must respond to written correspondence from the office and provide data, financial statements, and pertinent information as requested by the office or by the office's investigators, examiners, or inspectors. The office has standing to petition a circuit court for mandatory injunctive relief to compel access to and require the provider to produce the documents, data, records, and other information requested by the office or its investigators, examiners, or inspectors. The office may petition the circuit court in the county in which the facility is situated or the Circuit Court of Leon County to enforce this section ~~At the time of the routine examination, the office shall determine if all disclosures required under this chapter have been made to the president or chair of the residents' council and the executive officer of the governing body of the provider.~~

(7) Unless a provider or facility is impaired or subject to a regulatory action level event, any parent, subsidiary, or affiliate is not subject to examination by the office as part of a routine examination. However, if a provider or facility relies on a contractual or financial relationship with a parent,



872234

subsidiary, or affiliate in order to demonstrate the provider or facility's financial condition is in compliance with this chapter, the office may examine any parent, subsidiary, or affiliate that has a contractual or financial relationship with the provider or facility to the extent necessary to ascertain the financial condition of the provider.

(8) If a provider voluntarily contracts with an actuary for an actuarial study or review at regular intervals, the office may not use any recommendations made by the actuary as a measure of performance when conducting an examination or inspection. The office may not request, as part of the examination or inspection, documents associated with an actuarial study or review marked "restricted distribution" if the study or review is not required by this chapter.

Section 24. Section 651.106, Florida Statutes, is amended to read:

651.106 Grounds for discretionary refusal, suspension, or revocation of certificate of authority.—The office may deny an application or ~~suspend~~ or revoke the provisional certificate of authority or the certificate of authority of any applicant or provider if it finds that any one or more of the following grounds applicable to the applicant or provider exist:

(1) Failure by the provider to continue to meet the requirements for the authority originally granted.

(2) Failure by the provider to meet one or more of the qualifications for the authority specified by this chapter.

(3) Material misstatement, misrepresentation, or fraud in obtaining the authority, or in attempting to obtain the same.

(4) Demonstrated lack of fitness or trustworthiness.



872234

(5) Fraudulent or dishonest practices of management in the conduct of business.

(6) Misappropriation, conversion, or withholding of moneys.

(7) Failure to comply with, or violation of, any proper order or rule of the office or commission or violation of any provision of this chapter.

(8) The insolvent or impaired condition of the provider or the provider's being in such condition or using such methods and practices in the conduct of its business as to render its further transactions in this state hazardous or injurious to the public.

(9) Refusal by the provider to be examined or to produce its accounts, records, and files for examination, or refusal by any of its officers to give information with respect to its affairs or to perform any other legal obligation under this chapter when required by the office.

(10) Failure by the provider to comply with the requirements of s. 651.026 or s. 651.033.

(11) Failure by the provider to maintain escrow accounts or funds as required by this chapter.

(12) Failure by the provider to meet the requirements of this chapter for disclosure of information to residents concerning the facility, its ownership, its management, its development, or its financial condition or failure to honor its continuing care or continuing care at-home contracts.

(13) Any cause for which issuance of the license could have been refused had it then existed and been known to the office.

(14) Having been found guilty of, or having pleaded guilty or nolo contendere to, a felony in this state or any other



872234

state, without regard to whether a judgment or conviction has been entered by the court having jurisdiction of such cases.

(15) In the conduct of business under the license, engaging in unfair methods of competition or in unfair or deceptive acts or practices prohibited under part IX of chapter 626.

(16) A pattern of bankrupt enterprises.

(17) The ownership, control, or management of the organization includes any person:

(a) Who is not reputable and of responsible character;

(b) Who is so lacking in management expertise as to make the operation of the provider hazardous to potential and existing residents;

(c) Who is so lacking in management experience, ability, and standing as to jeopardize the reasonable promise of successful operation;

(d) Who is affiliated, directly or indirectly, through ownership or control, with any person whose business operations are or have been marked by business practices or conduct that is detrimental to the public, stockholders, investors, or creditors; or

(e) Whose business operations are or have been marked by business practices or conduct that is detrimental to the public, stockholders, investors, or creditors.

(18) The provider has not filed a notice of change in management, fails to remove a disapproved manager, or persists in appointing disapproved managers.

Revocation of a certificate of authority under this section does not relieve a provider from the provider's obligation to



872234

residents under the terms and conditions of any continuing care or continuing care at-home contract between the provider and residents or the provisions of this chapter. The provider shall continue to file its annual statement and pay license fees to the office as required under this chapter as if the certificate of authority had continued in full force, but the provider shall not issue any new contracts. The office may seek an action in the Circuit Court of Leon County to enforce the office's order and the provisions of this section.

Section 25. Section 651.1065, Florida Statutes, is created to read:

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

(1) Regardless of whether delinquency proceedings as to a continuing care retirement community have been or are to be initiated, a proprietor, general partner, member, officer, director, trustee, or manager of a continuing care retirement community may not actively solicit, approve the solicitation or acceptance of, or accept new continuing care contracts in this state after the proprietor, general partner, member, officer, director, trustee, or manager knew, or reasonably should have known, that the continuing care retirement community was impaired or insolvent, except with the written permission of the office, unless the facility has declared bankruptcy, in which case the bankruptcy court or trustee appointed by the court has jurisdiction over such matters. The office must approve or disapprove the continued marketing of new contracts within 15 days after receiving a request from a provider.

(2) A proprietor, general partner, member, officer,



872234

director, trustee, or manager who violates this section commits
a felony of the third degree, punishable as provided in s.
775.082, s. 775.083, or s. 775.084.

Section 26. Section 651.111, Florida Statutes, is amended
to read:

651.111 Requests for inspections.—

(1) Any interested party may request an inspection of the
records and related financial affairs of a provider providing
care in accordance with ~~the provisions of~~ this chapter by
transmitting to the office notice of an alleged violation of
applicable requirements prescribed by statute or by rule,
specifying to a reasonable extent the details of the alleged
violation, which notice must ~~shall~~ be signed by the complainant.

(2) The substance of the complaint must ~~shall~~ be given to
the provider no earlier than the time of the inspection. Unless
the complainant specifically requests otherwise, neither the
substance of the complaint which is provided to the provider nor
any copy of the complaint, closure statement, or any record
which is published, released, or otherwise made available to the
provider may ~~shall~~ disclose the name of any person mentioned in
the complaint except the name of any duly authorized officer,
employee, or agent of the office conducting the investigation or
inspection pursuant to this chapter.

(3) Upon receipt of a complaint, the office shall make a
preliminary review; and, unless the office determines that the
complaint is without any reasonable basis or the complaint does
not request an inspection, the office shall make an inspection.
The office shall provide the complainant with a written
acknowledgment of the complaint within 15 days after receipt by



872234

the office. Such acknowledgment must include the case number assigned by the office to the complaint and the name and contact information of any duly authorized officer, employee, or agent of the office conducting the investigation or inspection pursuant to this chapter. The complainant must ~~shall~~ be advised, within 30 days after the receipt of the complaint by the office, of the proposed course of action of the office, including an estimated timeframe for the handling of the complaint. If the office does not conclude its inspection or investigation within the office's estimated timeframe, the office must advise the complainant in writing within 15 days after any revised course of action, including a revised estimated timeframe for the handling of the complaint. Within 15 days after the office completes its inspection or concludes its investigation, the office shall provide the complainant and the provider a written closure statement specifying the office's findings and the results of any inspection or investigation.

(4) A ~~No~~ provider operating under a certificate of authority under this chapter may not discriminate or retaliate in any manner against a resident or an employee of a facility providing care because such resident or employee or any other person has initiated a complaint pursuant to this section.

Section 27. Section 651.114, Florida Statutes, is amended to read:

651.114 Delinquency proceedings; remedial rights.—

(1) Upon determination by the office that a provider is not in compliance with this chapter, the office may notify the chair of the Continuing Care Advisory Council, who may assist the office in formulating a corrective action plan.



872234

(2) Within 30 days after a request by either the advisory council or the office, a provider shall make a plan for obtaining compliance or solvency available to the advisory council and the office, ~~within 30 days after being requested to do so by the council, a plan for obtaining compliance or solvency.~~

(3) Within 30 days after receipt of a plan for obtaining compliance or solvency, the office, or notification, the advisory council at the request of the office, shall:

(a) Consider and evaluate the plan submitted by the provider.

(b) Discuss the problem and solutions with the provider.

(c) Conduct such other business as is necessary.

(d) Report its findings and recommendations to the office, which may require additional modification of the plan.

This subsection may not be interpreted so as to delay or prevent the office from taking any regulatory measures it deems necessary regarding the provider that submitted the plan.

(4) If the financial condition of a continuing care facility or provider is impaired or is such that if not modified or corrected, its continued operation would result in insolvency, the office may direct the provider to formulate and file with the office a corrective action plan. If the provider fails to submit a plan within 30 days after the office's directive, or submits a plan that is insufficient to correct the condition, the office may specify a plan and direct the provider to implement the plan. Before specifying a plan, the office may seek a recommended plan from the advisory council.



872234

(5)~~(4)~~ After receiving approval of a plan by the office, the provider shall submit a progress report monthly to the advisory council or the office, or both, in a manner prescribed by the office. After 3 months, or at any earlier time deemed necessary, the council shall evaluate the progress by the provider and shall advise the office of its findings.

~~(6)(5)~~ If ~~should~~ the office finds ~~find~~ that sufficient grounds exist for rehabilitation, liquidation, conservation, reorganization, seizure, or summary proceedings of an insurer as set forth in ss. 631.051, 631.061, and 631.071, the department ~~office~~ may petition for an appropriate court order or may pursue such other relief as is afforded in part I of chapter 631. Before invoking its powers under part I of chapter 631, the department ~~office~~ shall notify the chair of the advisory council.

(7) Notwithstanding s. 631.011, impairment of a provider, for purposes of s. 631.051, is defined according to the term "impaired" in s. 651.011.

~~(8)(6)~~ In the event an order of conservation, rehabilitation, liquidation, or ~~conservation, reorganization, seizure, or summary proceeding~~ has been entered against a provider, the department and office are vested with all of the powers and duties they have under ~~the provisions of~~ part I of chapter 631 in regard to delinquency proceedings of insurance companies. A provider shall give written notice of the proceeding to its residents within 3 business days after the initiation of a delinquency proceeding under chapter 631 and shall include a notice of the delinquency proceeding in any written materials provided to prospective residents.



872234

~~(7) If the financial condition of the continuing care facility or provider is such that, if not modified or corrected, its continued operation would result in insolvency, the office may direct the provider to formulate and file with the office a corrective action plan. If the provider fails to submit a plan within 30 days after the office's directive or submits a plan that is insufficient to correct the condition, the office may specify a plan and direct the provider to implement the plan.~~

(9) A provider subject to an order to show cause entered pursuant to chapter 631 must file its written response to the order, together with any defenses it may have to the department's allegations, no later than 20 days after service of the order to show cause, but no less than 15 days before the date of the hearing set by the order to show cause.

(10) A hearing held pursuant to chapter 631 to determine whether cause exists for the department to be appointed receiver must be commenced within 60 days after an order directing a provider to show cause.

(11) (a) ~~(8) (a)~~ The rights of the office described in this section are subordinate to the rights of a trustee or lender pursuant to the terms of a resolution, ordinance, loan agreement, indenture of trust, mortgage, lease, security agreement, or other instrument creating or securing bonds or notes issued to finance a facility, and the office, subject to the provisions of paragraph (c), may ~~shall~~ not exercise its remedial rights provided under this section and ss. 651.018, 651.106, 651.108, and 651.116 with respect to a facility that is not in default of any financial or contractual obligation other than ~~subject to~~ a lien, mortgage, lease, or other encumbrance or



872234

trust indenture securing bonds or notes issued in connection with the financing of the facility, if the trustee or lender, by inclusion or by amendment to the loan documents or by a separate contract with the office, agrees that the rights of residents under a continuing care or continuing care at-home contract will be honored and will not be disturbed by a foreclosure or conveyance in lieu thereof as long as the resident:

1. Is current in the payment of all monetary obligations required by the contract;

2. Is in compliance and continues to comply with all provisions of the contract; and

3. Has asserted no claim inconsistent with the rights of the trustee or lender.

(b) This subsection does not require a trustee or lender to:

1. Continue to engage in the marketing or resale of new continuing care or continuing care at-home contracts;

2. Pay any rebate of entrance fees as may be required by a resident's continuing care or continuing care at-home contract as of the date of acquisition of the facility by the trustee or lender and until expiration of the period described in paragraph (d);

3. Be responsible for any act or omission of any owner or operator of the facility arising before the acquisition of the facility by the trustee or lender; or

4. Provide services to the residents to the extent that the trustee or lender would be required to advance or expend funds that have not been designated or set aside for such purposes.

(c) Should the office determine, at any time during the



872234

suspension of its remedial rights as provided in paragraph (a), that the trustee or lender is not in compliance with paragraph (a), or that a lender or trustee has assigned or has agreed to assign all or a portion of a delinquent or defaulted loan to a third party without the office's written consent, the office shall notify the trustee or lender in writing of its determination, setting forth the reasons giving rise to the determination and specifying those remedial rights afforded to the office which the office shall then reinstate.

(d) Upon acquisition of a facility by a trustee or lender and evidence satisfactory to the office that the requirements of paragraph (a) have been met, the office shall issue a 90-day temporary certificate of authority granting the trustee or lender the authority to engage in the business of providing continuing care or continuing care at-home and to issue continuing care or continuing care at-home contracts subject to the office's right to immediately suspend or revoke the temporary certificate of authority if the office determines that any of the grounds described in s. 651.106 apply to the trustee or lender or that the terms of the contract used as the basis for the issuance of the temporary certificate of authority by the office have not been or are not being met by the trustee or lender since the date of acquisition.

Section 28. Section 651.1141, Florida Statutes, is created to read:

651.1141 Immediate final orders.—The office may issue an immediate final order to cease and desist if the office finds that installation of a general partner of a provider or assumption of ownership or possession or control of 10 percent



872234

or more of a provider's assets in violation of s. 651.024 or s. 651.0245, the removal or commitment of 10 percent or more of the required minimum liquid reserve funds in violation of s. 651.035, or the assumption of control over a facility's operations in violation of s. 651.043 has occurred.

Section 29. Paragraphs (d) and (e) of subsection (1) of section 651.121, Florida Statutes, are amended to read:

651.121 Continuing Care Advisory Council.—

(1) The Continuing Care Advisory Council to the office is created consisting of 10 members who are residents of this state appointed by the Governor and geographically representative of this state. Three members shall be administrators of facilities that hold valid certificates of authority under this chapter and shall have been actively engaged in the offering of continuing care contracts in this state for 5 years before appointment. The remaining members include:

~~(d) An attorney.~~

~~(d)(e)~~ Four ~~Three~~ residents who hold continuing care or continuing care at-home contracts with a facility certified in this state.

Section 30. Subsections (1) and (4) of section 651.125, Florida Statutes, are amended to read:

651.125 Criminal penalties; injunctive relief.—

(1) Any person who maintains, enters into, or, as manager or officer or in any other administrative capacity, assists in entering into, maintaining, or performing any continuing care or continuing care at-home contract subject to this chapter without ~~doing so in pursuance of~~ a valid provisional certificate of authority or certificate of authority ~~or renewal thereof~~, as



872234

contemplated by or provided in this chapter, or who otherwise violates any provision of this chapter or rule adopted in pursuance of this chapter, commits a felony of the third degree, punishable as provided in s. 775.082 or s. 775.083. Each violation of this chapter constitutes a separate offense.

(4) Any action brought by the office against a provider shall not abate by reason of a sale or other transfer of ownership of the facility used to provide care, which provider is a party to the action, except with the express written consent of the ~~director of the~~ office.

Section 31. This act shall take effect July 1, 2018.

===== T I T L E A M E N D M E N T =====

And the title is amended as follows:

Delete everything before the enacting clause
and insert:

A bill to be entitled
An act relating to continuing care contracts; amending
s. 651.011, F.S.; defining and redefining terms;
amending s. 651.012, F.S.; conforming a cross-
reference; deleting an obsolete date; amending s.
651.013, F.S.; revising applicability of specified
provisions of the Florida Insurance Code to the Office
of Insurance Regulation's authority to regulate
providers of continuing care and continuing care at-
home; amending s. 651.019, F.S.; revising notice and
filing requirements for providers and facilities with
respect to new and additional financing and
refinancing; amending s. 651.021, F.S.; conforming



872234

2273 provisions to changes made by the act; creating s.
2274 651.0215, F.S.; specifying conditions that qualify an
2275 applicant for a certificate of authority without first
2276 obtaining a provisional certificate of authority;
2277 specifying requirements for the consolidated
2278 application; requiring an applicant to obtain separate
2279 certificates of authority for multiple facilities;
2280 specifying procedures and requirements for the
2281 office's review of such applications and issuance or
2282 denial of certificates of authority; providing
2283 requirements for reservation contracts, entrance fees,
2284 and reservation deposits; authorizing a provider to
2285 secure release of moneys held in escrow under
2286 specified circumstances; providing construction
2287 relating to the release of escrow funds; amending s.
2288 651.022, F.S.; revising the office's authority to make
2289 certain inquiries in the review of applications for
2290 provisional certificates of authority; specifying
2291 requirements for application amendments if material
2292 changes occur; requiring applicants to submit a
2293 specified feasibility study; revising procedures and
2294 requirements for the office's review of such
2295 applications; conforming a provision to changes made
2296 by the act; making a technical change; conforming
2297 cross-references; amending s. 651.023, F.S.; revising
2298 requirements for an application for a certificate of
2299 authority; specifying requirements for application
2300 amendments if material changes occur; revising
2301 procedures and requirements for the office's review of



872234

2302 such applications; revising minimum unit reservation
2303 and minimum deposit requirements; revising conditions
2304 under which a provider is entitled to secure release
2305 of certain moneys held in escrow; conforming
2306 provisions to changes made by the act; conforming
2307 cross-references; amending s. 651.024, F.S.; providing
2308 and revising applicability of certain provisions to a
2309 person seeking to assume the role of general partner
2310 of a provider or seeking specified ownership,
2311 possession, or control of a provider's assets;
2312 providing applicability of certain provisions to a
2313 person seeking to acquire and become the provider for
2314 a facility; providing procedures for filing a
2315 disclaimer of control; defining terms; providing
2316 standing to the office to petition a circuit court in
2317 certain proceedings; creating s. 651.0245, F.S.;
2318 prohibiting a person, without the office's prior
2319 written approval, from acquiring a facility operating
2320 under a subsisting certificate of authority and
2321 engaging in the business of providing continuing care;
2322 providing requirements for an applicant seeking
2323 simultaneous acquisition of a facility and issuance of
2324 a certificate of authority; requiring the Financial
2325 Services Commission to adopt by rule certain
2326 application requirements; requiring the office to
2327 review applications and issue approvals or
2328 disapprovals of filings in accordance with specified
2329 provisions; defining terms; providing standing to the
2330 office to petition a specified circuit court under



872234

2331 certain circumstances; providing procedures for filing
2332 a disclaimer of control; providing construction;
2333 authorizing the commission to adopt, amend, and repeal
2334 rules; creating s. 651.0246, F.S.; requiring a
2335 provider to obtain written approval from the office
2336 before commencing construction or marketing for
2337 specified expansions of a certificated facility;
2338 providing that a provider is automatically granted
2339 approval for certain expansions under specified
2340 circumstances; defining the term "existing units";
2341 providing applicability; specifying requirements for
2342 applying for such approval; requiring the office to
2343 consider certain factors in reviewing such
2344 applications; providing procedures and requirements
2345 for the office's review of applications and approval
2346 or denial of expansions; specifying requirements for
2347 escrowed moneys and for the release of the moneys;
2348 defining the term "initial entrance fee"; providing
2349 construction; amending s. 651.026, F.S.; revising
2350 requirements for annual reports that providers file
2351 with the office; revising guidelines for commission
2352 rulemaking; requiring the office to publish, within
2353 specified timeframes, a specified annual report;
2354 amending s. 651.0261, F.S.; revising requirements for
2355 quarterly statements filed by providers and facilities
2356 with the office; authorizing the office to waive
2357 certain filing requirements under certain
2358 circumstances; authorizing the office to require,
2359 under certain circumstances, providers or facilities



872234

2360 to file monthly unaudited financial statements and
2361 certain other information; authorizing the commission
2362 to adopt certain rules; amending s. 651.028, F.S.;
2363 authorizing the office, under certain circumstances,
2364 to waive any requirement of ch. 651, F.S., for
2365 providers or obligated groups having certain
2366 accreditations or credit ratings; amending s. 651.033,
2367 F.S.; revising requirements for escrow accounts and
2368 escrow agreements; revising requirements for, and
2369 restrictions on, agents of escrow accounts; revising
2370 permissible investments for funds in an escrow
2371 account; revising requirements for the withdrawal of
2372 escrowed funds under certain circumstances; creating
2373 s. 651.034, F.S.; specifying requirements and
2374 procedures for the office if a regulatory action level
2375 event occurs; authorizing the office to use members of
2376 the Continuing Care Advisory Council or retain
2377 consultants for specified purposes; requiring affected
2378 providers to bear fees, costs, and expenses for such
2379 consultants; requiring the office to take certain
2380 actions if an impairment occurs; authorizing the
2381 office to forego taking action for a certain timeframe
2382 under certain circumstances; providing immunity from
2383 liability to the commission, the Department of
2384 Financial Services, the office, and their employees or
2385 agents for certain actions; requiring the office to
2386 transmit any notice that may result in regulatory
2387 action by certain methods; authorizing the office to
2388 exempt a provider from specified requirements under



872234

2389 certain circumstances and for a specified timeframe;
2390 authorizing the commission to adopt rules; providing
2391 construction; amending s. 651.035, F.S.; revising
2392 provider minimum liquid reserve requirements under
2393 specified circumstances; deleting an obsolete date;
2394 authorizing providers, under certain circumstances, to
2395 withdraw funds held in escrow without the office's
2396 approval; providing procedures and requirements to
2397 request approval for certain withdrawals; providing
2398 procedures and requirements for the office's review of
2399 such requests; authorizing the office, under certain
2400 circumstances, to order the immediate transfer of
2401 funds in the minimum liquid reserve to the custody of
2402 the department; providing that certain debt service
2403 reserves of a provider are not subject to such
2404 transfer provision; requiring facilities to file
2405 annual calculations of their minimum liquid reserves
2406 with the office and maintain such reserves beginning
2407 at specified periods; requiring providers to fund
2408 reserve shortfalls within a specified timeframe;
2409 providing construction; creating s. 651.043, F.S.;
2410 defining the term "management"; providing requirements
2411 for a contract for management made after a certain
2412 date; specifying procedures and requirements for
2413 providers filing notices of change in management with
2414 the office; specifying procedures, requirements, and
2415 factors for the office's review of such changes and
2416 approval or disapproval of the new management;
2417 requiring management disapproved by the office to be



872234

2418 removed within a specified timeframe; authorizing the
2419 office to take certain disciplinary actions under
2420 certain circumstances; requiring providers to
2421 immediately remove management under certain
2422 circumstances; amending s. 651.051, F.S.; revising
2423 requirements for the maintenance of a provider's
2424 records and assets; amending s. 651.057, F.S.;
2425 conforming cross-references; amending s. 651.071,
2426 F.S.; revising construction as to the priority of
2427 continuing care and continuing care at-home contracts
2428 in the event of receivership or liquidation
2429 proceedings against a provider; amending s. 651.091,
2430 F.S.; revising requirements for continuing care
2431 facilities and providers relating to the availability,
2432 distribution, and posting of reports and records;
2433 amending s. 651.105, F.S.; providing applicability of
2434 a provision of the Insurance Code relating to
2435 examinations and investigations to the office's
2436 authority in examining certain applicants and
2437 providers; requiring providers to respond to written
2438 correspondence from the office and provide certain
2439 information; declaring that the office has standing to
2440 petition a circuit court for certain injunctive
2441 relief; specifying venue; deleting a requirement for
2442 the office to determine if certain disclosures have
2443 been made; providing that a provider's or facility's
2444 parent, subsidiary, or affiliate is not subject to
2445 routine examination by the office except under certain
2446 circumstances; authorizing the office to examine



872234

2447 certain parents, subsidiaries, or affiliates to
2448 ascertain the financial condition of a provider under
2449 certain circumstances; prohibiting the office, when
2450 conducting an examination or inspection, from using
2451 certain actuary recommendations for a certain purpose
2452 or requesting certain documents under certain
2453 circumstances; amending s. 651.106, F.S.; authorizing
2454 the office to deny an application for a provisional
2455 certificate of authority or a certificate of authority
2456 on certain grounds; revising and adding grounds for
2457 application denial or disciplinary action by the
2458 office; creating s. 651.1065, F.S.; prohibiting
2459 certain persons of a continuing care retirement
2460 community, except with the office's written
2461 permission, from actively soliciting, approving the
2462 solicitation or acceptance of, or accepting new
2463 continuing care contracts if they knew or should have
2464 known that the retirement community was impaired or
2465 insolvent; providing an exception; requiring the
2466 office to approve or disapprove the continued
2467 marketing of new contracts within a specified
2468 timeframe; providing a criminal penalty; amending s.
2469 651.111, F.S.; revising procedures and requirements
2470 for the office's review of complaints requesting
2471 inspections of records and related financial affairs
2472 of a provider; amending s. 651.114, F.S.; providing
2473 that certain duties relating to a certain compliance
2474 or solvency plan must be performed by the office, or
2475 the Continuing Care Advisory Council at the request of



872234

2476 the office, rather than solely by the council;
2477 providing construction relating to the office's
2478 authority to take certain measures; authorizing the
2479 office to seek a recommended plan from the advisory
2480 council; replacing the office with the department as
2481 the entity taking certain actions under ch. 631, F.S.;
2482 providing construction; revising circumstances under
2483 which the department and office are vested with
2484 certain powers and duties in regard to delinquency
2485 proceedings; specifying requirements for providers to
2486 notify residents and prospective residents of
2487 delinquency proceedings; specifying procedures
2488 relating to orders to show cause and hearings pursuant
2489 to ch. 631, F.S.; revising facilities with respect to
2490 which the office may not exercise certain remedial
2491 rights; creating s. 651.1141, F.S.; authorizing the
2492 office to issue an immediate final order for a
2493 provider to cease and desist from specified
2494 violations; amending s. 651.121, F.S.; revising the
2495 composition of the Continuing Care Advisory Council;
2496 amending s. 651.125, F.S.; providing a criminal
2497 penalty for certain actions performed without a valid
2498 provisional certificate of authority; making a
2499 technical change; providing an effective date.

By Senator Lee

20-00386-18

2018438__

1 A bill to be entitled
 2 An act relating to continuing care contracts; amending
 3 s. 651.011, F.S.; defining and redefining terms;
 4 amending s. 651.012, F.S.; conforming a cross-
 5 reference; deleting an obsolete date; amending s.
 6 651.013, F.S.; revising applicability of specified
 7 provisions of the Florida Insurance Code as to the
 8 Office of Insurance Regulation's authority to regulate
 9 providers of continuing care and continuing care at-
 10 home; amending s. 651.019, F.S.; revising notice and
 11 filing requirements for providers and facilities with
 12 respect to new and additional financing and
 13 refinancing; amending s. 651.021, F.S.; conforming
 14 provisions to changes made by the act; amending s.
 15 651.022, F.S.; revising information required in an
 16 application for a provisional certificate of
 17 authority; specifying requirements for application
 18 amendments if material changes occur; revising
 19 procedures and requirements for the office's review of
 20 such applications; making technical changes; amending
 21 s. 651.023, F.S.; revising requirements for an
 22 application for a certificate of authority; revising
 23 procedures and requirements for the office's review of
 24 such applications; conforming provisions to changes
 25 made by the act; conforming cross-references; amending
 26 s. 651.024, F.S.; providing and revising applicability
 27 of certain requirements for a person seeking to
 28 acquire or assume a specified role of a provider or
 29 seeking specified ownership, possession, or control of

Page 1 of 70

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

20-00386-18

2018438__

30 a provider's assets; providing applicability of
 31 certain requirements for a person seeking to acquire
 32 and become the provider for a facility; providing
 33 procedures for filing a disclaimer of control;
 34 providing construction; creating s. 651.0245, F.S.;
 35 prohibiting a person, without the office's prior
 36 written approval, from acquiring a facility operating
 37 under a subsisting certificate of authority and
 38 engaging in the business of providing continuing care;
 39 specifying requirements for an application for the
 40 simultaneous acquisition of a facility and issuance of
 41 a certificate of authority and for the applicant;
 42 defining terms; providing standing to the office to
 43 petition a specified circuit court under certain
 44 circumstances; providing procedures for filing a
 45 disclaimer of control; providing construction;
 46 requiring and authorizing the Financial Services
 47 Commission to adopt, amend, and repeal rules; creating
 48 s. 651.0246, F.S.; requiring written approval from the
 49 office before construction or marketing for specified
 50 expansions of a certificated facility may commence;
 51 providing applicability; specifying application
 52 requirements; requiring the office to consider certain
 53 factors in reviewing such applications; specifying
 54 requirements for moneys to be escrowed and for the
 55 release of the moneys; defining the term "initial
 56 entrance fee"; providing procedures and requirements
 57 for the office's review of applications; providing
 58 construction; creating s. 651.025, F.S.; prohibiting

Page 2 of 70

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

20-00386-18

2018438__

59 persons who served in specified capacities with
 60 insolvent facilities or providers within a specified
 61 timeframe from thereafter serving in such capacities,
 62 except under certain circumstances; amending s.
 63 651.026, F.S.; revising requirements for annual
 64 reports filed with the office by providers and
 65 facilities; amending s. 651.0261, F.S.; revising
 66 requirements for quarterly statements filed with the
 67 office by providers and facilities; authorizing the
 68 office to require, under certain circumstances,
 69 providers or facilities to file monthly statements and
 70 certain other information; authorizing the commission
 71 to adopt rules; amending s. 651.033, F.S.; revising
 72 requirements for and restrictions on agents of escrow
 73 accounts; revising permissible investments for funds
 74 in an escrow account; creating s. 651.034, F.S.;
 75 specifying requirements for providers if a company
 76 information level event occurs; specifying procedures
 77 and requirements for the office's review of provider
 78 company information reports; requiring the office to
 79 take specified actions if a regulatory action level
 80 event occurs; authorizing the office to retain
 81 consultants for specified purposes; requiring affected
 82 providers or parties directed by the office to bear
 83 fees, costs, and expenses for such consultants;
 84 requiring and authorizing the office to take certain
 85 actions if an impairment occurs; requiring the office
 86 to transmit any notice that may result in regulatory
 87 action; providing construction; authorizing the

Page 3 of 70

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

20-00386-18

2018438__

88 commission to adopt rules; authorizing the office to
 89 exempt a provider from specified requirements under
 90 certain circumstances; amending s. 651.035, F.S.;
 91 revising provider minimum liquid reserve requirements
 92 under specified circumstances; deleting an obsolete
 93 date; authorizing providers to withdraw funds from
 94 specified reserves with the office's consent;
 95 providing procedures and requirements to request
 96 approval for certain withdrawals; providing procedures
 97 and requirements for the office's review of such
 98 requests; authorizing the office, under certain
 99 circumstances, to order the immediate transfer of
 100 funds in the minimum liquid reserve to the custody of
 101 the Department of Financial Services; requiring
 102 facilities to file annual calculations of their
 103 minimum liquid reserves with the office and maintain
 104 such reserves beginning at specified periods; creating
 105 s. 651.043, F.S.; defining the term "management";
 106 providing requirements for a contract for management;
 107 specifying procedures and requirements for providers
 108 filing notices of change in management with the
 109 office; specifying procedures and requirements for the
 110 office's review of such changes; requiring management
 111 disapproved by the office to be removed within a
 112 specified timeframe; authorizing the office to take
 113 certain disciplinary actions; requiring providers to
 114 immediately remove management under certain
 115 circumstances; amending s. 651.051, F.S.; requiring
 116 all provider records and assets to be maintained in

Page 4 of 70

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

20-00386-18

2018438__

117 this state; requiring the office's prior approval for
 118 a certain electronic storage platform; amending s.
 119 651.057, F.S.; conforming a cross-reference; amending
 120 s. 651.071, F.S.; revising construction as to the
 121 priority of continuing care and continuing care at-
 122 home contracts in the event of receivership or
 123 liquidation proceedings against a provider; amending
 124 s. 651.091, F.S.; revising requirements for continuing
 125 care facilities and providers relating to the
 126 availability, distribution, and posting of reports and
 127 records; amending s. 651.105, F.S.; providing
 128 applicability of a provision of the Insurance Code
 129 relating to examinations and investigations to the
 130 office's authority in examining certain applicants and
 131 providers; authorizing the office to examine certain
 132 parents, subsidiaries, or affiliates to ascertain the
 133 financial condition of a provider; creating s.
 134 651.1055, F.S.; requiring providers to cooperate with
 135 the office; amending s. 651.106, F.S.; authorizing the
 136 office to deny an application on certain grounds;
 137 revising and adding grounds for application denial or
 138 disciplinary action by the office; creating s.
 139 651.1065, F.S.; prohibiting certain persons of a
 140 continuing care retirement community, except with the
 141 office's written permission, from permitting the
 142 retirement community to solicit or accept new
 143 continuing care contracts if they knew or should have
 144 known that the retirement community was impaired or
 145 insolvent; providing a criminal penalty; amending s.

Page 5 of 70

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

20-00386-18

2018438__

146 651.111, F.S.; authorizing residents to file
 147 complaints that include requests for an inspection of
 148 a provider's records and related financial affairs;
 149 revising procedures of and requirements for the
 150 office's review and response to such complaints;
 151 amending s. 651.114, F.S.; authorizing the office to
 152 request that a provider make a plan for obtaining
 153 compliance or solvency in delinquency proceedings;
 154 providing construction; defining the term "impaired";
 155 requiring a provider to provide, within a specified
 156 timeframe, a certain notice to residents after the
 157 initiation of a delinquency proceeding; providing
 158 procedures and requirements for providers in
 159 delinquency proceedings; revising conditions under
 160 which the office's rights are subordinate to the
 161 rights of a trustee or lender pursuant to certain
 162 instruments; creating s. 651.1141, F.S.; providing
 163 that violations of certain provisions constitute an
 164 immediate danger to the public health, safety, or
 165 welfare; authorizing the office to issue an immediate
 166 final order to cease and desist from such violations;
 167 amending s. 651.1151, F.S.; requiring providers to
 168 submit to the office certain administrative, vendor,
 169 and management contracts; authorizing the office to
 170 disapprove such contracts under certain circumstances;
 171 deleting an obsolete date; amending s. 651.121, F.S.;
 172 revising the composition of the Continuing Care
 173 Advisory Council; amending s. 651.125, F.S.; providing
 174 a criminal penalty for certain actions performed

Page 6 of 70

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

20-00386-18

2018438

175 without a valid provisional certificate of authority;
 176 making a technical change; providing an effective
 177 date.

178
 179 Be It Enacted by the Legislature of the State of Florida:

180
 181 Section 1. Section 651.011, Florida Statutes, is amended to
 182 read:

183 651.011 Definitions.—As used in this chapter, the term:

184 (1) "Actuarial opinion" means an opinion issued by an
 185 actuary in accordance with the standards of practice adopted by
 186 the Actuarial Standards Board.

187 (2) "Actuarial study" means an analysis addressing the
 188 current actuarial financial condition of a provider or the
 189 projected actuarial financial condition of an applicant, which
 190 is performed by an actuary in accordance with accepted actuarial
 191 principles and the standards of practice adopted by the
 192 Actuarial Standards Board and which includes all of the
 193 following:

194 (a) An actuarial report.

195 (b) A statement of actuarial opinion.

196 (c) An actuarial balance sheet.

197 (d) A cohort pricing analysis.

198 (e) A cash-flow projection.

199 (f) A description of the actuarial methodology, formulas,
 200 and assumptions used in the study.

201 (g) Other information as reasonably requested by the
 202 office.

203 (3) "Actuary" means an individual who is qualified to sign

Page 7 of 70

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

20-00386-18

2018438

204 an actuarial opinion in accordance with the American Academy of
 205 Actuaries' qualification standards and who is a member in good
 206 standing of the American Academy of Actuaries.

207 (4)(1) "Advertising" means the dissemination of written,
 208 visual, or electronic information by a provider, or any person
 209 affiliated with or controlled by a provider, to potential
 210 residents or their representatives for the purpose of inducing
 211 such persons to subscribe to or enter into a contract for
 212 continuing care or continuing care at-home.

213 (5) "Company information level event" means that any of the
 214 following has occurred:

215 (a) A provider's debt service coverage ratio is less than
 216 1.3:1.

217 (b) A provider's days cash on hand is less than 125.

218 (c) The occupancy at a provider's facility is less than 80
 219 percent, unless the provider's debt service coverage ratio is
 220 greater than 3:1 or the provider's days cash on hand is greater
 221 than 365.

222 (6)(2) "Continuing care" or "care" means, pursuant to a
 223 contract, furnishing shelter and nursing care or personal
 224 services to a resident who resides in a facility, whether such
 225 nursing care or personal services are provided in the facility
 226 or in another setting designated in the contract for continuing
 227 care, by an individual not related by consanguinity or affinity
 228 to the resident, upon payment of an entrance fee.

229 (7)(3) "Continuing Care Advisory Council" or "advisory
 230 council" means the council established in s. 651.121.

231 (8)(4) "Continuing care at-home" means, pursuant to a
 232 contract other than a contract described in subsection (6) (2),

Page 8 of 70

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

20-00386-18

2018438

furnishing to a resident who resides outside the facility the right to future access to shelter and nursing care or personal services, whether such services are provided in the facility or in another setting designated in the contract, by an individual not related by consanguinity or affinity to the resident, upon payment of an entrance fee.

(9) "Corrective order" means an order issued by the office which specifies corrective actions the office has determined are required.

(10) "Days cash on hand" means the quotient reached by dividing the value of the sum in paragraph (a) by the value of the quotient in paragraph (b):

(a) The sum of unrestricted cash, unrestricted short- and long-term investments, and the minimum liquid reserve, where unrestricted cash, unrestricted short- and long-term investments, and minimum liquid reserve are as of the reporting date.

(b) Operating expenses less depreciation and amortization, divided by 365. Operating expenses, depreciation, and amortization are each the sum of their respective values over the prior 12 months ending with the reporting date.

With prior written approval of the office, a demand note or other parental guarantee may be considered a short- or long-term investment for the purposes of paragraph (a). However, the total of all demand notes issued by the parent may not, at any time, be more than the sum of unrestricted cash and unrestricted short- and long-term investments held by the parent.

(11) "Debt service coverage ratio" means the quotient

Page 9 of 70

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

20-00386-18

2018438

reached by dividing the value of the difference in paragraph (a) by the value of the sum in paragraph (b):

(a) The sum of total expenses less interest expense on the facility, depreciation, and amortization, subtracted from the sum of total revenues and gross entrance fees received less earned entrance fees and refunds paid. Expenses, interest expense on the facility, depreciation, amortization, revenues, gross entrance fees, earned entrance fees, and refunds are each the sum of their respective values over the prior 12 months ending with the reporting date.

(b) Total annual principal and interest expense due on the facility. Principal is as of the reporting date and interest due is the sum of the interest over the prior 12 months ending with the reporting date.

(12)~~(5)~~ "Entrance fee" means an initial or deferred payment of a sum of money or property made as full or partial payment for continuing care or continuing care at-home. An accommodation fee, admission fee, member fee, or other fee of similar form and application are considered to be an entrance fee.

(13)~~(6)~~ "Facility" means a place where continuing care is furnished and may include one or more physical plants on a primary or contiguous site or an immediately accessible site. As used in this subsection, the term "immediately accessible site" means a parcel of real property separated by a reasonable distance from the facility as measured along public thoroughfares, and the term "primary or contiguous site" means the real property contemplated in the feasibility study required by this chapter.

(14)~~(7)~~ "Generally accepted accounting principles" means

Page 10 of 70

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

20-00386-18

2018438__

those accounting principles and practices adopted by the Financial Accounting Standards Board and the American Institute of Certified Public Accountants, including Statement of Position 90-8 with respect to any full year to which the statement applies.

(15) "Impaired" means that any of the following have occurred:

(a) A provider has failed to maintain its minimum liquid reserve as required in s. 651.035, unless the provider has received prior written approval from the office for a withdrawal pursuant to s. 651.035(6) and is compliant with the approved payment schedule; or

(b) Beginning January 1, 2020:

1. A provider's debt service coverage ratio is less than 1.3:1, the provider's days cash on hand is less than 125, and the occupancy at the provider's facility is less than 80 percent;

2. A provider's debt service coverage ratio is less than 1:1; or

3. A provider's days cash on hand is less than 60.

(16)-(8) "Insolvency" means the condition in which a the provider is unable to pay its obligations as they come due in the normal course of business.

(17)-(9) "Licensed" means that a the provider has obtained a certificate of authority from the office department.

(18) "Manager" or "management company" means a person who administers the day-to-day business operations of a facility for a provider, subject to the policies, directives, and oversight of the provider.

20-00386-18

2018438__

(19)-(10) "Nursing care" means those services or acts rendered to a resident by an individual licensed or certified pursuant to chapter 464.

(20) "Occupancy" means the total number of occupied units in a facility divided by the total number of units in the facility.

(21)-(11) "Personal services" has the same meaning as in s. 429.02.

(22)-(12) "Provider" means the owner or operator, whether a natural person, partnership or other unincorporated association, however organized, trust, or corporation, of an institution, building, residence, or other place, whether operated for profit or not, which owner or operator provides continuing care or continuing care at-home for a fixed or variable fee, or for any other remuneration of any type, whether fixed or variable, for the period of care, payable in a lump sum or lump sum and monthly maintenance charges or in installments. The term does not apply to an entity that has existed and continuously operated a facility located on at least 63 acres in this state providing residential lodging to members and their spouses for at least 66 years on or before July 1, 1989, and has the residential capacity of 500 persons, is directly or indirectly owned or operated by a nationally recognized fraternal organization, is not open to the public, and accepts only its members and their spouses as residents.

(23)-(13) "Records" means all documents, correspondence, and the permanent financial, directory, and personnel information and data maintained by a provider pursuant to this chapter, regardless of the physical form, characteristics, or means of

20-00386-18

2018438__

transmission.

(24) "Regulatory action level event" means that any two of the following have occurred:

(a) The provider's debt service coverage ratio is less than 1.3:1.

(b) The provider's days cash on hand is less than 125.

(c) The occupancy at the provider's facility is less than 80 percent.

(25)(14) "Resident" means a purchaser of, a nominee of, or a subscriber to a continuing care or continuing care at-home contract. Such contract does not give the resident a part ownership of the facility in which the resident is to reside, unless expressly provided in the contract.

(26)(15) "Shelter" means an independent living unit, room, apartment, cottage, villa, personal care unit, nursing bed, or other living area within a facility set aside for the exclusive use of one or more identified residents.

Section 2. Section 651.012, Florida Statutes, is amended to read:

651.012 Exempted facility; written disclosure of exemption.—Any facility exempted under ss. 632.637(1)(e) and 651.011(22) ~~651.011(12)~~ must provide written disclosure of such exemption to each person admitted to the facility ~~after October 1, 1996~~. This disclosure must be written using language likely to be understood by the person and must briefly explain the exemption.

Section 3. Subsection (2) of section 651.013, Florida Statutes, is amended to read:

651.013 Chapter exclusive; applicability of other laws.—

20-00386-18

2018438__

(2) In addition to other applicable provisions cited in this chapter, the office has the authority granted under ss. 624.302 and 624.303, 624.307-624.312, ~~624.318~~ ~~624.308-624.312~~, 624.319(1)-(3), 624.320-624.321, 624.324, ~~and~~ 624.34, and 624.422 of the Florida Insurance Code to regulate providers of continuing care and continuing care at-home.

Section 4. Section 651.019, Florida Statutes, is amended to read:

651.019 New financing, additional financing, or refinancing.—

(1)(a) A provider shall provide notice to the residents' council of any new financing or refinancing at least 30 days before the closing date of the financing or refinancing transaction. The notice must include a general outline and the intended use of proceeds.

(b) If the facility does not have a residents' council, the facility must make available, in the same manner as other community notices, the information required by paragraph (a) After issuance of a certificate of authority, the provider shall submit to the office a general outline, including intended use of proceeds, with respect to any new financing, additional financing, or refinancing at least 30 days before the closing date of such financing transaction.

(2) Within 30 days after the closing date of such financing or refinancing transaction, The provider shall furnish any information the office may reasonably request in connection with any new financing, additional financing, or refinancing, including, but not limited to, the financing agreements and any related documents, escrow or trust agreements, and statistical

20-00386-18

2018438__

407 ~~or financial data,~~ the provider shall ~~also~~ submit to the office
 408 copies of executed financing documents, any related documents,
 409 escrow or trust agreements, and statistical or financial data
 410 prepared in support of such financing or refinancing
 411 transaction, and a copy of all documents required to be
 412 submitted to the residents' council under paragraph (1) (a)
 413 within 30 days after the closing date.

414 Section 5. Section 651.021, Florida Statutes, is amended to
 415 read:

416 651.021 Certificate of authority required.-

417 ~~(1) A~~ A ~~No~~ person may not engage in the business of providing
 418 continuing care, issuing contracts for continuing care or
 419 continuing care at-home, or constructing a facility for the
 420 purpose of providing continuing care in this state without a
 421 certificate of authority obtained from the office as provided in
 422 this chapter. This section subsection does not prohibit the
 423 preparation of a construction site or construction of a model
 424 residence unit for marketing purposes, or both. The office may
 425 allow the purchase of an existing building for the purpose of
 426 providing continuing care if the office determines that the
 427 purchase is not being made to circumvent the prohibitions in
 428 this section.

429 ~~(2) Written approval must be obtained from the office~~
 430 ~~before commencing construction or marketing for an expansion of~~
 431 ~~a certificated facility equivalent to the addition of at least~~
 432 ~~20 percent of existing units or 20 percent or more in the number~~
 433 ~~of continuing care at home contracts. This provision does not~~
 434 ~~apply to construction for which a certificate of need from the~~
 435 ~~Agency for Health Care Administration is required.~~

Page 15 of 70

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

20-00386-18

2018438__

436 ~~(a) For providers that offer both continuing care and~~
 437 ~~continuing care at-home, the 20 percent is based on the total of~~
 438 ~~both existing units and existing contracts for continuing care~~
 439 ~~at-home. For purposes of this subsection, an expansion includes~~
 440 ~~increases in the number of constructed units or continuing care~~
 441 ~~at-home contracts or a combination of both.~~

442 ~~(b) The application for such approval shall be on forms~~
 443 ~~adopted by the commission and provided by the office. The~~
 444 ~~application must include the feasibility study required by s.~~
 445 ~~651.022(3) or s. 651.023(1)(b) and such other information as~~
 446 ~~required by s. 651.023. If the expansion is only for continuing~~
 447 ~~care at home contracts, an actuarial study prepared by an~~
 448 ~~independent actuary in accordance with standards adopted by the~~
 449 ~~American Academy of Actuaries which presents the financial~~
 450 ~~impact of the expansion may be substituted for the feasibility~~
 451 ~~study.~~

452 ~~(c) In determining whether an expansion should be approved,~~
 453 ~~the office shall use the criteria provided in ss. 651.022(6) and~~
 454 ~~651.023(4).~~

455 Section 6. Subsection (2), paragraph (b) of subsection (5),
 456 and subsections (6) and (8) of section 651.022, Florida
 457 Statutes, are amended to read:

458 651.022 Provisional certificate of authority; application.-

459 (2) The application for a provisional certificate of
 460 authority must ~~shall~~ be on a form prescribed by the commission
 461 and must ~~shall~~ contain the following information:

462 (a) If the applicant or provider is a corporation, a copy
 463 of the articles of incorporation and bylaws; if the applicant or
 464 provider is a partnership or other unincorporated association, a

Page 16 of 70

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

20-00386-18

2018438__

copy of the partnership agreement, articles of association, or other membership agreement; and, if the applicant or provider is a trust, a copy of the trust agreement or instrument.

(b) The full names, residences, and business addresses of:

1. The proprietor, if the applicant or provider is an individual.

2. Every partner or member, if the applicant or provider is a partnership or other unincorporated association, however organized, having fewer than 50 partners or members, together with the business name and address of the partnership or other organization.

3. The principal partners or members, if the applicant or provider is a partnership or other unincorporated association, however organized, having 50 or more partners or members, together with the business name and business address of the partnership or other organization. If such unincorporated organization has officers and a board of directors, the full name and business address of each officer and director may be set forth in lieu of the full name and business address of its principal members.

4. The corporation and each officer and director thereof, if the applicant or provider is a corporation.

5. Every trustee and officer, if the applicant or provider is a trust.

6. The manager, whether an individual, corporation, partnership, or association.

7. Any stockholder holding at least a 10 percent interest in the operations of the facility in which the care is to be offered.

Page 17 of 70

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

20-00386-18

2018438__

8. Any person whose name is required to be provided in the application under this paragraph and who owns any interest in or receives any remuneration from, directly or indirectly, any professional service firm, association, trust, partnership, or corporation providing goods, leases, or services to the facility for which the application is made, with a real or anticipated value of \$10,000 or more, and the name and address of the professional service firm, association, trust, partnership, or corporation in which such interest is held. The applicant shall describe such goods, leases, or services and the probable cost to the facility or provider and shall describe why such goods, leases, or services should not be purchased from an independent entity.

9. Any person, corporation, partnership, association, or trust owning land or property leased to the facility, along with a copy of the lease agreement.

10. Any affiliated parent or subsidiary corporation or partnership.

(c)1. Evidence that the persons described in paragraph (b) are competent and trustworthy ~~applicant is reputable and of responsible character~~. If the applicant is a firm, association, organization, partnership, business trust, corporation, or company, the form must further shall require evidence that the members or shareholders ~~are reputable and of responsible character~~, and the person in charge of providing care under a certificate of authority, are competent and trustworthy shall ~~likewise be required to produce evidence of being reputable and of responsible character~~.

2. Evidence satisfactory to the office of the ability of

Page 18 of 70

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

20-00386-18

2018438

the applicant to comply with ~~the provisions of~~ this chapter and with rules adopted by the commission pursuant to this chapter.

3. A statement of whether a person identified in the application for a provisional certificate of authority or the administrator or manager of the facility, if such person has been designated, or any such person living in the same location:

a. Has been convicted of a felony or has pleaded nolo contendere to a felony charge, or has been held liable or has been enjoined in a civil action by final judgment, if the felony or civil action involved fraud, embezzlement, fraudulent conversion, or misappropriation of property.

b. Is subject to a currently effective injunctive or restrictive order or federal or state administrative order relating to business activity or health care as a result of an action brought by a public agency or department, including, without limitation, an action affecting a license under chapter 400 or chapter 429.

The statement ~~must~~ shall set forth the court or agency, the date of conviction or judgment, and the penalty imposed or damages assessed, or the date, nature, and issuer of the order. Before determining whether a provisional certificate of authority is to be issued, the office may make an inquiry to determine the accuracy of the information submitted pursuant to subparagraphs 1., 2., and 3. 1. and 2.

(d) The contracts for continuing care and continuing care at-home to be entered into between the provider and residents which meet the minimum requirements of s. 651.055 or s. 651.057 and which include a statement describing the procedures required

20-00386-18

2018438

by law relating to the release of escrowed entrance fees. Such statement may be furnished through an addendum.

(e) Any advertisement or other written material proposed to be used in the solicitation of residents.

(f) Such other reasonable data, financial statements, and pertinent information as the commission or office may reasonably require with respect to the provider or the facility, including the most recent audited financial statements of comparable facilities currently or previously owned, managed, or developed by the applicant or its principal, to assist in determining the financial viability of the project and the management capabilities of its managers and owners.

(g) The forms of the residency contracts, reservation contracts, escrow agreements, and wait list contracts, if applicable, which are proposed to be used by the provider in the furnishing of care. The office shall approve contracts and escrow agreements that comply with ss. 651.023(1)(c), 651.033, 651.055, and 651.057. Thereafter, no other form of contract or agreement may be used by the provider until it has been submitted to the office and approved.

(h) An actuarial study.

If any material change occurs in the facts set forth in an application filed with the office pursuant to this subsection, an amendment setting forth such changes must be immediately filed with the office, and a copy of the amendment must be sent by registered mail to the principal office of the facility and to the principal office of the controlling company.

(5)

20-00386-18

2018438

581 (b) An application is deemed complete upon receipt of all
 582 requested information and correction of any error or omission of
 583 which the applicant was timely notified or when the time for
 584 such notification has expired. The office shall notify the
 585 applicant in writing of the date on which the application was
 586 deemed complete ~~Within 15 days after receipt of all of the~~
 587 ~~requested additional information, the office shall notify the~~
 588 ~~applicant in writing that all of the requested information has~~
 589 ~~been received and the application is deemed to be complete as of~~
 590 ~~the date of the notice. Failure to so notify the applicant in~~
 591 ~~writing within the 15-day period shall constitute acknowledgment~~
 592 ~~by the office that it has received all requested additional~~
 593 ~~information, and the application shall be deemed to be complete~~
 594 ~~for purposes of review upon the date of the filing of all of the~~
 595 ~~requested additional information.~~

596 (6) Within 90 ~~45~~ days after the date an application is
 597 deemed complete as set forth in paragraph (5)(b), the office
 598 shall complete its review and issue a provisional certificate of
 599 authority to the applicant based upon its review and a
 600 determination that the application meets all requirements of
 601 law, that the feasibility study was based on sufficient data and
 602 reasonable assumptions, and that the applicant will be able to
 603 provide continuing care or continuing care at-home as proposed
 604 and meet all financial and contractual obligations related to
 605 its operations, including the financial requirements of this
 606 chapter. If the application is denied, the office shall notify
 607 the applicant in writing, citing the specific failures to meet
 608 the provisions of this chapter. Such denial entitles the
 609 applicant to a hearing pursuant to chapter 120.

Page 21 of 70

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

20-00386-18

2018438

610 (8) The office may ~~shall~~ not approve any application that
 611 ~~which~~ includes in the plan of financing any encumbrance of the
 612 ~~operating~~ reserves required by this chapter.

613 Section 7. Paragraph (c) of subsection (1), subsections (2)
 614 and (3), paragraph (a) of subsection (4), paragraph (b) of
 615 subsection (5), and subsections (8) and (9) of section 651.023,
 616 Florida Statutes, are amended, paragraph (i) is added to
 617 subsection (1) of that section, and paragraph (a) of subsection
 618 (1) of that section is republished, to read:

619 651.023 Certificate of authority; application.—

620 (1) After issuance of a provisional certificate of
 621 authority, the office shall issue to the holder of such
 622 provisional certificate a certificate of authority if the holder
 623 of the provisional certificate provides the office with the
 624 following information:

625 (a) Any material change in status with respect to the
 626 information required to be filed under s. 651.022(2) in the
 627 application for the provisional certificate.

628 (c) Subject to subsection (4), a provider may submit an
 629 application for a certificate of authority and any required
 630 exhibits upon submission of proof that the project has a minimum
 631 of 50 ~~30~~ percent of the units reserved for which the provider is
 632 charging an entrance fee. ~~This does not apply to an application~~
 633 ~~for a certificate of authority for the acquisition of a facility~~
 634 ~~for which a certificate of authority was issued before October~~
 635 ~~1, 1983, to a provider who subsequently becomes a debtor in a~~
 636 ~~case under the United States Bankruptcy Code, 11 U.S.C. ss. 101~~
 637 ~~et seq., or to a provider for which the department has been~~
 638 ~~appointed receiver pursuant to part II of chapter 631.~~

Page 22 of 70

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

20-00386-18

2018438__

639 (i) An actuarial study.
 640 (2) Within 30 days after receipt of the information
 641 required under subsection (1), the office shall examine such
 642 information and notify the provider in writing, specifically
 643 requesting any additional information the office is permitted by
 644 law to require. An application is deemed complete upon receipt
 645 of all requested information and correction of any error or
 646 omission of which the applicant was timely notified or when the
 647 time for such notification has expired. The office shall notify
 648 the applicant in writing of the date on which the application
 649 was deemed complete Within 15 days after receipt of all of the
 650 requested additional information, the office shall notify the
 651 provider in writing that all of the requested information has
 652 been received and the application is deemed to be complete as of
 653 the date of the notice. Failure to notify the applicant in
 654 writing within the 15-day period constitutes acknowledgment by
 655 the office that it has received all requested additional
 656 information, and the application shall be deemed complete for
 657 purposes of review on the date of filing all of the required
 658 additional information.
 659 (3) Within 90 45 days after an application is deemed
 660 complete as set forth in subsection (2), and upon completion of
 661 the remaining requirements of this section, the office shall
 662 complete its review and issue or deny a certificate of authority
 663 to the holder of a provisional certificate of authority. If a
 664 certificate of authority is denied, the office must notify the
 665 holder of the provisional certificate in writing, citing the
 666 specific failures to satisfy the provisions of this chapter. If
 667 denied, the holder of the provisional certificate is entitled to

Page 23 of 70

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

20-00386-18

2018438__

668 an administrative hearing pursuant to chapter 120.
 669 (4) The office shall issue a certificate of authority upon
 670 determining that the applicant meets all requirements of law and
 671 has submitted all of the information required by this section,
 672 that all escrow requirements have been satisfied, and that the
 673 fees prescribed in s. 651.015(2) have been paid.
 674 (a) ~~A Notwithstanding satisfaction of the 30-percent~~
 675 ~~minimum reservation requirement of paragraph (1)(c), no~~
 676 certificate of authority may not ~~shall~~ be issued until the
 677 project has a minimum of 50 percent of the units reserved for
 678 which the provider is charging an entrance fee, and proof is
 679 provided to the office. If a provider offering continuing care
 680 at-home is applying for a certificate of authority ~~or approval~~
 681 ~~of an expansion pursuant to s. 651.021(2), the same minimum~~
 682 reservation requirements must be met for the continuing care and
 683 continuing care at-home contracts, independently of each other.
 684 (5) Up to 25 percent of the moneys paid for all or any part
 685 of an initial entrance fee may be included or pledged for the
 686 construction or purchase of the facility or as security for
 687 long-term financing. The term "initial entrance fee" means the
 688 total entrance fee charged by the facility to the first occupant
 689 of a unit.
 690 (b) For an expansion as provided in s. 651.0246 ~~or~~
 691 ~~651.021(2)~~, a minimum of 75 percent of the moneys paid for all
 692 or any part of an initial entrance fee collected for continuing
 693 care and 50 percent of the moneys paid for all or any part of an
 694 initial fee collected for continuing care at-home shall be
 695 placed in an escrow account or on deposit with the department as
 696 prescribed in s. 651.033.

Page 24 of 70

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

20-00386-18

2018438

697 (8) ~~The timeframes provided under s. 651.022(5) and (6)~~
 698 ~~apply to applications submitted under s. 651.021(2).~~ The office
 699 may not issue a certificate of authority to a facility that does
 700 not have a component that is to be licensed pursuant to part II
 701 of chapter 400 or to part I of chapter 429 or that does not
 702 offer personal services or nursing services through written
 703 contractual agreement. A written contractual agreement must be
 704 disclosed in the contract for continuing care or continuing care
 705 at-home and is subject to ~~the provisions of~~ s. 651.1151,
 706 relating to administrative, vendor, and management contracts.

707 (9) The office may not approve an application that includes
 708 in the plan of financing any encumbrance of the ~~operating~~
 709 reserves required by this chapter.

710 Section 8. Section 651.024, Florida Statutes, is amended to
 711 read:

712 651.024 Acquisition.—

713 (1) A person who seeks to acquire a provider; assume the
 714 role of general partner of a provider; or otherwise assume
 715 ownership or possession of, or control over, 10 percent or more
 716 of a provider's assets is issued a certificate of authority to
 717 operate a continuing care facility or a provisional certificate
 718 of authority shall be subject to the provisions of s. 628.4615
 719 and is not required to make filings pursuant to s. 651.022 or s.
 720 651.023.

721 (2) A person who seeks to acquire, and become the provider
 722 for, a facility is subject to s. 651.0245 and is not required to
 723 make filings pursuant to ss. 628.4615, 651.022, and 651.023.

724 (3) A person may rebut a presumption of control by filing a
 725 disclaimer of control with the office on a form prescribed by

20-00386-18

2018438

726 the commission. The disclaimer must fully disclose all material
 727 relationships and bases for affiliation between the person and
 728 the provider or facility, as well as the basis for disclaiming
 729 the affiliation. In lieu of such form, a person or acquiring
 730 party may file with the office a copy of a Schedule 13G filed
 731 with the Securities and Exchange Commission pursuant to Rule
 732 13d-1(b) or (c), 17 C.F.R. s. 240.13d-1, under the Securities
 733 Exchange Act of 1934, as amended. After a disclaimer has been
 734 filed, the provider or facility is relieved of any duty to
 735 register or report under this section which may arise out of the
 736 provider's or facility's relationship with the person, unless
 737 the office disallows the disclaimer.

738 Section 9. Section 651.0245, Florida Statutes, is created
 739 to read:

740 651.0245 Application for the simultaneous acquisition of a
 741 facility and issuance of a certificate of authority.—

742 (1) Except with the prior written approval of the office, a
 743 person may not, individually or in conjunction with any
 744 affiliated person of such person, directly or indirectly acquire
 745 a facility operating under a subsisting certificate of authority
 746 and engage in the business of providing continuing care.

747 (2) An applicant must:

748 (a) Comply with the notice requirements of s.

749 628.4615(2) (a); and

750 (b) File an application in the form required by the office
 751 and cooperate with the office's review of the application.

752 (3) The commission shall adopt by rule application
 753 requirements equivalent to those described in ss. 628.4615(4)
 754 and (5), 651.022(2) (a)-(g) and (3), and 651.023(1) (b). The

20-00386-18

2018438

office shall review the application and issue an approval or disapproval of the filing in accordance with ss. 628.4615(6)(a) and (c), (7)-(12), (13)(c)-(e), and (14); 651.022(8); and 651.023(1)(b).

(4) As used in this section, the term:

(a) "Controlling company" means any corporation, trust, or association that directly or indirectly owns 25 percent or more of the voting securities of one or more facilities that are stock corporations, or 25 percent or more of the ownership interest of one or more facilities that are not stock corporations.

(b) "Natural person" means an individual.

(c) "Person" includes a natural person, corporation, association, trust, general partnership, limited partnership, joint venture, firm, proprietorship, or any other entity that may hold a license or certificate as a facility.

(5) In addition to the facility or the controlling party, the office has standing to petition a circuit court as described in s. 628.4615(9).

(6) A person may rebut a presumption of control by filing a disclaimer of control with the office on a form prescribed by the commission. The disclaimer must fully disclose all material relationships and bases for affiliation between the person and the provider or facility, as well as the basis for disclaiming the affiliation. In lieu of such form, a person or acquiring party may file with the office a copy of a Schedule 13G filed with the Securities and Exchange Commission pursuant to Rule 13d-1(b) or (c), 17 C.F.R. s. 240.13d-1, under the Securities Exchange Act of 1934, as amended. After a disclaimer has been

20-00386-18

2018438

filed, the provider or facility is relieved of any duty to register or report under this section which may arise out of the provider's or facility's relationship with the person, unless the office disallows the disclaimer.

(7) The commission may adopt, amend, or repeal rules pursuant to chapter 120 as necessary to administer this section.

Section 10. Section 651.0246, Florida Statutes, is created to read:

651.0246 Expansions.-

(1)(a) A provider must obtain written approval from the office before commencing construction or marketing for an expansion of a certificated facility equivalent to the addition of at least 20 percent of existing units or 20 percent or more in the number of continuing care at-home contracts. This section does not apply to construction for which a certificate of need from the Agency for Health Care Administration is required.

(b) The application for such approval must be on forms adopted by the commission and provided by the office. The application must include the feasibility study required by this section and such other information as required by s. 651.023 or as reasonably requested by the office. If the expansion is only for continuing care at-home contracts, an actuarial study prepared by an independent actuary in accordance with standards adopted by the American Academy of Actuaries which presents the financial impact of the expansion may be substituted for the feasibility study.

(c) In determining whether an expansion should be approved, the office shall consider:

1. Whether the application meets all requirements of law;

20-00386-18

2018438

2. Whether the feasibility study was based on sufficient data and reasonable assumptions; and

3. Whether the applicant will be able to provide continuing care or continuing care at-home as proposed and meet all financial obligations related to its operations, including the financial requirements of this chapter.

If the application is denied, the office must notify the applicant in writing, citing the specific failures to meet the provisions of this chapter. Such denial entitles the applicant to a hearing pursuant to chapter 120.

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

(a) An actuarial study.

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

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

2. An identification and evaluation of the primary and secondary market areas of the facility and the projected unit sales per month.

3. Projected revenues, including anticipated entrance fees; monthly service fees; nursing care rates, if applicable; and all other sources of revenue, including the total amount of debt financing required.

4. Projected expenses, including for staffing requirements and salaries; the cost of property, plant, and equipment,

20-00386-18

2018438

including depreciation expense; interest expense; marketing expense; and other operating expenses.

5. Current assets and liabilities of the applicant.

6. Expectations of the financial condition of the project, including the projected cash flow and a projected balance sheet and an estimate of the funds anticipated to be necessary to cover startup losses.

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

8. Project costs, marketing projections, resident fees and charges, the competition, resident contract provisions, and other factors that affect the feasibility of the facility.

9. The name of the person who prepared the feasibility study and the experience of such person in preparing similar studies or otherwise consulting in the field of continuing care.

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

11. An independent evaluation and examination opinion, or a comparable opinion acceptable to the office, by the independent certified public accountant who prepared the study, of the underlying assumptions used as a basis for the forecasts or projections in the study and that the assumptions are reasonable and proper and the project as proposed is feasible. The feasibility study must contain an examination opinion for the first 3 years of operations, and financial projections having a compilation opinion for the next 3 years.

20-00386-18

2018438

871 (c) Such other reasonable data, financial statements, and
 872 pertinent information as the commission or office may require
 873 with respect to the applicant or the facility to determine the
 874 financial status of the facility and the management capabilities
 875 of its managers and owners.

876 (3) A minimum of 75 percent of the moneys paid for all or
 877 any part of an initial entrance fee or reservation deposit
 878 collected for continuing care and 50 percent of the moneys paid
 879 for all or any part of an initial fee collected for continuing
 880 care at-home must be placed in an escrow account or on deposit
 881 with the department as prescribed in s. 651.033. Up to 25
 882 percent of the moneys paid for all or any part of an initial
 883 entrance fee or reservation deposit may be included or pledged
 884 for the construction or purchase of the facility or as security
 885 for long-term financing. As used in this section, the term
 886 "initial entrance fee" means the total entrance fee charged by
 887 the facility to the first occupant of a unit.

888
 889 Entrance fees and reservation deposits collected for expansions
 890 must be held pursuant to the escrow requirements of s.
 891 651.023(5) and (6).

892 (4) The provider is entitled to secure release of the
 893 moneys held in escrow within 7 days after receipt by the office
 894 of an affidavit from the provider, along with appropriate copies
 895 to verify, and notification to the escrow agent by certified
 896 mail, that the following conditions have been satisfied:

897 (a) A certificate of occupancy has been issued.

898 (b) Payment in full has been received for at least 70
 899 percent of the total units of a phase or of the total of the

20-00386-18

2018438

900 combined phases constructed. If a provider offering continuing
 901 care at-home is applying for a release of escrowed entrance
 902 fees, the same minimum requirement must be met for the
 903 continuing care and continuing care at-home contracts
 904 independently of each other.

905 (c) The consultant who prepared the feasibility study
 906 required by this section or a substitute approved by the office
 907 certifies within 12 months before the date of filing for office
 908 approval that there has been no material adverse change in
 909 status with regard to the feasibility study. If a material
 910 adverse change exists at the time of submission, sufficient
 911 information acceptable to the office and the feasibility
 912 consultant must be submitted which remedies the adverse
 913 condition.

914 (d) Proof that commitments have been secured or that a
 915 documented plan adopted by the applicant has been approved by
 916 the office for long-term financing.

917 (e) Proof that the provider has sufficient funds to meet
 918 the requirements of s. 651.035, which may include funds
 919 deposited in the initial entrance fee account.

920 (f) Proof as to the intended application of the proceeds
 921 upon release and proof that the entrance fees, when released,
 922 will be applied as represented to the office.

923
 924 Notwithstanding chapter 120, only the provider, the escrow
 925 agent, and the office have a substantial interest in any office
 926 decision regarding release of escrow funds in any proceedings
 927 under chapter 120 or this chapter regarding the release of
 928 escrow funds.

20-00386-18

2018438

(5) (a) Within 30 days after receipt of an application for expansion, the office shall examine the application and shall notify the applicant in writing, specifically setting forth and specifically requesting any additional information the office is permitted by law to require. If the application submitted is determined by the office to be substantially incomplete so as to require substantial additional information, including biographical information, the office may return the application to the applicant with a written notice that the application as received is substantially incomplete and therefore unacceptable for filing without further action required by the office. Any filing fee received must be refunded to the applicant.

(b) An application is deemed complete upon receipt of all requested information and the correction of any error or omission for which the applicant was timely notified or when the time for such notification has expired. The office shall notify the applicant in writing of the date on which the application was deemed complete.

(6) Within 90 days after the date on which an application is deemed complete as set forth in paragraph (5) (b), the office shall complete its review and, based upon its review, approve an expansion by the applicant and issue a determination that the application meets all requirements of law, that the feasibility study was based on sufficient data and reasonable assumptions, and that the applicant will be able to provide continuing care or continuing care at-home as proposed and meet all financial and contractual obligations related to its operations, including the financial requirements of this chapter. If the application is denied, the office must notify the applicant in writing,

20-00386-18

2018438

citing the specific failures to meet the provisions of this chapter. Such denial entitles the applicant to a hearing pursuant to chapter 120.

Section 11. Section 651.025, Florida Statutes, is created to read:

651.025 Insolvent facilities or providers.—A person who was a proprietor, general partner, member, officer, director, trustee, or manager of an entity and who served in that capacity within the 2-year period before the date the entity became insolvent or bankrupt may not thereafter serve as a proprietor, general partner, member, officer, director, trustee, or manager of a facility or provider authorized in this state unless such person demonstrates that his or her personal actions or omissions were not a significant contributing cause to the insolvency or bankruptcy.

Section 12. Present paragraph (f) of subsection (2) of section 651.026, Florida Statutes, is redesignated as paragraph (e), present paragraph (e) of subsection (2) and subsection (3) of that section are amended, and paragraph (a) of subsection (2) of that section is republished, to read:

651.026 Annual reports.—

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

(a) Any change in status with respect to the information required to be filed under s. 651.022(2).

~~(c) Each facility shall file with the office annually, together with the annual report required by this section, a computation of its minimum liquid reserve calculated in accordance with s. 651.035 on a form prescribed by the~~

20-00386-18

2018438

~~commission.~~

(3) The commission shall adopt by rule additional
~~meaningful~~ measures of assessing the financial viability of a
 provider. The rule may include the following factors:

(a) ~~Debt service coverage ratios.~~

~~(b)~~ Current ratios.

~~(b)~~ ~~(c)~~ Adjusted current ratios.

~~(c)~~ ~~(d)~~ Cash flows.

~~(e)~~ ~~Occupancy rates.~~

~~(d)~~ ~~(f)~~ Other measures, ratios, or trends.

~~(e)~~ ~~(g)~~ Other factors as may be appropriate.

Section 13. Section 651.0261, Florida Statutes, is amended
 to read:

651.0261 Quarterly and monthly statements.—

(1) Within 45 days after the end of each fiscal quarter,
 each provider shall file a quarterly unaudited financial
 statement of the provider or of the facility in the form
 prescribed by rule of the commission and a detailed listing of
 the assets maintained in the liquid reserve as required under s.
 651.035. This requirement may be waived by the office upon
 written request from a provider accredited under s. 651.028.

(2) If the office finds, ~~pursuant to rules of the~~
~~commission~~, that such information is needed to properly monitor
 the financial condition of a provider or facility or is
 otherwise needed to protect the public interest, the office may
 require the provider to file:

(a) Within 25 days after the end of each month, a monthly
 unaudited financial statement of the provider or of the facility
 in the form prescribed by the commission by rule and a detailed

20-00386-18

2018438

listing of the assets maintained in the liquid reserve as
required under s. 651.035, within 45 days after the end of each
fiscal quarter, a quarterly unaudited financial statement of the
provider or of the facility in the form prescribed by the
commission by rule. The commission may by rule require all or
part of the statements or filings required under this section to
be submitted by electronic means in a computer-readable form
compatible with the electronic data format specified by the
commission.

(b) Such other data, financial statements, and pertinent
 information as the commission or office may reasonably require
 with respect to the provider or the facility, or its directors,
 trustees, members, branches, subsidiaries, or affiliates, to
 determine the financial status of the provider or of the
 facility and the management capabilities of its managers and
 owners.

(3) A filing under subsection (2) may be required if any of
 the following apply:

(a) The facility has been operational for less than 2
 years.

(b) The provider is:

1. Subject to administrative supervision proceedings;
2. Required to submit a company information report to the
 office pursuant to s. 651.034(1);
3. Subject to a corrective action plan;
4. Subject to refinancing;
5. Subject to an acquisition; or
6. Subject to delinquency or receivership proceedings.

(c) The provider or facility displays a declining financial

20-00386-18

2018438__

1045 position.

1046 (4) The commission may by rule require all or part of the
 1047 statements or filings required under this section to be
 1048 submitted by electronic means in a computer-readable form
 1049 compatible with an electronic data format specified by the
 1050 commission.

1051 Section 14. Paragraphs (c) and (d) of subsection (1) and
 1052 subsections (2) and (3) of section 651.033, Florida Statutes,
 1053 are amended, and subsection (6) is added to that section, to
 1054 read:

1055 651.033 Escrow accounts.—

1056 (1) When funds are required to be deposited in an escrow
 1057 account pursuant to s. 651.022, s. 651.023, s. 651.035, or s.
 1058 651.055:

1059 (c) Any agreement establishing an escrow account required
 1060 under ~~the provisions of~~ this chapter is ~~shall be~~ subject to
 1061 approval by the office. The agreement must ~~shall~~ be in writing
 1062 and ~~shall~~ contain, in addition to any other provisions required
 1063 by law, a provision whereby the escrow agent agrees to abide by
 1064 the duties imposed by paragraphs (b) and (e), (3) (a), (3) (b),
 1065 and (5) (a) and subsection (6) under this section.

1066 (d) All funds deposited in an escrow account, if invested,
 1067 must ~~shall~~ be invested in cash, cash equivalents, mutual funds,
 1068 equities, or investment grade bonds as set forth in part II of
 1069 chapter 625; however, such investment may not diminish the funds
 1070 held in escrow below the amount required by this chapter. Funds
 1071 deposited in an escrow account are not subject to charges by the
 1072 escrow agent except escrow agent fees associated with
 1073 administering the accounts, or subject to any liens, judgments,

20-00386-18

2018438__

1074 garnishments, creditor's claims, or other encumbrances against
 1075 the provider or facility except as provided in s. 651.035(1).

1076 (2) ~~Notwithstanding s. 651.035(7), In addition, the escrow~~
 1077 ~~agreement shall provide that the escrow agent or another person~~
 1078 ~~designated to act in the escrow agent's place and the provider,~~
 1079 ~~except as otherwise provided in s. 651.035, shall notify the~~
 1080 ~~office in writing at least 10 days before the withdrawal of any~~
 1081 ~~portion of any funds required to be escrowed under the~~
 1082 ~~provisions of s. 651.035. However,~~ in the event of an emergency
 1083 and upon petition by the provider, the office may ~~waive the 10-~~
 1084 ~~day notification period and~~ allow a withdrawal of up to 10
 1085 percent of the required minimum liquid reserve. The office shall
 1086 have 3 working days to deny the petition for the emergency 10-
 1087 percent withdrawal. If the office fails to deny the petition
 1088 within 3 working days, the petition is ~~shall be~~ deemed to have
 1089 been granted by the office. For purposes ~~the purpose~~ of this
 1090 section, "working day" means each day that is not a Saturday,
 1091 Sunday, or legal holiday as defined by Florida law. Also, for
 1092 purposes ~~the purpose~~ of this section, the day the petition is
 1093 received by the office is ~~shall~~ not be counted as one of the 3
 1094 days.

1095 (3) ~~In addition,~~ When entrance fees are required to be
 1096 deposited in an escrow account pursuant to s. 651.022, s.
 1097 651.023, or s. 651.055:

1098 (a) The provider shall deliver to the resident a written
 1099 receipt. The receipt must show the payor's name and address, the
 1100 date, the price of the care contract, and the amount of money
 1101 paid. A copy of each receipt, together with the funds, must
 1102 ~~shall~~ be deposited with the escrow agent or as provided in

20-00386-18

2018438

paragraph (c). The escrow agent ~~must~~ ~~shall~~ release such funds to the provider 7 days after the date of receipt of the funds by the escrow agent if the provider, operating under a certificate of authority issued by the office, has met the requirements of s. 651.023(6). However, if the resident rescinds the contract within the 7-day period, the escrow agent ~~must~~ ~~shall~~ release the escrowed fees to the resident.

(b) At the request of an individual resident of a facility, the escrow agent shall issue a statement indicating the status of the resident's portion of the escrow account.

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

(d) A provider may assess a nonrefundable fee, which is separate from the entrance fee, for processing a prospective resident's application for continuing care or continuing care at-home.

(6) Except as described in paragraph (3)(a), the escrow agent may not release or otherwise permit the transfer of funds without the written approval of the office.

Section 15. Section 651.034, Florida Statutes, is created to read:

651.034 Financial and operating requirements for providers.-

(1)(a) If a company information level event occurs, the provider must provide the office with explanatory information

20-00386-18

2018438

and submit to the office a company information report, which ~~must~~:

1. Identify the conditions that contribute to the company information level event;

2. Contain proposals of corrective actions that the provider intends to take and that are reasonably expected to result in the elimination of the company information level event;

3. Provide projections of the provider's financial results in the current year and at least the 4 succeeding years, both in the absence of proposed corrective actions and if the proposed corrective actions are taken;

4. Identify the key assumptions affecting the provider's projections and the sensitivity of the projections to the assumptions; and

5. Identify the quality of and problems associated with the provider's business.

(b) The company information report must be submitted within 45 days after the occurrence of the company information level event.

(c) Within 60 days after the submission by a provider of a company information report to the office, the office shall notify the provider whether the corrective action identified in the company information report must be implemented or is unsatisfactory in the judgment of the office. If the office determines that the corrective action proposed in the company information report is unsatisfactory, the notification to the provider must set forth the reasons for the determination and may set forth proposed revisions. Upon notification from the

20-00386-18

2018438__

office, the provider shall prepare a revised company information report, which may incorporate by reference any revisions proposed by the office, and shall submit the revised company information report to the office within 45 days after the notification from the office; or

(d) If the office notifies a provider that the provider's company information report or revised company information report is unsatisfactory, the office may, at its discretion, specify in the notification that the notification is a regulatory action level event.

The occurrence of a company information level event may not be deemed a violation of the Insurance Code and the submission of a company information report may not be deemed a disciplinary action. However, the failure to file a company information report or other violation of this section constitutes a violation of the Insurance Code and may subject a provider to disciplinary action.

(2) (a) If a regulatory action level event occurs, the office must:

1. Require the provider to prepare and submit a corrective action plan or, if applicable, a revised corrective action plan;

2. Perform an examination pursuant to s. 624.316 or an analysis, as the office considers necessary, of the assets, liabilities, and operations of the provider, including a review of the corrective action plan or the revised corrective action plan; and

3. After the examination or analysis, issue a corrective order specifying any corrective actions that the office

20-00386-18

2018438__

determines are required.

(b) In determining corrective actions, the office shall consider any factor relevant to the provider based upon the office's examination or analysis of the assets, liabilities, and operations of the provider. The corrective action plan or the revised corrective action plan must be submitted within 45 days after the occurrence of the regulatory action level event.

(c) The office may retain actuaries, investment experts, and other consultants to review a provider's corrective action plan or revised corrective action plan, examine or analyze the assets, liabilities, and operations of a provider, and formulate the corrective order with respect to the provider. The fees, costs, and expenses relating to consultants must be borne by the affected provider or by any other party as directed by the office.

(3) If an impairment occurs, the office must take any action necessary to place the provider under regulatory control, including any remedy available under chapter 631. An impairment is sufficient grounds for the department to be appointed as receiver as provided in chapter 631. Notwithstanding s. 631.011, impairment of a provider, for purposes of s. 631.051, is defined according to the term "impaired" under s. 651.011. The office may forego taking action for up to 90 days after the impairment if the office finds there is a reasonable expectation that the impairment may be eliminated within the 90-day period.

(4) There is no liability on the part of, and a cause of action may not arise against, the commission, department, or office, or their employees or agents, for any action taken by them in the performance of their powers and duties under this

20-00386-18

2018438__

1219 section.

1220 (5) The office shall transmit any notice that may result in
 1221 regulatory action by registered mail, certified mail, or any
 1222 other method of transmission. Notice is effective when the
 1223 provider receives it.

1224 (6) This section is supplemental to the other laws of this
 1225 state and does not preclude or limit any power or duty of the
 1226 department or office under those laws or under the rules adopted
 1227 pursuant to those laws.

1228 (7) The commission may adopt rules to administer this
 1229 section, including, but not limited to, rules regarding
 1230 corrective action plans, adjusted corrective action plans,
 1231 corrective orders, and procedures to be followed in the event of
 1232 a triggering of a company information level event, a regulatory
 1233 action level event, or an impairment.

1234 (8) The office may exempt a provider from subsection (1),
 1235 subsection (2), or subsection (3) until stabilized occupancy is
 1236 reached or until the time projected to achieve stabilized
 1237 occupancy as reported in the last actuarial study required by
 1238 the office as part of an application filing under s. 651.022, s.
 1239 651.023, s. 651.024, s. 651.0245, or s. 651.0246 has elapsed,
 1240 but for no longer than 3 years from the date of issuance of the
 1241 certificate of occupancy.

1242 Section 16. Paragraphs (a) and (c) of subsection (1) of
 1243 section 651.035, Florida Statutes, are amended, and subsections
 1244 (7), (8), and (9) are added to that section, to read:

1245 651.035 Minimum liquid reserve requirements.—

1246 (1) A provider shall maintain in escrow a minimum liquid
 1247 reserve consisting of the following reserves, as applicable:

20-00386-18

2018438__

1248 (a) Each provider shall maintain in escrow as a debt
 1249 service reserve the aggregate amount of all principal and
 1250 interest payments due during the fiscal year on any mortgage
 1251 loan or other long-term financing of the facility, including
 1252 property taxes as recorded in the audited financial statements
 1253 required under s. 651.026. The amount must include any leasehold
 1254 payments and all costs related to such payments. If principal
 1255 payments are not due during the fiscal year, the provider must
 1256 ~~shall~~ maintain in escrow as a minimum liquid reserve an amount
 1257 equal to interest payments due during the next 12 months on any
 1258 mortgage loan or other long-term financing of the facility,
 1259 including property taxes noticed as required by s. 197.322(3)
 1260 and insurance. If a provider does not have a mortgage loan or
 1261 other financing on the facility, the provider must deposit
 1262 monthly in escrow as a minimum liquid reserve an amount equal to
 1263 one-twelfth of the annual property tax liability as indicated in
 1264 the most recent tax notice provided pursuant to s. 197.322(3).

1265 (c) Each provider shall maintain in escrow an operating
 1266 reserve equal to 30 percent of the total operating expenses
 1267 projected in the feasibility study required by s. 651.023 for
 1268 the first 12 months of operation. Thereafter, each provider
 1269 shall maintain in escrow an operating reserve equal to 15
 1270 percent of the total operating expenses in the annual report
 1271 filed pursuant to s. 651.026. If a provider has been in
 1272 operation for more than 12 months, the total annual operating
 1273 expenses must ~~shall~~ be determined by averaging the total annual
 1274 operating expenses reported to the office by the number of
 1275 annual reports filed with the office within the preceding 3-year
 1276 period subject to adjustment if there is a change in the number

20-00386-18

2018438

1277 of facilities owned. For purposes of this subsection, total
 1278 annual operating expenses include all expenses of the facility
 1279 except+ depreciation and amortization; interest and property
 1280 taxes included in paragraph (a); extraordinary expenses that are
 1281 adequately explained and documented in accordance with generally
 1282 accepted accounting principles; liability insurance premiums in
 1283 excess of those paid in calendar year 1999; and changes in the
 1284 obligation to provide future services to current residents. For
 1285 providers initially licensed during or after calendar year 1999,
 1286 liability insurance must ~~shall~~ be included in the total
 1287 operating expenses in an amount not to exceed the premium paid
 1288 during the first 12 months of facility operation. ~~Beginning~~
 1289 ~~January 1, 1993,~~ The operating reserves required under this
 1290 subsection must ~~shall~~ be in an unencumbered account held in
 1291 escrow for the benefit of the residents. Such funds may not be
 1292 encumbered or subject to any liens or charges by the escrow
 1293 agent or judgments, garnishments, or creditors' claims against
 1294 the provider or facility. However, if a facility had a lien,
 1295 mortgage, trust indenture, or similar debt instrument in place
 1296 before January 1, 1993, which encumbered all or any part of the
 1297 reserves required by this subsection and such funds were used to
 1298 meet the requirements of this subsection, then such arrangement
 1299 may be continued, unless a refinancing or acquisition has
 1300 occurred, and the provider is ~~shall be~~ in compliance with this
 1301 subsection.

1302 (7) A provider may withdraw funds from the operating
 1303 reserve or the debt service reserve as provided in s. 625.62
 1304 with the written consent of the office.

1305 (a) To withdraw funds in excess of the amount required

20-00386-18

2018438

1306 under this section, the provider must file notice with the
 1307 office 10 days before the date of such withdrawal. If no
 1308 disapproval is received within 10 days of the filing of such
 1309 notice, the withdrawal is deemed approved. Escrow agent fees as
 1310 allowed by s. 651.033(1)(d) may be withdrawn from funds in
 1311 excess of the amount required under this section without prior
 1312 approval of the office.

1313 (b)1. For all other proposed withdrawals, in order to
 1314 receive the consent of the office, the provider must file
 1315 documentation showing why the withdrawal is necessary for the
 1316 continued operation of the facility and such additional
 1317 information as the office reasonably requires.

1318 2. The office shall notify the provider when the file is
 1319 deemed complete. If the provider has complied with all prior
 1320 requests for information, the file is deemed complete after 30
 1321 days without communication from the office.

1322 3. Within 30 days after the date a file is deemed complete,
 1323 the office shall provide the provider with written notice of its
 1324 approval or disapproval of the request. The office may
 1325 disapprove any request to withdraw such funds if it determines
 1326 that the withdrawal is not in the best interest of the
 1327 residents.

1328 (8) The office may order the immediate transfer of up to
 1329 100 percent of the funds held in the minimum liquid reserve to
 1330 the custody of the department pursuant to part III of chapter
 1331 625 if the office finds that the provider is impaired or
 1332 insolvent. The office may order such a transfer regardless of
 1333 whether the office has suspended or revoked, or intends to
 1334 suspend or revoke, the certificate of authority of the provider.

20-00386-18

2018438

(9) Each facility shall file with the office annually, no later than 60 days before the end of the provider's fiscal year, a calculation of its minimum liquid reserve, determined in accordance with this section, on a form prescribed by the commission. The minimum liquid reserve must be maintained at the calculated level beginning no later than the first day of the subsequent fiscal year.

Section 17. Section 651.043, Florida Statutes, is created to read:

651.043 Approval of change in management.—

(1) As used in this section, the term "management" means:

(a) A manager or management company;

(b) An officer or director of the provider or of the manager or management company;

(c) Any other person performing duties similar to those of persons in paragraph (a) or paragraph (b); or

(d) A person who exercises or who has the ability to exercise effective control of the organization, or who influences or has the ability to influence the transaction of the business of the provider.

(2) Effective July 1, 2018, a contract for management must be in writing and include a provision that the contract will be canceled upon issuance of an order by the office pursuant to this section without the application of any cancellation fee or penalty.

(3) A provider must file notice with the office of any change in management within 5 days after the appointment of new management or the removal of approved management, whichever is earlier. For each new management appointment, the provider must

20-00386-18

2018438

submit the information required by s. 651.022(2) and a copy of the written management contract. The office shall complete its review and issue an approval or disapproval of the management contract within 30 days after the filing is deemed complete. A filing is deemed complete upon receipt of all requested information and correction of any error or omission for which the applicant was timely notified.

(4) The office may disapprove new management and order the provider to cancel the contract in accordance with the terms of the contract and applicable law if the office:

(a) Finds that the new management is incompetent or untrustworthy;

(b) Finds that the new management is so lacking in relevant managerial experience as to make the proposed operation hazardous to the residents or potential residents;

(c) Finds that the new management is so lacking in relevant experience, ability, and standing as to jeopardize the reasonable promise of successful operation; or

(d) Has good reason to believe that the new management is affiliated directly or indirectly through ownership, control, reinsurance transactions, or other insurance or business relations with any person or persons whose business operations are or have been marked by manipulation of assets, accounts, or reinsurance or by bad faith, to the detriment of policyholders, residents, stockholders, investors, creditors, or the public.

(5) Management disapproved by the office must be removed within 30 days after receipt by the provider of notice of such disapproval.

(6) The office may revoke, suspend, or take other

20-00386-18

2018438

1393 administrative action against the certificate of authority of
 1394 the provider if the provider:

1395 (a) Fails to timely remove management disapproved by the
 1396 office;

1397 (b) Fails to timely notify the office of a change in
 1398 management;

1399 (c) Appoints management without a written contract; or

1400 (d) Repeatedly appoints management that was previously
 1401 disapproved by the office or that is not approvable pursuant to
 1402 subsection (4).

1403 (7) The provider shall remove any management immediately
 1404 upon discovery of any of the following conditions, if the
 1405 conditions were not disclosed in the notice to the office
 1406 required in subsection (3):

1407 (a) That any person who exercises or has the ability to
 1408 exercise effective control of the provider, or who influences or
 1409 has the ability to influence the transaction of the business of
 1410 the provider, has been found guilty of, or has pled guilty or no
 1411 contest to, any felony or crime punishable by imprisonment of 1
 1412 year or more under the laws of the United States or any state
 1413 thereof or under the laws of any other country, which involves
 1414 moral turpitude, without regard to whether a judgment or
 1415 conviction has been entered by the court having jurisdiction in
 1416 such case.

1417 (b) That any person who exercises or has the ability to
 1418 exercise effective control of the organization, or who
 1419 influences or has the ability to influence the transaction of
 1420 the business of the provider, is now or was in the past
 1421 affiliated, directly or indirectly, through ownership interest

20-00386-18

2018438

1422 of 10 percent or more in, control of, or reinsurance
 1423 transactions with any business, corporation, or other entity
 1424 that has been found guilty of or has pled guilty or no contest
 1425 to any felony or crime punishable by imprisonment for 1 year or
 1426 more under the laws of the United States, any state, or any
 1427 other country, regardless of adjudication.

1428
 1429 The failure to remove such management is grounds for revocation
 1430 or suspension of the provider's certificate of authority.

1431 Section 18. Section 651.051, Florida Statutes, is amended
 1432 to read:

1433 651.051 Maintenance of assets and records in state.-All
 1434 records and assets of a provider must be maintained in this
 1435 state. No records or assets may be removed from this state by a
 1436 provider unless the office consents to such removal in writing
 1437 before such removal. Such consent must ~~shall~~ be based upon the
 1438 provider's submitting satisfactory evidence that the removal
 1439 will facilitate and make more economical the operations of the
 1440 provider and will not diminish the service or protection
 1441 thereafter to be given the provider's residents in this state.
 1442 ~~Before~~ Prior to such removal, the provider shall give notice to
 1443 the president or chair of the facility's residents' council. If
 1444 such removal is part of a cash management system which has been
 1445 approved by the office, disclosure of the system must ~~shall~~ meet
 1446 the notification requirements. The electronic storage of records
 1447 on a web-based, secured storage platform by contract with a
 1448 third party constitutes removal from the state and requires
 1449 prior approval by the office.

1450 Section 19. Subsection (2) of section 651.057, Florida

20-00386-18

2018438__

Statutes, is amended to read:

651.057 Continuing care at-home contracts.—

(2) A provider that holds a certificate of authority and wishes to offer continuing care at-home must also:

(a) Submit a business plan to the office with the following information:

1. A description of the continuing care at-home services that will be provided, the market to be served, and the fees to be charged;

2. A copy of the proposed continuing care at-home contract;

3. An actuarial study prepared by an independent actuary in accordance with the standards adopted by the American Academy of Actuaries which presents the impact of providing continuing care at-home on the overall operation of the facility; and

4. A market feasibility study that meets the requirements of s. 651.022(3) and documents that there is sufficient interest in continuing care at-home contracts to support such a program;

(b) Demonstrate to the office that the proposal to offer continuing care at-home contracts to individuals who do not immediately move into the facility will not place the provider in an unsound financial condition;

(c) Comply with the requirements of s. 651.0246(1) ~~s. 651.021(2)~~, except that an actuarial study may be substituted for the feasibility study; and

(d) Comply with the requirements of this chapter.

Section 20. Subsection (1) of section 651.071, Florida Statutes, is amended to read:

651.071 Contracts as preferred claims on liquidation or receivership.—

20-00386-18

2018438__

(1) In the event of receivership or liquidation proceedings against a provider, all continuing care and continuing care at-home contracts executed by a provider ~~are shall be~~ deemed preferred claims or policyholder loss preferred claims pursuant to s. 631.271(1)(b) against all assets owned by the provider; however, such claims are subordinate to any secured claim.

Section 21. Subsection (2) and present paragraph (g) of subsection (3) of section 651.091, Florida Statutes, are amended, present paragraphs (h) and (i) of subsection (3) of that section are redesignated as paragraphs (g) and (h), respectively, a new paragraph (i) and paragraphs (j), (k), and (l) are added to that subsection, and paragraph (d) of subsection (3) and subsection (4) of that section are republished, to read:

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

(2) Every continuing care facility shall:

(a) Display the certificate of authority in a conspicuous place inside the facility.

(b) Post in a prominent position in the facility which is accessible to all residents and the general public a concise summary of the last examination report issued by the office, with references to the page numbers of the full report noting any deficiencies found by the office, and the actions taken by the provider to rectify such deficiencies, indicating in such summary where the full report may be inspected in the facility.

(c) Provide notice to the president or chair of the residents' council within 3 business days after issuance of an examination report or the initiation of any legal or

20-00386-18

2018438

administrative proceeding by the office or the department and include a copy of such document.

(d)(e) Post in a prominent position in the facility which is accessible to all residents and the general public a summary of the latest annual statement, indicating in the summary where the full annual statement may be inspected in the facility. A listing of any proposed changes in policies, programs, and services must also be posted.

(e)(d) Distribute a copy of the full annual statement and a copy of the most recent third-party third-party financial audit filed with the annual report to the president or chair of the residents' council within 30 days after filing the annual report with the office, and designate a staff person to provide explanation thereof.

(f)(e) Deliver the information described in s. 651.085(4) in writing to the president or chair of the residents' council and make supporting documentation available upon request Notify the residents' council of any plans filed with the office to obtain new financing, additional financing, or refinancing for the facility and of any applications to the office for any expansion of the facility.

(g)(f) Deliver to the president or chair of the residents' council a summary of entrance fees collected and refunds made during the time period covered in the annual report and the refund balances due at the end of the report period.

(h)(g) Deliver to the president or chair of the residents' council a copy of each quarterly statement within 30 days after the quarterly statement is filed with the office if the facility is required to file quarterly.

20-00386-18

2018438

(i)(h) Upon request, deliver to the president or chair of the residents' council a copy of any newly approved continuing care or continuing care at-home contract within 30 days after approval by the office.

(j) Provide to the president or chair of the residents' council a copy of any notice filed with the office relating to any change in ownership within 3 business days after the receipt of such filing by the provider.

(k) Make the information available to prospective residents pursuant to paragraph (3)(d) available to current residents and provide notice of changes to that information to the president or chair of the residents' council within 3 business days.

(3) Before entering into a contract to furnish continuing care or continuing care at-home, the provider undertaking to furnish the care, or the agent of the provider, shall make full disclosure, and provide copies of the disclosure documents to the prospective resident or his or her legal representative, of the following information:

(d) In keeping with the intent of this subsection relating to disclosure, the provider shall make available for review master plans approved by the provider's governing board and any plans for expansion or phased development, 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.

~~(g) The amount and location of any reserve funds required by this chapter, and the name of the person or entity having a claim to such funds in the event of a bankruptcy, foreclosure,~~

20-00386-18

2018438

~~or rehabilitation proceeding.~~

(i) Notice of the issuance of an examination report or the initiation of any legal or administrative proceeding by the office or the department, including a copy of such document.

(j) Notice that the entrance fee is the property of the provider after the expiration of the 7-day escrow requirement under s. 651.055(2).

(k) If the provider operates multiple facilities, a disclosure of any distribution of assets or income between facilities that may occur and the manner in which such distributions would be made, or a statement that such distributions will not occur.

(l) Notice of any holding company system or obligated group of which the provider is a member.

(4) A true and complete copy of the full disclosure document to be used must be filed with the office before use. A resident or prospective resident or his or her legal representative may inspect the full reports referred to in paragraph (2)(b); the charter or other agreement or instrument required to be filed with the office pursuant to s. 651.022(2), together with all amendments thereto; and the bylaws of the corporation or association, if any. Upon request, copies of the reports and information shall be provided to the individual requesting them if the individual agrees to pay a reasonable charge to cover copying costs.

Section 22. Subsection (1) of section 651.105, Florida Statutes, is amended, and subsection (7) is added to that section, to read:

651.105 Examination and inspections.—

Page 55 of 70

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

20-00386-18

2018438

(1) The office may at any time, and shall at least once every 3 years, examine the business of any applicant for a certificate of authority and any provider engaged in the execution of care contracts or engaged in the performance of obligations under such contracts, in the same manner as is provided for the examination of insurance companies pursuant to ~~ss. 624.316 and 624.318 s. 624.316~~. For a provider as described ~~defined~~ in s. 651.028, such examinations must ~~shall~~ take place at least once every 5 years. Such examinations must ~~shall~~ be made by a representative or examiner designated by the office whose compensation will be fixed by the office pursuant to s. 624.320. Routine examinations may be made by having the necessary documents submitted to the office; and, for this purpose, financial documents and records conforming to commonly accepted accounting principles and practices, as required under s. 651.026, are deemed adequate. The final written report of each examination must be filed with the office and, when so filed, constitutes a public record. Any provider being examined shall, upon request, give reasonable and timely access to all of its records. The representative or examiner designated by the office may at any time examine the records and affairs and inspect the physical property of any provider, whether in connection with a formal examination or not.

(7) To the extent necessary to ascertain the financial condition of a provider, the office may examine any parent, subsidiary, or affiliate that has a contractual or financial relationship with the provider.

Section 23. Section 651.1055, Florida Statutes, is created to read:

Page 56 of 70

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

20-00386-18

2018438

1625 651.1055 Duty of provider to cooperate.—A provider has a
 1626 duty to cooperate with the office, including responding to
 1627 written correspondence and providing data, financial statements,
 1628 and pertinent information as requested by the office.

1629 Section 24. Section 651.106, Florida Statutes, is amended
 1630 to read:

1631 651.106 Grounds for discretionary refusal, suspension, or
 1632 revocation of certificate of authority.—The office may deny an
 1633 application or, suspend, or revoke the provisional certificate
 1634 of authority or the certificate of authority of any applicant or
 1635 provider if it finds that any one or more of the following
 1636 grounds applicable to the applicant or provider exist:

1637 (1) Failure by the provider to continue to meet the
 1638 requirements for the authority originally granted.

1639 (2) Failure by the provider to meet one or more of the
 1640 qualifications for the authority specified by this chapter.

1641 (3) Material misstatement, misrepresentation, or fraud in
 1642 obtaining the authority, or in attempting to obtain the same.

1643 (4) Demonstrated lack of fitness or trustworthiness.

1644 (5) Fraudulent or dishonest practices of management in the
 1645 conduct of business.

1646 (6) Misappropriation, conversion, or withholding of moneys.

1647 (7) Failure to comply with, or violation of, any proper
 1648 order or rule of the office or commission or violation of any
 1649 provision of this chapter.

1650 (8) The insolvent or impaired condition of the provider or
 1651 the provider's being in such condition or using such methods and
 1652 practices in the conduct of its business as to render its
 1653 further transactions in this state hazardous or injurious to the

20-00386-18

2018438

1654 public.

1655 (9) Refusal by the provider to be examined or to produce
 1656 its accounts, records, and files for examination, or refusal by
 1657 any of its officers to give information with respect to its
 1658 affairs or to perform any other legal obligation under this
 1659 chapter when required by the office.

1660 (10) Failure by the provider to comply with the
 1661 requirements of s. 651.026 or s. 651.033.

1662 (11) Failure by the provider to maintain escrow accounts or
 1663 funds as required by this chapter.

1664 (12) Failure by the provider to meet the requirements of
 1665 this chapter for disclosure of information to residents
 1666 concerning the facility, its ownership, its management, its
 1667 development, or its financial condition or failure to honor its
 1668 continuing care or continuing care at-home contracts.

1669 (13) Any cause for which issuance of the license could have
 1670 been refused had it then existed and been known to the office.

1671 (14) Having been found guilty of, or having pleaded guilty
 1672 or nolo contendere to, a felony in this state or any other
 1673 state, without regard to whether a judgment or conviction has
 1674 been entered by the court having jurisdiction of such cases.

1675 (15) In the conduct of business under the license, engaging
 1676 in unfair methods of competition or in unfair or deceptive acts
 1677 or practices prohibited under part IX of chapter 626.

1678 (16) A pattern of bankrupt enterprises.

1679 (17)(a) The ownership, control, or management of the
 1680 organization includes any person:

1681 1. Who is incompetent or untrustworthy;

1682 2. Who is so lacking in continuing care expertise as to

20-00386-18

2018438

make the operation of the provider hazardous to potential and existing residents;

3. Who is so lacking in continuing care experience, ability, and standing as to jeopardize the reasonable promise of successful operation;

4. Who is affiliated, directly or indirectly, through ownership, control, reinsurance transactions, or other business relations, with any person whose business operations are or have been marked by business practices or conduct that is to the detriment of the public, stockholders, investors, or creditors; or

5. Whose business operations are or have been marked by business practices or conduct that is to the detriment of the public, stockholders, investors, or creditors.

(b) Any person, including any stock subscriber, stockholder, or incorporator, who exercises or has the ability to exercise effective control of the organization, or who influences or has the ability to influence the transaction of the provider's business, does not possess the financial standing and business experience for the successful operation of the provider.

(18) The provider has not filed a notice of change in management, fails to remove a disapproved manager, or persists in appointing disapproved or unapprovable managers.

Revocation of a certificate of authority under this section does not relieve a provider from the provider's obligation to residents under the terms and conditions of any continuing care or continuing care at-home contract between the provider and

20-00386-18

2018438

residents or the provisions of this chapter. The provider shall continue to file its annual statement and pay license fees to the office as required under this chapter as if the certificate of authority had continued in full force, but the provider shall not issue any new contracts. The office may seek an action in the circuit court of Leon County to enforce the office's order and the provisions of this section.

Section 25. Section 651.1065, Florida Statutes, is created to read:

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

(1) Regardless of whether delinquency proceedings as to a continuing care retirement community have been or are to be initiated, a proprietor, general partner, member, officer, director, trustee, or manager of a continuing care retirement community, except with the written permission of the office, may not permit the continuing care retirement community to solicit or accept new continuing care contracts in this state after the proprietor, general partner, member, officer, director, trustee, or manager knew, or reasonably should have known, that the continuing care retirement community was impaired or insolvent.

(2) A proprietor, general partner, member, officer, director, trustee, or manager who violates this section commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 26. Section 651.111, Florida Statutes, is amended to read:

651.111 Resident complaints and requests for inspections.—

(1) Any interested party or resident may file a complaint

20-00386-18

2018438

that may include a request for an inspection of the records and related financial affairs of a provider providing care in accordance with the provisions of this chapter by transmitting to the office notice of an alleged violation of applicable requirements prescribed by statute or by rule, specifying to a reasonable extent the details of the alleged violation or complaint, which notice must ~~shall~~ be signed by the complainant.

(2) If the complaint requests an inspection, the substance of the complaint must ~~shall~~ be given to the provider no earlier than the time of the inspection. Unless the complainant specifically requests otherwise, neither the substance of the complaint which is provided to the provider nor any copy of the complaint or any record which is published, released, or otherwise made available to the provider may ~~shall~~ disclose the name of any person mentioned in the complaint except the name of any duly authorized officer, employee, or agent of the office conducting the investigation or inspection pursuant to this chapter.

(3) Upon receipt of a complaint, the office shall make a preliminary review; and, unless the office determines that the complaint is without any reasonable basis or the complaint does not request an inspection, the office shall make an inspection. The office shall provide the complainant with a written acknowledgment of the complaint within 15 days after receipt by the office. Such acknowledgment must include the case number assigned by the office to the complaint and the name and contact information of any duly authorized officer, employee, or agent of the office conducting the investigation or inspection pursuant to this chapter. The complainant must ~~shall~~ be advised,

20-00386-18

2018438

within 30 days after the receipt of the complaint by the office, of the proposed course of action of the office, including an estimated timeframe for the handling of the complaint. If the office does not conclude its inspection or investigation within the office's estimated timeframe, the office must advise the complainant in writing within 15 days after any revised course of action, including a revised estimated timeframe for the handling of the complaint. Within 15 days after the office completes its inspection or concludes its investigation, the office shall provide the complainant a written closure statement specifying the office's findings and the results of the inspection or investigation.

(4) A ~~No~~ provider operating under a certificate of authority under this chapter may not discriminate or retaliate in any manner against a resident or an employee of a facility providing care because such resident or employee or any other person has initiated a complaint pursuant to this section.

Section 27. Section 651.114, Florida Statutes, is amended to read:

651.114 Delinquency proceedings; remedial rights.—

(1) Upon determination by the office that a provider is not in compliance with this chapter, the office may notify the chair of the Continuing Care Advisory Council, who may assist the office in formulating a corrective action plan.

(2) Within 30 days after a request by either the advisory council or the office, a provider shall make a plan for obtaining compliance or solvency available to the advisory council and the office, ~~within 30 days after being requested to do so by the council, a plan for obtaining compliance or~~

20-00386-18

2018438__

1799 ~~solvency.~~

1800 (3) Within 30 days after receipt of a plan for obtaining
 1801 compliance or solvency, the office, or notification, the
 1802 advisory council at the request of the office, shall:

1803 (a) Consider and evaluate the plan submitted by the
 1804 provider.

1805 (b) Discuss the problem and solutions with the provider.

1806 (c) Conduct such other business as is necessary.

1807 (d) Report its findings and recommendations to the office,
 1808 which may require additional modification of the plan.

1809
 1810 This subsection may not be interpreted so as to delay or prevent
 1811 the office from taking any regulatory measures it deems
 1812 necessary regarding the provider that submitted the plan.

1813 (4) If the financial condition of a continuing care
 1814 facility or provider is impaired or is such that if not modified
 1815 or corrected, its continued operation would result in
 1816 insolvency, the office may direct the provider to formulate and
 1817 file with the office a corrective action plan. If the provider
 1818 fails to submit a plan within 30 days after the office's
 1819 directive, or submits a plan that is insufficient to correct the
 1820 condition, the office may specify a plan and direct the provider
 1821 to implement the plan.

1822 ~~(5)-(4)~~ After receiving approval of a plan by the office,
 1823 the provider shall submit a progress report monthly to the
 1824 advisory council or the office, or both, in a manner prescribed
 1825 by the office. After 3 months, or at any earlier time deemed
 1826 necessary, the council shall evaluate the progress by the
 1827 provider and shall advise the office of its findings.

20-00386-18

2018438__

1828 ~~(6)-(5)~~ If should the office finds find that sufficient
 1829 grounds exist for rehabilitation, liquidation, conservation,
 1830 reorganization, seizure, or summary proceedings of an insurer as
 1831 set forth in ss. 631.051, 631.061, and 631.071, the department
 1832 ~~office~~ may petition for an appropriate court order or may pursue
 1833 such other relief as is afforded in part I of chapter 631.
 1834 Before invoking its powers under part I of chapter 631, the
 1835 department office shall notify the chair of the advisory
 1836 council.

1837 (7) Notwithstanding s. 631.011, impairment of a provider,
 1838 for purposes of s. 631.051, is defined according to the term
 1839 "impaired" in s. 651.011.

1840 ~~(8)-(6)~~ In the event an order of conservation,
 1841 rehabilitation, liquidation, or conservation, reorganization,
 1842 seizure, ~~or summary proceeding~~ has been entered against a
 1843 provider, the department and office are vested with all of the
 1844 powers and duties they have under the provisions of part I of
 1845 chapter 631 in regard to delinquency proceedings of insurance
 1846 companies. A provider shall give written notice of the
 1847 proceeding to its residents within 3 business days after the
 1848 initiation of a delinquency proceeding under chapter 631 and
 1849 shall include a notice of the delinquency proceeding in any
 1850 written materials provided to prospective residents.

1851 ~~(7) If the financial condition of the continuing care~~
 1852 ~~facility or provider is such that, if not modified or corrected,~~
 1853 ~~its continued operation would result in insolvency, the office~~
 1854 ~~may direct the provider to formulate and file with the office a~~
 1855 ~~corrective action plan. If the provider fails to submit a plan~~
 1856 ~~within 30 days after the office's directive or submits a plan~~

20-00386-18

2018438__

that is insufficient to correct the condition, the office may specify a plan and direct the provider to implement the plan.

(9) A provider subject to an order to show cause entered pursuant to chapter 631 must file its written response to the order, together with any defenses it may have to the department's allegations, no later than 20 days after service of the order to show cause, but no less than 15 days before the date of the hearing set by the order to show cause.

(10) A hearing held pursuant to chapter 631 to determine whether cause exists for the department to be appointed receiver must be commenced within 60 days after an order directing a provider to show cause.

(11) (a) ~~(b)~~ (a) If the petition for rehabilitation, liquidation, conservation, reorganization, seizure, or summary proceedings is based solely upon the default of the insurer under the terms of a resolution, ordinance, loan agreement, indenture of trust, mortgage, lease, security agreement, or other instrument creating or securing bonds or notes issued to finance a facility, the rights of the office described in this section are subordinate to the rights of a trustee or lender pursuant to the terms of a resolution, ordinance, loan agreement, indenture of trust, mortgage, lease, security agreement, or other instrument creating or securing bonds or notes issued to finance a facility, and the office, subject to the provisions of paragraph (c), may ~~shall~~ not exercise its remedial rights provided under this section and ss. 651.018, 651.106, 651.108, and 651.116 with respect to a facility that is subject to a lien, mortgage, lease, or other encumbrance or trust indenture securing bonds or notes issued in connection

20-00386-18

2018438__

with the financing of the facility, if the trustee or lender, by inclusion or by amendment to the loan documents or by a separate contract with the office, agrees that the rights of residents under a continuing care or continuing care at-home contract will be honored and will not be disturbed by a foreclosure or conveyance in lieu thereof as long as the resident:

1. Is current in the payment of all monetary obligations required by the contract;

2. Is in compliance and continues to comply with all provisions of the contract; and

3. Has asserted no claim inconsistent with the rights of the trustee or lender.

(b) This subsection does not require a trustee or lender to:

1. Continue to engage in the marketing or resale of new continuing care or continuing care at-home contracts;

2. Pay any rebate of entrance fees as may be required by a resident's continuing care or continuing care at-home contract as of the date of acquisition of the facility by the trustee or lender and until expiration of the period described in paragraph (d);

3. Be responsible for any act or omission of any owner or operator of the facility arising before the acquisition of the facility by the trustee or lender; or

4. Provide services to the residents to the extent that the trustee or lender would be required to advance or expend funds that have not been designated or set aside for such purposes.

(c) Should the office determine, at any time during the suspension of its remedial rights as provided in paragraph (a),

20-00386-18

2018438

that the trustee or lender is not in compliance with paragraph (a), or that a lender or trustee has assigned or has agreed to assign all or a portion of a delinquent or defaulted loan to a third party without the office's written consent, the office shall notify the trustee or lender in writing of its determination, setting forth the reasons giving rise to the determination and specifying those remedial rights afforded to the office which the office shall then reinstate.

(d) Upon acquisition of a facility by a trustee or lender and evidence satisfactory to the office that the requirements of paragraph (a) have been met, the office shall issue a 90-day temporary certificate of authority granting the trustee or lender the authority to engage in the business of providing continuing care or continuing care at-home and to issue continuing care or continuing care at-home contracts subject to the office's right to immediately suspend or revoke the temporary certificate of authority if the office determines that any of the grounds described in s. 651.106 apply to the trustee or lender or that the terms of the contract used as the basis for the issuance of the temporary certificate of authority by the office have not been or are not being met by the trustee or lender since the date of acquisition.

Section 28. Section 651.1141, Florida Statutes, is created to read:

651.1141 Immediate final orders.—The Legislature finds that a violation of s. 651.024, s. 651.0245, s. 651.025, s. 651.035(3), s. 651.043, s. 651.083, or s. 651.105 constitutes an immediate danger to the public health, safety, or welfare. Pursuant to s. 120.569, the office may issue an immediate final

20-00386-18

2018438

order to cease and desist if it finds that a provider is in violation of such sections.

Section 29. Section 651.1151, Florida Statutes, is amended to read:

651.1151 Administrative, vendor, and management contracts.—

(1) ~~The office may require~~ A provider must ~~to~~ submit to the office any contract for administrative, vendor, or management services ~~if the office has information and belief that a provider has entered into a contract~~ with an affiliate, an entity controlled by the provider, or an entity controlled by an affiliate of the provider, ~~which has not been disclosed to the office or which contract requires the provider to pay a fee that is unreasonably high in relation to the service provided.~~

(2) The office may disapprove a contract for administrative, vendor, or management services if it finds that the fees to be paid are so unreasonably high as compared with similar contracts entered into by other providers in similar circumstances that the contract is detrimental to the facility or its residents.

(3) ~~(2)~~ After review of the contract, the office may order the provider to cancel the contract in accordance with the terms of the contract and applicable law if it determines that the fees to be paid are so unreasonably high as compared with similar contracts entered into by other providers in similar circumstances that the contract is detrimental to the facility or its residents.

(4) ~~(3)~~ Any contract with an affiliate, an entity controlled by the provider, or an entity controlled by an affiliate of the provider for administrative, vendor, or management services

20-00386-18

2018438__

1973 ~~entered into or renewed after October 1, 1991,~~ must include a
 1974 provision that the contract will be canceled upon issuance of an
 1975 order by the office pursuant to this section. A copy of the
 1976 current management services contract, pursuant to this section,
 1977 if any, must be on file in the marketing office or other area
 1978 accessible to residents and the appropriate residents' council.
 1979 (5) ~~(4)~~ Any action of the office under this section is
 1980 subject to review pursuant to the procedures provided in chapter
 1981 120.

1982 Section 30. Paragraphs (d) and (e) of subsection (1) of
 1983 section 651.121, Florida Statutes, are amended to read:

1984 651.121 Continuing Care Advisory Council.—

1985 (1) The Continuing Care Advisory Council to the office is
 1986 created consisting of 10 members who are residents of this state
 1987 appointed by the Governor and geographically representative of
 1988 this state. Three members shall be administrators of facilities
 1989 that hold valid certificates of authority under this chapter and
 1990 shall have been actively engaged in the offering of continuing
 1991 care contracts in this state for 5 years before appointment. The
 1992 remaining members include:

1993 ~~(d) An attorney.~~

1994 (d) ~~(e)~~ Four ~~Three~~ residents who hold continuing care or
 1995 continuing care at-home contracts with a facility certified in
 1996 this state.

1997 Section 31. Subsections (1) and (4) of section 651.125,
 1998 Florida Statutes, are amended to read:

1999 651.125 Criminal penalties; injunctive relief.—

2000 (1) Any person who maintains, enters into, or, as manager
 2001 or officer or in any other administrative capacity, assists in

20-00386-18

2018438__

2002 entering into, maintaining, or performing any continuing care or
 2003 continuing care at-home contract subject to this chapter without
 2004 ~~doing so in pursuance of~~ a valid provisional certificate of
 2005 authority or certificate of authority ~~or renewal thereof~~, as
 2006 contemplated by or provided in this chapter, or who otherwise
 2007 violates any provision of this chapter or rule adopted in
 2008 pursuance of this chapter, commits a felony of the third degree,
 2009 punishable as provided in s. 775.082 or s. 775.083. Each
 2010 violation of this chapter constitutes a separate offense.

2011 (4) Any action brought by the office against a provider
 2012 shall not abate by reason of a sale or other transfer of
 2013 ownership of the facility used to provide care, which provider
 2014 is a party to the action, except with the express written
 2015 consent of the ~~director of the office~~.

2016 Section 32. This act shall take effect July 1, 2018.



The Florida Senate

Committee Agenda Request

To: Senator Anitere Flores, Chair
Senate Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: October 25th, 2017

I respectfully request that **Senate Bill #438**, relating to **Continuing Care Contracts**, be placed on the:

- ☐ committee agenda at your earliest possible convenience.
- ☒ next committee agenda.

A handwritten signature in blue ink that reads "Tom Lee".

Senator Tom Lee
Florida Senate, District 20

THE FLORIDA SENATE

APPEARANCE RECORD

1/16/18

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

Meeting Date

438

Bill Number (if applicable)

872234

Amendment Barcode (if applicable)Topic Continuing CareName Bennett Napier, CAE "Na - Pier"Job Title Executive DirectorAddress 325 John Knox Road L103StreetTallahasseeCityFLState32303ZipPhone 850-906-9314Email bennett@executiveoffice.orgSpeaking: ☒ For ☐ Against ☐ InformationWaive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)Representing Florida Life Care Residents AssociationAppearing at request of Chair: ☐ Yes ☒ NoLobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: SB 492

INTRODUCER: Senator Garcia

SUBJECT: Provision of Pharmaceutical Services

DATE: January 12, 2018

REVISED: _____

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Johnson	Knudson	BI	Favorable
2. _____	_____	HP	_____
3. _____	_____	AP	_____

I. Summary:

SB 492 prohibits an insurer or health maintenance organization (HMOs) issuing individual or group health policies or contracts from requiring an insured or subscriber to obtain a prescription drug for the treatment of a chronic illness exclusively from a mail-order pharmacy unless the drug is considered an excluded drug. The bill defines the term “chronic illness” to mean human immunodeficiency virus infection (HIV), epilepsy, hypertension, or diabetes. The bill defines the term “excluded drug” to mean a drug subject to restricted distribution by the U.S. Food and Drug Administration or a drug that requires special handling, provider coordination, or patient education and cannot be provided by a retail pharmacy. The bill allows an insured to obtain prescription drugs, other than an excluded drug, for the treatment of a chronic illness through any retail pharmacy that accepts the same terms and reimbursements as those given to a mail-order pharmacy by an insurer or health maintenance organization.

The bill requires insurers and HMOs that issue major medical policies or contracts and provide coverage through a mail order pharmacy to disclose in the outline of coverage that an insured or subscriber may obtain prescription drugs for treatment of a chronic illness from a retail pharmacy and that the exclusive use of a mail order pharmacy is not required, unless the drug is an excluded drug. Currently, state law does not prohibit an insurer or HMO from requiring an insured to obtain prescription drugs from a mail-order pharmacy or from charging a higher copayment for the use of a retail pharmacy.

It is anticipated that the bill will have a minimal impact on the State Group Insurance program.

II. Present Situation:

Access to Prescription Drugs

Private-sector entities that offer prescription drug insurance coverage, such as employers, labor unions, and managed care companies, often hire pharmacy benefit managers (PBMs) to manage these insurance benefits. The PBMs engage in many activities to manage their clients' prescription drug insurance coverage. The PBMs assemble networks of retail pharmacies so that a plan sponsor's members can fill prescriptions easily and in multiple locations by just paying a co-payment amount. The PBMs consult with plan sponsors to decide which drugs a plan sponsor will provide insurance coverage to treat each medical condition. The PBM manages this list of preferred drug products (formulary) for each of its plan sponsor clients. Consumers with insurance coverage are provided incentives, such as low copayments, to use formulary drugs.

Mail-Order Pharmacies

The PBMs may use mail-order pharmacies to manage prescription drug costs. Many plan sponsors encourage patients with chronic conditions who require repeated refills to seek the discounts that 90-day prescriptions and high-volume mail-order pharmacies can offer. Many PBMs own their own mail-order pharmacies. Insurers and PBMs use a variety of incentives to encourage the use of mail order pharmacies; especially for beneficiaries taking maintenance medications. Plans may offer lower copayments for mail order drugs, charge deductibles for retail purchases, or impose limitations on the number of prescriptions at a retail pharmacy. Some health plans have "mandatory mail order" programs that reimburse beneficiaries for maintenance medications only if the beneficiaries fill those prescriptions by mail. Some insurers are ambivalent about the savings offered by mail order or point to equivalent or better savings that can be achieved from filling 90-day supplies in network retail pharmacies. These payers contend that enrollees benefit from face-to-face contact with a pharmacist.¹

While PBMs provide pharmacy claims processing and mail-order pharmacy services to their customers, many provide additional services, including rebate negotiations with drug manufacturers, development of pharmacy networks, formulary management, prospective and retrospective drug utilization reviews, generic drug substitutions, and disease management programs. The decision of plan sponsors to use PBMs to control pharmacy benefit costs, however, can shift business away from retail pharmacies.

Concerns about Mail-Order Pharmacy

According to advocates of this bill, there is much documented reporting of inconsistencies across the healthcare system in the execution of the mail-order pharmacy model, as summarized below.

- Unlike specialty or many local pharmacies, mail-order pharmacies are often not consistent in proactively reaching out to the patients to provide refill reminders. The healthcare community has observed better health outcomes for chronically ill patients when pharmacies maintain close contact with their patients.

¹ Maryland Health Care Commission and Maryland Insurance Administration, Maintenance Drug Prescriptions-Mail Order Purchases Study (Dec. 23, 2005) (on file with Senate Committee on Banking and Insurance).

- Delivery methods are also inconsistent. Patients report privacy concerns (i.e., medication being delivered to family members, roommates, or neighbors who do not have knowledge of the patient's health status). Couriers sometimes leave medication requiring refrigeration outside, potentially rendering the medication ineffective. Leaving the medication package at the door also exposes it to possible theft.
- Although patients may save money through mail order, filling medication through mail order for a 90-day period can be cost prohibitive to the patient from a cash flow perspective. A copayment for a 30-day supply of medication is often more affordable for a patient than a copayment for a 90-day supply when required at the point of sale.²

Federal Patient Protection and Affordable Care Act

Health Insurance Reforms

The federal Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010.³ The PPACA provides fundamental changes to the U.S. health care system by requiring health insurers to make coverage available to all individuals and employers, without exclusions for preexisting conditions and without basing premiums on any health-related factors. The PPACA imposes many insurance requirements including required essential health benefits and rating and underwriting standards.⁴ PPACA requires health plans that are required to provide coverage of essential health benefits (EHB), to meet cost-sharing limits and actuarial value requirements. The law directs that EHBs cover at least 10 specified categories of coverage, including prescription drugs.⁵

Prescription Drug Coverage

Currently, for purposes of a health plan complying with the essential health benefits, insurers and HMOs must include in their formulary drug list the greater of one drug for each U.S. Pharmacopeia (USP) category and class; or the same number of drugs in each USP category and class as the state's essential health benefit (EHB) benchmark plan. For plan years beginning on or after January 1, 2017, plans must also use a pharmacy and therapeutics (P&T) committee process that meets certain requirements. The P&T committee must design formularies using scientific evidence that will include consideration of safety and efficacy, cover a range of drugs in a broad distribution of therapeutic categories and classes, and provide access to drugs that are included in broadly accepted treatment guidelines.⁶

Formulary Drug List. The federal regulations require health plans to publish a current and complete list of all covered drugs on its formulary drug list, including any tiered structure and any restrictions on the manner in which a drug can be obtained, in a manner that is easily accessible to plan enrollees, prospective enrollees, the state and federal government, and the

² AIDS Healthcare Foundation email (Jan. 28, 2016) (on file with Committee on Banking and Insurance).

³ The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. P.L. 111-148.

⁴ Most of the insurance regulatory provisions in PPACA amend Title XXVII of the Public Health Service Act (PHSA), (42 U.S.C. 300gg *et seq.*).

⁵ See <https://www.cms.gov/ccio/resources/data-resources/ehb.html> (last viewed Jan.10, 2018) for Florida's benchmark plan.

⁶ 45 CFR s. 156.122.

public. Additionally, insurers and HMOs must also make this information available in a standard-readable format to provide the opportunity for third parties to create resources that aggregate information on different plans.⁷

Access at Retail Pharmacies

For plans years beginning on or after January 1, 2017, an individual or small group health plan⁸ providing essential health benefits must implement the following access procedures:

A health plan must allow enrollees to obtain prescription drug benefits at in-network retail pharmacies, unless:

- The drug is subject to restricted distribution by the U.S. Food and Drug Administration; or
- The drug requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.⁹

A health plan may charge enrollees a different cost-sharing amount for obtaining a covered drug at a retail pharmacy, but all cost sharing will count towards the plan's annual limitation on cost sharing.¹⁰

The health plans retain the flexibility to charge a lower cost-sharing amount when obtaining the drug at an in-network retail pharmacy. While this provision requires coverage of a drug at an in-network retail pharmacy, for plans that do not have a network, the enrollee may go to any pharmacy to access his prescription drug benefit and those plans will be in compliance with this standard.

The plans need only provide enrollees with the option to access drugs that are not exempted under 45 CFR s. 156.122(e) at an in-network retail pharmacy. According to the HHS final rules, certain drugs have a Risk Evaluation and Mitigation Strategy (REMS) that includes Elements to Assure Safe Use that may require that pharmacies, practitioners, or health care settings that dispense the drug be specially certified and that may limit access to the drugs to certain health care settings.¹¹ If the health plan finds it necessary to restrict access to a drug for either of the reasons listed above, it must indicate this restricted access on the formulary drug list that plans must make publicly available under 45 CFR s. 156.122(d).¹²

The federal Department of Health and Human Services (HHS) notes that there are instances in which obtaining a drug through a mail-order pharmacy may not be a viable option, such as when an individual does not have a stable living environment and does not have a permanent address, or when a retail pharmacy option better ensures that consumers can access their EHB prescription drug benefit on short notice.¹³

⁷ See 45 C.F.R. 156.122(d).

⁸ These provisions of PPACA do not apply to large group plans, self-insured plans, transitional plans, or grandfathered plans.

⁹ See 45 C.F.R. s. 156.122(e)(2).

¹⁰ See 45 CFR s. 156.130.

¹¹ FDA requires a Risk Evaluation and Mitigation Strategies (REMS) for specified drugs to ensure that the benefits of a drug or biological product outweigh its risks. The following is FDA's list of currently approved REMS: <http://www.accessdata.fda.gov/scripts/cder/remis/index.cfm> (last viewed Jan. 10, 2018).

¹² PPACA; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10820, 10821.

¹³ *Id.*

Regulation of Health Insurers and Health Maintenance Organizations in Florida

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, HMOs, and other risk-bearing entities.¹⁴ The Agency for Health Care Administration (agency) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must obtain a Health Care Provider Certificate from the agency.¹⁵

Florida's State Group Insurance Program

Under the authority of s. 110.123, F.S., the Department of Management Services (DMS), through the Division of State Group Insurance, administers the state group health insurance program under a cafeteria plan.¹⁶ To administer the state group health insurance program, the DMS contracts with third party administrators for self-insured health plans, insured health maintenance organizations (HMOs), and a pharmacy benefits manager (PBM), for the state employees' self-insured prescription drug program.¹⁷

The state employees' self-insured prescription drug program has four dispensing avenues: participating 30-day retail pharmacies, participating 90-day retail pharmacies, the PBM's mail order pharmacies, and the PBM's specialty pharmacies. Contractually, and as stated in the benefit documents, specialty drugs, as defined by the PBM, must be dispensed by the PBM's specialty pharmacies. Specialty drugs are often high-cost prescription medications or medications for conditions. These drugs generally require additional monitoring for compliance and adherence. The drugs are used to treat complex and/or chronic conditions such as cancer, rheumatoid arthritis, human immunodeficiency virus, and multiple sclerosis. Specialty drugs often require special handling (e.g., refrigeration during shipping) and administration (e.g., injection or infusion).

The program typically makes benefits changes on a plan year basis, which is January 1 through December 31. Copayments (and coinsurance for high deductible plans) for each drug tier are the same for all members, as follows:

Drug Tier	Retail – Up to 30-Day Supply	Retail and Mail – Up to 90-Day Supply and Specialty Medications
Generic	\$7	\$14
Preferred Brand	\$30	\$60
Non-Preferred Brand	\$50	\$100

III. Effect of Proposed Changes:

Sections 1, 2 and 3 prohibit insurers and health maintenance organizations offering major medical individual or group health policies or contracts, respectively from requiring an insured

¹⁴ Section 20.121(3)(a), F.S.

¹⁵ Section 641.21(1), F.S.

¹⁶ 26 U.S.C. s. 125.

¹⁷ Section 110.12315, F.S.

or subscriber to obtain a prescription drug for the treatment of a chronic illness exclusively from a mail order pharmacy, unless the drug is an excluded drug. “Chronic illness” is defined as human immunodeficiency virus infection (HIV), epilepsy, hypertension or diabetes. “Excluded drug” is defined to mean a drug subject to restricted distribution by the U.S. Food and Drug Administration or a drug that requires special handling, provider coordination, or patient education and cannot be provided by a retail pharmacy.

The bill allows an insured or subscriber to obtain prescription drugs for the treatment of a chronic illness, through a retail pharmacy that agrees to the same terms and conditions, including credentialing, applicable to a mail order pharmacy and accepts payment or reimbursement from the health insurer or HMO. This requirement applies unless the drug is an excluded drug. This reimbursement or payment may not exceed the amount paid to a network mail order pharmacy for the same prescription drugs for the treatment of a chronic illness.

Further, insurers and HMOs that issue a major medical policies or contracts that provide coverage for prescription drugs through a mail order pharmacy are required to disclose in the outline of coverage that an insured may obtain prescription drugs for the treatment of a chronic illness from a retail pharmacy, and that the exclusive use of a mail order pharmacy is not required unless the drug is an excluded drug.

The requirements in sections 1 and 2 (relating to individual and group health insurance policies) do not apply to grandfathered plans as defined in s. 627.402, F.S., or to benefits set forth in s. 627.6561(5)(b), (c), (d), and (e), F.S.

The requirements in section 3 (relating to health maintenance organizations) do not apply to grandfathered health plans as defined in s. 641.313(1)(c), F.S., or to benefits set forth in s. 641.31071(b), (c), (d), and (e), F.S.

Section 4 provides the bill will take effect January 1, 2019.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The mandate restrictions do not apply because the bill does not require counties and municipalities to spend funds, reduce the ability of counties or municipalities to raise revenue, or reduce the percentage of a state tax shares with counties and municipalities.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

None.

B. Private Sector Impact:

The bill may provide greater choice for consumers in filling prescriptions at local retail pharmacies rather than through mail order. Further, advocates of the bill note that the healthcare community has observed better health outcomes for chronically ill patients when pharmacies maintain close contact with their patients.

Retail pharmacies may experience an indeterminate increase in pharmaceutical sales volume to the extent patients shift their prescription drug purchases from mail order pharmacies to retail pharmacies. Mail order pharmacies may experience a similar reduction in sales volume. The impact of the bill on health insurers or HMOs with defined networks is indeterminate.

The provisions of the bill will not apply to employers that offer self-insured plans.¹⁸ In Florida, an estimated 63 percent of private sector enrollees are enrolled in self-insured plans.

C. Government Sector Impact:**The Division of State Group Insurance**

Under the current PBM that administers the state employees' self-insured prescription drug program, CVS/caremark, all drugs to treat HIV infection are classified as specialty drugs due to the sensitive nature of the diagnosis, privacy concerns, and history of noncompliance of these drugs. The bill would not apply to drugs that are injectable or require special handling. As a result, those types of drugs used to treat HIV infection or any of the other specific chronic conditions would continue to be dispensed by the PBM's specialty pharmacy. CVS/caremark, expects the implementation of the bill would have a minimal negative fiscal impact on the state employees' self-insured prescription drug program.¹⁹

Office of Insurance Regulation

None.²⁰

¹⁸ The federal Employee Retirement Income Security Act of 1975 (ERISA) allows employers to self-insure in order to offer uniform health benefits across states. A plan that is self-insured is subject to ERISA's requirements. Such employers are not required to cover health care services for state-mandated benefits.

¹⁹ Department of Management Services, *2018 Legislative Analysis SB 492* (Jan. 5, 2018) (on file with Senate Committee on Banking and Insurance).

²⁰ Office of Insurance Regulation, *2018 Legislative Analysis of SB 492* (Oct. 20, 2017) (on file with Senate Committee on Banking and Insurance).

VI. Technical Deficiencies:

Limiting the coverage or effects of this bill to insureds and subscribers who have one of the four “chronic conditions” delineated (immunodeficiency virus infection, epilepsy, hypertension or diabetes) may be considered discriminatory. Under the federal regulations, a group health plan is not required to provide coverage for any particular benefits to any group of similarly situated individuals. However, benefits provided under a plan must be uniformly available to all similarly situated individuals.²¹

The bill does not amend s. 627.6699, F.S., relating to small group policies. Therefore, the restrictions on the copayments that may be imposed when an insured elects to use a pharmacy that is not a mail order pharmacy may not apply to these policies.

VII. Related Issues:

The bill has potential privacy concerns as pharmacies would have to be notified that a person has one of the four specified chronic conditions in order to receive the benefits under the bill. The insured may not understand that these protections apply only to medications treating the chronic illness and may not want to have this medical information disclosed or may want to receive other prescription drugs from the retail pharmacy.²²

VIII. Statutes Affected:

This bill substantially amends section 641.31 of the Florida Statutes.

This bill creates the following sections of the Florida Statutes: 627.6442 and 627.6572.

IX. Additional Information:**A. Committee Substitute – Statement of Changes:**

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill’s introducer or the Florida Senate.

²¹ 45 C.F.R. s. 146.121.

²² Office of Insurance Regulation, *2018 Legislative Analysis of SB 492* (Oct. 20, 2017) (on file with Senate Banking and Insurance Committee).

By Senator Garcia

36-00104-18

2018492__

A bill to be entitled

An act relating to the provision of pharmaceutical services; creating ss. 627.6442 and 627.6572, F.S.; defining terms; prohibiting certain health insurance policies from requiring insureds to obtain certain prescription drugs exclusively from mail order pharmacies for the treatment of specified chronic illnesses; providing that such insureds who elect to use retail pharmacies may not be required to pay copayments or satisfy other conditions under certain circumstances; requiring certain health insurers to include specified disclosures in their outlines of coverage regarding such prescription drugs; providing applicability; amending s. 641.31, F.S.; defining terms; prohibiting certain health maintenance contracts from requiring subscribers to obtain certain prescription drugs exclusively from mail order pharmacies for the treatment of specified chronic illnesses; providing that such subscribers who elect to use retail pharmacies may not be required to pay copayments or satisfy other conditions under certain circumstances; requiring certain health maintenance organizations to include specified disclosures in their outlines of coverage regarding such prescription drugs; providing applicability; providing an effective date.

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

Page 1 of 6

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

36-00104-18

2018492__

Section 1. Section 627.6442, Florida Statutes, is created to read:

627.6442 Access to prescription drugs.—

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

(a) "Chronic illness" means human immunodeficiency virus infection, epilepsy, hypertension, or diabetes.

(b) "Excluded drug" means a drug subject to restricted distribution by the United States Food and Drug Administration or a drug that requires special handling, provider coordination, or patient education and cannot be provided by a retail pharmacy.

(2) A health insurance policy issued, delivered, or renewed in this state which provides major medical coverage and prescription drug coverage may not require an insured to obtain a prescription drug for the treatment of a chronic illness exclusively from a mail order pharmacy unless the prescription drug is an excluded drug.

(3) An insured who elects not to use a mail order pharmacy to obtain a prescription drug, other than an excluded drug, prescribed for the treatment of a chronic illness may not be required to pay a copayment or satisfy other conditions that are not imposed on an insured who uses a mail order pharmacy if the retail pharmacy used by the insured:

(a) Agrees to the same terms and conditions, including credentialing, applicable to a mail order pharmacy; and

(b) Accepts payment or reimbursement from the insurer which is no more than the amount that would be paid to a mail order pharmacy for the same prescription drugs for the treatment of a chronic illness.

Page 2 of 6

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

36-00104-18

2018492

(4) A health insurer that issues a major medical policy providing coverage for prescription drugs through a mail order pharmacy shall disclose in the outline of coverage that an insured may obtain prescription drugs for the treatment of a chronic illness from a retail pharmacy and that the exclusive use of a mail order pharmacy is not required unless the drug is an excluded drug.

(5) This section does not apply to grandfathered plans as defined in s. 627.402 or to benefits set forth in s. 627.6562(3)(b), (c), (d), and (e).

Section 2. Section 627.6572, Florida Statutes, is created to read:

627.6572 Access to prescription drugs.—

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

(a) "Chronic illness" means human immunodeficiency virus infection, epilepsy, hypertension, or diabetes.

(b) "Excluded drug" means a drug subject to restricted distribution by the United States Food and Drug Administration or a drug that requires special handling, provider coordination, or patient education and cannot be provided by a retail pharmacy.

(2) A health insurance policy issued, delivered, or renewed in this state which provides major medical coverage and prescription drug coverage may not require an insured to obtain a prescription drug for the treatment of a chronic illness exclusively from a mail order pharmacy unless the prescription drug is an excluded drug.

(3) An insured who elects not to use a mail order pharmacy to obtain a prescription drug, other than an excluded drug,

Page 3 of 6

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

36-00104-18

2018492

prescribed for the treatment of a chronic illness may not be required to pay a copayment or satisfy other conditions that are not imposed on an insured who uses a mail order pharmacy if the retail pharmacy used by the insured:

(a) Agrees to the same terms and conditions, including credentialing, applicable to a mail order pharmacy; and

(b) Accepts payment or reimbursement from the insurer which is no more than the amount that would be paid to a mail order pharmacy for the same prescription drugs for the treatment of a chronic illness.

(4) A health insurer that issues a major medical policy providing coverage for prescription drugs through a mail order pharmacy shall disclose in the outline of coverage that an insured may obtain prescription drugs for the treatment of a chronic illness from a retail pharmacy and that the exclusive use of a mail order pharmacy is not required unless the drug is an excluded drug.

(5) This section does not apply to grandfathered plans as defined in s. 627.402 or to benefits set forth in s. 627.6562(3)(b), (c), (d), and (e).

Section 3. Subsection (44) is added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.—

(44)(a) As used in this section, the term:

1. "Chronic illness" means human immunodeficiency virus infection, epilepsy, hypertension, or diabetes.

2. "Excluded drug" means a drug subject to restricted distribution by the United States Food and Drug Administration or a drug that requires special handling, provider coordination,

Page 4 of 6

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

36-00104-18

2018492__

117 or patient education and cannot be provided by a retail
 118 pharmacy.

119 (b) A health maintenance contract issued, delivered, or
 120 renewed in this state which provides major medical coverage and
 121 prescription drug coverage may not require a subscriber to
 122 obtain a prescription drug for the treatment of a chronic
 123 illness exclusively from a mail order pharmacy unless the
 124 prescription drug is an excluded drug.

125 (c) A subscriber who elects not to use a mail order
 126 pharmacy to obtain a prescription drug, other than an excluded
 127 drug, prescribed for the treatment of a chronic illness may not
 128 be required to pay a copayment or satisfy other conditions that
 129 are not imposed on a subscriber who uses a mail order pharmacy
 130 if the retail pharmacy used by the subscriber:

131 1. Agrees to the same terms and conditions, including
 132 credentialing, applicable to a mail order pharmacy; and

133 2. Accepts payment or reimbursement from the health
 134 maintenance organization which is no more than the amount that
 135 would be paid to a mail order pharmacy for the same prescription
 136 drugs for the treatment of a chronic illness.

137 (d) A health maintenance organization that issues a health
 138 maintenance contract providing coverage for prescription drugs
 139 through a mail order pharmacy shall disclose in the outline of
 140 coverage that a subscriber may obtain prescription drugs for the
 141 treatment of a chronic illness from a retail pharmacy and that
 142 the exclusive use of a mail order pharmacy is not required
 143 unless the drug is an excluded drug.

144 (e) This section does not apply to grandfathered health
 145 plans as defined in s. 641.313(1)(c) or to benefits set forth in

Page 5 of 6

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

36-00104-18

2018492__

146 s. 627.6562(3)(b), (c), (d), and (e).

147 Section 4. This act shall take effect January 1, 2019.

Page 6 of 6

CODING: Words ~~stricken~~ are deletions; words underlined are additions.



The Florida Senate
State Senator René García
36th District

Please reply to:

☐ **District Office:**

1490 West 68 Street
Suite # 201
Hialeah, FL. 33014
Phone# (305) 364-3100

October 27, 2017

The Honorable Anitere Flores
Chair, Banking and Insurance Committee
320 Knott Building
404 S. Monroe Street
Tallahassee, FL 32399-1100

Dear Senator Flores,

Please have this letter serve as my formal request to have **SB 492: Provision of Pharmaceutical Services** be heard during the next scheduled Banking and Insurance Committee Meeting. Should you have any questions or concerns, please do not hesitate to contact my office.

Sincerely,

A handwritten signature in black ink, appearing to read "René García".

State Senator René García
District 36

CC: James Knudson
Sheri Green

Committees: Children, Families, and Elder Affairs, Chair, Appropriations Subcommittee on Finance and Tax, Vice Chair, Appropriations Subcommittee on the Environment and Natural Resources, Appropriations Subcommittee on General Government, Banking and Insurance, Judiciary, Joint Administrative Procedures Committee.

APPEARANCE RECORD

1/16/18
Meeting Date

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

492
Bill Number (if applicable)Topic Mail Order Pharmacy

Amendment Barcode (if applicable)

Name Towson FraserJob Title LobbyistAddress 115 E Park Ave
StreetPhone 443 1444Tall FL 32301
City State ZipEmail Towson@FLlobby.comSpeaking: ☐ For ☐ Against ☐ InformationWaive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)Representing AIDS Healthcare FoundationAppearing at request of Chair: ☐ Yes ☒ No Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

APPEARANCE RECORD

1/16/2018

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

492

Meeting Date

Bill Number (if applicable)

Topic

PROVISION OF PHARMACEUTICAL SERVICES

Amendment Barcode (if applicable)

Name

BILL MINCY

Job Title

VICE PRESIDENT, PPSC

Address

3375 - I CAPITAL CIRCLE NE

Phone

850-656-0100

Street

TALLAHASSEE

State

FL

Zip

32308

Email

Speaking:

☐

For

☐

Against

☐

Information

Waive Speaking:

☒

In Support

☐

Against

(The Chair will read this information into the record.)

Representing

PPSC / FIPN
SMALL BUSINESS PHARMACIES

Appearing at request of Chair:

☐

Yes

☒

No

Lobbyist registered with Legislature:

☐

Yes

☒

No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

APPEARANCE RECORD

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

1-16-18

Meeting Date

SB492

Bill Number (if applicable)

Topic Pharmacy Services

Amendment Barcode (if applicable)

Name Joy Ryan

Job Title

Address 300 S. Duval St., #410

Street

Phone 425-4000

City

State

Zip

Email joy@meenanlawfirm.com

Speaking: ☐ For ☒ Against ☐ Information

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

Representing ALTP, Prime Therapeutics

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: SB 518

INTRODUCER: Senator Bean

SUBJECT: Motor Vehicle Insurance Coverage Exclusions

DATE: January 9, 2017

REVISED: _____

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Matiyow	Knudson	BI	Pre-meeting
2. _____	_____	CM	_____
3. _____	_____	RC	_____

I. Summary:

SB 518 authorizes private passenger motor vehicle policyholders to exclude named members of their household who are of driving age, from all coverages under their policy. Such exclusions do not apply when the excluded member is not operating a motor vehicle covered under the policy, or if the exclusion is unfairly discriminatory by law, as determined by the Office of Insurance Regulation (OIR), or if the exclusion is inconsistent with the underwriting guidelines filed by the insurer with OIR. The exclusion of an identified named driver is invalid unless the named policyholder consents in writing to the exclusion of a named driver and the excluded named drivers are listed on the policy's declarations page or policy endorsement.

II. Present Situation:

Part XI of ch. 627, F.S., Motor Vehicle and Casualty Insurance Contracts, and ch. 324, F.S., the Financial Responsibility Law of 1955, establish motor vehicle coverage requirements. Owners and operators of motor vehicles must maintain the ability to respond in damages at specified minimum amounts for personal injury protection, bodily injury or death, and property damage. Current laws require insurance coverage that provides personal injury protection, or that is used to meet mandatory financial responsibility requirements be issued to all driving age individuals residing in the same household. For example, personal injury protection insurance is required to cover persons operating the insured motor vehicle and relatives residing in the same household as the policyholder, (i.e. named insured).¹ A motor vehicle liability policy providing coverage for bodily injury, death, and property damage is required to provide coverage for individuals named on the policy and anyone operating a motor vehicle listed on the policy when the operator has the express or implied permission of the insured motor vehicle owner.² An insured motor vehicle that is operated without the express or implied consent of the insured vehicle's owner is an

¹ s. 627.736(1) and s. 627.7407(5)(a), F.S.

² s. 324.151(1)(a), F.S.

uninsured/underinsured motor vehicle for purposes of uninsured/underinsured motor vehicle coverage. Unless there are separate policies issued that provide coverage for each individual driver, neither the policyholder nor the insurer can exclude anyone residing in the same household. Insurers may cancel a motor vehicle insurance policy if the named insured or any operator who resides in the same household or customarily operates a motor vehicle insured under the policy has her or his driver license revoked or suspended.

There is no authority under the motor vehicle insurance laws for an insurer to exclude mandatory coverages of a named individual, up to minimum limits required under Florida law. Such coverages include personal injury protection (PIP) coverage, property damage (PD) liability coverage, bodily injury (BI) liability coverage (if the policy is certified as proof of financial responsibility, and uninsured motorist (UM) coverage (if BI is certified as proof of financial responsibility and the UM coverage is not specifically declined by the policyholder. For these mandatory coverages insurers may choose not to write a policy in order to avoid specific individuals unless the practice is unfair discrimination. This results in consumers who reside with another individual that is a high insurance risk being denied opportunities to purchase motor vehicle insurance or having to pay more because they live with individuals that the policyholder or insurer would like to exclude from the policy. Additionally, policyholders may have their policy cancelled if the license or registration of a co-resident is suspended or revoked.

III. Effect of Proposed Changes:

The bill authorizes insurers and policyholders to exclude identified individuals from coverage under a private passenger motor vehicle insurance policy. An individual would not be covered for damages that occur while operating a motor vehicle that is insured under a policy that excludes the individual by name. The bill prohibits exclusion when the named excluded individual is injured while not operating a motor vehicle, if the OIR determines the exclusion is unfairly discriminatory, or if the exclusion is inconsistent with the underwriting guidelines filed by the insurer with OIR. The exclusion of an identified driver is not valid unless the named insured on the policy consents in writing to the exclusion of a named driver and the excluded drivers are named on the policy's declarations page or on a policy endorsement.

The effective date of the bill is July 1, 2018.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

None.

B. Private Sector Impact:

Policyholders who reside in the same household as a high-risk individual who is of driving age could see a decrease in their rates if they exclude such drivers from all coverages. Additionally, applicants for mandatory coverages may have an easier time obtaining insurance when no longer coupled with a high-risk household member.

The bill may increase the incidence of uninsured drivers operating motor vehicles if the excluded, high-risk driver does not have motor vehicle insurance.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 324.151, 627.736, and 627.7407.

This bill creates section 627.747 of the Florida Statutes.

IX. Additional Information:**A. Committee Substitute – Statement of Changes:**

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.



710292

LEGISLATIVE ACTION

Senate

.
.
.
.
.
.

House

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

Senate Amendment (with title amendment)

Delete lines 16 - 42

and insert:

627.747 Named driver exclusion.—

(1) A private passenger motor vehicle policy may exclude an individual identified by name on the declarations page as an excluded driver from coverage while such individual is operating a vehicle designated as an insured vehicle on the policy, but only as provided in this section. The coverages from which the



710292

identified individual may be excluded are:

(a) Coverages the named insured are not required by law to purchase, other than uninsured motorist coverage; and

(b) Bodily injury liability coverage and property damage liability coverage as required under chapter 324, but only as authorized under s. 324.151(1) (a) .

(2) Notwithstanding any other law to the contrary, a private passenger motor vehicle policy may not exclude:

(a) Coverage when the identified individual is injured while not operating a motor vehicle as defined in s. 324.021(1);

(b) Coverage when the exclusion is unfairly discriminatory as determined by the office under the insurance code;

(c) Coverage when the exclusion is inconsistent with the underwriting rules filed by the insurer pursuant to s. 627.0651(13) (a); or

(d) Uninsured motorist coverage for the excluded driver, if such coverage was included in the policy.

(3) This section does not eliminate any financial responsibility obligation under chapter 324 for the excluded driver.

===== T I T L E A M E N D M E N T =====

And the title is amended as follows:

Delete line 8

and insert:

circumstances; providing construction; amending ss.

324.151, 627.736, and



565706

LEGISLATIVE ACTION

Senate

.
.
.
.
.
.

House

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

Senate Amendment

Delete lines 18 - 37
and insert:
identified individual from the following coverages while the
identified individual is operating a motor vehicle, provided the
identified individual is specifically excluded by name on the
declarations page or by endorsement, and a policyholder consents
in writing to such exclusion:
(a) Notwithstanding the Florida Motor Vehicle No-Fault Law,



565706

the personal injury protection coverage specifically applicable to the identified excluded individual's injuries, lost wages, and death benefits.

(b) Property damage liability coverage.

(c) Bodily injury liability coverage, if required by law and purchased by the policyholder.

(d) Uninsured motorist coverage for any damages sustained by the identified excluded individual, if the policyholder has purchased such coverage.

(e) Any coverage the policyholder is not required by law to purchase.

(2) A private passenger motor vehicle policy may not exclude coverage when:

(a) The identified excluded individual is injured while not

By Senator Bean

4-00624-18

2018518__

A bill to be entitled

An act relating to motor vehicle insurance coverage exclusions; creating s. 627.747, F.S.; providing that private passenger motor vehicle policies may exclude certain identified individuals from specified coverages under certain circumstances; providing that such policies may not exclude coverage under certain circumstances; amending ss. 324.151, 627.736, and 627.7407, F.S.; conforming provisions to changes made by the act; providing an effective date.

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

Section 1. Section 627.747, Florida Statutes, is created to read:

627.747 Named driver exclusion.—

(1) A private passenger motor vehicle policy may exclude an identified individual who is not a named insured from the following coverages while the identified individual is operating a motor vehicle, provided the identified individual is named on the declarations page or by endorsement, and the named insured consents in writing to such exclusion:

(a) Notwithstanding the Florida Motor Vehicle No-Fault Law, the personal injury protection coverage specifically applicable to the identified individual's injuries, lost wages, and death benefits.

(b) Property damage liability coverage.

(c) Bodily injury liability coverage, if required by law and purchased by the named insured.

4-00624-18

2018518__

(d) Uninsured motorist coverage for any damages sustained by the identified excluded individual, if the named insured has purchased such coverage.

(e) Any coverage the named insured is not required by law to purchase.

(2) A private passenger motor vehicle policy may not exclude coverage when:

(a) The identified individual is injured while not operating a motor vehicle;

(b) The exclusion is unfairly discriminatory under the Florida Insurance Code, as determined by the office; or

(c) The exclusion is inconsistent with the underwriting rules filed by the insurer pursuant to s. 627.0651(13)(a).

Section 2. Paragraph (a) of subsection (1) of section 324.151, Florida Statutes, is amended to read:

324.151 Motor vehicle liability policies; required provisions.—

(1) A motor vehicle liability policy to be proof of financial responsibility under s. 324.031(1), shall be issued to owners or operators under the following provisions:

(a) An owner's liability insurance policy must ~~shall~~ designate by explicit description or by appropriate reference all motor vehicles with respect to which coverage is thereby granted, must and shall ~~and shall~~ insure the owner named therein, and, except for a named driver excluded under s. 627.747, must insure any other person as operator using such motor vehicle or motor vehicles with the express or implied permission of such owner against loss from the liability imposed by law for damage arising out of the ownership, maintenance, or use of such motor

4-00624-18

2018518__

vehicle or motor vehicles within the United States or the Dominion of Canada, subject to limits, exclusive of interest and costs with respect to each such motor vehicle as is provided for under s. 324.021(7). Insurers may make available, with respect to property damage liability coverage, a deductible amount not to exceed \$500. In the event of a property damage loss covered by a policy containing a property damage deductible provision, the insurer shall pay to the third-party claimant the amount of any property damage liability settlement or judgment, subject to policy limits, as if no deductible existed.

Section 3. Subsection (1) of section 627.736, Florida Statutes, is amended to read:

627.736 Required personal injury protection benefits; exclusions; priority; claims.—

(1) REQUIRED BENEFITS.—An insurance policy complying with the security requirements of s. 627.733 must provide personal injury protection to the named insured, relatives residing in the same household unless excluded under s. 627.747, persons operating the insured motor vehicle, passengers in the motor vehicle, and other persons struck by the motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to subsection (2) and paragraph (4)(e), to a limit of \$10,000 in medical and disability benefits and \$5,000 in death benefits resulting from bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

(a) *Medical benefits.*—Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic

4-00624-18

2018518__

devices and medically necessary ambulance, hospital, and nursing services if the individual receives initial services and care pursuant to subparagraph 1. within 14 days after the motor vehicle accident. The medical benefits provide reimbursement only for:

1. Initial services and care that are lawfully provided, supervised, ordered, or prescribed by a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, or a chiropractic physician licensed under chapter 460 or that are provided in a hospital or in a facility that owns, or is wholly owned by, a hospital. Initial services and care may also be provided by a person or entity licensed under part III of chapter 401 which provides emergency transportation and treatment.

2. Upon referral by a provider described in subparagraph 1., followup services and care consistent with the underlying medical diagnosis rendered pursuant to subparagraph 1. which may be provided, supervised, ordered, or prescribed only by a physician licensed under chapter 458 or chapter 459, a chiropractic physician licensed under chapter 460, a dentist licensed under chapter 466, or, to the extent permitted by applicable law and under the supervision of such physician, osteopathic physician, chiropractic physician, or dentist, by a physician assistant licensed under chapter 458 or chapter 459 or an advanced registered nurse practitioner licensed under chapter 464. Followup services and care may also be provided by the following persons or entities:

a. A hospital or ambulatory surgical center licensed under chapter 395.

4-00624-18

2018518__

- 117 b. An entity wholly owned by one or more physicians
 118 licensed under chapter 458 or chapter 459, chiropractic
 119 physicians licensed under chapter 460, or dentists licensed
 120 under chapter 466 or by such practitioners and the spouse,
 121 parent, child, or sibling of such practitioners.
 122 c. An entity that owns or is wholly owned, directly or
 123 indirectly, by a hospital or hospitals.
 124 d. A physical therapist licensed under chapter 486, based
 125 upon a referral by a provider described in this subparagraph.
 126 e. A health care clinic licensed under part X of chapter
 127 400 which is accredited by an accrediting organization whose
 128 standards incorporate comparable regulations required by this
 129 state, or
 130 (I) Has a medical director licensed under chapter 458,
 131 chapter 459, or chapter 460;
 132 (II) Has been continuously licensed for more than 3 years
 133 or is a publicly traded corporation that issues securities
 134 traded on an exchange registered with the United States
 135 Securities and Exchange Commission as a national securities
 136 exchange; and
 137 (III) Provides at least four of the following medical
 138 specialties:
 139 (A) General medicine.
 140 (B) Radiography.
 141 (C) Orthopedic medicine.
 142 (D) Physical medicine.
 143 (E) Physical therapy.
 144 (F) Physical rehabilitation.
 145 (G) Prescribing or dispensing outpatient prescription

Page 5 of 8

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

4-00624-18

2018518__

- 146 medication.
 147 (H) Laboratory services.
 148 3. Reimbursement for services and care provided in
 149 subparagraph 1. or subparagraph 2. up to \$10,000 if a physician
 150 licensed under chapter 458 or chapter 459, a dentist licensed
 151 under chapter 466, a physician assistant licensed under chapter
 152 458 or chapter 459, or an advanced registered nurse practitioner
 153 licensed under chapter 464 has determined that the injured
 154 person had an emergency medical condition.
 155 4. Reimbursement for services and care provided in
 156 subparagraph 1. or subparagraph 2. is limited to \$2,500 if a
 157 provider listed in subparagraph 1. or subparagraph 2. determines
 158 that the injured person did not have an emergency medical
 159 condition.
 160 5. Medical benefits do not include massage as defined in s.
 161 480.033 or acupuncture as defined in s. 457.102, regardless of
 162 the person, entity, or licensee providing massage or
 163 acupuncture, and a licensed massage therapist or licensed
 164 acupuncturist may not be reimbursed for medical benefits under
 165 this section.
 166 6. The Financial Services Commission shall adopt by rule
 167 the form that must be used by an insurer and a health care
 168 provider specified in sub-subparagraph 2.b., sub-subparagraph
 169 2.c., or sub-subparagraph 2.e. to document that the health care
 170 provider meets the criteria of this paragraph. Such rule must
 171 include a requirement for a sworn statement or affidavit.
 172 (b) *Disability benefits.*—Sixty percent of any loss of gross
 173 income and loss of earning capacity per individual from
 174 inability to work proximately caused by the injury sustained by

Page 6 of 8

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

4-00624-18

2018518__

the injured person, plus all expenses reasonably incurred in obtaining from others ordinary and necessary services in lieu of those that, but for the injury, the injured person would have performed without income for the benefit of his or her household. All disability benefits payable under this provision must be paid at least every 2 weeks.

(c) *Death benefits.*—Death benefits of \$5,000 per individual. Death benefits are in addition to the medical and disability benefits provided under the insurance policy. The insurer may pay death benefits to the executor or administrator of the deceased, to any of the deceased's relatives by blood, legal adoption, or marriage, or to any person appearing to the insurer to be equitably entitled to such benefits.

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and such insurer may not require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such benefits. Insurers may not require that property damage liability insurance in an amount greater than \$10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. An insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice violates part IX of chapter 626, and such violation constitutes an unfair method of competition or an unfair or deceptive act or practice involving

4-00624-18

2018518__

the business of insurance. An insurer committing such violation is subject to the penalties provided under that part, as well as those provided elsewhere in the insurance code.

Section 4. Paragraph (a) of subsection (5) of section 627.7407, Florida Statutes, is amended to read:

627.7407 Application of the Florida Motor Vehicle No-Fault Law.—

(5) No later than November 15, 2007, each motor vehicle insurer shall provide notice of the provisions of this section to each motor vehicle insured who is subject to subsection (1). The notice is not subject to approval by the Office of Insurance Regulation. The notice must clearly inform the policyholder:

(a) That beginning on January 1, 2008, Florida law requires the policyholder to maintain personal injury protection ("PIP") insurance coverage and that this insurance pays covered medical expenses for injuries sustained in a motor vehicle crash by the policyholder, passengers, and relatives residing in the policyholder's household unless excluded under s. 627.747.

Section 5. This act shall take effect July 1, 2018.



The Florida Senate

Committee Agenda Request

To: Senator Anitere Flores, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: November 7, 2017

I respectfully request that **Senate Bill #518**, relating to Motor Vehicle Insurance Coverage Exclusions, be placed on the:

- ☐ committee agenda at your earliest possible convenience.
- ☒ next committee agenda.

A handwritten signature in blue ink that reads "Aaron Bean". The signature is written in a cursive style.

Senator Aaron Bean
Florida Senate, District 4

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: SB 640

INTRODUCER: Senator Rouson

SUBJECT: Consumer Finance Loans

DATE: January 12, 2018

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Matiyow	Knudson	BI	Favorable
2.			CM	
3.			RC	

I. Summary:

SB 640 establishes the Access to Responsible Credit Pilot Program. The intent of the program is to provide greater access to small dollar consumer loans and assist consumers in building their credit. The Office of Financial Regulation (OFR) is responsible for regulating this program. The pilot program would operate under the following terms and conditions:

- A program licensee may make loans of at least \$300 and no more than \$10,000, at a maximum fixed interest rate of 36 percent per annum.
- A program licensee may also charge the borrower an origination fee of 6 percent of the principal amount of the program loan exclusive of the origination fee or \$75, whichever is less.
- The borrower has a right to rescind the program loan and return the principal amount by the end of the next business day.
- A program loan must have a minimum term of 120 days and a maximum term of 60 months and may not impose a prepayment penalty.
- A program licensee must underwrite each program loan to determine the borrower's ability and willingness to repay. A program licensee must not make a program loan if the borrower's monthly debt service, including the program loan, exceeds 35 percent of the borrower's gross monthly income.
- The OFR is required to examine licensees at least once every 24 months.
- A program licensee may use a referral partner to perform marketing, servicing, and other services on behalf of the program licensee. The compensation for a referral partner is capped at \$60 per program loan, on average, assessed annually, and \$2 for each payment received by the referral partner on behalf of the program licensee.
- In order to participate in the pilot program, a person must be licensed as a consumer finance lender with the OFR under ch. 516, F.S., and must submit a pilot program application and \$1,000 fee plus \$30 per branch office.

Currently, the Florida Consumer Finance Act (act) sets forth licensing requirements for consumer finance lenders and the terms and conditions under which a consumer finance loan is allowed in Florida. The act sets forth maximum interest rates for consumer finance loans, which are loans of money, credit, goods, or a provision of a line of credit, in an amount or to a value of \$25,000 or less. The allowable interest rates on such loans are tiered and limited based on the principal amount that falls within each tier of the loan, as follows:

- 30 percent a year, computed on the first \$3,000 of the principal amount;
- 24 percent a year on that part of principal from \$3,001 to \$4,000; and
- 18 percent per year on that part of principal from \$4,001 to \$25,000.

II. Present Situation:

Federal Truth in Lending Act (TILA)

The purpose of TILA,¹ is to promote the informed use of credit through “a meaningful disclosure of credit terms so that the consumer will be able to compare more readily the various credit terms available.”² Regulation Z, which implements TILA, requires the calculation and disclosure of the Annual Percentage Rate (APR) for consumer loans.³ Finance charges include interest, any charges, or fees payable by the consumer and imposed by the financial institution as an incident to or as a condition of an extension of consumer credit. Regulation Z includes examples, applicable both to open-end and closed-end credit transactions, of what must, must not, or need not be included in the calculation and disclosure of the finance charge.⁴

State Regulation of Consumer Lending

The Office of Financial Regulation (OFR) has regulatory oversight of state-chartered financial institutions, securities brokers, investment advisers, mortgage loan originators, deferred presentment providers or payday loan lenders, consumer finance companies, title loan lenders, debt collectors, and other financial service entities. The Division of Financial Institutions of the OFR charters and regulates entities that engage in financial institution business in Florida in accordance with the Florida Financial Institutions Codes (codes).⁵ The OFR may examine, investigate, and take disciplinary actions against such state-chartered financial institutions for violation of the codes.⁶

Consumer Finance Loans

The Florida Consumer Finance Act (ch. 516, F.S.) sets forth licensing requirements for consumer finance lenders and the terms and conditions under which a consumer loan is authorized in Florida. The act sets forth maximum interest rates for consumer finance loans, which are “loan[s]

¹ 15 U.S.C. s. 1601 et seq., as implemented by Regulation Z, 12 C.F.R. part 226.

² 15 U.S.C. s. 1601(a).

³ 15 U.S.C. s. 1604-1606.

⁴ 12 C.F.R. s. 1026.4.

⁵ Chapters 655, 657, 658, 660, 663, 665, and 667, F.S.

⁶ These entities are also subject to laws and regulation by various federal entities. For example, the Federal Deposit Insurance Corporation (FDIC) supervises state-chartered banks that are not members of the Federal Reserve System and state-chartered savings associations. The FDIC also insures deposits in banks and savings associations in the event of bank failure. The Federal Reserve Board supervises state-chartered banks that are members of the Federal Reserve System.

of money, credit, goods, or a provision of a line of credit, in an amount or to a value of \$25,000 or less at an interest rate greater than 18 percent per annum.”⁷ The maximum allowable interest rates on consumer finance loans are tiered and limited based on the principal amount that falls within each tier of the loan, as provided below:

- 30 percent a year, computed on the first \$3,000 of the principal amount;
- 24 percent a year on that part of principal between \$3,001 to \$4,000; and
- 18 percent per year on that part of principal between \$4,001 to \$25,000.⁸

These principal amounts are the same as the financed amounts determined by the TILA and Regulation Z.⁹ The APR for all loans under the act may equal, but cannot exceed, the APR for the loan as required to be computed and disclosed by the TILA and Regulation Z.¹⁰ Lenders are required to provide written disclosures to consumers that include the APR under Regulation Z. Besides the applicable interest rates described above, the act allows consumer finance lenders to charge borrowers the following charges and fees:¹¹

- Up to \$25 for investigating the credit and character of the borrower;
- A \$25 annual fee on the anniversary date of each line-of-credit account;
- Brokerage fees for certain loans and appraisals of real property offered as security;
- Intangible personal property tax, if secured by a loan note on real property;
- Documentary excise tax and lawful fees;
- Insurance premiums;
- Actual and reasonable attorney fees and court costs;
- Actual and commercially reasonable expenses for recovering the collateral property;
- Delinquency charges of up to \$15 for each payment in default for at least 10 days, if agreed upon in writing before the charge is imposed; and
- A dishonored check charge of up to \$20.

Lastly, the act requires all consumer finance loans must be repaid in equal monthly installments, except for repayment on lines of credit.¹²

California Small Dollar Loan Pilot Programs

Based on a business model developed by California-based Progreso Financiero (Progress Financial), the California State Assembly enacted the Affordable Credit Building Opportunities Pilot Program in 2010.¹³ The pilot program covers consumer loans of \$250-\$2,500. The goal was to increase consumers’ access to capital by encouraging development of a more robust small dollar loan market in California. In 2015, California enacted legislation to revise provisions relating to the small-dollar loan pilot program.¹⁴ The new pilot program covers consumer loans of \$300-\$2,500 and allows the use of “finders” to connect borrowers with lenders. Finders cannot provide advice or counseling to borrowers. They can distribute lenders’ marketing

⁷ Section 516.01(2), F.S.

⁸ Section 516.031(1), F.S.

⁹ Section 516.031(2), F.S.

¹⁰ *Id.*

¹¹ Section 516.031(3), F.S.

¹² Section 516.36, F.S.

¹³ See http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=200920100SB1146 (last visited January 5, 2018).

¹⁴ See http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160SB235 (last visited January 5, 2018).

materials, provide information about loan terms and conditions, help borrowers with loan applications and obtain borrowers' signatures on documents, and other functions. Their fees are capped at \$65 per loan plus \$2 for each payment received by a finder. The fees are paid by lenders, cannot be based on the principal amount of loans, and cannot be passed on to borrowers. According to the California Senate staff analysis, the proponents view the use of finders as a means to lower costs of customer acquisition, which is the largest cost of maintaining a small dollar loan program.¹⁵

The California pilot program legislation also required the state's Department of Business Oversight (DBO) to post a report summarizing findings of the pilot program. In June 2015, the California DBO's report noted the following findings from 2011-2014:

- *Lender participation*: At the end of 2014, six lenders and six finders participated in the program.
- *Loan applications*: Borrower applications increased by 58.5 percent after the state revised the pilot program.
- *Dollar amounts*: Smaller loans (\$300-\$499) decreased by 42.3 percent, while larger loans (\$500-\$999) increased by 106 percent.
- *Interest rates*: Smaller loans generally carried an APR of 40-50 percent. Mid-range loans generally carried an APR of 35-50 percent. Larger loans (\$1,500-\$2,499) saw a more even APR distribution.
- *Delinquency rates*: In 2014, 22.5 percent were delinquent for 7 days to 29 days, 7.3 percent were delinquent for 30 days to 59 days, and 3.9 percent were delinquent for 60 days or more.
- *Credit scores*: The share of multiple-loan borrowers who obtained higher credit scores on subsequent loans averaged 61 percent annually over the 4-year period.
- *Loan term*: In 2014, of the 164,300 loans made, 50.9 percent were for 360 days or more. The ratios for other terms: 120 days to 179 days, essentially 0 percent (only two loans); 180 days to 269 days, 20.2 percent; and 270 days to 359 days, 28.8 percent.
- *Loan purpose*: Of the 164,300 loans made in 2014, borrowers took out 45 percent (74,026) to build or repair credit.

The California DBO noted that while the revised pilot program did increase lender participation from its inception in 2010, the total number of participating lenders remains less than 10. Additionally, the revisions did not significantly affect the amount of lending activity conducted by the individual companies.¹⁶

III. Effect of Proposed Changes:

Access to Responsible Credit Pilot Program (Section 1)

The bill establishes the Access to Responsible Credit Pilot Program (program). The program would allow consumers to enter into a program loan with a principal amount of at least \$300 and up to a maximum of \$10,000 at an interest rate not to exceed 36 percent per annum. Under

¹⁵ Id.

¹⁶ California Department of Business Oversight, Report of Activity under Small Dollar Loan Pilot Programs (Jun. 2015), at http://www.dbo.ca.gov/Licensees/Finance_Lenders/pdf/Pilot%20Program%20Report%202015%20Final.pdf. (last visited January 5, 2018).

current law, licensed consumer finance lenders may make loans in this amount at a maximum rate of 30 percent, with no minimum or maximum loan term.

Definitions (Section 2)

The bill creates s. 516.41, F.S., to provide the following definitions for purposes of the pilot program:

- Consumer reporting agency
- Credit score
- Data furnisher
- Pilot program or program
- Pilot program license
- Program branch office
- Program licensee
- Program loan
- Referral partner
- Refinance program loan

Regulation of Program Licensees (Lenders) and Referral Partners (Sections 3 and 5)

Program Licensees

Persons seeking participation under the program as a lender are required to be licensed to make consumer finance loans under ch. 516, F.S., not be subject of any insolvency proceedings, and not be the subject of an enforcement action by the OFR or any financial regulatory agency in Florida or have a deficiency at the time of the person's application. Applicants are required to pay a \$1,000 nonrefundable application fee and an application with the OFR. The biennial renewal fee is \$1,000. The legislation provides for the establishment of application forms by rule.

Each branch office of a program licensee must be licensed. The program licensee must submit an application and an initial nonrefundable fee of \$30 per program branch office. The biennial renewal fee for each branch office is \$30.

The bill requires applicants to be accepted as a "data furnisher" with a consumer-reporting agency¹⁷ before the OFR may approve an applicant as a program licensee.

Referral Partners

The bill allows a program licensee to engage in arrangements with referral partners. All such arrangements must be in writing; must contain a provision that the referral partner agrees to comply with s. 516.44, F.S., and must contain a provision allowing the OFR access to the referral

¹⁷ The bill defines "consumer reporting agency" as the same definition in federal Fair Credit Reporting Act: "Any person which, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties, and which uses any means or facility of interstate commerce for the purpose of preparing or furnishing consumer reports."

partner's books and records related to the referral partner's operations under the agreement with the program licensee.

A referral partner may engage in the following activities:

- Advertise on behalf of the program licensee;
- Provide written factual information about the pilot program and discuss the program information with a prospective borrower in general terms;
- Notify the prospective borrower of information needed to complete an application under the program;
- Enter information provided by a prospective borrower on a preprinted or electronic application form or in a preformatted computer database;
- Assemble credit applications and other materials obtained in the course of a credit application transaction for submission to the program licensee;
- Contact the program licensee to determine the status of a program loan application;
- Communicate to a borrower a response that is returned by the program licensee's automated underwriting system;
- Obtain a borrower's signature on documents prepared by the program licensee and deliver final copies of the documents to the borrower;
- Disburse program loan proceeds to a borrower, and receive program loan payments from a borrower;
- Receive a program loan payment from the borrower if this method of payment is acceptable to the borrower; and
- Operate an electronic access point through which a prospective borrower may directly access the website of the program licensee to apply for a program loan.

Any program payments received by a referral partner must be applied to the program loan and be deemed received by the program licensee at the time the referral partner receives the payment.

When payment is made, a referral partner must deliver a receipt to the borrower that includes certain information. Additionally, the bill holds a borrower harmless if a referral partner fails to transmit, or is delayed in transmitting, a payment to the program licensee. A referral partner must maintain records related to disbursements and payments for 2 years.

Referral partners are required to provide certain communications and disclosures to program loan applicants related to identifying information of the program licensee and referral partner. The bill requires a referral partner to make a good faith effort to assist the applicant in making direct contact with the program licensee in cases where a referral partner is not permitted to answer questions about the loan program.

The bill allows a program licensee to compensate a referral partner. Compensation paid to a referral partner may not be passed on to a borrower. The compensation must be made pursuant to a written agreement and a mutually agreed upon compensation schedule. Additionally, the compensation must meet the following requirements:

- Compensation may not be paid to a referral partner until the program loan is consummated.
- Compensation may not be paid to a referral partner based upon the principal amount of the program loan.

- The total compensation paid to a referral partner over the life of a program loan may not exceed the sum of the origination fee and interest charges paid by the borrower in connection with that program loan.
- Subject to certain limitations, the total compensation paid by a program licensee to a referral partner may not exceed the sum of \$60 per program loan, on average; and \$2 per payment received by the referral partner on behalf of the program licensee for the duration of the loan.

The bill prohibits a referral partner from engaging in the following activities:

- Providing counseling or advice to a borrower or prospective borrower;
- Providing to a borrower or prospective borrower loan-related marketing material that has not been approved by the program licensee;
- Negotiate a loan term between a program licensee and a prospective borrower;
- Offering information pertaining to a single prospective borrower to more than one program licensee, except where a program licensee has provided notification of its denial of a program loan to the borrower; and
- Requiring a borrower to pay any fees other than those permitted under the bill.

The program licensee is responsible for violations of ch. 516, F.S., that are committed by a referral partner.

Terms and Conditions of the Small Dollar Loans (Section 4)

The bill requires a program licensee to comply with certain conditions in making program loans, including the following:

- A program loan must be unsecured.
- A program loan must have a minimum term of 120 days and a maximum term of 60 months and may not impose a prepayment penalty.
- A program loan must be repayable by the borrower in substantially equal periodic installments made every 2 weeks, semimonthly or monthly.
- A program loan must include a borrower's right to rescind the program loan by notifying the program licensee of the borrower's intent to rescind the program loan and return the principal advanced by the end of the business day after the program loan was consummated.
- A program loan must apply an interest rate which must be fixed for the term of the loan and be calculated on a simple-interest basis through the application of a daily periodic rate to the actual unpaid principal balance each day. The maximum per annum interest rate depends on the size of the loan, as follows:
 - For loans up to and including \$3,000, the maximum annual interest rate is 36 percent.
 - For loans over \$3,000, and up to and including \$4,000, the maximum annual interest rate is 30 percent.
 - For loans over \$4,000 and up to and including \$10,000, the maximum interest rate is 24 percent.
- A program licensee must provide a receipt for payments made.

When refinancing a program loan, the principal amount may not include more than 60 days' unpaid interest accrued on the previous program loan. Additionally, a program licensee is

prohibited from refinancing a program loan unless the borrower is current on the outstanding program loan at the time the borrower submits an application to refinance.

The bill prohibits a program licensee from refinancing a program loan unless all of the following conditions are met:

- The principal amount payable does not include more than 60 days of unpaid interest accrued on the previous program loan;
- For program loans with an original term of less than 25 months, the borrower has repaid at least 60 percent of the outstanding principal remaining on the existing program loan;
- For program loans with an original term of greater than 25 months but no more than 60 months, the borrower has made current payments for at least 9 months on the program loan;
- The borrower is current on his or her outstanding program loan.

Program Loan Underwriting. A program licensee must underwrite each program loan to determine the borrower's willingness and ability to repay the program loan. A program licensee may not make a loan if it determines that a borrower's total monthly debt service payments, including the program loan and all outstanding forms of credit that can be independently verified by the program licensee, exceed 35 percent of the borrower's gross monthly income.

The program licensee is required to seek information and documentation pertaining to all of a borrower's outstanding debt obligations during the loan application and underwriting process, including loans that are self-reported by the borrower but not available through independent verification. The program licensee shall verify such information using a credit report from at least one consumer reporting agency that compiles and maintains files on consumers on a nationwide basis or through other available electronic debt verification services. The program licensee is not required to consider loans made to a borrower by friends or family in determining the borrower's debt-to-income ratio.

The program licensee is required to verify the borrower's income in determining the debt-to-income ratio using information from:

- Electronic means or services that provide reliable evidence of the borrower's actual income; or
- Internal Revenue Service Form W-2, tax returns, payroll receipts, bank statements, or other third-party documents that provide reasonably reliable evidence of the borrower's actual income.

Interest Rate Reduction. The program licensee must reduce the rate on each subsequent loan to the same borrower by at least one-twelfth of 1 percent per month if all of these conditions are met:

- The subsequent program loan is originated no more than 180 days after the prior program loan is fully repaid;
- The borrower was never more than 15 days delinquent on the prior program loan;
- The prior program loan was outstanding for at least one half of its original term before its repayment.

The bill prohibits a program licensee from inducing or permitting any person from becoming obligated to the program licensee under more than one program loan at the same time with the program licensee.

Fees. The bill allows a program licensee to contract for and receive an origination fee, which may not exceed 6 percent of the principal amount, exclusive of the origination fee, or \$75, whichever is less. A program licensee may not charge a borrower an origination fee more than twice in any 12-month period.

The bill caps the fee for insufficient funds at \$20, and any delinquency charge is capped at \$15 for each calendar month for payments in default for at least 10 days. In attempting to collect a delinquent payment, a program licensee or its wholly owned subsidiary must attempt to collect the payment for 30 days before selling or assigning the unpaid debt to an independent party for collection.

Consumer Disclosures. The bill requires a program licensee must provide the following written disclosures to a borrower:

- The amount, date, and maturity date of the program loan.
- The name and address of the borrower and of the program licensee.
- The interest rate charged.
- The monthly installment payment amount.
- The delinquency charge amount.
- A specified statement relating to a borrower's ability to reduce the interest amount by repaying the loan early.
- A statement describing the borrower's right of rescission.

The bill allows a program licensee to provide the disclosures in a mobile or other electronic application if the program licensee complies with certain parameters. Additionally the bill allows the disclosures to be completed in any language the loan is negotiated in.

Before disbursing program proceeds to a borrower, a program licensee must direct a borrower to consumer credit counseling services promoted by the OFR or provide a credit education program or materials to the borrower at no cost to the borrower. The borrower is not required to participate in the program.

The bill prohibits a program licensee from requiring a borrower to waive any right, penalty, remedy, forum, or procedure. Further, the lender may not require a borrower to agree to the application of laws other than those of Florida or require a borrower to agree to resolve disputes in a jurisdiction outside of Florida. Any waiver, other than a prohibited waiver, must be knowing, voluntary, in writing, and not expressly made as a condition of doing business with the program licensee. A waiver that is required as a condition of doing business with the program licensee is presumed involuntary, unconscionable, against public policy, and unenforceable. The program licensee has the burden of proving that a waiver of any rights, penalties, forums, or procedures was knowing, voluntary, and not expressly made a condition of the contract with the borrower.

Examination of Program Licensees (Section 6)

The legislation requires the OFR to examine program licensees at least once every 24 months. Costs of examination are borne by the program licensee. A program licensee who violates any applicable provision of ch. 516, F.S., is subject to disciplinary action. A program licensee is also subject to disciplinary action certain violations committed by its referral partners.

Reporting Requirements (Sections 4, 5, and 7)

Program Licensee. The bill requires a program licensee to report a borrower's payment performance to at least one consumer-reporting agency that compiles and maintains files on consumers on a nationwide basis. In addition, as part of the credit reporting requirements, a licensee must provide the borrower with the name(s) of the credit reporting agency or agencies to which it will report the borrower's payment history. (Section 4)

The program licensee is required to provide certain information to the OFR within 15 days after entering into a contract with a referral partner. Such information includes the referral partner's identifying information, and a provision that allows the OFR to request any other information. The program licensee must conduct due diligence with respect to the referral partner and confirm to the OFR that the referral partner has not filed a bankruptcy or reorganization petition and is not currently subject to an administrative or judicial license suspension or revocation proceeding. The program licensee must confirm to the OFR that the referral partner or an affiliated party has not been convicted of a felony and is not subject to a felony indictment. Finally, the program licensee must confirm to OFR that it does not suspect that the referral partner has committed a criminal act and that there has not been notification that the referral partner is under criminal investigation. The referral partner must report changes in this information to the program licensee. (Section 5)

OFR Program Report. A program licensee is required to file, on or before March 15 of each year, a report with the OFR in a manner prescribed by rule. (Section 7)

The bill directs the OFR to post a report on its website by January 1, 2021, summarizing the results of the program. The report must include the following information:

- The period covered.
- The number of entities that applied and were accepted for program participation.
- The reasons for program rejection.
- The number of program loan applications received by participating program licensees.
- The number and total amount of program loans made.
- The distribution of loan lengths, interest rates, and principal amounts upon origination.
- The number of borrowers who obtained more than one program loan.
- The distribution of the number of program loans per borrower.
- Of the number of borrowers who obtained more than one program loan, the percentage of borrowers whose credit scores increased between successive loans.
- The average size of the increased credit score.

- The income distribution of borrowers upon program loan origination, including the number of borrowers who obtained a program loan and who resided in a low-income or moderate-income census tract at the time of loan application.
- The number of borrowers who obtained program loans for the following purposes, based on borrower responses:
 - Pay medical expenses.
 - Pay for vehicle repair or a vehicle purchase.
 - Pay bills.
 - Consolidate debt.
 - Build or repair credit history.
 - Pay other expenses.
- The number of borrowers who self-report that they had a bank account at the time of their loan application and the number of borrowers who self-report that they did not have a bank account at the time of their loan application.

In regards to refinanced program loans, the report must include the following information:

- The number and percentage of borrowers who applied for a refinance program loan.
- Of the borrowers who applied for a refinance program loan, the number and percentage of borrowers who obtained a refinance program loan.
- The number and type of referral partners used by program licensees.
- The number and percentage of borrowers who obtained one or more program loans where delinquency charges were assessed.
- The total amount of delinquency charges assessed.
- The average delinquency charge assessed by dollar amount and as a percentage of the principal amount loaned.

In addition, the report must address the performance of program loans as reflected by the following information:

- The number and percentage of borrowers who experienced at least one delinquency lasting between 7 to 29 days, 30 to 59 days, and 60 days or more.
- The distribution of principal loan amounts corresponding to those delinquencies.
- The number and types of documented violations of ss. 516.40-516.47, F.S., by referral partners and program licensees.
- The number of times the OFR disqualified a referral partner from performing services, barred a referral partner from performing services at a specific location, terminated a written agreement between a referral partner and a program licensee, or imposed an administrative penalty.
- The number and nature of complaints received about a program licensee or referral partner.
- Recommendations for improving the program, and whether the program should be reenacted after January 1, 2022.

Section 8 provides that ss. 516.40-516.47, F.S., are subject to repeal on December 31, 2023, unless reenacted or superseded by another enacted law before that date.

Section 9 provides the act shall take effect October 1, 2018.

IV. Constitutional Issues:**A. Municipality/County Mandates Restrictions:**

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

Persons that want to participate in the Access to Responsible Credit Pilot Loan Program (program) would be required to obtain a consumer finance license as well as a program license. The bill provides for a \$1,000 application fee and \$1,000 biennial renewal fee for program licensees in addition to a \$30 branch application and \$30 renewal fee. Furthermore, the bill provides for a \$30 referral partner fee for each referral partner filed with the OFR. The bill also provides rulemaking authority to establish costs for examinations of program licensees.

B. Private Sector Impact:

Indeterminate at this time. The number of lenders, referral partners, and borrowers who would participate in this pilot program is unknown at this time. The intent of the program is to provide greater access to small dollar consumer loans. The maximum annual interest rates for such loans under the bill is increased by 6 percent over the maximum interest rates currently authorized for consumer finance loans under ch. 516, F.S. The bill requires a reduction of the interest rate on subsequent loans under the pilot program of at least 1/12 of 1 percent on subsequent loans if certain conditions are met.

C. Government Sector Impact:

Office of Financial Regulation resources will be required to process applications; process referral partner notices; process complaints; examine records of program licensees and referral partners; and, if necessary, initiate enforcement actions for non-compliance or fraud. As of December 31, 2016, the state of California had a total of fourteen program licensees. Assuming a comparable number of businesses apply to become a program licensee, the OFR estimates that it would need less than one full-time equivalent resource to handle the additional duties and responsibilities proposed in this bill. The OFR proposes to closely monitor and track the added duties and responsibilities and utilize current OPS funding if it determines an additional resource is needed. Subsequent to that determination, the OFR will reassess its funding needs based on volume of activity for this new program and may request additional funding in future fiscal years for an added

full-time equivalent position(s). The OFR would also incur insignificant costs associated with rulemaking which can be absorbed within its current budget.

The bill will require configuration and other updates to the OFR's Regulatory Enforcement and Licensing (REAL) system internal system and website. The bill will also require the OFR to create electronic forms for applications and reporting. The bill would require the OFR to post on its website a report that includes extensive information regarding the pilot program. Implementing such changes would cost the agency an estimated \$150,000.¹⁸

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates the following sections of the Florida Statutes: 516.40, 516.41, 516.42, 516.43, 516.44, 516.45 and 516.46.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

¹⁸ Office of Financial Regulation, *Bill Analysis of SB 640*, December 7, 2017 (on file with the Committee).

By Senator Rouson

19-00837-18

2018640__

1 A bill to be entitled
 2 An act relating to consumer finance loans; creating s.
 3 516.40, F.S.; establishing the Access to Responsible
 4 Credit Pilot Program within the Office of Financial
 5 Regulation; providing legislative findings and intent;
 6 creating s. 516.41, F.S.; defining terms; creating s.
 7 516.42, F.S.; prohibiting a person from certain
 8 actions relating to program loans unless the person
 9 obtains a pilot program license from the office;
 10 providing criteria for participation in the pilot
 11 program; specifying application requirements and fees;
 12 providing for construction; specifying a renewal fee;
 13 providing that only one pilot program license is
 14 required for a person to make program loans; requiring
 15 licensure of branch offices of a program licensee;
 16 specifying application requirements and fees for a
 17 program branch office license; requiring program
 18 branch office licenses to be renewed biennially and
 19 specifying a branch office renewal fee; creating s.
 20 516.43, F.S.; providing requirements, limitations, and
 21 prohibitions relating to program loans and the
 22 refinancing of program loans; authorizing licensees to
 23 provide certain documents in the language in which the
 24 loan was negotiated; requiring a program licensee to
 25 pay for certain translation costs incurred by the
 26 office; requiring a program licensee to provide
 27 specified disclosures; authorizing a program licensee
 28 to contract for and receive a specified origination
 29 fee from a borrower on a program loan; specifying

Page 1 of 30

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

19-00837-18

2018640__

30 methods for collecting the origination fee; specifying
 31 limitations on the amount and frequency of the
 32 origination fee; authorizing a program licensee to
 33 collect specified insufficient funds fees and
 34 delinquency charges; providing that program licensees
 35 or their wholly owned subsidiaries may not sell or
 36 assign unpaid debts to independent third parties for
 37 collection purposes unless the debt has been
 38 delinquent for a specified timeframe; requiring
 39 program licensees to direct borrowers to certain
 40 credit counseling services or provide certain credit
 41 education to borrowers before disbursing program loan
 42 proceeds; requiring program licensees to report
 43 borrowers' payment performance to at least one
 44 specified consumer reporting agency; defining the term
 45 "consumer reporting agency that compiles and maintains
 46 files on consumers on a nationwide basis"; prohibiting
 47 the office from approving a person for the program
 48 before the person is accepted as a data furnisher by a
 49 consumer reporting agency; requiring program licensees
 50 to provide borrowers with the names of consumer
 51 reporting agencies that payment histories are reported
 52 to; requiring a program licensee to underwrite each
 53 program loan; prohibiting a program licensee from
 54 making a program loan under certain circumstances;
 55 providing underwriting procedures and requirements;
 56 prohibiting a program licensee from requiring certain
 57 waivers from a borrower or from certain acts against a
 58 borrower who refuses certain waivers; providing

Page 2 of 30

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

19-00837-18

2018640__

59 applicability and construction; creating s. 516.44,
 60 F.S.; requiring arrangements between a program
 61 licensee and a referral partner to be specified in a
 62 written agreement; providing requirements for such
 63 agreement; specifying authorized services of referral
 64 partners; providing requirements for a referral
 65 partner who accepts program loan payments from a
 66 borrower; providing construction; prohibiting referral
 67 partners from performing specified activities;
 68 requiring a referral partner to provide a specified
 69 notice to an applicant for a program loan and certain
 70 assistance to the applicant under certain
 71 circumstances; specifying requirements, limitations,
 72 and prohibitions for the compensation of a referral
 73 partner by a program licensee; requiring a program
 74 licensee to provide, within a certain timeframe, a
 75 specified notice to the office after entering into a
 76 contract with a referral partner; requiring a referral
 77 partner to provide, within a specified timeframe,
 78 written notice to the program licensee of changes to
 79 certain information; providing that program licensees
 80 are responsible for the acts of referral partners
 81 which are in violation of ch. 516, F.S.; requiring a
 82 program licensee to pay a specified fee to the office
 83 to file a referral partner notice; requiring the
 84 Financial Services Commission to adopt rules; creating
 85 s. 516.45, F.S.; requiring the office, beginning on a
 86 specified date, to examine program licensees at
 87 specified intervals; providing an exception; requiring

Page 3 of 30

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

19-00837-18

2018640__

88 program licensees to pay the cost of examinations;
 89 authorizing the office to maintain an action for
 90 recovery of such cost; authorizing a method to
 91 determine the cost of examinations; providing a
 92 limitation to the scope of investigations or
 93 examinations; providing that a program licensee is
 94 subject to certain disciplinary actions for certain
 95 violations; authorizing the office to take certain
 96 disciplinary actions; creating s. 516.46, F.S.;
 97 requiring a program licensee, beginning on a certain
 98 date, to file a specified annual report with the
 99 office; requiring the office to post, by a certain
 100 date, a report to its website summarizing the use of
 101 the program; specifying information to be contained in
 102 the office's report; providing for conditional future
 103 repeal of the program; providing an effective date.

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

106
 107 Section 1. Section 516.40, Florida Statutes, is created to
 108 read:

109 516.40 Access to Responsible Credit Pilot Program.—
 110 (1) There is established within the Office of Financial
 111 Regulation the Access to Responsible Credit Pilot Program.
 112 (2) The Legislature finds that demand for responsible
 113 consumer finance loans in principal amounts of at least \$300 and
 114 no more than \$10,000 exceeds the supply of these loans. As a
 115 first step toward addressing this gap, the Access to Responsible
 116 Credit Pilot Program would allow more Floridians to obtain

Page 4 of 30

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

19-00837-18 2018640

responsible consumer finance loans of at least \$300 and no more than \$10,000. The pilot program is also intended to assist consumers in building their credit and has additional consumer protections for these loans which exceed current protections under general law.

Section 2. Section 516.41, Florida Statutes, is created to read:

516.41 Definitions for ss. 516.40-516.46.—As used in ss. 516.40-516.46, the term:

(1) "Consumer reporting agency" has the same meaning as in s. 603(p) of the Fair Credit Reporting Act, 15 U.S.C. s. 1681a(p).

(2) "Credit score" has the same meaning as in s. 609(f)(2)(A) of the Fair Credit Reporting Act, 15 U.S.C. s. 1681g(f)(2)(A).

(3) "Data furnisher" has the same meaning as the term "furnisher" in 12 C.F.R. s. 1022.41(c).

(4) "Pilot program" or "program" means the Access to Responsible Credit Pilot Program.

(5) "Pilot program license" means a license issued under ss. 516.40-516.46 authorizing a program licensee to make and collect program loans.

(6) "Program branch office" means a location, other than a program licensee's or referral partner's principal place of business:

(a) The address of which appears on business cards, stationery, or advertising used by the program licensee in connection with business conducted under this chapter;

(b) At which the program licensee's name, advertising or

19-00837-18 2018640

promotional materials, or signage suggests that program loans are originated, negotiated, funded, or serviced; or

(c) At which program loans are originated, negotiated, funded, or serviced by a program licensee.

(7) "Program licensee" means a person who is licensed to make and collect program loans under this chapter and who is approved by the office to participate in the program.

(8) "Program loan" means a consumer finance loan with a principal amount of at least \$300 and no more than \$10,000 originated pursuant to ss. 516.40-516.44, excluding the amount of the origination fee authorized under s. 516.43(3).

(9) "Referral partner" means an entity that, at the referral partner's physical location for business or through other means, performs one or more of the services authorized in s. 516.44(2) on behalf of a program licensee. A referral partner is not a credit service organization as defined in s. 817.7001 or a loan broker as defined in s. 687.14.

(10) "Refinance program loan" means a program loan that extends additional principal to a borrower and replaces and revises an existing program loan contract with the borrower. A refinance program loan does not include an extension, a deferral, or a rewrite of the program loan.

Section 3. Section 516.42, Florida Statutes, is created to read:

516.42 Requirements for program participation; program application requirements; fees.—

(1) A person may not advertise, offer, or make a program loan or impose any charges or fees pursuant to s. 516.43 unless the person first obtains a pilot program license from the

19-00837-18

2018640__

office.

(2) (a) In order to participate in the program, a person must meet the following criteria:

1. Be licensed to make consumer finance loans under s. 516.05.

2. Not be the subject of any insolvency proceeding.

3. Not be subject to the issuance of a cease and desist order; the issuance of a removal order; the denial, suspension, or revocation of a license; or any other action within the authority of the office or other financial regulatory agency in this state.

4. Not have a deficiency at the time of the person's application.

5. Pay a nonrefundable application fee of \$1,000 to the office at the time of making the application, pursuant to rule of the commission.

(b) A program applicant shall file with the office a digital application, in a form and manner prescribed by commission rule, which contains all of the following information with respect to the applicant:

1. The legal business name and any other name the applicant operates under.

2. The applicant's main address.

3. The telephone number and e-mail address of the applicant.

4. The address of any program branch office.

5. The name, title, address, telephone number, and e-mail address of the contact person for the applicant.

6. The applicant's license number, if the applicant is

19-00837-18

2018640__

licensed under this chapter.

7. A statement as to whether the applicant intends to use the services of one or more referral partners under s. 516.44.

8. A statement that the applicant has been accepted as a data furnisher by a consumer reporting agency and will report to a consumer reporting agency the payment performance of each borrower on all loans made under the program.

9. The signature and certification of an authorized person of the applicant.

(3) A person who desires to participate in the program but who is not licensed to make consumer finance loans pursuant to s. 516.05 must concurrently submit the following digital applications to the office, in the form and manner specified in this chapter:

(a) An application and fee pursuant to s. 516.03 for licensure to make consumer finance loans; and

(b) An application and fee for admission to the program in accordance with subsection (2).

(4) Except as otherwise provided in ss. 516.40-516.46, a program licensee is subject to all of the laws and rules governing consumer finance loans under this chapter.

(5) A program licensee shall pay a nonrefundable biennial renewal fee of \$1,000 pursuant to commission rule.

(6) Notwithstanding s. 516.05(3), only one pilot program license is required for a person to make program loans under ss. 516.40-516.46, regardless of whether the program licensee offers program loans to prospective borrowers at its own physical business locations, through referral partners, or through an electronic access point through which a prospective borrower may

19-00837-18

2018640

233 directly access the website of the program licensee.

234 (7) Each branch office of a program licensee must be
 235 licensed under this section.

236 (8) The office shall issue a program branch office license
 237 to a program licensee after the office determines that the
 238 program licensee submitted a completed electronic application
 239 for a program branch office license in a form prescribed by
 240 commission rule and paid an initial nonrefundable program branch
 241 office license fee of \$30 per branch office as prescribed by
 242 rule of the commission. Application fees may not be prorated for
 243 partial years of licensure. The program branch office license
 244 must be issued in the name of the program licensee that
 245 maintains the branch office. An application is considered
 246 received for purposes of s. 120.60 upon receipt of a completed
 247 application form and the required fees. The application for a
 248 program branch office license must contain the following
 249 information:

250 (a) The legal business name and any other name the
 251 applicant operates under.

252 (b) The applicant's main address.

253 (c) The applicant's telephone number and e-mail address.

254 (d) The address of each program branch office.

255 (e) The name, title, address, telephone number, and e-mail
 256 address of the contact person for the applicant.

257 (f) The applicant's license number, if the applicant is
 258 licensed under this chapter.

259 (g) The signature and certification of an authorized person
 260 of the applicant.

261 (9) A program branch office license must be renewed

19-00837-18

2018640

262 biennially at the time of program license renewal under
 263 subsection (5). A nonrefundable branch renewal fee of \$30 per
 264 program branch office, by commission rule, must be submitted at
 265 the time of renewal.

266 Section 4. Section 516.43, Florida Statutes, is created to
 267 read:

268 516.43 Requirements for program loans.—

269 (1) GENERAL REQUIREMENTS.—A program licensee shall comply
 270 with each of the following requirements in making program loans:

271 (a) A program loan must be unsecured.

272 (b) A program loan must have a minimum term of 120 days and
 273 a maximum term of 60 months, but it may not impose a prepayment
 274 penalty.

275 (c) A program loan must be repayable by the borrower in
 276 substantially equal periodic installments, except that the final
 277 payment may be less than the amount of the prior installments.
 278 Installments may be due every 2 weeks, semimonthly, or monthly.

279 (d) A program loan must include a borrower's right to
 280 rescind the program loan by notifying the program licensee of
 281 the borrower's intent to rescind the program loan and return the
 282 principal advanced by the end of the business day after the day
 283 the program loan is consummated.

284 (e) Notwithstanding s. 516.031, the maximum annual interest
 285 rate that may be charged on a program loan to the borrower on
 286 that portion of the unpaid principal balance of the program
 287 loan:

288 1. Up to and including \$3,000 is 36 percent.

289 2. Over \$3,000, and up to and including \$4,000, is 30
 290 percent.

19-00837-18

2018640

291 3. Over \$4,000, and up to and including \$10,000, is 24
 292 percent.

293
 294 The original principal amount of the program loan is equal to
 295 the amount financed as defined by the federal Truth in Lending
 296 Act and Regulation Z of the federal Consumer Financial
 297 Protection Bureau. In determining compliance with the statutory
 298 maximum interest rates in this paragraph, the computations used
 299 must be simple interest, through the application of a daily
 300 periodic rate to the actual unpaid principal balance each day,
 301 and may not be add-on interest or any other computations.

302 (f) If two or more interest rates are applied to the
 303 principal amount of a program loan, the licensee may charge,
 304 contract for, and receive interest at that single annual
 305 percentage rate that, if applied according to the actuarial
 306 method to each of the scheduled periodic balances of principal,
 307 would produce at maturity the same total amount of interest as
 308 would result from the application of the two or more rates
 309 otherwise permitted, based upon the assumption that all payments
 310 are made as agreed.

311 (g) The program licensee must reduce the rate on each
 312 subsequent program loan to the same borrower by a minimum of
 313 one-twelfth of 1 percent per month, if all of the following
 314 conditions are met:

315 1. The subsequent program loan is originated no more than
 316 180 days after the prior program loan is fully repaid.

317 2. The borrower was never more than 15 days delinquent on
 318 the prior program loan.

319 3. The prior program loan was outstanding for at least one-

19-00837-18

2018640

320 half of its original term before its repayment.

321 (h) A program licensee may not induce or permit any person
 322 to become obligated to the program licensee, directly or
 323 contingently, or both, under more than one program loan at the
 324 same time with the program licensee.

325 (i) A program licensee may not refinance a program loan
 326 unless all of the following conditions are met at the time the
 327 borrower submits an application to refinance:

328 1. The principal amount payable does not include more than
 329 60 days of unpaid interest accrued on the previous program loan
 330 in accordance with s. 516.031(5);

331 2. For program loans with an original term of less than 25
 332 months, the borrower has repaid at least 60 percent of the
 333 outstanding principal remaining on his or her existing program
 334 loan;

335 3. For program loans with an original term of greater than
 336 25 months but no more than 60 months, the borrower has made
 337 current payments for at least 9 months on his or her program
 338 loan;

339 4. The borrower is current on his or her outstanding
 340 program loan; and

341 5. The program licensee has underwritten the new program
 342 loan in accordance with subsection (7).

343 (j) In lieu of the provisions of s. 687.08, a program
 344 licensee or, if applicable, its approved referral partner shall
 345 make available to the borrower by either electronic or physical
 346 means a plain and complete receipt of payment at the time that a
 347 payment is made by the borrower. For audit purposes, a program
 348 licensee shall maintain an electronic record for each receipt

19-00837-18 2018640

made available to a borrower, which must include a copy of the receipt and the date and time that the receipt was generated. Each receipt of payment must show all of the following:

1. The name of the borrower.
2. The name of the referral partner, if applicable.
3. The total payment amount received.
4. The date of payment.
5. The program loan balance before and after application of the payment.
6. The amount of the payment that was applied to the principal, interest, and fees.
7. The type of payment made by the borrower.
8. The following statement, prominently displayed in a type size equal to or greater than the type size used to display the other items on the receipt: "If you have any questions about your loan now or in the future, you should direct those questions to ...(name of program licensee)... by ...(at least two different ways in which a borrower may contact the program licensee)...."

(2) WRITTEN DISCLOSURES.—

(a) Notwithstanding s. 516.15(1), the loan contract and all written disclosures and statements may be provided in English or in the language in which the loan is negotiated. A program licensee shall pay for any translation costs incurred by the office.

(b) A program licensee shall provide those disclosures required of all licensees in s. 516.15.

(3) ORIGATION FEES.—

(a) Notwithstanding s. 516.031, a program licensee may

19-00837-18 2018640

contract for and receive an origination fee from a borrower on a program loan. The program licensee may either deduct the origination fee from the principal amount of the loan disbursed to the borrower or capitalize the origination fee into the principal balance of the loan. The origination fee is fully earned and nonrefundable immediately upon the making of the program loan and may not exceed the lesser of 6 percent of the principal amount of the program loan made to the borrower, exclusive of the origination fee, or \$75.

(b) A program licensee may not charge a borrower an origination fee more than twice in any 12-month period.

(4) INSUFFICIENT FUNDS FEES AND DELINQUENCY CHARGES.—

Notwithstanding s. 516.031, a program licensee approved by the office to participate in the program may:

(a) Require payment from a borrower of no more than \$20 for fees incurred by the program licensee from a dishonored payment due to insufficient funds of the borrower.

(b) Notwithstanding s. 516.031(3)(a)9., contract for and receive a delinquency charge of up to \$15 for each calendar month for each payment in default for at least 10 days, if the charge is agreed upon in writing between the parties before it is imposed.

The program licensee, or any wholly owned subsidiary of the program licensee, may not sell or assign an unpaid debt to an independent third party for collection purposes unless the debt has been delinquent for at least 30 days.

(5) CREDIT EDUCATION.—Before disbursement of program loan proceeds to the borrower, the program licensee must:

19-00837-18

2018640

(a) Direct the borrower to the consumer credit counseling services offered by an independent third party; or

(b) Provide a credit education program or materials to the borrower. A borrower is not required to participate in any of these education programs or seminars. A credit education program or seminar offered pursuant to this subsection must be provided at no cost to the borrower.

(6) CREDIT REPORTING.—

(a) The program licensee shall report each borrower's payment performance to at least one consumer reporting agency that compiles and maintains files on consumers on a nationwide basis. As used in this section, the term "consumer reporting agency that compiles and maintains files on consumers on a nationwide basis" has the same meaning as in s. 603(p) of the Fair Credit Reporting Act, 15 U.S.C. s. 1681a(p).

(b) The office may not approve a person for the program before the person has been accepted as a data furnisher by a consumer reporting agency.

(c) The program licensee shall provide each borrower with the name or names of the consumer reporting agency or agencies to which it will report the borrower's payment history.

(7) PROGRAM LOAN UNDERWRITING.—

(a) The program licensee shall underwrite each program loan to determine a borrower's ability and willingness to repay the program loan pursuant to the program loan terms. The program licensee may not make a program loan if it determines that the borrower's total monthly debt service payments at the time of origination, including the program loan for which the borrower is being considered and all outstanding forms of credit that can

19-00837-18

2018640

be independently verified by the program licensee, exceed 35 percent of the borrower's gross monthly income.

(b)1. The program licensee shall seek information and documentation pertaining to all of a borrower's outstanding debt obligations during the loan application and underwriting process, including loans that are self-reported by the borrower but not available through independent verification. The program licensee shall verify such information using a credit report from at least one consumer reporting agency that compiles and maintains files on consumers on a nationwide basis or through other available electronic debt verification services that provide reliable evidence of a borrower's outstanding debt obligations.

2. The program licensee is not required to consider loans made to a borrower by friends or family in determining the borrower's debt-to-income ratio.

(c) The program licensee shall also verify the borrower's income in determining the debt-to-income ratio using information from:

1. Electronic means or services that provide reliable evidence of the borrower's actual income; or

2. Internal Revenue Service Form W-2, tax returns, payroll receipts, bank statements, or other third-party documents that provide reasonably reliable evidence of the borrower's actual income.

(8) PROVISIONS ON WAIVERS.—

(a) A program licensee may not require, as a condition of providing the program loan, that the borrower:

1. Waive any right, penalty, remedy, forum, or procedure

19-00837-18

2018640

provided for in any law applicable to the program loan, including the right to file and pursue a civil action or file a complaint with or otherwise communicate with the office, any court, or other governmental entity.

2. Agree to the application of laws other than those of this state.

3. Agree to resolve disputes in a jurisdiction outside of this state.

(b) A waiver that is required as a condition of doing business with the program licensee is presumed involuntary, unconscionable, against public policy, and unenforceable.

(c) A program licensee may not refuse to do business with or discriminate against a borrower or an applicant on the basis of the borrower's or applicant's refusal to waive any right, penalty, remedy, forum, or procedure, including the right to file and pursue a civil action or complaint with, or otherwise notify, the office, a court, or any other governmental entity. The exercise of a person's right to refuse to waive any right, penalty, remedy, forum, or procedure, including a rejection of a contract requiring a waiver, does not affect any otherwise legal terms of a contract or an agreement.

(d) This subsection does not apply to any agreement to waive any right, penalty, remedy, forum, or procedure, including any agreement to arbitrate a claim or dispute, after a claim or dispute has arisen. This subsection does not affect the enforceability or validity of any other provision of the contract.

Section 5. Section 516.44, Florida Statutes, is created to read:

19-00837-18

2018640

516.44 Referral partners.—

(1) REFERRAL PARTNER AGREEMENT.—All arrangements between a program licensee and a referral partner must be specified in a written referral partner agreement between the parties. The agreement must contain a provision that the referral partner agrees to comply with this section and all rules adopted under this section regarding the activities of referral partners, and that the office has access to the referral partner's books and records pertaining to the referral partner's operations under the agreement with the program licensee in accordance with s. 516.45(4) and the office may examine the referral partner pursuant to s. 516.45.

(2) AUTHORIZED SERVICES.—A program licensee may use the services of one or more referral partners as provided in this section. A referral partner may perform one or more of the following services for a program licensee:

(a) Distributing, circulating, using, or publishing printed brochures, flyers, fact sheets, or other written materials relating to program loans that the program licensee may make or negotiate. The written materials must be reviewed and approved in writing by the program licensee before being distributed, circulated, used, or published.

(b) Providing written factual information about program loan terms, conditions, or qualification requirements to a prospective borrower which has been prepared by the program licensee or reviewed and approved in writing by the program licensee. A referral partner may discuss the information with a prospective borrower in general terms.

(c) Notifying a prospective borrower of the information

19-00837-18

2018640

needed in order to complete a program loan application.

(d) Entering information provided by the prospective borrower on a preprinted or an electronic application form or in a preformatted computer database.

(e) Assembling credit applications and other materials obtained in the course of a credit application transaction for submission to the program licensee.

(f) Contacting the program licensee to determine the status of a program loan application.

(g) Communicating a response that is returned by the program licensee's automated underwriting system to a borrower or a prospective borrower.

(h) Obtaining a borrower's signature on documents prepared by the program licensee and delivering final copies of the documents to the borrower.

(i) Disbursing program loan proceeds to a borrower if this method of disbursement is acceptable to the borrower, subject to the requirements of subsection (3). A loan disbursement made by a referral partner under this paragraph is deemed to be made by the program licensee on the date that the funds are disbursed or otherwise made available by the referral partner to the borrower.

(j) Receiving a program loan payment from the borrower if this method of payment is acceptable to the borrower, subject to the requirements of subsection (3).

(k) Operating an electronic access point through which a prospective borrower may directly access the website of the program licensee to apply for a program loan.

(3) RECEIPT OR DISBURSEMENT OF PROGRAM LOAN PAYMENTS.—

19-00837-18

2018640

(a) A loan payment made by a borrower to a referral partner under paragraph (2)(j) must be applied to the borrower's program loan and is deemed received by the program licensee as of the date the payment is received by the referral partner.

(b) A referral partner that receives loan payments must deliver or cause to be delivered to the borrower a plain and complete receipt showing all of the information specified in s. 516.43(1)(j) at the time that the payment is made by the borrower.

(c) A borrower who submits a loan payment to a referral partner under this subsection is not liable for a failure or delay by the referral partner in transmitting the payment to the program licensee.

(d) A referral partner that disburses or receives loan payments pursuant to paragraph (2)(i) or paragraph (2)(j) must maintain records of all disbursements made and loan payments received for a period of at least 2 years.

(4) PROHIBITED ACTIVITIES.—A referral partner may not engage in any of the following activities:

(a) Providing counseling or advice to a borrower or prospective borrower with respect to any loan term.

(b) Providing loan-related marketing material that has not previously been approved by the program licensee to a borrower or a prospective borrower.

(c) Negotiating a loan term between a program licensee and a prospective borrower.

(d) Offering information pertaining to a single prospective borrower to more than one program licensee. However, if a program licensee has declined to offer a program loan to a

19-00837-18

2018640

581 prospective borrower and has so notified the prospective
 582 borrower in writing, the referral partner may then offer
 583 information pertaining to that borrower to another program
 584 licensee with whom it has a referral partner agreement.

585 (e) Requiring a borrower to pay any fees or charges other
 586 than those permitted under ss. 516.40-516.46 to the referral
 587 partner or to any other person in connection with a program
 588 loan.

589 (5) DISCLOSURE NOTICE AND COMMUNICATION.—

590 (a) At the time the referral partner receives or processes
 591 an application for a program loan, the referral partner shall
 592 provide the following statement to the applicant on behalf of
 593 the program licensee, in no smaller than 10-point type, and
 594 shall request that the applicant acknowledge receipt of the
 595 statement in writing:

596
 597 Your loan application has been referred to us by
 598 ...(name of referral partner).... We may pay a fee to
 599 ...(name of referral partner)... for the successful
 600 referral of your loan application. If you are approved
 601 for the loan, ...(name of program licensee)... will
 602 become your lender. If you have any questions about
 603 your loan, now or in the future, you should direct
 604 those questions to ...(name of program licensee)... by
 605 ...(insert at least two different ways in which a
 606 borrower may contact the program licensee).... If you
 607 wish to report a complaint about ...(name of referral
 608 partner)... or ...(name of program licensee)...
 609 regarding this loan transaction, you may contact the

Page 21 of 30

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

19-00837-18

2018640

610 Division of Consumer Finance of the Office of
 611 Financial Regulation at 850-487-9687 or
 612 <http://www.flofr.com>.
 613

614 (b) If the loan applicant has questions about the program
 615 loan which the referral partner is not permitted to answer, the
 616 referral partner must make a good faith effort to assist the
 617 applicant in making direct contact with the program licensee
 618 before the program loan is consummated.

619 (6) COMPENSATION.—

620 (a) The program licensee may compensate a referral partner
 621 in accordance with a written agreement and a compensation
 622 schedule that is mutually agreed to by the program licensee and
 623 the referral partner, subject to the requirements in paragraph
 624 (b).

625 (b) The compensation of a referral partner by a program
 626 licensee is subject to all of the following requirements:

627 1. Compensation may not be paid to a referral partner in
 628 connection with a loan application unless the program loan is
 629 consummated.

630 2. Compensation may not be paid to a referral partner based
 631 upon the principal amount of the program loan.

632 3. Compensation may not be directly or indirectly passed on
 633 to a borrower through a fee or other compensation, or a portion
 634 of a fee or other compensation, charged to a borrower.

635 4. Subject to the limitations specified in subparagraphs
 636 1., 2., and 3., the total compensation paid by a program
 637 licensee to a referral partner for the services specified in
 638 subsection (2) may not exceed the sum of:

Page 22 of 30

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

19-00837-18

2018640

a. Sixty dollars per program loan, on average, assessed annually, whether paid at the time of consummation, through installments, or in a manner otherwise agreed upon by the program licensee and the referral partner; and

b. Two dollars per payment received by the referral partner on behalf of the program licensee for the duration of a program loan, if the referral partner receives borrower loan payments on the program licensee's behalf in accordance with subsection (3).

5. The referral partner's location for services and other information required by subsection (7) must be reported to the office.

(c) A program licensee or a referral partner may not pass on to a borrower, whether directly or indirectly, any additional cost or other charge for compensation paid to a referral partner under this program.

(7) NOTICE TO OFFICE.—A program licensee that uses the service of a referral partner must notify the office, in a form and manner prescribed by the commission, within 15 days after entering into a contract with a referral partner regarding all of the following:

(a) The name, business address, and licensing details of the referral partner and all locations at which the referral partner will perform services under this section.

(b) The name and contact information for an employee of the referral partner who is knowledgeable about, and has the authority to execute, the referral partner agreement.

(c) The name and contact information of one or more employees of the referral partner who are responsible for that referral partner's referring activities on behalf of the program

19-00837-18

2018640

licensee.

(d) A statement by the program licensee that it has conducted due diligence with respect to the referral partner and has confirmed that none of the following applies:

1. The filing of a petition under the United States Bankruptcy Code for bankruptcy or reorganization by the referral partner.

2. The commencement of an administrative or judicial license suspension or revocation proceeding, or the denial of a license request or renewal, by any state, the District of Columbia, any United States territory, or any foreign country in which the referral partner operates, plans to operate, or is licensed to operate.

3. A felony indictment involving the referral partner or an affiliated party.

4. A felony conviction, guilty plea, or plea of nolo contendere, regardless of adjudication, of the referral partner or an affiliated party.

5. Any suspected criminal act perpetrated in this state relating to activities regulated under this chapter by the referral partner.

6. Notification by a law enforcement or prosecutorial agency that the referral partner is under criminal investigation which includes, but is not limited to, subpoenas to produce records or testimony and warrants issued by a court of competent jurisdiction which authorize the search and seizure of any records relating to a business activity regulated under this chapter.

19-00837-18

2018640

As used in this paragraph, the term "affiliated party" means a director, an officer, a responsible person, an employee, or a foreign affiliate of a referral partner; or a person who has a controlling interest in a referral partner.

(e) Any other information requested by the office subject to the limitations specified in s. 516.45(4).

(8) NOTICE OF CHANGES.—A referral partner must provide the program licensee with written notice, sent by registered mail, within 30 days after any changes are made to the information specified in paragraphs (7)(a)-(c) or within 30 days after the occurrence or knowledge of any of the events specified in paragraph (7)(d), whichever is later.

(9) RESPONSIBILITY FOR ACTS OF A REFERRAL PARTNER.—A program licensee is responsible for any act of its referral partner if the act is a violation of this chapter.

(10) REFERRAL PARTNER FEE.—The program licensee shall pay to the office at the time it files a referral partner notice with the office a one-time, nonrefundable fee of \$30 for each referral partner, as prescribed by commission rule.

Section 6. Section 516.45, Florida Statutes, is created to read:

516.45 Examinations; disciplinary actions.—

(1) Notwithstanding any other law, commencing on January 1, 2019, the office shall examine each program licensee that is accepted into the program in accordance with this chapter at least once every 24 months.

(2) Notwithstanding subsection (1), the office may waive one or more branch office examinations if the office finds that such examinations are not necessary for the protection of the

19-00837-18

2018640

public due to the centralized operations of the program licensee or other factors acceptable to the office.

(3) The examined program licensee shall pay for the cost of an examination to the office, pursuant to commission rule, and the office may maintain an action for the recovery of the cost in any court of competent jurisdiction. In determining the cost of the examination, the office may use the estimated average hourly cost for all persons performing examinations of program licensees or other persons subject to ss. 516.40-516.46 for the fiscal year.

(4) The scope of any investigation or examination of a program licensee or referral partner must be limited to those books, accounts, records, documents, materials, and matters reasonably necessary to determine compliance with this chapter.

(5) A program licensee who violates any applicable provision of this chapter is subject to disciplinary action pursuant to s. 516.07(2). Any such disciplinary action is subject to s. 120.60. A program licensee is also subject to disciplinary action for a violation of s. 516.44 committed by any of its referral partners.

(6) The office may take any of the following actions against a referral partner who violates s. 516.44:

(a) Disqualify the referral partner from performing services under this chapter;

(b) Bar the referral partner from performing services at one or more specific locations of the referral partner;

(c) Terminate a written agreement between a referral partner and a program licensee;

(d) Impose an administrative fine not to exceed \$1,000 for

19-00837-18

2018640__

each such act of the referral partner; and

(e) Prohibit program licensees from using the referral partner, if the office deems it to be in the public interest.

Section 7. Section 516.46, Florida Statutes, is created to read:

516.46 Annual reports; reports by the office.—

(1) Beginning in 2020, on or before March 15 of each year, a program licensee shall file a report with the office on each of the items specified in subsection (2), on a form and in a manner as prescribed by commission rule, which contains aggregated or anonymized data without reference to any borrower's nonpublic personal information or any proprietary or trade secret information of the program licensee.

(2) On or before January 1, 2021, the office shall post a report on its website summarizing the use of the program based on the information contained in reports filed by each program licensee under subsection (1). The report must state the information in the aggregate so as not to identify data by specific program licensee and must specify the period to which the report corresponds. The report must include, but not be limited to, the following for that period:

(a) The number of entities that applied to participate in the program.

(b) The number of entities accepted to participate in the program.

(c) The office's reasons for rejecting applications for participation, if applicable. This information must be provided in a manner that does not identify the entity or entities rejected.

19-00837-18

2018640__

(d) The number of program loan applications received by program licensees participating in the program, the number of program loans made under the program, the total amount loaned, the distribution of loan lengths upon origination, and the distribution of interest rates and principal amounts upon origination among those program loans.

(e) The number of borrowers who obtained more than one program loan and the distribution of the number of program loans per borrower.

(f) Of the borrowers who obtained more than one program loan, the percentage of those borrowers whose credit scores increased between successive loans, based on information from at least one major credit bureau, and the average size of the increase.

(g) The income distribution of borrowers upon program loan origination, including the number of borrowers who obtained at least one program loan and who resided in a low-income or moderate-income census tract at the time of their loan applications.

(h) The number of borrowers who obtained program loans for the following purposes, based on borrower responses at the time of their loan applications indicating the primary purpose for which the program loan was obtained:

1. Pay medical expenses.

2. Pay for vehicle repair or a vehicle purchase.

3. Pay bills.

4. Consolidate debt.

5. Build or repair credit history.

6. Pay other expenses.

19-00837-18

2018640

813 (i) The number of borrowers who self-report that they had a
 814 bank account at the time of their loan application and the
 815 number of borrowers who self-report that they did not have a
 816 bank account at the time of their loan application.

817 (j) With respect to refinance program loans, the report
 818 must specifically include the following information:

819 1. The number and percentage of borrowers who applied for a
 820 refinance program loan.

821 2. Of those borrowers who applied for a refinance program
 822 loan, the number and percentage of borrowers who obtained a
 823 refinance program loan.

824 (k) The number and type of referral partners used by
 825 program licensees.

826 (l) The number and percentage of borrowers who obtained one
 827 or more program loans on which delinquency charges were
 828 assessed, the total amount of delinquency charges assessed, and
 829 the average delinquency charge assessed by dollar amount and as
 830 a percentage of the principal amount loaned.

831 (m) The performance of program loans under the program as
 832 reflected by all of the following:

833 1. The number and percentage of borrowers who experienced
 834 at least one delinquency lasting between 7 and 29 days, and the
 835 distribution of principal loan amounts corresponding to those
 836 delinquencies.

837 2. The number and percentage of borrowers who experienced
 838 at least one delinquency lasting between 30 and 59 days, and the
 839 distribution of principal loan amounts corresponding to those
 840 delinquencies.

841 3. The number and percentage of borrowers who experienced

19-00837-18

2018640

842 at least one delinquency lasting 60 days or more, and the
 843 distribution of principal loan amounts corresponding to those
 844 delinquencies.

845 (n) The number and types of violations of ss. 516.40-516.46
 846 by referral partners which were documented by the office.

847 (o) The number and types of violations of ss. 516.40-516.46
 848 by program licensees which were documented by the office.

849 (p) The number of times that the office disqualified a
 850 referral partner from performing services, barred a referral
 851 partner from performing services at one or more specific
 852 locations of the referral partner, terminated a written
 853 agreement between a referral partner and a program licensee, or
 854 imposed an administrative penalty.

855 (q) The number of complaints received by the office about a
 856 program licensee or a referral partner and the nature of those
 857 complaints.

858 Section 8. Sections 516.40-516.46, Florida Statutes, are
 859 repealed on December 31, 2023, unless reenacted or superseded by
 860 another law enacted by the Legislature before that date.

861 Section 9. This act shall take effect October 1, 2018.



The Florida Senate

Committee Agenda Request

To: Senator Anitere Flores, Chair
Banking and Insurance

Subject: Committee Agenda Request

Date: November 9, 2017

I respectfully request that **Senate Bill # 640**, relating to Consumer Finance Loans, be placed on the:

- ☒ committee agenda at your earliest possible convenience.
- ☐ next committee agenda.

A handwritten signature in blue ink, reading "Darryl Rouson", is written over a horizontal line.

Senator Darryl Rouson
Florida Senate, District 19

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/16/18

Meeting Date

SB640 Roush

Bill Number (if applicable)

Topic

Amendment Barcode (if applicable)

Name JAMES GUTIERREZ

Job Title FOUNDER/CEO, INSIGHT

Address 333 BUSH ST #1704
Street

Phone

SAN FRAN CA 94106
City State Zip

Email JAMES@INSIGHT.COM

Speaking: ☒ For ☐ Against ☐ Information

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

Representing INSIGHT

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

Meeting Date

Bill Number (if applicable)

Topic

Amendment Barcode (if applicable)

Name

Job Title

Address

Street

City

State

Zip

Phone

Email

Speaking:

☐

For

☐

Against

☐

Information

Waive Speaking:

☒

In Support

☐

Against

(The Chair will read this information into the record.)

Representing

Appearing at request of Chair:

☐

Yes

☐

No

Lobbyist registered with Legislature:

☐

Yes

☐

No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/16/18
Meeting Date

640

Bill Number (if applicable)

Topic Consumer Finance

Amendment Barcode (if applicable)

Name Alice Vickers

Job Title Attorney

Address 623 Beard St Tallahassee

Phone 850 556 3121

Tallahassee FL 32303
City State Zip

Email alicevickers@focpa.org

Speaking: ☐ For ☒ Against ☐ Information

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

Representing FL Alliance for Consumer Protection

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

THE FLORIDA SENATE
APPEARANCE RECORD

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

Jan 16 2018
Meeting Date

SB 640
Bill Number (if applicable)

Topic Consumer Finance Loans

Amendment Barcode (if applicable)

Name Dorene Barker

Job Title Associate State Director

Address 200 W. College Ave

Phone 850-228-6387

Street

Tall
City

FL
State

32303
Zip

Email dobarker@aarps.org

Speaking: ☐ For ☒ Against ☐ Information

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

Representing AARP Florida

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

THE FLORIDA SENATE
APPEARANCE RECORD

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

1/16/18
Meeting Date

640
Bill Number (if applicable)

Topic Consumer Finance

Amendment Barcode (if applicable)

Name Arthur Rosenberg

Job Title Attorney

Address 3000 Biscayne Blvd, #106

Phone 407-801-4713

Street

Miami

FL

33137

City

State

Zip

Email arthur@floridalegal.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Legal Services

Appearing at request of Chair: ☐ Yes ☐ No Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: SB 756

INTRODUCER: Senator Grimsley

SUBJECT: Unfair Insurance Trade Practices

DATE: January 12, 2018

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Knudson	BI	Favorable
2.			CM	
3.			RC	

I. Summary:

SB 756 creates an exemption from the Unfair Insurance Trade Practices Act that will allow an insurer to refuse to insure a person who fails to purchase motor vehicle services from a membership organization that, since January 1, 2018, has more than 1 million members in this state and is affiliated with an admitted insurer.

II. Present Situation:

The Unfair Insurance Trade Practices Act¹ (Act) regulates trade practices relating to insurance by prohibiting all practices which constitute unfair methods of competition or unfair or deceptive acts or practices.² The prohibited practices are set forth primarily³ in s. 626.9541, F.S., examples of which include false advertising, unfair discrimination in issuing coverage or calculating rates, unfair claim settlement practices, or providing unlawful inducement to purchase insurance by providing securities or unlawful rebates.

The bill amends s. 626.9541(1)(x)4., F.S., which prohibits the refusal to insure an individual or risk solely because the insured or applicant fails to purchase noninsurance services or commodities, including automobile services. Automobile services are defined in s. 624.124, F.S., which allows any person to sell the following motor vehicle related services without being deemed an insurer and without being subject to the Florida Insurance Code:

¹ Sections 626.951–626.99, F.S.

² Section 626.951, F.S.

³ Examples of other practices prohibited by the Act include but are not limited to coercing a person to use a particular insurer as a condition of lending money or credit (s. 626.9551, F.S.), failing to allow Holocaust victims to make insurance claims irrespective of a statute of limitations under a reasonable standard of proof and failing to diligently and expeditiously investigate all such claims (s. 626.9543, F.S.), increasing motor vehicle insurance rates or refusing to issue such coverage because of certain minor traffic violations (s. 626.9702, F.S.), refusing to issue a life insurance or disability insurance policy or issuing such policy at a rate higher than permitted by statute because the policyholder has a severe disability or sickle-cell trait. (ss. 626.9705, 626.9706, and 626.9707, F.S.).

- Towing service.
- Procuring from an insurer group coverage for bail and arrest bonds or for accidental death and dismemberment.
- Emergency service.
- Procuring prepaid legal services, or providing reimbursement for legal services, except that this is not an exemption from the legal expense insurance requirements of ch. 642, F.S.
- Offering assistance in locating or recovering stolen or missing motor vehicles.
- Paying emergency living and transportation expenses of the owner of a damaged motor vehicle.

The Act is enforced by the Department of Financial Services (DFS) and Office of Insurance Regulation (OIR) which, within their respective regulatory jurisdictions, have authority to examine and investigate every person involved in the business of insurance to determine compliance.⁴ Each violation of the act is subject to a fine of \$5,000 for each non-willful violation up to an aggregate of \$20,000, or a fine of \$40,000 for each willful violation up to an aggregate of \$200,000.⁵ Certain prohibited actions are subject to higher fines.⁶

The OIR and DFS each have authority to conduct a hearing in accordance with ch. 120, F.S., which either has reason to believe that a person has engaged, or is engaging in, an unfair or deceptive trade practice prohibited by s. 626.9541, F.S., or s. 626.9551, F.S., or is engaging in the business of insurance without a license.⁷ Upon a final order that a person has engaged in an unfair or deceptive act or is unlawfully transacting insurance, the OIR or DFS must enter a cease and desist order and may suspend or revoke a certificate of authority, license, or eligibility for a certificate of authority or license if the violator knew, or reasonably should have known, he or she violated the Act.

III. Effect of Proposed Changes:

The bill creates an exemption from the Unfair Insurance Trade Practices Act that will allow an insurer to refuse to insure a person who fails to purchase motor vehicle services from a membership organization that, since January 1, 2018, has more than 1 million members in this state and is affiliated with an admitted insurer.

The effective date is July 1, 2018.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

⁴ Section 626.9561, F.S.

⁵ Section 626.9521(2), F.S.

⁶ See s. 626.9521(3), F.S.

⁷ Section 626.9571, F.S.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

None.

B. Private Sector Impact:

The bill allows insurers to sell motor vehicle insurance only to persons who purchase motor vehicle services from a membership organization that, since January 1, 2018, has more than 1 million members in this state and is affiliated with an admitted insurer. This may result in motor vehicle insurance companies that require policyholders to purchase motor vehicle services from a membership organization offering motor vehicle insurance coverage in this state.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 626.9541 of the Florida Statutes.

IX. Additional Information:**A. Committee Substitute – Statement of Changes:**

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By Senator Grimsley

26-00813A-18

2018756__

A bill to be entitled

An act relating to unfair insurance trade practices; amending s. 626.9541, F.S.; authorizing insurers to refuse to insure or refuse to continue to insure an applicant or insured for failing to purchase certain noninsurance motor vehicle services; providing an effective date.

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

Section 1. Paragraph (x) of subsection (1) of section 626.9541, Florida Statutes, is amended to read:

626.9541 Unfair methods of competition and unfair or deceptive acts or practices defined.—

(1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS.—The following are defined as unfair methods of competition and unfair or deceptive acts or practices:

(x) *Refusal to insure*.—In addition to other provisions of this code, the refusal to insure, or continue to insure, any individual or risk solely because of:

1. Race, color, creed, marital status, sex, or national origin;

2. The residence, age, or lawful occupation of the individual or the location of the risk, unless there is a reasonable relationship between the residence, age, or lawful occupation of the individual or the location of the risk and the coverage issued or to be issued;

3. The insured's or applicant's failure to agree to place collateral business with any insurer, unless the coverage

Page 1 of 2

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

26-00813A-18

2018756__

applied for would provide liability coverage which is excess over that provided in policies maintained on property or motor vehicles;

4. The insured's or applicant's failure to purchase noninsurance services or commodities, including motor vehicle automobile services as defined in s. 624.124 except for motor vehicle services purchased from a membership organization that, since January 1, 2018, has more than 1 million members in this state and is affiliated with an admitted insurer;

5. The fact that the insured or applicant is a public official; or

6. The fact that the insured or applicant had been previously refused insurance coverage by any insurer, when such refusal to insure or continue to insure for this reason occurs with such frequency as to indicate a general business practice.

Section 2. This act shall take effect July 1, 2018.

Page 2 of 2

CODING: Words ~~stricken~~ are deletions; words underlined are additions.



The Florida Senate

Committee Agenda Request

To: Senator Anitere Flores, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: November 15, 2017

I respectfully request that **Senate Bill #756**, relating to Unfair Insurance Trade Practices, be placed on the:

- ☐ committee agenda at your earliest possible convenience.
- ☒ next committee agenda.

A handwritten signature in black ink that reads "Denise Grimsley". The signature is written in a cursive style with a large, looped "D" and a long, sweeping "y".

Senator Denise Grimsley
Florida Senate, District 26

cc: James Knudson, Staff Director
Sheri Green, Committee Administrative Assistant

APPEARANCE RECORD

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

Meeting Date _____

756
Bill Number (if applicable) _____

Topic SB 756

Amendment Barcode (if applicable) _____

Name Heather DRAKE

Job Title VP- Government AFFAIRS

Address 120 N. Washington St

Phone _____

Street

City

State

Zip

Email _____

Speaking: ☒ For ☐ Against ☐ Information

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

Representing AAA / Auto Club Group

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: SB 920

INTRODUCER: Senators Bradley and Braynon

SUBJECT: Deferred Presentment Transactions

DATE: January 12, 2018

REVISED: _____

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Knudson	Knudson	BI	Favorable
2. _____	_____	CM	_____
3. _____	_____	RC	_____

I. Summary:

SB 920 authorizes deferred presentment installment transactions under Florida law. The maximum face amount of a check taken for a deferred presentment installment transaction may not exceed \$1,000, exclusive of fees. The term of a deferred presentment installment transaction may not be less than 60 days or more than 90 days. The bill retains current law in s. 560.404(19), F.S., that a provider may not enter into a deferred presentment transaction with any person who has an outstanding deferred presentment transaction or whose previous transaction has been terminated for less than 24 hours.

The maximum fees on a deferred presentment installment transaction that may be charged by a provider or its affiliate are 8 percent of the outstanding transaction balance on a biweekly basis. Fees for a deferred presentment installment transaction are calculated using simple interest. Prepayment penalties are prohibited.

A deferred presentment installment transaction must be fully amortizing (the balance due will be entirely paid after the last payment is made) and repayable in substantially equal and consecutive installments. The time between installment payments must be at least 13 days but not greater than 1 calendar month.

The provider must provide a grace period for payment of a scheduled installment if the drawer informs the deferred presentment installment transaction provider in writing or in person by noon of the business day before a scheduled payment.

The effective date of the bill is July 1, 2018.

II. Present Situation:

Deferred Presentment

A deferred presentment transaction means providing currency or a payment instrument in exchange for a drawer's check and agreeing to hold the check for a number of days until depositing, presenting, or redeeming the payment instrument.¹ The transactions are commonly referred to as "payday loans." These transactions are governed by part IV of ch. 560, F.S. The only persons who may engage in deferred presentment transactions are financial institutions as defined in s. 655.005, F.S.,² and money services business licensed under part II³ or part III⁴ of ch. 560, F.S.

Florida law contains provisions designed to prevent consumers from being caught in a "debt trap" wherein the consumer has to continuously enter into lending transactions to pay off the principal and fees from previous transactions. The face amount of a check taken for deferred presentment may not exceed \$500, exclusive of fees.⁵ Fees generally may not exceed 10 percent of payment provided to the drawer, except for an additional verification fee not to exceed \$5 may also be charged.⁶ The term of a deferred presentment agreement may not be less than 7 days or greater than 31 days. A deferred presentment provider may not enter into a deferred presentment transaction with a drawer (customer) who has an outstanding deferred presentment transaction with any provider or within 24 hours of the termination of a previous transaction.⁷ A deferred presentment provider also may not engage in the rollover of a deferred presentment agreement and may not redeem, extend, or otherwise consolidate a deferred presentment agreement with the proceeds of another deferred presentment transaction made by it or an affiliate.⁸

If the drawer, at the end of the deferment period, informs the deferred presentment provider in person that the drawer cannot redeem or pay in full in cash the amount due, the drawer must be given a grace period that extends the term of the agreement for 60 additional days.⁹ As a condition of receiving the grace period, the drawer must make an appointment with a consumer

¹ See s. 560.402, F.S.

² Section 655.005, F.S., defines a "financial institution" to mean a state or federal savings or thrift association, bank, savings back, trust company, international bank agency, international banking corporation, international branch, international representative office, international administrative office, international trust entity, international trust company representative office, qualified limited service affiliate, credit union, or an agreement corporation operating pursuant to s. 25 of the Federal Reserve Act, 12 U.S.C. ss. 601 et seq. or Edge Act corporation organized pursuant to s. 25(a) of the Federal Reserve Act, 12 U.S.C. ss. 611 et Seq.

³ Licensure as a money transmitter. A money transmitter is defined by s. 560.103(23), F.S., as a corporation, limited liability company, limited liability partnership, or foreign entity qualified to do business in this state which receives currency, monetary value, or payment instruments for the purpose of transmitting the same by any means, including transmission by wire, facsimile, electronic transfer, courier, the Internet, or through bill payment services or other businesses that facilitate such transfer within this country, or to or from this country. Money transmitters may engage in check cashing under part III of ch. 560, F.S.

⁴ Licensure as a check casher. Section 655.005(6), F.S., defines a "check casher" to mean a person who sells currency in exchange for payment instruments received, except travelers checks.

⁵ Section 560.404(5), F.S.

⁶ Section 560.404(6), F.S.

⁷ Section 560.404(19), F.S.

⁸ Section 560.404(18), F.S.

⁹ Section 560.404(22), F.S.

credit counseling agency within 7 days after the end of the deferment period and complete counseling by the end of the grace period.

The deferred presentment provider may not include in the agreement a hold harmless clause, a confession of judgment clause, an assignment of or order for payment of wages or other compensation for services, or a provision in which the drawer waives any claim or defense arising out of the agreement or any provision of part VI, ch. 560, F.S.¹⁰ The deferred presentment provider must comply with state and federal disclosure requirements.¹¹ The loan loss rate is 1.8 percent of total transactions representing an advance amount of approximately \$50.4 million. Grace periods were used for approximately 0.71 percent of transactions from July 2016 to June 2017.

As of June 30, 2017, there were 923 licensed locations in Florida that engage in deferred presentment transactions.¹² Between July 2016 and June 2017, approximately 7.7 million deferred presentment transactions were conducted in Florida, representing a total advance amount of \$3.09 billion with total advance fees of \$306 million. The average transaction from July 2016 to June 2017 was \$400.77 and the average transaction fee was 9.9 percent of the advance plus an average verification fee of \$3.09. Of all consumers who entered into a deferred presentment transaction from July 2016 to June 2017, 31.8 percent engaged in 1 to 3 transactions, 30.7 engaged in 4 to 9 transactions, and 37.6 percent engaged in 10 or more transactions.

Bureau of Consumer Financial Protection Rule Governing Payday, Vehicle Title, and Certain High-Cost Installment Loans

On October 5, 2017, the Bureau of Consumer Financial Protection (CFPB) finalized a rule governing certain consumer credit products.¹³ The CFPB has stated that the rule is aimed at stopping payday debt traps by requiring lenders to determine upfront whether consumers have the ability to repay their loans.¹⁴ The key provisions of the rule are as follows:¹⁵

The Lender Must Determine the Consumer's Ability to Repay

Makes it an unfair and abusive practice for a lender to make covered short-term or longer-term balloon-payment loans,¹⁶ including payday and vehicle title loans, without reasonably determining that consumer have the ability to repay the loans according to their terms. The ability to repay standard requires a reasonable determination by the lender that the consumer would be able to make loan payments and also meet the consumer's basic living expenses and

¹⁰ Section 560.404(10), F.S.

¹¹ Section 560.404(13) and (20), F.S.

¹² Office of Financial Regulation, Florida Trends in Deferred Presentment – State of Florida Deferred Presentment Program Through June 2017 (June 2017)(On file with the Senate Committee on Banking and Insurance).

¹³ 82 FR 54472.

¹⁴ Bureau of Consumer Financial Protection, *CFPB Finalizes Rule to Stop Payday Debt Traps* (October 5, 2017) <https://www.consumerfinance.gov/about-us/newsroom/cfpb-finalizes-rule-stop-payday-debt-traps> (last accessed January 12, 2018).

¹⁵ The summary of key provisions of the CFPB rule is taken from 82 FR 54472 at pgs. 1-9, unless otherwise indicated.

¹⁶ A balloon payment loan is a larger than usual one-time payment at the end of the loan term.

other major financial obligations without needing to re-borrow over the ensuing 30 days. The lender must:

- Verify the consumer's net monthly income using a reliable record of income payment, unless a reliable record is not reasonably available;
- Verify the consumer's monthly debt obligations using a national consumer report and a consumer report from a registered information system as defined by the rule;
- Verify the consumer's monthly housing costs using a national consumer report if possible, or otherwise rely on the consumer's written statement of monthly housing expenses;
- Forecast a reasonable amount for basic living expenses, other than debt obligations and housing costs; and
- Determine the consumer's ability to repay the loan based on the lender's projections of the consumer's residual income or debt-to-income ratio.

The rule also prohibits lenders from making a covered loan to a consumer who has already taken out three covered short-term or longer-term balloon-payment loans within 30 days of each other, or for 30 days after the third loan is not outstanding.

The rule exempts certain loans from the underwriting criteria prescribed in the rule if they have specific consumer protections. Under the exemption, a lender may make up to three covered short-term loans in short succession, provided that the first loan has a principal amount no larger than \$500, the second loan has a principal amount at least one-third smaller than the principal amount on the first loan, and the third loan has a principal amount at least two-thirds smaller than the principal amount on the first loan. A lender may not make a covered short-term loan under the exemption if it would result in the consumer having more than six covered short-term loans during a consecutive 12-month period or being in debt for more than 90 days on covered short-term loans during a consecutive 12-month period.

Payment Practices

The rule makes it an unfair and abusive practice for a lender to attempt to withdraw payment from consumers' accounts after two consecutive failed payments, unless the consumer provides a new, specific authorization to do so. This applies to the same loans as the ability to repay requirement, and also applies to specified high-cost longer-term loans. Lenders must provide notices to consumers when the prohibition has been triggered and follow certain procedures in obtaining new authorizations.

Lenders must also provide written notice, depending on means of delivery, a certain number of days before its first attempt to withdraw payment for a covered loan from a consumer's checking, savings, or prepaid account. Notice is also required before the lender attempts to withdraw a payment in a different amount than the regularly scheduled payment amount, on a date other than the regularly scheduled payment date, by a different payment channel than the prior payment, or to re-initiate a returned prior transfer. The notice must contain specified information about the upcoming payment attempt and, if applicable, alter the consumer to unusual payment attempts. The notice may be provided electronically with the consumer's consent.

Lender Reporting and Compliance Requirements

The rule requires lenders to furnish to registered information systems certain information concerning loans covered by the rule. Information must be submitted at loan consummation, during the period that the loan is outstanding, and when the loan ceases to be outstanding. The registered information systems will provide consumer reports that include a reasonably comprehensive record of a consumer's recent and current use of loans addressed by the rule. Before making such loans, a lender must obtain and consider a consumer report from a registered information system.

Lenders must also develop and follow written policies and procedures that are reasonably designed to ensure compliance with the rule. Lenders must also retain the loan agreement, documentation obtained for any covered loan, and electronic records regarding origination calculations and determinations, the type of loan, and the loan terms.

The CFPB rule provides minimum consumer protections and allows State and local jurisdictions to adopt further regulatory measures to protect consumers. Lender compliance with the rule is required on August 19, 2019.

Many Florida deferred presentment transactions are affected by the rule because they are for 45 days or less and do not qualify for one of the rule's exceptions. Thus deferred presentment transaction providers will have to comply with the underwriting requirements of the rule or conform their business practices to meet the exception to underwriting. Deferred presentment transactions made pursuant to SB 920 would be exempt from the underwriting requirement of the CFPB rule because such loans would be for a term longer than 30 days, and would not be a longer-term balloon payment loan because the bill requires installment payment to be as equal as practicable.

III. Effect of Proposed Changes:

The bill authorizes deferred presentment installment transactions under Florida law. Deferred presentment transactions made pursuant to SB 920 would be exempt from the underwriting requirement of the CFPB rule because such loans would be for a term longer than 30 days, and would not be a longer-term balloon payment loan because the bill requires installment payment to be as equal as practicable. Provisions of the CFPB rule relating to payment practices, lender reporting, and compliance will apply to deferred presentment installment transaction lenders that provide loans with a term longer than 45 days, with a cost of credit exceeding 36 percent per annum, and that have a leveraged payment mechanism.

Section 1 amends s. 560.402, F.S., to define a "deferred presentment installment transaction" to mean "a deferred presentment transaction that is repayable in installments."

Section 2 amends s. 560.404, F.S., to authorize deferred presentment installment transactions under Florida law.

The maximum face amount of a check taken for a deferred presentment installment transaction may not exceed \$1,000, exclusive of fees.¹⁷ The term of a deferred presentment installment transaction may not be less than 60 days or more than 90 days. The bill retains current law in s. 560.404(19), F.S., that a provider may not enter into a deferred presentment transaction with any person who has an outstanding deferred presentment transaction or whose previous transaction has been terminated for less than 24 hours.

The maximum fees on a deferred presentment installment transaction that may be charged by a provider or its affiliate are 8 percent of the outstanding transaction balance on a biweekly basis.¹⁸ Fees for a deferred presentment installment transaction are calculated using simple interest. Prepayment penalties are prohibited.

A deferred presentment installment transaction must be fully amortizing (the balance due will be entirely paid after the last payment is made) and repayable in substantially equal and consecutive installments. The time between installment payments must be at least 13 days but not greater than 1 calendar month.

The provider must provide a grace period for payment of a scheduled installment if the drawer informs the deferred presentment installment transaction provider in writing or in person by noon of the business day before a scheduled payment. The grace period postpones the due date of an installment until after the last scheduled installment payment, at an interval which is no less than the intervals between the originally scheduled payments. Thus, for a deferred presentment installment transaction in which payments are due once every 2 weeks, the grace period must be at least 2 weeks after the final installment payment is due.

The bill amends the notice that must be prominently posted by the provider and included in the deferred presentment agreement.¹⁹ The notice will now detail the availability of the single grace period for a deferred presentment installment transaction.

Section 3 amends s. 560.405, F.S., to allow a deferred presentment provider to present a check before the end of a deferment period if the check is for a missed scheduled payment for a deferred presentment installment transaction. A technical amendment is also made clarifying that the drawer (customer) may redeem the check used in the deferred presentment transaction by paying the outstanding transaction balance and earned fees.

Section 4 reenacts s. 560.111, F.S., for the purpose of incorporating the amendments made by the bill to ss. 560.404 and 560.405, F.S. Section 560.111, F.S., makes willful violations of those sections a third degree felony.

Section 5 provides an effective date of July 1, 2018.

¹⁷ See s. 560.404(5), F.S.

¹⁸ See s. 560.404(6), F.S.

¹⁹ See s. 460.404(20), F.S.

IV. Constitutional Issues:**A. Municipality/County Mandates Restrictions:**

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

The bill allows the deferred presentment transaction database fee to vary with the term of the loan, thus increasing the total possible database fee from \$1 to \$3.

B. Private Sector Impact:

The bill will generally raise the fees that customers must pay to engage in a deferred presentment transaction. The Office of Financial Regulation provided a comparison between a payday loan under SB 920 of \$1,000 with a 60 day term and two current payday loan transactions totaling \$1,000:²⁰

Loan Comparison	Current Loan 1	Current Loan 2	Current Loan Total	SB 920 Loan
Loan Amount	\$500.00	\$500.00	\$1,000.00	\$1,000.00
Fees	\$55.00	\$55.00	\$110.00	\$214.68
Term (days)	30	30	60	60
Payments	1	1	2	4
Payment Amount	\$555.00	\$555.00	\$555.00	\$216.96
Total Payment	\$555.00	\$555.00	\$1,110.00	\$1,216.96

There are circumstances where the new loan would result in lower fees than a current payday loan. For instance, if the drawer (customer) redeems the check on a SB 920 loan after 14 days, only 8 percent fees would be owing and due, whereas a redemption after 14 days of a current payday loan would still require the payment of 10 percent in fees.

Many payday lenders assert that the CFPB rule imposes additional costs and administrative burdens that will result in reducing the availability of deferred presentment transactions. Some consumer advocates assert that the CFPB rule provides necessary safeguards to prevent consumers from being caught in debt traps.

²⁰ Office of Financial Regulation, *2018 Agency Legislative Bill Analysis for Senate Bill 920* (December 28, 2017) (On file with the Senate Committee on Banking and Insurance).

C. Government Sector Impact:**Office of Financial Regulation²¹**

The Office of Financial Regulation assesses each deferred present provider a \$1 transaction fee for each deferred presentment transaction to maintain an Internet database that records all deferred presentment transactions in the state. Deferred presentment providers and the OFR use the database to verify whether any deferred presentment transactions are outstanding for a particular person. The database is required by s. 560.404(23), F.S. The OFR anticipates imposing a \$2 fee for deferred presentment installment transactions with a 60-day term and a \$3 fee for transactions with a 90-day term. Because the impact of the bill on the number of transactions is unknown, the impact of the bill on these revenues is indeterminate. The OFR received \$7,657,486 in revenue related to the \$1 transaction fee during fiscal year 2016-2017.

The OFR contracts with a third-party vendor that maintains a database that records all deferred presentment transactions in the state, the cost of which is directly related to the number of deferred presentment transactions and database fees collected. For fiscal year 2016-2017, the OFR paid its third-party vendor \$2,656,269 for hosting, maintaining, and operating the database. The bill may increase or decrease this cost if the statutory authorization of deferred presentment installment transactions increases or decreases the number of deferred presentment transactions.

The bill would require modifications to the database, which the OFR would obtain through a procurement requiring a legislative budget appropriation and between 18 to 24 months to implement. The actual cost would not be known until bids are received from vendors pursuant to the procurement process.

The OFR believes that the provisions of the bill would require the office, through the Financial Services Commission, to amend a number of administrative rules. The cost incurred by the OFR for the rulemaking filings could be absorbed within the current budget of the Division of Consumer Finance.

VI. Technical Deficiencies:

Lines 191 through 200 should be amended to refer to subsection (22) and subsection (23).

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 560.402, 560.404, 560.405, and 560.111.

²¹ Office of Financial Regulation, *2018 Agency Legislative Bill Analysis for Senate Bill 920* (December 28, 2017) (On file with the Senate Committee on Banking and Insurance).

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By Senator Bradley

5-00976-18

2018920__

1 A bill to be entitled
 2 An act relating to deferred presentment transactions;
 3 amending s. 560.402, F.S.; defining the term "deferred
 4 presentment installment transaction"; amending s.
 5 560.404, F.S.; specifying the maximum face amount of
 6 checks which may be taken for deferred presentment
 7 installment transactions, exclusive of fees;
 8 specifying the maximum rate and frequency of fees that
 9 deferred presentment providers or their affiliates may
 10 charge on deferred presentment installment
 11 transactions; specifying when fees are earned for
 12 certain deferred presentment transactions; specifying
 13 the calculation of fees earned for deferred
 14 presentment installment transactions; prohibiting
 15 prepayment penalties; specifying the minimum and
 16 maximum terms of a deferred presentment installment
 17 transaction; providing an exception to a prohibition
 18 against the acceptance or holding of undated checks or
 19 checks with certain dates by a preferred presentment
 20 provider or its affiliate; conforming a cross-
 21 reference; revising a notice in deferred presentment
 22 agreements; providing an exception to a prohibition,
 23 under certain circumstances, against a deferred
 24 presentment provider's deposit or presentment of a
 25 drawer's check; requiring a provider of a deferred
 26 presentment installment transaction to allow a drawer
 27 to defer a scheduled payment under certain
 28 circumstances; providing requirements for the deferred
 29 payment; specifying the frequency a certain fee may be

Page 1 of 13

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

5-00976-18

2018920__

30 imposed by Financial Services Commission rule for data
 31 on certain transactions submitted by deferred
 32 presentment providers to a certain database; providing
 33 an exception to a limitation on a deferred presentment
 34 provider's acceptance of a certain check or
 35 authorization; specifying requirements for
 36 amortization, installment repayments, and calculation
 37 of charges for deferred presentment installment
 38 transactions; conforming provisions to changes made by
 39 the act; amending s. 560.405, F.S.; providing an
 40 exception to a prohibition against a deferred
 41 presentment provider's or its affiliate's presentment
 42 of a drawer's check before the end of the deferment
 43 period; revising a condition under which a deferred
 44 presentment provider may allow the check to be
 45 redeemed in lieu of presentment; revising a
 46 prohibition against requiring a drawer to redeem his
 47 or her check before the agreed-upon date; reenacting
 48 s. 560.111(5), F.S., relating to prohibited acts, to
 49 incorporate the amendments made to ss. 560.404 and
 50 560.405, F.S., in references thereto; providing an
 51 effective date.

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

54
 55 Section 1. Present subsections (3) through (7) of section
 56 560.402, Florida Statutes, are redesignated as subsections (4)
 57 through (8), respectively, and a new subsection (3) is added to
 58 that section, to read:

Page 2 of 13

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

5-00976-18

2018920

59 560.402 Definitions.—For the purposes of this part, the
60 term:

61 (3) "Deferred presentment installment transaction" means a
62 deferred presentment transaction that is repayable in
63 installments.

64 Section 2. Subsections (5), (6), (8), and (14), paragraph
65 (b) of subsection (19), and subsections (20), (21), and (22) of
66 section 560.404, Florida Statutes, are amended, present
67 subsections (23) and (24) of that section are redesignated as
68 subsections (24) and (25), respectively, and amended, and a new
69 subsection (23) and subsection (26) are added to that section,
70 to read:

71 560.404 Requirements for deferred presentment
72 transactions.—

73 (5) The face amount of a check taken for deferred
74 presentment may not exceed \$500, exclusive of the fees allowed
75 under this part. The face amount of a check taken for a deferred
76 presentment installment transaction may not exceed \$1,000,
77 exclusive of fees allowed under this part.

78 (6) (a) A deferred presentment provider or its affiliate may
79 not charge fees that exceed 10 percent of the currency or
80 payment instrument provided. A deferred presentment provider or
81 its affiliate may not charge fees on any deferred presentment
82 installment transaction which exceed 8 percent of the
83 outstanding transaction balance on a biweekly basis.

84 (b) Notwithstanding paragraph (a) ~~However~~, a verification
85 fee may be charged as provided in s. 560.309(8). The fees in
86 paragraph (a) ~~The 10-percent fee~~ may not be applied to the
87 verification fee.

5-00976-18

2018920

88 (c) Fees are earned at the time of origination for a
89 deferred presentment transaction scheduled to be paid off in 31
90 days or less; however, fees for a deferred presentment
91 installment transaction are earned using a simple interest
92 calculation. A deferred presentment provider may charge only
93 those fees specifically authorized in this section. Prepayment
94 penalties are prohibited.

95 (8) A deferred presentment agreement may not be for a term
96 longer than 31 days or less than 7 days, except for a deferred
97 presentment installment transaction, which may not be for a term
98 longer than 90 days or less than 60 days.

99 (14) A deferred presentment provider or its affiliate may
100 not accept or hold an undated check or a check dated on a date
101 other than the date on which the deferred presentment provider
102 agreed to hold the check and signed the deferred presentment
103 transaction agreement, except when a customer provides a new
104 payment instrument reflecting the new outstanding transaction
105 balance and anticipated fees upon making a payment on a deferred
106 presentment installment transaction.

107 (19) A deferred presentment provider may not enter into a
108 deferred presentment transaction with a drawer who has an
109 outstanding deferred presentment transaction with that provider
110 or with any other deferred presentment provider, or with a
111 person whose previous deferred presentment transaction with that
112 provider or with any other provider has been terminated for less
113 than 24 hours. The deferred presentment provider must verify
114 such information as follows:

115 (b) The deferred presentment provider shall access the
116 office's database established pursuant to subsection (24) ~~(23)~~

5-00976-18

2018920__

and shall verify whether any other deferred presentment provider has an outstanding deferred presentment transaction with a particular person or has terminated a transaction with that person within the previous 24 hours. If a provider has not established a database, the deferred presentment provider may rely upon the written verification of the drawer as provided in subsection (20).

(20) A deferred presentment provider shall provide the following notice in a prominent place on each deferred presentment agreement in at least 14-point type in substantially the following form and must obtain the signature of the drawer where indicated:

NOTICE

1. STATE LAW PROHIBITS YOU FROM HAVING MORE THAN ONE DEFERRED PRESENTMENT AGREEMENT AT ANY ONE TIME. STATE LAW ALSO PROHIBITS YOU FROM ENTERING INTO A DEFERRED PRESENTMENT AGREEMENT WITHIN 24 HOURS AFTER TERMINATING ANY PREVIOUS DEFERRED PRESENTMENT AGREEMENT. FAILURE TO OBEY THIS LAW COULD CREATE SEVERE FINANCIAL HARDSHIP FOR YOU AND YOUR FAMILY.

YOU MUST SIGN THE FOLLOWING STATEMENT:

I DO NOT HAVE AN OUTSTANDING DEFERRED PRESENTMENT AGREEMENT WITH ANY DEFERRED PRESENTMENT PROVIDER AT THIS TIME. I HAVE NOT TERMINATED A DEFERRED PRESENTMENT AGREEMENT WITHIN THE PAST 24 HOURS.

Page 5 of 13

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

5-00976-18

2018920__

(Signature of Drawer)

2. YOU CANNOT BE PROSECUTED IN CRIMINAL COURT FOR A CHECK WRITTEN UNDER THIS AGREEMENT, BUT ALL LEGALLY AVAILABLE CIVIL MEANS TO ENFORCE THE DEBT MAY BE PURSUED AGAINST YOU.

3. STATE LAW PROHIBITS A DEFERRED PRESENTMENT PROVIDER (THIS BUSINESS) FROM ALLOWING YOU TO "ROLL OVER" YOUR DEFERRED PRESENTMENT TRANSACTION. THIS MEANS THAT YOU CANNOT BE ASKED OR REQUIRED TO PAY AN ADDITIONAL FEE IN ORDER TO FURTHER DELAY THE DEPOSIT OR PRESENTMENT OF YOUR CHECK FOR PAYMENT.

4. FOR DEFERRED PRESENTMENT TRANSACTIONS NOT PAYABLE IN INSTALLMENTS: IF YOU INFORM THE PROVIDER IN PERSON THAT YOU CANNOT COVER THE CHECK OR PAY IN FULL THE AMOUNT OWING AT THE END OF THE TERM OF THIS AGREEMENT, YOU WILL RECEIVE A GRACE PERIOD EXTENDING THE TERM OF THE AGREEMENT FOR AN ADDITIONAL 60 DAYS AFTER THE ORIGINAL TERMINATION DATE, WITHOUT ANY ADDITIONAL CHARGE. THE DEFERRED PRESENTMENT PROVIDER SHALL REQUIRE THAT YOU, AS A CONDITION OF OBTAINING THE GRACE PERIOD, COMPLETE CONSUMER CREDIT COUNSELING PROVIDED BY AN AGENCY INCLUDED ON THE LIST THAT WILL BE PROVIDED TO YOU BY THIS PROVIDER. YOU MAY ALSO AGREE TO COMPLY WITH AND ADHERE TO A REPAYMENT PLAN APPROVED BY THAT AGENCY. IF YOU DO NOT COMPLY WITH AND ADHERE TO A REPAYMENT PLAN APPROVED BY THAT AGENCY, WE

Page 6 of 13

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

5-00976-18

2018920__

175 MAY DEPOSIT OR PRESENT YOUR CHECK FOR PAYMENT AND
 176 PURSUE ALL LEGALLY AVAILABLE CIVIL MEANS TO ENFORCE
 177 THE DEBT AT THE END OF THE 60-DAY GRACE PERIOD.

178
 179 5. FOR DEFERRED PRESENTMENT INSTALLMENT TRANSACTIONS:
 180 IF YOU INFORM THE PROVIDER IN PERSON THAT YOU CANNOT
 181 PAY IN FULL THE SCHEDULED AMOUNT OWING BEFORE THE DUE
 182 DATE AS PROVIDED BY THE AGREEMENT, YOU MAY DEFER THE
 183 SCHEDULED PAYMENT, WITHOUT ANY ADDITIONAL FEES OR
 184 CHARGES, AND THE PROVIDER MAY NOT DEFAULT THE ACCOUNT
 185 AND ACCELERATE THE FULL BALANCE. YOU MAY REQUEST ONLY
 186 ONE DEFERRED PAYMENT PER LOAN. THE DEFERRED PAYMENT
 187 WILL BE ADDED AFTER THE LAST SCHEDULED PAYMENT AND IS
 188 DUE AT AN INTERVAL NO LESS THAN THE INTERVALS BETWEEN
 189 THE SCHEDULED PAYMENTS.

190
 191 (21) The deferred presentment provider may not deposit or
 192 present the drawer's check if the drawer informs the provider in
 193 person that the drawer cannot redeem or pay in full in cash the
 194 amount due and owing the deferred presentment provider without
 195 first complying with subsection (23). No additional fees or
 196 penalties may be imposed on the drawer by virtue of any
 197 misrepresentation made by the drawer as to the sufficiency of
 198 funds in the drawer's account. Additional fees may not be added
 199 to the amounts due and owing to the deferred presentment
 200 provider.

201 (22) As to deferred presentment transactions not payable in
 202 installments, if, by the end of the deferment period, the drawer
 203 informs the deferred presentment provider in person that the

5-00976-18

2018920__

204 drawer cannot redeem or pay in full in cash the amount due and
 205 owing the deferred presentment provider, the deferred
 206 presentment provider shall provide a grace period extending the
 207 term of the agreement for an additional 60 days after the
 208 original termination date, without any additional charge.

209 (a) The provider shall require ~~that~~ as a condition of
 210 providing a grace period, that the drawer make an appointment
 211 with a consumer credit counseling agency within 7 days after the
 212 end of the deferment period and complete the counseling by the
 213 end of the grace period. The drawer may agree to, comply with,
 214 and adhere to a repayment plan approved by the counseling
 215 agency. If the drawer agrees to comply with and adhere to a
 216 repayment plan approved by the counseling agency, the provider
 217 must also comply with and adhere to that repayment plan. The
 218 deferred presentment provider may not deposit or present the
 219 drawer's check for payment before the end of the 60-day grace
 220 period unless the drawer fails to comply with such conditions or
 221 the drawer fails to notify the provider of such compliance.
 222 Before each deferred presentment transaction, the provider may
 223 verbally advise the drawer of the availability of the grace
 224 period consistent with the written notice in subsection (20),
 225 and may not discourage the drawer from using the grace period.

226 (b) At the commencement of the grace period, the deferred
 227 presentment provider shall provide the drawer:

228 1. Verbal notice of the availability of the grace period
 229 consistent with the written notice in subsection (20).

230 2. A list of approved consumer credit counseling agencies
 231 prepared by the office. The office list shall include nonprofit
 232 consumer credit counseling agencies affiliated with the National

5-00976-18

2018920__

Foundation for Credit Counseling which provide credit counseling services to state residents in person, by telephone, or through the Internet. The office list must include phone numbers for the agencies, the counties served by the agencies, and indicate the agencies that provide telephone counseling and those that provide Internet counseling. The office shall update the list at least once each year.

3. The following notice in at least 14-point type in substantially the following form:

AS A CONDITION OF OBTAINING A GRACE PERIOD EXTENDING THE TERM OF YOUR DEFERRED PRESENTMENT AGREEMENT FOR AN ADDITIONAL 60 DAYS, UNTIL [DATE], WITHOUT ANY ADDITIONAL FEES, YOU MUST COMPLETE CONSUMER CREDIT COUNSELING PROVIDED BY AN AGENCY INCLUDED ON THE LIST THAT WILL BE PROVIDED TO YOU BY THIS PROVIDER. YOU MAY ALSO AGREE TO COMPLY WITH AND ADHERE TO A REPAYMENT PLAN APPROVED BY THE AGENCY. THE COUNSELING MAY BE IN PERSON, BY TELEPHONE, OR THROUGH THE INTERNET. YOU MUST NOTIFY US WITHIN 7 DAYS, BY [DATE], THAT YOU HAVE MADE AN APPOINTMENT WITH A CONSUMER CREDIT COUNSELING AGENCY. YOU MUST ALSO NOTIFY US WITHIN 60 DAYS, BY [DATE], THAT YOU HAVE COMPLETED THE CONSUMER CREDIT COUNSELING. WE MAY VERIFY THIS INFORMATION WITH THE AGENCY. IF YOU FAIL TO PROVIDE THE 7-DAY OR 60-DAY NOTICE, OR IF YOU HAVE NOT MADE THE APPOINTMENT OR COMPLETED THE COUNSELING WITHIN THE TIME REQUIRED, WE MAY DEPOSIT OR PRESENT YOUR CHECK FOR PAYMENT AND PURSUE ALL LEGALLY AVAILABLE CIVIL MEANS TO ENFORCE

5-00976-18

2018920__

THE DEBT.

(c) If a drawer completes an approved payment plan, the deferred presentment provider shall pay one-half of the drawer's fee for the deferred presentment agreement to the consumer credit counseling agency.

(23) As to deferred presentment installment transactions, if a drawer informs the deferred presentment installment transaction provider in writing or in person by noon of the business day before a scheduled payment that the drawer cannot pay in full the scheduled payment amount due and owing the deferred presentment installment provider, the deferred presentment installment provider must provide the drawer the opportunity to defer the scheduled payment, at no additional fee or charges, until after the last scheduled payment. Such deferred payment must be due at an interval after the last scheduled payment which is no less than the intervals between the originally scheduled payments.

~~(24)~~ The office shall implement a common database with real-time access through an Internet connection for deferred presentment providers, as provided in this subsection. The database must be accessible to the office and the deferred presentment providers in order to verify whether any deferred presentment transactions are outstanding for a particular person. Deferred presentment providers shall submit such data before entering into each deferred presentment transaction in such format as required by rule, including the drawer's name, social security number or employment authorization alien number, address, driver license number, amount of the transaction, date

5-00976-18

2018920

291 of transaction, the date that the transaction is closed, and
 292 such additional information as is required by rule. The
 293 commission may by rule impose a fee of up to \$1 per transaction,
 294 or for each month that a balance is scheduled to be outstanding
 295 on transactions that have multiple scheduled payments, for data
 296 that must be submitted by a deferred presentment provider. A
 297 deferred presentment provider may rely on the information
 298 contained in the database as accurate and is not subject to any
 299 administrative penalty or civil liability due to relying on
 300 inaccurate information contained in the database. A deferred
 301 presentment provider must notify the office, in a manner as
 302 prescribed by rule, within 15 business days after ceasing
 303 operations or no longer holding a license under part II or part
 304 III of this chapter. Such notification must include a
 305 reconciliation of all open transactions. If the provider fails
 306 to provide notice, the office shall take action to
 307 administratively release all open and pending transactions in
 308 the database after the office becomes aware of the closure. This
 309 section does not affect the rights of the provider to enforce
 310 the contractual provisions of the deferred presentment
 311 agreements through any civil action allowed by law. The
 312 commission may adopt rules to administer this subsection and to
 313 ensure that the database is used by deferred presentment
 314 providers in accordance with this section.

315 (25)-(24) A deferred presentment provider may not accept
 316 more than one check or authorization to initiate more than one
 317 automated clearinghouse transaction to collect on a deferred
 318 presentment transaction for a single deferred presentment
 319 transaction, except for deferred presentment installment

Page 11 of 13

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

5-00976-18

2018920

320 transactions in which such checks or authorizations represent
 321 multiple scheduled payments.

322 (26) A deferred presentment installment transaction must be
 323 fully amortizing and repayable in substantially equal and
 324 consecutive installments according to a payment schedule agreed
 325 upon by the parties with no less than 13 days and not more than
 326 1 calendar month between payments, except that the first
 327 installment period may be longer than the remaining installment
 328 periods by not more than 15 days, and the first installment
 329 payment may be larger than the remaining installment payments by
 330 the amount of charges applicable to the extra days. In
 331 calculating charges under this subsection, when the first
 332 installment period is longer than the remaining installment
 333 periods, the amount of the charges applicable to the extra days
 334 may not exceed those that would accrue under a simple interest
 335 calculation based on the rates allowed under subsection (6).

336 Section 3. Subsections (1), (3), and (4) of section
 337 560.405, Florida Statutes, are amended to read:

338 560.405 Deposit; redemption.—

339 (1) The deferred presentment provider or its affiliate may
 340 not present the drawer's check before the end of the deferment
 341 period, except for a missed scheduled payment for a deferred
 342 presentment installment transaction, as reflected and described
 343 in the deferred presentment transaction agreement.

344 (3) Notwithstanding subsection (1), in lieu of presentment,
 345 a deferred presentment provider may allow the check to be
 346 redeemed at any time upon payment of the outstanding transaction
 347 balance and earned fees ~~face amount of the drawer's check.~~
 348 However, payment may not be made in the form of a personal

Page 12 of 13

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

5-00976-18

2018920__

349 check. Upon redemption, the deferred presentment provider shall
350 return the drawer's check and provide a signed, dated receipt
351 showing that the drawer's check has been redeemed.

352 (4) A drawer may not be required to redeem his or her check
353 in full before the agreed-upon date; however, the drawer may
354 choose to redeem the check before the agreed-upon presentment
355 date.

356 Section 4. For the purpose of incorporating the amendments
357 made by this act to sections 560.404 and 560.405, Florida
358 Statutes, in references thereto, subsection (5) of section
359 560.111, Florida Statutes, is reenacted to read:

360 560.111 Prohibited acts.—

361 (5) Any person who willfully violates any provision of s.
362 560.403, s. 560.404, or s. 560.405 commits a felony of the third
363 degree, punishable as provided in s. 775.082, s. 775.083, or s.
364 775.084.

365 Section 5. This act shall take effect July 1, 2018.



The Florida Senate

Committee Agenda Request

To: Senator Anitere Flores, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: December 4, 2017

I respectfully request that **Senate Bill # 920**, relating to Deferred Presentment Transactions, be placed on the:

- ☒ committee agenda at your earliest possible convenience.
- ☐ next committee agenda.

A handwritten signature in black ink, appearing to read "Rob Bradley", is written over a horizontal line.

Senator Rob Bradley
Florida Senate, District 5

THE FLORIDA SENATE

APPEARANCE RECORD

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

Jan 16 2018
Meeting Date

SB 920
Bill Number (if applicable)

Topic Deferred Presentments Transactions

Amendment Barcode (if applicable)

Name Dorene Barker

Job Title Associate State Director

Address 200 W. College Ave
Street

Phone 850 228-6387

Tall FL 32303
City State Zip

Email dobarker@aarfp.org

Speaking: ☐ For ☒ Against ☐ Information

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

Representing AARP Florida

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

APPEARANCE RECORD

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

1/16/18

Meeting Date

SB 920

Bill Number (if applicable)

Topic ~~DEFER~~ DEFERRED PRESENTMENT INSTALLMENT Amendment Barcode (if applicable)Name IAN A. MACHECHNIEJob Title EXEC. VICE CHAIR.Address 600 N. WESTSHORE BLVD #1200Phone 813-637-6205

Street

TAMPAFL33629

City

State

Zip

Email iamachechaie@amscot.comSpeaking: ☒ For ☐ Against ☐ InformationWaive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)Representing AMSCOT FINANCIAL + FCFSAAppearing at request of Chair: ☐ Yes ☒ NoLobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

THE FLORIDA SENATE
APPEARANCE RECORD

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

1/16/18
Meeting Date

920
Bill Number (if applicable)

Topic Deferred Presentment Transactions

Amendment Barcode (if applicable)

Name Pamela Burch Fort

Job Title _____

Address 104 S. Monroe Street
Street
Tallahassee FL 32301
City State Zip

Phone 850-425-1344

Email TcgLobby@aol.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Conference of NAACP Branches

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting

THE FLORIDA SENATE
APPEARANCE RECORD

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

1-16-18

Meeting Date

920

Bill Number (if applicable)

Topic

Predatory Lending

Amendment Barcode (if applicable)

Name

Brian DeVane (DeVane)

Job Title

MS

Address

1225 E. Brevard St

Phone

251-4280

Street

Jacksonville

FL

32308

Email

briandevane1@yahoo.com

City

State

Zip

Speaking:

☐

For

☐

Against

☐

Information

Waive Speaking:

☐

In Support

☒

Against

(The Chair will read this information into the record.)

Representing

FL Alliance for Retired Americans

Appearing at request of Chair:

☐

Yes

☐

No

Lobbyist registered with Legislature:

☒

Yes

☐

No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

APPEARANCE RECORD

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

Meeting Date

Bill Number (if applicable)

Topic

Amendment Barcode (if applicable)

Name

Job Title

Address

Street

City

State

Zip

Phone

Email

Speaking: ☒ For ☐ Against ☐ Information

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

Representing

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

APPEARANCE RECORD

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

SB 920

Bill Number (if applicable)

Meeting Date _____

Topic SB 920

Amendment Barcode (if applicable) _____

Name Kendrick

Job Title Former Congressman / Former Senator

Address _____

Phone _____

Street

Miami

FL

State

Zip

Email _____

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Financial Services Center of FL

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/16/18

Meeting Date

SB 920

Bill Number (if applicable)

Topic

SB 920

Amendment Barcode (if applicable)

Name

ALVOY d ANTHONY SANDERS

Job Title

PASTOR - BOARD MEMBER - SCLC / FLA MINORITY CONSUMER ALLIANCE

Address

632 W HALLANDALE BEACH

Phone

954 454 9696

Street

HALLANDALE BEACH FL.

33009

Email

sanderbag1005@gmail.com

City

State

Zip

Speaking:

☒

For

☐

Against

☐

Information

Waive Speaking:

☐

In Support

☐

Against

(The Chair will read this information into the record.)

Representing

HIGHER VISION MINISTRIES

Appearing at request of Chair:

☐

Yes

☐

No

Lobbyist registered with Legislature:

☐

Yes

☐

No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

JAN 16, 2018

Meeting Date

SB 920

Bill Number (if applicable)

Topic SB 920

Amendment Barcode (if applicable)

Name RODERICK CUNNINGHAM

Job Title VICE PRESIDENT, PINELLAS COUNTY URBAN LEAGUE

Address 150 COMMONWEALTH COURT N.

Street

Phone 813-380-8045

ST. PETE, FL 33716

City

State

Zip

Email

Speaking: ☒ For ☐ Against ☐ Information

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

Representing URBAN LEAGUE

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

THE FLORIDA SENATE
APPEARANCE RECORD

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

1/16/18

Meeting Date

920

Bill Number (if applicable)

Topic Deferred Presentment

Amendment Barcode (if applicable)

Name Arthur Rosenberg

Job Title Attorney

Address 3000 Biscayne BLVD, #106

Phone 407-801-4713

Street

Miami

City

FL

State

33137

Zip

Email arthur@floridalegal.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Legal Services

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

11/14/18
Meeting Date

920
Bill Number (if applicable)

Topic SB 920

Amendment Barcode (if applicable)

Name Joseph Gibbons

Job Title President A. Gibbons Consult.

Address 300 Three Islands Blvd

Phone (954) 684-1880

Street
Holladay Beach, FL

Email jg923480@gmail.com

City State Zip

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Amsoft Financial

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

APPEARANCE RECORD

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

1/16/18

Meeting Date

SB 920

Bill Number (if applicable)

Topic SB 920

Amendment Barcode (if applicable)

Name Dwight Gibbons

Job Title Amstat Financial / SRE Vice President

Address 1050 18th Ave S. St. Pete

Phone 727 452-0970

Street

St. Pete

City

State

33705

Zip

Email

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Amstat Financial

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

APPEARANCE RECORD

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

01/16/18

Meeting Date

SB 920

Bill Number (if applicable)

Topic

SB 920

Amendment Barcode (if applicable)

Name

Rev. Dr. Wayne E. Wilson

Job Title

Pastor / Retired Educator

Address

6791 Colony Dr. S.

Street

Phone

(727) 867-1022

St. Petersburg, FL

City

State

33705

Zip

Email

revwayne.wilson@hotmail.com

Speaking:

☒

For

☐

Against

☐

Information

Waive Speaking:

☐

In Support

☐

Against

(The Chair will read this information into the record.)

Representing

United Community Church / Students / St. Pete Community

Appearing at request of Chair:

☐

Yes

☐

No

Lobbyist registered with Legislature:

☐

Yes

☐

No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/16/18

Meeting Date

920

Bill Number (if applicable)

Topic Deferred Presentment Transaction

Amendment Barcode (if applicable)

Name Jared Ross

Job Title SVP, Governmental Affairs

Address 3692 Coolidge Ct

Phone (850) 322-6956

Street

Tallahassee

City

FL

State

32311

Zip

Email jared.ross@scu.coop

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Credit Union Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

APPEARANCE RECORD1/16/18

Meeting Date

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

SB 920

Bill Number (if applicable)

Topic

Deferred Presentment Providers

Amendment Barcode (if applicable)

Name

Rev. James T. Golden, Esq.

Job Title

AME Church - Social Action Director

Address

P.O.B. 299

Phone

941-773-4031

Street

Bradenton, FL

State

Zip

34206

Email

jame the gold@aol.com

Speaking:

☐

For

☒

Against

☐

Information

Waive Speaking:

☐

In Support

☒

Against

(The Chair will read this information into the record.)

Representing

11th Episcopal District - African Methodist Episcopal Church

Appearing at request of Chair:

☐

Yes

☒

No

Lobbyist registered with Legislature:

☐

Yes

☒

No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

APPEARANCE RECORD

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

Meeting Date _____

SB 920
Bill Number (if applicable)

Topic SB 920

Amendment Barcode (if applicable) _____

Name Rev. Troy A. Adams Sr.

Job Title Pastor

Address 1715 18th Ave. South

Phone 227-318-9663

Street

St. Petersburg

FL

State

33712

Zip

Email njmbe@live.com

Speaking: ☒ For ☐ Against ☐ Information

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

Representing New Jerusalem M. B. Church

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

THE FLORIDA SENATE

APPEARANCE RECORD

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

1-16-18

Meeting Date

SB 920

Bill Number (if applicable)

Topic SB 920

Amendment Barcode (if applicable)

Name DR. Evelyn Bethune

Job Title CEO

Address 732 Orange Ave

Street

Phone 386-265-3733

Daytona Beach FL 32114

City

State

Zip

Email docbethune@gmail.com

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Mary McLeod Bethune Legacy Foundation

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

APPEARANCE RECORD

1/16/18

Meeting Date

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

SB 920

Bill Number (if applicable)

Topic

Deferred Presentation Providers

Amendment Barcode (if applicable)

Name

Rev. Rachel Gunter Shepard

Job Title

Assoc. Coordinator Cooperative Baptist Fellowship of FL

Address

9430 Kells Rd.

Phone

904-502-5158

Street

Jacksonville, FL

State

32257

Zip

Email

rshapard12@florida
cbf.org

Speaking:

☐

For

☒

Against

☐

Information

Waive Speaking:

☐

In Support

☒

Against

(The Chair will read this information into the record.)

Representing

Cooperative Baptist Fellowship of FL

Appearing at request of Chair:

☐

Yes

☒

No

Lobbyist registered with Legislature:

☐

Yes

☒

No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

APPEARANCE RECORD

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

1/16/18
Meeting Date920
Bill Number (if applicable)Topic Deferred Presentment Provider

Amendment Barcode (if applicable)

Name Alie VickersJob Title AttorneyAddress 623 Beard St.
StreetPhone 850 556 3121Tallahassee, FL 32303
City State ZipEmail alievickers@flcp.orgSpeaking: ☒ For ☒ Against ☐ InformationWaive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)Representing FL Alliance for Consumer ProtectionAppearing at request of Chair: ☐ Yes ☒ NoLobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

THE FLORIDA SENATE
APPEARANCE RECORD

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

1/16/18
Meeting Date

SB 920
Bill Number (if applicable)

Topic Deferred Presentation Transactions

Amendment Barcode (if applicable)

Name Brewster Bevis

Job Title Senior VP

Address 516 W Adams St

Phone 224-7175

Street

TLH

City

FL

State

Zip

Email bbevis@aif.ca

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Associated Industries of Florida

Appearing at request of Chair: ☐ Yes ☒ No Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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

S-001 (10/14/14)

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: SB 1168

INTRODUCER: Senator Steube

SUBJECT: Insurance

DATE: January 12, 2018

REVISED: _____

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Billmeier	Knudson	BI	Pre-meeting
2. _____	_____	JU	_____
3. _____	_____	RC	_____

I. Summary:

SB 1168 creates new requirements for assignment of post-loss benefits from personal residential property insurance policies. The bill does not allow personal lines residential or commercial residential property insurance policies to prohibit the post-loss assignment of benefits. It provides, however, that an agreement to assign post-loss benefits is not valid unless the agreement:

- Is in writing;
- Is limited to claims for work performed or work to be performed by the assignee;
- Contains an accurate and up-to-date statement of the scope of work to be performed;
- Allows the insured to rescind the assignment within 7 days after execution;
- Provides that the insured may be responsible for payment for any work performed before the rescission of the assignment; and
- Contains a notice provision informing the homeowner of certain rights and obligations.

The bill requires the assignee to:

- Provide a copy of the assignment agreement to the insurer within a specified time;
- Provide the insurer with a written estimate of the work to be done; and
- Provide specified notice to the insurer no later than 30 days before initiating litigation against an insurer.

The bill allows the insurer to inspect the property at any time. It provides the acceptance by an assignee of a valid assignment agreement constitutes a waiver by the assignee of any claims, with specified exceptions, against named insureds for payment arising from the loss. This waiver is valid even if the assignment agreement is determined to be invalid.

The bill provides that in a civil action relating to a residential homeowner's property insurance claim under a policy in which an assignment agreement was executed, a proposal for settlement may be made by any party no earlier than 30 days after the civil action has commenced.

The bill requires each insurer to report specified data on each residential property claim paid pursuant to an assignment agreement in the prior calendar year to the Office of Insurance Regulation (OIR).

The bill restricts an insurer's ability to deny claims or rescind a policy based on misrepresentations on insurance applications.

The bill amends s. 627.062, F.S., to provide that attorney fees paid pursuant to s. 627.428, F.S., may not be included in the insurer's rate base and may not be used to justify a rate or rate change. These provisions will bar the use of attorney fees paid pursuant to s. 627.428, F.S., in rate making in property, casualty, surety, motor vehicle, employer liability, title, wet marine, credit life or credit disability, and health insurance.

II. Present Situation:

Insurance Rates (Section 1 of the bill)

Section 627.062, F.S., specifies the rate filing process for property and casualty insurers and provides rating standards for these insurers. The rating law applies to property, casualty and surety insurance and prohibits rates that are excessive, inadequate, or unfairly discriminatory. At the same time, an insurer is allowed a reasonable rate of return. The Office of Insurance Regulation (OIR) regulates insurer rate and form filing.

A rate is excessive if:

- It is likely to produce a profit from Florida business that is unreasonably high in relation to the risk involved or if expenses are unreasonably high in relation to the services rendered.
- The rate structure established by a stock insurance company provides for replenishment of surpluses from premiums, when the replacement is attributable to investment losses.¹

A rate is inadequate if:

- It is clearly insufficient, together with the investment income attributable to them to sustain projected losses and expenses in the class of business to which it applies.
- If discounts or credits are allowed that exceed a reasonable reflection of expense savings and reasonably expected loss experience from the risk or group of risks.²

A rate is unfairly discriminatory if:

- The rating plan, including discounts, credits, or surcharges fails to clearly and equitably reflect consideration of the policyholder's participation in a risk management program pursuant to s. 627.0625, F.S.

¹ ss. 627.062(2)(e)1. and 2., F.S.

² ss. 627.062(2)(e)3. and 5., F.S.

- As to a risk or group of risks, the application of premium discounts, credits, or surcharges among the risks does not bear a reasonable relationship to the expected loss and expense experience among the various risks.³

Section 627.0651, F.S., is the rating law for motor vehicle insurance. It is similar to the law for property. Rates must not be excessive, inadequate, or unfairly discriminatory. At the same time, an insurer is allowed a reasonable rate of return. Workers' compensation insurance rate filings must meet the requirements of ss. 627.062, F.S., and 627.072, F.S.⁴ Section 627.410, F.S., governs health insurance filings and rates. The OIR reviews health insurance filings to determine the reasonableness of benefits in relation to premiums charged.

Attorney Fees in Insurance Litigation

Section 627.428, F.S., provides, in part:

Upon the rendition of a judgment or decree by any of the courts of this state against an insurer and in favor of any named or omnibus insured or the named beneficiary under a policy or contract executed by the insurer, the trial court or, in the event of an appeal in which the insured or beneficiary prevails, the appellate court shall adjudge or decree against the insurer and in favor of the insured or beneficiary a reasonable sum as fees or compensation for the insured's or beneficiary's attorney prosecuting the suit in which the recovery is had.

This statute allows the insured or the insured's assignee⁵ to recover attorney's fees if the insured or assignee prevails in an action against an insurer. Florida courts have interpreted the statute broadly to allow recovery of fees when the insurer ultimately settles the case before trial.⁶ Fees are awarded pursuant to the statute even if the insurer does not act in bad faith.⁷ The Florida Supreme Court recently explained the purpose of the statute:

The need for fee and cost reimbursement in the realm of insurance litigation is deeply rooted in public policy. Namely, the Legislature recognized that it was essential to "level the playing field" between the economically-advantaged and sophisticated insurance companies and the individual citizen. Most assuredly, the average policyholder has neither the finances nor the expertise to single-handedly take on an insurance carrier. Without the funds necessary to compete with an insurance carrier, often a concerned policyholder's only means to take protective action is to hire that expertise in the form of legal counsel... For this reason, the Legislature recognized that an insured is not made whole when an insurer simply

³ ss. 627.062(2)(e)4. and 6., F.S.

⁴ s. 627.151, F.S.

⁵ *All Ways Reliable Bldg. Maintenance, Inc. v. Moore*, 261 So.2d 131 (Fla. 1972).

⁶ *Johnson v. Omega Ins. Co.*, 200 So.3d 1207, 1215 (Fla. 2016) (noting that "it is well settled that the payment of a previously denied claim following the initiation of an action for recovery, but prior to the issuance of a final judgment, constitutes the functional equivalent of a confession of judgment").

⁷ *Johnson v. Omega Ins. Co.*, 200 So.3d 1207, 1216 (Fla. 2016) (noting "the insurer's intentions do not factor into a policyholder's recovery of fees; it is the fact that the denial of benefits was ultimately incorrect that triggers the statute"); *Ins. Co. of N. Am. v. Lexow*, 602 So.2d 928, 531 (Fla. 1992) ("INA's good faith in bringing this suit is irrelevant. If the dispute is within the scope of s. 627.428, F.S., and the insurer loses, the insurer is always obligated for attorney's fees").

grants the previously denied benefits without fees. The reality is that once the benefits have been denied and the plaintiff retains counsel to dispute that denial, additional costs that require relief have been incurred. Section 627.428, F.S., takes these additional costs into consideration and levels the scales of justice for policyholders by providing that the insurer pay the attorney's fees resulting from incorrectly denied benefits.⁸

Attorney Fees in Insurance Rates

Generally, attorney fees, including those paid pursuant to s. 627.428, F.S., are expenses that insurers can use to justify a rate.⁹ However, motor vehicle insurers cannot use attorney fees to justify a rate or rate change if those fees are related to bad faith or punitive damages.¹⁰ Medical malpractice insurers are likewise prohibited from using attorney fees related to bad faith to justify a rate or rate change.¹¹

Section 627.062(10), F.S., provides that an insurer cannot include interest paid to a policyholder when an insurer does not act on a claim within statutory time limits.

Misrepresentations in Insurance Applications (Section 2 of the bill)

Section 627.409, F.S., provides that recovery under an insurance policy may be prevented if a misrepresentation, omission, concealment of fact, or incorrect statement on an application for insurance:

- (1) is fraudulent or is material either to the acceptance of the risk or to the hazard assumed by the insurer; or
- (2) if the true facts had been known to the insurer, the insurer would not have issued the policy, would not have issued it at the same premium rate, would not have issued a policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss.

If an insurer discovers a misrepresentation or omission after issuing the policy, it may deny coverage after a claim is made. In *Nationwide Mutual Fire Insurance Company v. Kramer*,¹² an insurer refused to pay a claim for a stolen automobile because the insureds did not disclose a previous bankruptcy filing. In *Kieser v. Old Line Insurance Company of America*,¹³ an insurance company refused to pay a life insurance policy because the insured failed to disclose certain health conditions and failed to disclose that he was shopping for other life insurance policies. In *Universal Property and Casualty Insurance Company v. Johnson*,¹⁴ an insurance company refused to pay a property insurance claim because the insureds failed to disclose prior criminal

⁸ *Johnson v. Omega Ins. Co.*, 200 So.3d 1207, 1215-1216 (Fla. 2016)(internal citations omitted).

⁹ *See, e.g.*, s. 627.062(2)(b), F.S. (requiring the OIR to consider expenses when reviewing a rate filing).

¹⁰ s. 627.0651(12), F.S.

¹¹ s. 627.062(7)(a), F.S.

¹² 725 So.2d 1141 (Fla. 2^d DCA 1998).

¹³ 712 So.2d 1261 (Fla. 1st DCA 1998).

¹⁴ 114 So.3d 1031 (Fla. 1st DCA 2013).

history. A misrepresentation from or an omission in an insurance application need not be intentional in order for the insurance company to deny recovery.¹⁵

A misrepresentation does not need to have a causal connection to the claim in order for the misrepresentation to be material.¹⁶ One commenter explained the rationale for the general rule:

There is a very sound reason for not requiring a causal connection: such a requirement may encourage fraud. If a loss is caused by something other than the fact misrepresented, there will be coverage. If the cause of loss is connected to the misrepresented fact, the insured has lost nothing, because he wouldn't have had coverage anyway. If the cause of loss is not connected, he has coverage he otherwise couldn't have obtained. Thus, he had nothing to lose by misrepresenting.¹⁷

Assignment of Benefits (Sections 3 and 4 of the bill)

Background on Assignment of Benefits

An assignment is the voluntary transfer of the rights of one party under a contract to another party. Current law generally allows an insurance policyholder to assign the benefits of the policy, such as the right to be paid, to another party. Once an assignment is made, the assignee can take action to enforce the contract. Accordingly, if the benefits are assigned and the insurer refuses to pay, the assignee may file a lawsuit against the insurer to recover the insurance benefits.

Section 627.422, F.S., governs assignability of insurance contracts and provides that a policy may or may not be assignable according to its terms. In *Lexington Insurance Company v. Simkins Industries*,¹⁸ the court held that a provision in an insurance contract prohibiting assignment of the policy was enforceable under the plain language of s. 627.422, F.S. The court explained that the purpose of a provision prohibiting assignment was to protect an insurer against unbargained-for risks.¹⁹ However, an assignment made after the loss is valid even if the contract states otherwise.²⁰ In *Continental Casualty Company v. Ryan Incorporated*,²¹ the court noted that it is a “well-settled rule that [anti-assignment provisions do] not apply to an assignment after loss.” A court explained that a rationale for post-loss assignments is that “assignment of the policy, or rights under the policy, before the loss is incurred transfers the insurer’s contractual relationship to a party with whom it never intended to contract, but an assignment after loss is

¹⁵ *Universal Property and Casualty Insurance Company*, 114 So.3d at 1035.

¹⁶ John Dwight Ingram, *Misrepresentations in Applications for Insurance*, University of Miami Business Law Review, 14:103 (2005) at p. 111 (“In most jurisdictions, a misrepresentation is considered material and sufficient grounds for rescission or denial of a claim regardless of whether the fact represented has any causal connection with the death or loss involved in the claim”).

¹⁷ *Id.* at 111.

¹⁸ 704 So.2d 1384 (Fla. 1998).

¹⁹ *Id.* at 1386.

²⁰ *West Fla. Grocery Co. v. Teutonia Fire Ins. Co.*, 74 Fla. 220, 77 So. 209 (1917); *Gisela Inv., N.V. v. Liberty Mut. Ins. Co.*, 452 So.2d 1056 (Fla. 3d DCA 1984).

²¹ 974 So.2d 368, 377 n. 7 (Fla. 2000).

simply the transfer of the right to a claim for money” and “has no effect upon the insurer’s duty under the policy.”²²

Assignments have been prohibited by contract in other insurance contexts. In *Kohl v. Blue Cross Blue Shield of Florida, Inc.*,²³ the court found anti-assignment language was sufficiently clear and upheld language prohibiting the assignment of a health insurance claim. The court explained that anti-assignment clauses “prohibiting an insured’s assignments to out-of-network medical providers are valuable tools in persuading health [care] providers to keep their costs down and as such override the general policy favoring the free alienability of choses in action.”²⁴

Section 627.428, F.S., provides, in part:

Upon the rendition of a judgment or decree by any of the courts of this state against an insurer and in favor of any named or omnibus insured or the named beneficiary under a policy or contract executed by the insurer, the trial court or, in the event of an appeal in which the insured or beneficiary prevails, the appellate court shall adjudge or decree against the insurer and in favor of the insured or beneficiary a reasonable sum as fees or compensation for the insured’s or beneficiary’s attorney prosecuting the suit in which the recovery is had.

This statute allows the insured to recover attorney’s fees if the insured prevails in an action against an insurer. A person who takes an assignment of benefits is entitled to attorney’s fees if that assignee prevails in an action against an insurer.²⁵

Assignment of Benefits in Property Insurance Cases

In recent years, insurers have complained of abuse of the assignment of benefits process. An insurance company described the issue in a court filing:

The typical scenario surrounding the use of an “assignment of benefits” involved vendors and contractors, mostly water remediation companies, who were called by an insured immediately after a loss to perform emergency remediation services, such as water extraction. The vendor came to the insured’s home and, before performing any work, required the insured to sign an “assignment of benefits” – when the insured would be most vulnerable to fraud and price gouging. Vendors advised the insured, “We’ll take care of everything for you.” The vendor then submitted its bill to the insurer that was, on average, nearly 30 percent higher than comparative estimates from vendors without an assignment of benefits. Some vendors added to the invoice an additional 20 percent for “overhead and profit,” even though a general contractor would not be required or hired to oversee the work. Vendors used these inflated invoices to extract higher

²² *Wehr Constructors, Inc. v. Assurance Company of America*, 384 S.W.3d 680, 683 (Ky. 2012).

²³ 955 So.2d 1140 (Fla. 4th DCA 2007).

²⁴ *Id.* at 1144-1145.

²⁵ *All Ways Reliable Bldg. Maint., Inc. v. Moore*, 261 So.2d 131 (Fla. 1972); *Allstate Insurance Co. v. Regar*, 942 So.2d 969 (Fla.2d DCA 2006).

settlements from insurers. This, in turn, significantly increases litigation over the vendors' invoices.²⁶

In a court filing in a different case, a company that provides emergency repair and construction services explained the rationale behind assignments of insurance benefits:

As a practical matter, a homeowner often will not be able to afford or hire a contractor immediately following a loss unless the contractor accepts an assignment of benefits to ensure payment. A homeowner may be unable to comply with the ... provision requiring the homeowner to protect and repair the premises unless the remediation contractor accepts an assignment of benefits, however, contractors will become unwilling to accept payments by assignment if court decisions render the assignments unenforceable ...

Whether the repair invoice is routed through the insured or submitted by the service provider directly by assignment, the service provider's repair invoice is submitted to the insurer for coverage and reviewed by an adjuster. The only difference an assignment makes is that, if an insurance company wishes to partially deny coverage or contest an invoice as unreasonable, the insured policyholder is not mired in litigation in which he or she has no stake.²⁷

There have been a number of cases in recent years where courts have held that post-loss benefits are assignable.²⁸

Data and Recommendations for Reform

According to the Department of Financial Services, the number of lawsuits related to water claims where the claimant is an assignee has increased in recent years. In 2006, there were 8 lawsuits and in 2010, there were 483. The numbers increased in subsequent years:

2011 – 989
 2012 – 1,603
 2013 – 2,083
 2014 – 2,786
 2015 – 5,328
 2016 – 8,488
 2017 through September 30 – 5,968²⁹

²⁶ *Security First Insurance Company v. State of Florida, Office of Insurance Regulation*, Case No. 1D14-1864 (Fla. 1st DCA), Appellant's Initial Brief at pp. 3-4 (appellate record citations omitted).

²⁷ *One Call Property Services, Inc. v. Security First Insurance Company*, Case No. 4D14-0424 (Fla. 4th DCA), Appellant's Initial Brief at 46-48.

²⁸ See, e.g., *Security First Ins. Co. v. State of Florida Office of Insurance Regulation*, 177 So.3d 627, rehearing denied (Fla. 1st DCA 2015); *Bioscience W., Inc. v. Gulfstream Prop. & Cas. Ins. Co.*, 185 So.2d 638 (Fla.2d DCA 2016); *One Call Property Services, Inc. v. Security First Ins. Co.*, 165 So.3d 749 (Fla. 4th DCA 2015); *Accident Cleaners, Inc. v. Universal Ins. Co.*, 186 So.3d 1 (Fla. 5th DCA 2015).

²⁹ Information provided by the DFS to Committee staff (on file with the Committee).

In 2015, the Office of Insurance Regulation (OIR) did a data call to attempt to determine the effect of assignment of benefits in the insurance market.³⁰ The OIR found that water losses alone could require rate increases of 10 percent per year.³¹ One company reported that, in 2015, the claim cost of a claim with an assignment of benefits was 141 percent greater than the claim cost of a claim without an assignment of benefits.³² The company reported 90 cases of suspected insurance fraud to the Department of Financial Services in 2015 and part of 2016.

Citizens Property Insurance Company reported that the percentage of claims litigated with an assignment of benefits increased from 9.6 percent in 2012 to 46.9 percent in 2015.³³ It projects that the average premium will increase in Miami-Dade County from \$2,926 to \$4,712 by 2022, and in Broward County from \$2,390 to \$3,850 by 2022.³⁴ Citizens reports that water claims, including those that do not involve an assignment of benefits, have been increasing:

8,097 new lawsuits were filed against Citizens between January and November 2016, a 30 percent increase from the same period in 2015. Meanwhile, Citizens' policy count dropped by 26.3 percent between January 2015 and November 2016.³⁵

Citizens noted that factors other than assignment of benefits contribute to the increase in the number of lawsuits. It noted that in many cases, it is made aware of a loss only after repairs are made or the policyholder has hired an attorney or a public adjuster.³⁶

Citizens reported 16,150 closed non-weather water claims between January 1, 2016, and June 30, 2017:

	Number of Claims	Severity
Attorney Involved and AOB	5,042	\$29,889
Attorney Involved, No AOB	4,644	\$21,289
No Attorney Involved and AOB	636	\$ 9,530
No Attorney Involved, No AOB	5,828	\$ 4,430 ³⁷

In a presentation to the Florida Cabinet on February 7, 2017, the State Insurance Commissioner explained that the frequency of water claims rose by 46 percent from 2010 to 2015 and the

³⁰ <http://www.floir.com/Sections/PandC/AssignmentofBenefits.aspx> (last accessed January 8, 2018).

³¹ Office of Insurance Regulation, *2015 Report on Review of the 2015 Assignment of Benefits Data Call* (February 8, 2016) at p. 8.

³² Security First Insurance, *Troubled Water: An Analysis of Water Damage Claims and the Impact on Homeowner's Insurance Premiums in Florida* (July 20, 2016) at p. 13.

³³ Citizens Property Insurance Corporation, *Non-Catastrophic Homeowners Water Claims* (January 2016) at p. 3. The report can be found here: <https://www.citizensfla.com/documents/20702/1335431/20160121+White+Paper+Non-Catastrophic+Homeowners+Water+Claims.pdf/f66d4f43-e4cf-4e6e-b857-d457d761f5d6> (last accessed January 8, 2018).

³⁴ Citizens Property Insurance Company, *AOB Reform Makes Pocket Sense* (on file with the Committee on Banking and Insurance).

³⁵ https://www.citizensfla.com/-/20161207_bog-press-release (last accessed January 8, 2018).

³⁶ *Id.*

³⁷ Citizens Property Insurance Corporation, *President's Report*, December 13, 2017 at p 14 (on file with the Committee).

amount the insurers pay on those claims has increased 28 percent.³⁸ Data gathered in a data call by the OIR showed that the use of assignments of benefits has increased from 5.7 percent of the claims in 2010 to 15.9 percent of the claims in 2015.³⁹ The Commissioner continued:

Absent any other type of reform, absent any other type of coverage or other expense that might be present on an insurance policy, were these trends to continue unchecked, policyholders would expect to see about a 10 percent rate increase going forward just to keep up with the water trends that are covering their policy.⁴⁰

The Commissioner recommended various reforms:

- Amending s. 627.428, F.S., to apply to insureds only and not to assignees;
- Consumer protections so that consumers are not left “holding the bag” if there is a dispute between the insurance company and a contractor; and
- Notice requirements so the insurer is aware of the assignment and can participate in the claims adjustment process.⁴¹

The First District Court of Appeal recently noted:

[W]e are not unmindful of the concerns that Security First expressed in support of [limiting assignment of benefits], providing evidence that inflated or fraudulent post-loss claims filed by remediation companies exceeded by thirty percent comparable services; that policyholders may sign away their rights without understanding the implications; and that a “cottage industry” of “vendors, contractors, and attorneys” exists that use the “assignments of benefits and the threat of litigation” to “extract higher payments from insurers.” These concerns, however, are matters of policy that we are ill-suited to address.⁴²

The Fourth District Court of Appeal explained the competing policy arguments raised by the assignment of benefits issue:

Turning to the practical implications of this case, we note that this issue boils down to two competing public policy considerations. On the one side, the insurance industry argues that assignments of benefits allow contractors to unilaterally set the value of a claim and demand payment for fraudulent or inflated invoices. On the other side, contractors argue that assignments of benefits allow homeowners to hire contractors for emergency repairs immediately after a

³⁸ Transcript of the Meeting of the Governor and Cabinet, February 7, 2017, at p. 11. The transcript can be found at <http://www.myflorida.com/myflorida/cabinet/agenda17/0207/transcript.pdf> (last accessed January 8, 2018).

³⁹ Office of Insurance Regulation, *2015 Report on Review of the 2015 Assignment of Benefits Data Call* (February 8, 2016) at p. 6 and 11.

⁴⁰ *Id.* at 11-12.

⁴¹ *Id.* at 16-18.

⁴² *Security First Ins. Co. v. State of Florida Office of Insurance Regulation*, 177 So.3d 627, 628, *rehearing denied* (Fla. 1st DCA 2015).

loss, particularly in situations where the homeowners cannot afford to pay the contractors up front.⁴³

The court noted that if “studies show that these assignments are inviting fraud and abuse, then the legislature is in the best position to investigate and undertake comprehensive reform.”⁴⁴

Proposals for Settlement (Lines 173-177 of the bill)

The “offer of judgment” provided by s. 768.79, F.S., awards attorney’s fees to:

- A defendant in any civil action for damage whose proposal for settlement is rejected where the judgment is 75 percent or less than the defendant’s offer (including where the plaintiff is awarded nothing or there is a finding of no liability); or
- A plaintiff whose proposal for settlement is rejected where the judgment is at least 25 percent more than the plaintiff’s offer.

Section 768.79, F.S., does not provide a time for making settlement proposals. However, Florida Rule of Civil Procedure 1.442(b) provides:

A proposal to a defendant shall be served no earlier than 90 days after service of process on the defendant; a proposal to the plaintiff shall be serviced no earlier than 90 days after the action has been commenced.

III. Effect of Proposed Changes:

Insurance Rates (Section 1 of the bill)

The bill amends s. 627.062, F.S., to provide that attorney fees paid pursuant to s. 627.428, F.S., may not be included in the insurer’s rate base and may not be used to justify a rate or rate change. These provisions will bar the use of attorney fees paid pursuant to s. 627.428, F.S., in rate making in property, casualty, surety, motor vehicle, employer liability, title, wet marine, credit life or credit disability, and health insurance.

Misrepresentations in Insurance Applications (Section 2 of the bill)

The bill amends s. 627.409, F.S., to provide that a misrepresentation, omission, concealment of fact or incorrect statement on an insurance application may prevent recovery only if the misrepresentation, omission, concealment of fact, or incorrect statement directly relates to the cause of the claim. If the misrepresentation, omission, concealment of fact or incorrect statement directly relates to the cause of the claim, one of the following must apply:

- (1) The misrepresentation, omission, concealment, or statement is fraudulent or is material to the acceptance of the risk or to the hazard assumed by the insurer; or
- (2) If the true facts relative to the loss claimed had been known to the insurer pursuant to a policy requirement or other requirement, the insurer in good faith would not have:
 - Issued the policy or contract;

⁴³ *One Call Property Services, Inc. v. Security First Ins. Co.*, 165 So.3d 749, 755 (Fla. 4th DCA 2015).

⁴⁴ *Id.*

- Issued the policy or contract at a premium rate at least 20 percent higher than the rate actually charged;
- Issued a policy or contract in as large an amount; or
- Provided coverage with respect to the hazard resulting in the loss.

Assignment of Benefits (Sections 3 and 4)

The bill provides that a personal lines residential property insurance policy or a commercial residential property insurance policy may not restrict the assignment of post-loss benefits. This provision is a restatement of case law that prohibits the restriction of post-loss assignments.

The bill provides that an agreement to assign post-loss benefits of a residential homeowner's property insurance policy is not valid unless the agreement:

- Is in writing;
- Is limited to claims for work performed or work to be performed by the assignee;
- Contains an accurate and up-to-date statement of the scope of work to be performed;
- Allows the insured to rescind the assignment within 7 days after the execution of the assignment;
- Provides that the insured may be responsible for payment for any work performed before the rescission of the assignment; and
- Contains a provision, in 14-point boldfaced type, which allows the insured to rescind the agreement within 7 days after execution of the assignment, and with a notice that if the assignment is rescinded, the homeowner is responsible to pay for the work done up to the date of the rescission and that the homeowner is not otherwise responsible to pay for the work covered by the assignment.

The bill requires the assignee to provide a copy of the assignment agreement to the insurer within the earlier of 7 days after execution of the agreement, or 48 hours after beginning nonemergency work if the insurer has a facsimile number and e-mail address on its website designated for the delivery of such documents. The notice⁴⁵ must be accompanied by a written estimate of the work to be done, with unit prices indicated where appropriate, and the basis for calculating lump sum fees if unit prices are inappropriate. The estimate must be timely updated if conditions require a change in scope. The failure to comply with this requirement constitutes a defense to any payment obligation under the policy or the assignment, if the insurer can establish prejudice resulting from the failure.

The bill allows the insurer to inspect the property at any time. If the insurer fails to attempt in good faith to inspect the property within 7 days after learning of the loss and promptly deliver to the assignee written notice of any perceived deficiency in the assignee's notice or the work being performed, the failure may be raised to estop the insurer from asserting that work done was not reasonably necessary or that the notice was insufficient.

The bill provides that notwithstanding any other law, the acceptance by an assignee of a valid assignment agreement constitutes a waiver by the assignee or transferee, and any subcontractor

⁴⁵ The bill uses "notice" although the assignee is required to provide the entire "agreement" to the insurer.

of the assignee or transferee, of any and all claims against named insureds for payment arising from the specified loss. However, all named insureds remain responsible for:

- The payment of any deductible amount provided for by the terms of the insurance policy;
- The payment for work performed before the rescission of the assignment agreement, if there is a rescission;
- The cost of any betterment specifically authorized by the insured in a writing that identifies the work as betterment for which the insured will be liable; and
- A misrepresentation of the existence of homeowner's coverage by the homeowner.

This waiver is valid even if the assignment agreement is determined to be invalid.

The bill's requirements relating to assignment agreements do not apply to:

- An assignment, transfer, or conveyance granted to a subsequent purchaser of the property with an insurable interest in the property following a loss; or
- A power of attorney under ch. 709, F.S., which grants to a management company, family member, guardian, or similarly situated person of an insured the authority to act on behalf of an insured as it relates to a property insurance claim.

Presuit Notice (Lines 168-172 of the bill)

The bill requires an assignee to provide the insurer an invoice for all work that has been performed and a current estimate of work remaining to be performed no later than 30 days before an assignee initiates litigation against an insurer relating to a residential homeowner's property insurance claim.

Proposals for Settlement (Lines 174-177 of the bill)

The bill provides that in a civil action relating to a residential homeowner's property insurance claim under a policy in which an assignment agreement was executed, an offer of settlement under s. 768.79, F.S., by any party may be made no earlier than 30 days after the civil action has commenced.

Required Reports to the Office of Insurance Regulation (Lines 178-186 of the bill)

The bill requires each insurer to report data on each residential property claim paid pursuant to an assignment agreement in the prior calendar year. The data must include specific data about claims adjustment and settlement timeframes and trends grouped by whether litigated or not litigated, by loss adjustment expenses, and by the amount and type of attorney fees incurred or paid. The bill provides that the office may adopt rules to administer these provisions.

The required information must be reported by January 30, 2021, and each year thereafter.

The bill takes effect July 1, 2018.

IV. Constitutional Issues:**A. Municipality/County Mandates Restrictions:**

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:**Court Rulemaking**

Lines 173-177 of the bill allow either party to make a proposal for settlement no earlier than 30 days after the civil action has commenced. Florida Rule of Civil Procedure 1.442(b) provides that a proposal for settlement to a defendant shall be served no earlier than 90 days after service of process on that defendant. A proposal to a plaintiff shall be served no earlier than 90 days after the action has been commenced. Florida Rule of Civil Procedure 1.442(a) provides that the rule applies to all proposals for settlement and “supersedes all other provisions of the rules and statutes that may be inconsistent with this rule.”

Article V, section 2(a), of the Florida Constitution provides, in relevant part:

The supreme court shall adopt rules for the practice and procedure in all courts including the time for seeking appellate review, the administrative supervision of all courts, the transfer to the court having jurisdiction of any proceeding when the jurisdiction of another court has been improvidently invoked, and a requirement that no cause shall be dismissed because an improper remedy has been sought.

Article II, section 3 of the Florida Constitution, reads:

The powers of the state government shall be divided into legislative, executive and judicial branches. No person belonging to one branch shall exercise any powers appertaining to either of the other branches unless expressly provided herein.

These provisions have been interpreted to give the Florida Supreme Court exclusive jurisdiction over procedural matters while the Legislature has exclusive jurisdiction over substantive law.

The issue created by the bill is whether the Legislature has the constitutional power to set a time for service of proposals for settlement which conflicts with the time set in court rule. The Florida Rules of Civil Procedure are rules of procedure adopted by the Florida Supreme Court. If the timing of service of proposals for settlement is deemed procedural, then the Florida Supreme Court has exclusive jurisdiction to set the time. If it is substantive, then the Legislature can set the time by general law.

The Florida Supreme Court has not specifically addressed the issue. If the statute were to be challenged, the court would have a number of options. In *Timmons v. Coombs*,⁴⁶ the court found that s. 768.79, F.S., contained procedural portions and adopted those as rules of court without explaining which portions of the law were procedural and which portions were substantive. If the court were to find the time for service is procedural, it would strike down the statute and require parties to follow rule 1.442.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Section 1 of this bill is similar to a provision in CS/SB 1684 filed during the 2017 session. In its analysis of that bill, the OIR expressed concerns that if insurers are not allowed to use attorney fees as part of the ratemaking process, the OIR might be forced to approve rates that are insufficient. The OIR was also concerned that insurers may pay many more claims to avoid paying attorney fees and that this could lead to rate increases.⁴⁷

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

Line 186 provides rulemaking authority to the OIR. Section 20.121(3)(c), F.S., provides that the Financial Services Commission is the agency head for purposes of ch. 120 rulemaking.

VII. Related Issues:

None.

⁴⁶ 608 So.2d 1 (1992).

⁴⁷ Office of Insurance Regulation, *Analysis of SB 1684* (March 28, 2017)(on file with the Committee on Banking and Insurance).

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 627.062, 627.409, 627.422, and 627.7152.

IX. Additional Information:**A. Committee Substitute – Statement of Changes:**

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.



804018

LEGISLATIVE ACTION

Senate

.
.
.
.
.
.

House

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause
and insert:

Section 1. Section 627.7152, Florida Statutes, is created
to read:

627.7152 Assignment of property insurance post-loss
benefits.—

(1) As used in this section, the term "assignment
agreement" means any instrument by which post-loss property



804018

insurance benefits for services to protect, repair, restore, or replace property, or to mitigate against further damage to property, are assigned, transferred, or conveyed, regardless of how named or styled.

(2) Notwithstanding any other law, as to suits based on claims arising under property insurance policies, attorney fees may not be awarded under s. 626.9373 or s. 627.428 in favor of any person or entity seeking relief against the insurer pursuant to an assignment agreement.

(3) An assignment agreement is not valid unless it meets all of the following requirements:

(a) The assignment agreement is in writing and is executed by all named insureds;

(b) The assignment agreement contains a provision that permits all named insureds to rescind the assignment agreement without any penalty or rescission or cancellation fee within 7 business days after the date the assignment agreement is executed by all named insureds;

(c) The assignment agreement contains a provision requiring the assignee or transferee to provide a copy of the executed assignment agreement to the insurer no later than 3 business days after the assignment agreement is executed by any named insured; and

(d) The assignment agreement contains a written, itemized, per-unit cost estimate of the work to be performed by the assignee or transferee.

(4) The following provisions may not be included in an assignment agreement and are deemed to be invalid and unenforceable against the property insurer or named insureds:



804018

40 (a) A penalty or fee for rescission of the assignment
41 agreement pursuant to subsection (3);

42 (b) A check or mortgage processing fee;

43 (c) A penalty or fee for cancellation of the assignment
44 agreement pursuant to subsection (3); or

45 (d) An administrative fee.

46 (5) As to claims arising under an assignment agreement, the
47 failure to comply with any provision of this subsection creates
48 a presumption that the insurer is prejudiced by such failure to
49 comply and shifts the burden in any proceeding or suit to the
50 party seeking benefits, rights, or proceeds from the insurer to
51 demonstrate that the insurer was not prejudiced. The assignee or
52 transferee must do all of the following:

53 (a) Maintain records of all services provided under the
54 assignment agreement;

55 (b) Cooperate with the insurer in the investigation of a
56 claim;

57 (c) Provide the insurer with any and all records and
58 documents requested related to services provided and permit the
59 insurer to make copies;

60 (d) Deliver a copy of the executed assignment agreement to
61 the insurer no later than 3 business days after the assignment
62 agreement is executed by all named insureds; and

63 (e) Concurrently with any request for payment of benefits
64 under the insurance policy, provide the insurer with a written,
65 itemized, per-unit cost statement of services actually performed
66 pursuant to the assignment agreement.

67 (6) As to claims arising under an assignment agreement, an
68 assignee must, as a condition precedent to filing a suit under



804018

the policy:

(a) If required by the insurer, submit to examinations under oath and recorded statements conducted by the insurer or the insurer's representative which are limited to matters related to the services provided, the costs of services, and the assignment or transfer; and

(b) Participate in an appraisal or other alternative dispute resolution method in accordance with the terms of the policy.

(7) An activity in compliance with subsections (5) and (6) does not constitute practice as a public adjuster pursuant to part VI of chapter 626.

(8) Notwithstanding any other law, the acceptance by a person of any assignment agreement constitutes a waiver by the assignee or transferee, and any subcontractor of the assignee or transferee, of any and all claims against all named insureds for payment arising from the specified loss, except that all named insureds remain responsible for the payment of any deductible amount provided for by the terms of the insurance policy and for the cost of any betterment ordered by all named insureds. This waiver remains in effect notwithstanding any subsequent determination that the assignment agreement is invalid or the rescission of the assignment agreement by all named insureds.

(9) This section does not permit an assignment agreement to modify or eliminate any term, condition, or defense relating to any managed repair arrangement provided for in the insurance policy to which the assignment agreement relates.

(10) This section does not apply to:

(a) An assignment, transfer, or conveyance granted to a



804018

subsequent purchaser of property who acquires an insurable
interest in the property following a loss;

(b) A power of attorney granted to a management company,
family member, guardian, or similarly situated person which
complies with chapter 709 and which may include, as part of the
authority granted, the authority to act on behalf of a principal
as it relates to a property insurance claim; or

(c) Liability coverage under a property insurance policy.

(11) This section applies to assignment agreements that are
executed after July 1, 2018.

Section 2. (1) Within 60 days after the effective date of
this section, the Office of Insurance Regulation shall enter
into a contract with an independent consultant to calculate the
savings expected as a result of this act. The contract must
require the use of generally accepted actuarial techniques and
standards in determining the expected impact on losses and
expenses. By September 15, 2018, the office shall submit to the
Governor, the President of the Senate, and the Speaker of the
House of Representatives a report concerning the results of the
independent consultant's calculations.

(2) By October 1, 2018, an insurer writing property
insurance in this state shall make a rate filing with the Office
of Insurance Regulation. A rate certification does not satisfy
this requirement. If the insurer requests a rate in excess of a
10 percent reduction as applied to the current rate in its
overall base rate for property insurance, the insurer must
include in its rate filing a detailed explanation of the reasons
for its failure to achieve a 10 percent reduction.

(3) By January 1, 2020, an insurer writing property



804018

insurance in this state shall make a rate filing with the Office of Insurance Regulation. A rate certification does not satisfy this requirement. If the insurer requests a rate in excess of a 25 percent reduction as applied to the rate in effect as of July 1, 2018, in its overall base rate for property insurance since July 1, 2018, the insurer must include in its rate filing a detailed explanation of the reasons for its failure to achieve a 25 percent reduction.

(4) If an insurer fails to provide the detailed explanation required by subsection (2) or subsection (3), the Office of Insurance Regulation must order the insurer to stop writing new property insurance policies in this state until it provides the required explanation.

(5) The sum of \$200,000 of nonrecurring revenue is appropriated from the Insurance Regulatory Trust Fund to the Office of Insurance Regulation for the purpose of implementing the requirements of subsection (1) during the 2017-2018 fiscal year. Any unexpended balance of the appropriation at the end of the fiscal year shall be carried forward and be available for expenditure for that purpose during the 2018-2019 fiscal year. Notwithstanding s. 287.057, Florida Statutes, the office may retain an independent consultant to implement the requirements of subsection (1) without a competitive solicitation.

(6) This section shall take effect upon this act becoming a law.

Section 3. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect July 1, 2018.



804018

===== T I T L E A M E N D M E N T =====

And the title is amended as follows:

Delete everything before the enacting clause
and insert:

A bill to be entitled

An act relating to the assignment of property
insurance benefits; creating s. 627.7152, F.S.;
defining the term "assignment agreement"; prohibiting
certain awards of attorney fees to certain persons or
entities in suits based on claims arising under
property insurance policies; providing that an
assignment agreement is not valid unless specified
requirements are met; prohibiting certain provisions
in an assignment agreement; specifying requirements
for an assignee or transferee; requiring an assignee
to meet certain requirements as a condition precedent
to filing suit under a policy; providing construction;
providing applicability; requiring the Office of
Insurance Regulation, within a specified timeframe, to
contract with an independent consultant to calculate
expected savings as a result of this act; requiring
the contract to require the use of certain actuarial
techniques and standards; requiring the office to
submit a certain report to the Governor and the
Legislature by a specified date; requiring property
insurers to make rate filings with the office by
specified dates; providing construction; requiring an
insurer to include a certain explanation in its rate



804018

185 filing under certain circumstances; requiring the
186 office to order an insurer that fails to provide such
187 explanation to stop writing new property insurance
188 policies until it provides the explanation; providing
189 an appropriation; authorizing the office to retain the
190 consultant without a competitive solicitation;
191 providing effective dates.



178904

LEGISLATIVE ACTION

Senate

.
.
.
.
.
.

House

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

Senate Amendment (with title amendment)

Between lines 103 and 104
insert:

Section 4. Paragraph (a) of subsection (3) of section
627.7011, Florida Statutes, is amended to read:

627.7011 Homeowners' policies; offer of replacement cost
coverage and law and ordinance coverage.—

(3) In the event of a loss for which a dwelling or personal
property is insured on the basis of replacement costs:



178904

(a) For a dwelling:

1. The insurer must initially pay at least the actual cash value of the insured loss, less any applicable deductible. The insurer shall pay any remaining amounts necessary to perform such repairs as work is performed and expenses are incurred. If a total loss of a dwelling occurs, the insurer shall pay the replacement cost coverage without reservation or holdback of any depreciation in value, pursuant to s. 627.702.

2. The insurer may not require that a particular vendor make repairs to such dwelling.

3. The insurer may not, unless expressly requested by the insured, recommend or suggest a particular vendor for repairs to be made to such dwelling.

===== T I T L E A M E N D M E N T =====

And the title is amended as follows:

Delete line 14

and insert:

assignment of post-loss benefits; amending s.
627.7011, F.S.; prohibiting specified acts by insurers
relating to certain losses under homeowners' insurance
policies; creating s.



382922

LEGISLATIVE ACTION

Senate

.
.
.
.
.
.

House

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

Senate Amendment

Delete line 134
and insert:
such documents. This assignment agreement must be accompanied by
a written



202936

LEGISLATIVE ACTION

Senate

.
.
.
.
.
.

House

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

Senate Amendment (with title amendment)

Delete lines 150 - 167

and insert:

(3) Notwithstanding any other law, the acceptance by a person of any assignment agreement constitutes a waiver by the assignee or transferee, and any subcontractor of the assignee or transferee, of any and all claims against all named insureds for payment arising from the specified loss, except that all named insureds remain responsible for the payment of any deductible



202936

amount provided for by the terms of the insurance policy and for
the cost of any betterment ordered by all named insureds. This
waiver remains in effect notwithstanding any subsequent
determination that the assignment agreement is invalid or
notwithstanding the rescission of the assignment agreement by
all named insureds, except that the assignee is entitled to
payment for the reasonable cost of any contracted work performed
before the assignor rescinded the assignment agreement.

===== T I T L E A M E N D M E N T =====

And the title is amended as follows:

Delete lines 29 - 35

and insert:

certain assertions by the insurer; providing that a
person's acceptance of an assignment agreement
constitutes a waiver by the assignee or transferee, or
any subcontractor of the assignee or transferee, of
certain claims against named insureds, except under
specified circumstances; providing construction
relating to such waiver; requiring an



313360

LEGISLATIVE ACTION

Senate

.
.
.
.
.
.

House

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

Senate Amendment (with title amendment)

Delete lines 186 - 194

and insert:

The commission may adopt rules to administer this subsection.

(7) This section does not apply to:

(a) An assignment, transfer, or conveyance granted to a subsequent purchaser of the property with an insurable interest in the property following a loss; or

(b) A power of attorney under chapter 709 which grants to a



313360

management company, family member, guardian, or similarly
situated person of an insured the authority to act on behalf of
an insured as it relates to a property insurance claim.

Section 5. The amendment made by this act to s. 627.422,
Florida Statutes, and the creation by this act of s. 627.7152,
Florida Statutes, apply to assignment agreements executed on or
after July 1, 2018.

===== T I T L E A M E N D M E N T =====

And the title is amended as follows:

Delete line 44

and insert:

authorizing the Financial Services Commission to adopt
rules; providing



606060

LEGISLATIVE ACTION

Senate

.
.
.
.
.
.

House

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

Senate Amendment

Delete lines 118 - 122

and insert:

days after the execution of the assignment without a penalty or fee;

(e) Prohibits any check or mortgage processing fee or administrative fee;

(f) Provides that the insured may be responsible for payment for any work performed before the rescission of the



606060

11 assignment; and

12 (g) Contains a provision, in 14-point boldfaced type, which

By Senator Steube

23-01236C-18

20181168__

1 A bill to be entitled
 2 An act relating to insurance; amending s. 627.062,
 3 F.S.; providing that certain attorney fees and costs
 4 paid by property insurers may not be included in the
 5 property insurer's rate base and may not be used to
 6 justify a rate increase or rate change; amending s.
 7 627.409, F.S.; adding and revising conditions under
 8 which certain misrepresentations, omissions,
 9 concealments of fact, or incorrect statements may
 10 prevent recovery under an insurance policy or annuity
 11 contract; amending s. 627.422, F.S.; providing that
 12 personal lines residential and commercial residential
 13 property insurance policies may not restrict the
 14 assignment of post-loss benefits; creating s.
 15 627.7152, F.S.; providing that an agreement to assign
 16 post-loss benefits of a residential homeowner's
 17 property insurance is not valid unless specified
 18 conditions are met; requiring the assignee, under
 19 certain circumstances, to provide a copy of the
 20 assignment agreement and a specified written estimate
 21 to the insurer within a specified timeframe; requiring
 22 the estimate to be timely updated if conditions
 23 require a change in scope; providing construction
 24 relating to failure to comply with such requirement;
 25 authorizing an insurer to inspect the property at any
 26 time; providing that an insurer's failure to make a
 27 certain attempt to inspect the property and deliver a
 28 certain notice, under certain circumstances, may estop
 29 certain assertions by the insurer; providing that an

Page 1 of 7

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

23-01236C-18

20181168__

30 assignee's acceptance of a valid assignment agreement
 31 constitutes a waiver by the assignee or transferee, or
 32 any subcontractor of the assignee or transferee, of
 33 certain claims against named insureds, except under
 34 specified circumstances; providing construction
 35 relating to the validity of such waiver; requiring an
 36 assignee, before initiating certain litigation against
 37 an insurer, to provide a certain invoice and estimate
 38 to the insurer within a specified timeframe; providing
 39 that certain offers of settlement in certain civil
 40 actions may not be made until after a specified
 41 timeframe; requiring the office to require each
 42 insurer to annually report specified data relating to
 43 certain claims paid pursuant to assignment agreements;
 44 authorizing the office to adopt rules; providing
 45 applicability; providing an effective date.

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

48
 49 Section 1. Subsection (11) is added to section 627.062,
 50 Florida Statutes, to read:

51 627.062 Rate standards.—

52 (11) Attorney fees and costs paid by a property insurer
 53 pursuant to s. 627.428 may not be included in the property
 54 insurer's rate base and may not be used to justify a rate
 55 increase or rate change.

56 Section 2. Subsection (1) of section 627.409, Florida
 57 Statutes, is amended to read:

58 627.409 Representations in applications; warranties.—

Page 2 of 7

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

23-01236C-18

20181168

(1) Any statement or description made by or on behalf of an insured or annuitant in an application for an insurance policy or annuity contract, or in negotiations for a policy or contract, is a representation and not a warranty. Except as provided in subsection (3), a misrepresentation, omission, concealment of fact, or incorrect statement may prevent recovery under the contract or policy only if the misrepresentation, omission, concealment of fact, or incorrect statement directly relates to the cause of the claim being made and any of the following apply:

(a) The misrepresentation, omission, concealment, or statement is fraudulent or is material to the acceptance of the risk or to the hazard assumed by the insurer.

(b) If the true facts relative to the loss claimed had been known to the insurer pursuant to a policy requirement or other requirement, the insurer in good faith would not have:

1. Issued the policy or contract; ~~it would not have~~
2. Issued the policy or contract ~~it~~ at a ~~the same~~ premium rate at least 20 percent higher than the rate actually charged; ~~it would not have~~
3. Issued a policy or contract in as large an amount; ~~or~~
4. ~~would not have~~ Provided coverage with respect to the hazard resulting in the loss.

Section 3. Section 627.422, Florida Statutes, is amended to read:

627.422 Assignment of policies or post-loss benefits.—A policy may be assignable, or not assignable, as provided by its terms.

(1) LIFE OR HEALTH INSURANCE POLICIES.—Subject to its terms

23-01236C-18

20181168

relating to assignability, any life or health insurance policy under the terms of which the beneficiary may be changed upon the sole request of the policyowner may be assigned either by pledge or transfer of title, by an assignment executed by the policyowner alone and delivered to the insurer, whether or not the pledgee or assignee is the insurer. Any such assignment shall entitle the insurer to deal with the assignee as the owner or pledgee of the policy in accordance with the terms of the assignment, until the insurer has received at its home office written notice of termination of the assignment or pledge or written notice by or on behalf of some other person claiming some interest in the policy in conflict with the assignment.

(2) POST-LOSS BENEFITS UNDER CERTAIN PROPERTY INSURANCE POLICIES.—A personal lines residential property insurance policy or a commercial residential property insurance policy may not restrict the assignment of post-loss benefits.

Section 4. Section 627.7152, Florida Statutes, is created to read:

627.7152 Assignment of residential homeowner's property insurance post-loss benefits; prelitigation invoice; offer of settlement; annual reporting.—

(1) An agreement to assign post-loss benefits of a residential homeowner's property insurance policy is not valid unless the agreement:

- (a) Is in writing;
- (b) Is limited to claims for work performed or work to be performed by the assignee;
- (c) Contains an accurate and up-to-date statement of the scope of work to be performed;

23-01236C-18

20181168

117 (d) Allows the insured to rescind the assignment within 7
 118 days after the execution of the assignment;
 119 (e) Provides that the insured may be responsible for
 120 payment for any work performed before the rescission of the
 121 assignment; and
 122 (f) Contains a provision, in 14-point boldfaced type, which
 123 allows the insured to rescind the agreement within 7 days after
 124 execution of the assignment, and with a notice that if the
 125 assignment is rescinded, the homeowner is responsible to pay for
 126 the work done up to the date of the rescission and that the
 127 homeowner is not otherwise responsible to pay for the work
 128 covered by the assignment.
 129 (2) (a) The assignee shall provide a copy of the assignment
 130 agreement to the insurer within 7 days after execution of the
 131 agreement, or within 48 hours after beginning nonemergency work,
 132 whichever is earlier, if the insurer has a facsimile number and
 133 e-mail address on its website designated for the delivery of
 134 such documents. This notice must be accompanied by a written
 135 estimate of the work to be done, with unit prices indicated
 136 where appropriate, and the basis for calculating lump sum fees
 137 if unit prices are inappropriate. The estimate must be timely
 138 updated if conditions require a change in scope. The failure to
 139 comply with this requirement constitutes a defense to any
 140 payment obligation under the policy or the assignment, if the
 141 insurer can establish prejudice resulting from the failure.
 142 (b) The insurer may inspect the property at any time. If
 143 the insurer fails to attempt in good faith to do so within 7
 144 days after learning of the loss and promptly deliver to the
 145 assignee written notice of any perceived deficiency in the

Page 5 of 7

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

23-01236C-18

20181168

146 assignee's notice or the work being performed, the failure may
 147 be raised to estop the insurer from asserting that work done was
 148 not reasonably necessary or that the notice was insufficient to
 149 comply with this section.
 150 (3) Notwithstanding any other law, the acceptance by an
 151 assignee of a valid assignment agreement constitutes a waiver by
 152 the assignee or transferee, and any subcontractor of the
 153 assignee or transferee, of any and all claims against named
 154 insureds for payment arising from the specified loss, except
 155 that all named insureds remain responsible for:
 156 (a) The payment of any deductible amount provided for by
 157 the terms of the insurance policy;
 158 (b) The payment for work performed before the rescission of
 159 the assignment agreement, if there is a rescission;
 160 (c) The cost of any betterment specifically authorized by
 161 the insured in a writing that identifies the work as betterment
 162 for which the insured will be liable; and
 163 (d) A misrepresentation of the existence of homeowner's
 164 coverage by the homeowner.
 165 The waiver in this subsection is valid even if the assignment
 166 agreement is determined to be invalid.
 167 (4) No later than 30 days before an assignee initiates
 168 litigation against an insurer relating to a residential
 169 homeowner's property insurance claim, the assignee must provide
 170 the insurer an invoice for all work that has been performed and
 171 a current estimate of work remaining to be performed.
 172 (5) In a civil action relating to a residential homeowner's
 173 property insurance claim under a policy in which an assignment
 174

Page 6 of 7

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

23-01236C-18

20181168__

175 agreement under this section was executed, an offer of
176 settlement under s. 768.79 by any party may be made no earlier
177 than 30 days after the civil action has commenced.

178 (6) The office shall require each insurer to report by
179 January 30, 2021, and each year thereafter, data on each
180 residential property insurance claim paid in the prior calendar
181 year pursuant to an assignment agreement. Such data must
182 include, but are not limited to, specific data about claims
183 adjustment and settlement timeframes and trends grouped by
184 whether litigated or not litigated, by loss adjustment expenses,
185 and by the amount and type of attorney fees incurred or paid.
186 The office may adopt rules to administer this subsection.

187 (7) This section does not apply to:

188 (a) An assignment, transfer, or conveyance granted to a
189 subsequent purchaser of the property with an insurable interest
190 in the property following a loss; or

191 (b) A power of attorney under chapter 709 which grants to a
192 management company, family member, guardian, or similarly
193 situated person of an insured the authority to act on behalf of
194 an insured as it relates to a property insurance claim.

195 Section 5. This act shall take effect July 1, 2018.



THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:

Judiciary, *Chair*
Banking and Insurance, *Vice Chair*
Agriculture
Appropriations Subcommittee on Finance and Tax
Appropriations Subcommittee on Pre-K - 12 Education
Children, Families, and Elder Affairs
Regulated Industries

JOINT COMMITTEE:

Joint Committee on Public Counsel Oversight

SENATOR GREG STEUBE

23rd District

December 18, 2017

The Honorable Anitere Flores
Florida Senate
404 Senate Office Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Senator Flores,

I am writing this letter because my bill, SB 1168 Insurance, has been referred to the Senate Banking and Insurance Committee. I am respectfully requesting that you place the bill on your committee's calendar for the next committee week.

Thank you for your consideration. Please contact me if you have any questions.

Very respectfully yours,

A handwritten signature in blue ink, appearing to be "W. Gregory Steube".

W. Gregory Steube, District 23

REPLY TO:

- ☐ 6230 University Parkway, Suite 202, Sarasota, Florida 34240 (941) 342-9162
- ☐ 326 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5023

Senate's Website: www.flsenate.gov

JOE NEGRON
President of the Senate

ANITERE FLORES
President Pro Tempore

CourtSmart Tag Report

Room: EL 110 **Case No.:**
Caption: Senate Banking and Insurance Committee

Type:
Judge:

Started: 1/16/2018 4:03:37 PM
Ends: 1/16/2018 5:57:34 PM **Length:** 01:53:58

4:04:15 PM Chair Flores calls meeting to order -- quorum present
4:04:41 PM TAB 4-- SB 438 Sen. Lee Continuing Care Contracts
4:14:19 PM Sen. Lee reconized to explain delete all amend. 872234
4:14:38 PM Amendment Adopted
4:15:02 PM Sen. Lee recognized to close on bill
4:15:22 PM Roll call on CS/SB 438 - Favorable
4:15:53 PM TAB 2 SB 396 by Sen. Hukill
4:16:06 PM Sen. Hukill recognized to explain the bill.
4:22:40 PM Amd. 144400 by Sen. Steube
4:23:07 PM Amd. to Amd. 408714 by Sen. Bradley
4:25:01 PM Explanation of amendment by Sen. Bradley --
4:29:23 PM Ashley Kalfin representing AIA
4:33:00 PM Leslie Kroeger, FL Justice Association
4:33:29 PM
4:33:33 PM
4:35:22 PM Amendment to Amd. 408714 - Sen. Hukill explains amd. to amd.
4:36:29 PM Sen. Bradley to close on Amd. to Amd. (408714) - Adopted without objection
4:37:02 PM Sen. Steube recognized on Amd. 144400 (as amended)
4:37:11 PM Jan Gorrie, CARCO
4:38:50 PM Matthew Blair, FL Independent Glass Association
4:39:45 PM Jeff Kottkamp, Florida Justice Association
4:41:53 PM Ashley Kallah, AIA
4:43:05 PM Senator Gainer in debate on SB 396
4:43:46 PM Senator Thurston in debate on bill
4:44:38 PM Sen. Steube in debate on bill
4:46:53 PM Senator Bradley in debate on bill
4:49:29 PM Senator Hukill recognized in debate on Amendment
4:50:10 PM Senator Steube in response to debate on amendment
4:50:26 PM Amd. Adopted
4:50:45 PM Brewster Bevis -in support
4:50:46 PM
4:51:29 PM Sen. Hukill waives close on bill
4:51:50 PM Roll call on CS/SB 396 - Favorable
4:52:29 PM TAB 3 - SB 416 by Sen. Thurston
4:54:01 PM Sen. Thurston recognized to explain delete all amendment (945032)
4:54:41 PM Katie Crutoot, FL Bankers Association - waives in support of bill
4:55:12 PM Amd. 945032 delete all amendment adopted without objection
4:55:32 PM Roll call - Adopted
5:00:19 PM Bill Mincy, Small Business Pharmacies waives in support of bill
5:00:54 PM Joy Ryan representing AHIP
5:01:30 PM Senator Garcia with question for Joy Ryan
5:02:42 PM Towson Fraser - waives in support of bill
5:03:06 PM Sen. Garcia recognized to close on bill
5:04:52 PM Roll call on SB 492 - Favorable
5:05:25 PM TAB 1 - SB 280 by Senator Bean
5:06:26 PM Senator Bean recognized to explain delete all amd. 856092
5:06:59 PM Amend. to Amend. 773864 (Technical Amendment) w/o adopted
5:07:24 PM Back to Delete all Amd. as amended
5:08:16 PM Lauren Faison, Administrator, TMH
5:12:42 PM Marti Coley Eubanks - Nemours Children's Health System
5:16:20 PM Joni Higgins - Bay Care Health System
5:17:13 PM Delete all Amend. (856092) Adopted

5:17:40 PM Dorene Barker, Assoc. State Director, AARP Florida
5:19:22 PM Senator Bean recognized to close on CS/SB 280
5:19:43 PM Roll call on CS/SB 280 - Favorable
5:20:20 PM TAB 7-- SB 640 by Sen. Rouson, Consumer Finance Loans
5:21:52 PM Senator Rouson recognized to explain the bill
5:23:38 PM Dorene Barker, Assoc. State Director, AARP Florida speaking against bill
5:24:32 PM Alice Vickers, Attorney, FL Alliance for Consumer Protection
5:32:09 PM Senator Rouson recognized to close on the bill.
5:32:51 PM Roll call on SB 640 - Favorable
5:33:36 PM TAB 8 SB 756 by Sen. Grimsley - Unfair Insurance Trade Practices
5:34:02 PM Sen. Grimsley explains the bill.
5:34:16 PM Sen. Grimsley waives close on bill
5:34:26 PM Roll call on SB 756 - Favorable
5:35:00 PM TAB 9 SB 920 by Sen. Bradley - Deferred Presentment
5:35:14 PM Senator Bradley recognized to explain the bill.
5:39:55 PM Alice Vickers - Attorney - FL Alliance for Consumer Protection
5:47:46 PM Rev. Rachel Gunter Shepard - Cooperative Baptist Fellowship of FL
5:48:09 PM Carol Stewart, SR. VP Advance America
5:51:18 PM Deveen Gibbons - AMScot Financial
5:51:47 PM Dorene Barker, AARP Florida
5:54:34 PM Senator Broxson in debate on SB 920
5:55:04 PM Senator Bradley recognized to close on bill.
5:56:29 PM Roll call on SB 920 - Favorable
5:57:22 PM Motion to adjourn meeting by Gainer