A bill to be entitled

An act relating to insurance regulations; amending s. 48.151, F.S.; providing that the Chief Financial Officer is the agent for service of process on health maintenance organizations; amending s. 252.63, F.S.; revising the content of a publication from the Commissioner of Insurance Regulation relating to orders applicable to insurance in areas under the state of emergency; amending s. 624.4085, F.S.; revising the definition of the term "life and health insurer"; amending s. 624.422, F.S.; providing that the appointment of the Chief Financial Officer for service of process applies to insurers withdrawing from and ceasing operations in this state until all insurers' liabilities in this state are extinguished; amending s. 624.45, F.S.; conforming a provision to changes made by the act; amending s. 624.610, F.S.; removing certain provisions relating to credits allowed in specified reinsurance circumstances and relating to assuming insurers' accreditations; requiring filing fees from reinsurers requesting to operate in this state; removing applicability provisions; amending s. 626.9651, F.S.; requiring the Office of Insurance Regulation and the Financial Services Commission to adopt rules on cybersecurity of

certain insurance data; providing requirements for such rules; providing duties of the office; amending s. 627.062, F.S.; prohibiting personal residential property insurers from submitting more than one "use and file" filing under certain circumstances; providing an exception; amending s. 627.0621, F.S.; requiring certain rate filings with the office from residential property insurers to include rate transparency reports; providing for acceptance or rejection by the office of such reports; providing requirements for such reports; requiring insurers to provide such reports to consumers; requiring the office to define terms used in such reports; requiring the office to establish and maintain a specified center on its website; providing requirements for the website; amending s. 627.0645, F.S.; revising requirements of rate filing with the office; amending s. 627.0651, F.S.; prohibiting motor vehicle insurers from submitting more than one "use and file" filing under certain circumstances; amending s. 627.4554, F.S.; requiring that certain forms be posted on the website of the Department of Financial Services, rather than the office; amending s. 627.6699, F.S.; removing and revising definitions; removing provisions relating to the creation of the Florida Small Employer

Health Reinsurance Program; amending s. 627.711, F.S.; requiring the office to contract with a state university to design, operate, upgrade, and maintain a specified database; requiring property insurers to file certain policyholder forms in the database; requiring the commission to adopt rules; amending s. 627.7152, F.S.; removing provisions relating to requirements for reporting and rulemaking regarding property insurance claims paid under assignment agreements; creating s. 627.9145, F.S.; providing reporting requirements for residential property insurers; requiring the commission to adopt rules; amending s. 627.915, F.S.; revising reporting requirements for private passenger automobile insurers; requiring the commission to adopt rules; providing requirements for such rules; removing reporting requirement provisions for certain insurers; amending ss. 628.081 and 628.091, F.S.; removing the requirement that domestic insurer incorporators execute articles of incorporation and file them with the office in triplicate; amending s. 628.111, F.S.; removing the requirement that domestic insurers make copies of amendments to articles of incorporation in triplicate; amending s. 628.461, F.S.; specifying the method of sending notifications regarding transactions

or proposed transactions of voting securities of stock insurers or controlling companies; revising the method of filing certain statements; amending s. 628.4615, F.S.; revising the method by which amendments to certain applications must be sent to specialty insurers; amending s. 628.717, F.S.; revising requirements for the office's responses upon receipt of articles of incorporation; amending s. 628.719, F.S.; revising the method by which mutual insurance holding companies show their adoption of article of incorporation amendments and deliver the amendments to the office; revising the requirements for the office's responses upon receipt of amendments; amending s. 628.910, F.S.; removing the requirement that captive insurance company incorporators file articles of incorporation in triplicate; revising the office's responses upon receipt of captive insurance company articles of incorporation; amending s. 629.011, F.S.; revising and providing definitions; amending s. 629.071, F.S.; authorizing assessable and nonassessable reciprocal insurers, rather than domestic reciprocal insurers, to transact insurance if they maintain specified amounts of surplus funds; amending s. 629.081, F.S.; conforming a provision to changes made by the act; creating s. 629.082, F.S.;

providing that attorneys in fact of reciprocals are affiliates of the reciprocals for specified purposes; creating s. 629.1015, F.S.; requiring documentation supporting that fees, commissions, and other financial considerations and payments to affiliates by reciprocal insurers are fair and reasonable; providing guidelines for the office in determining whether the fees, commissions, and other financial considerations and payments are fair and reasonable; providing requirements for documentation of such fees; amending s. 629.121, F.S.; providing that certain bonds filed with the office as security are filed by attorneys in fact, rather than attorneys of domestic reciprocal insurers; increasing the bond amount; creating s. 629.162, F.S.; authorizing reciprocal insurers to require subscriber contributions; providing disclosure and reporting requirements for subscriber contributions; creating s. 629.163, F.S.; authorizing reciprocal insurers to establish subscriber savings accounts; providing construction; providing requirements for subscriber savings accounts; creating s. 629.164, F.S.; authorizing reciprocal insurers to make distributions to subscribers from subscriber savings accounts; granting to subscribers' advisory committees sole authority to authorize distributions,

subject to prior written approval by the office; providing requirements for reciprocal insurers that prohibit subscribers from receiving distributions for a specified period of time; providing construction; authorizing reciprocal insurers to return to subscribers unused premiums, savings, and credits accruing to their accounts; authorizing domestic reciprocal insurers to pay portions of unassigned funds; providing distribution limits; prohibiting distribution discriminations; amending s. 629.171, F.S.; revising requirements for filing with the office annual statements by reciprocal insurers; amending s. 629.181, F.S; replacing surplus deposits of subscribers with subscriber contributions; providing limits on subscriber contributions; amending s. 629.201, F.S.; requiring that each domestic reciprocal insurer have a subscribers' advisory committee; requiring that such committee be formed in compliance with specified laws; requiring that rules and amendments adopted by subscribers have prior approval by the office; revising subscribers' advisory committees' duties and membership; providing for election and terms; repealing s. 629.271, F.S., relating to distribution of savings; amending s. 629.291, F.S.; providing that forms filed with the

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

maintenance organizations; amending s. 651.011, F.S.; providing and revising definitions; amending s. 651.018, F.S.; providing duties for the office if certain conditions exist in continuing care facilities; amending s. 651.019, F.S.; requiring continuing care providers to provide to the office specified information on financing and intended use of proceeds under certain circumstances; creating s. 651.0212, F.S.; requiring and authorizing the office to deny or revoke a provider's authority to engage in certain continuing care activities under certain circumstances; amending s. 651.0215, F.S.; revising the timeframe for the office to examine and respond to consolidated applications for provisional certificates of authority and certificates of authority for providers of continuing care; removing provisions relating to the duties of the office in responding to such applications; amending s. 651.022, F.S.; revising requirements for applications for provisional certificates of authority of providers of continuing care; removing provisions relating to duties of the office in responding to such applications; amending s. 651.023, F.S.; conforming cross-references and provisions to changes made by the act; amending s. 651.024, F.S.; providing applicability of certain

specialty insurer provisions and nonapplicability of certain continuing care provider requirements to bondholders under certain circumstances; defining the term "consent rights"; providing applicability of such provisions to certain entities under certain circumstances; amending s. 651.0246, F.S.; revising requirements for applications for expansion of certificated continuing care facilities; removing specified duties of the office in responding to such applications; revising the timeframe for the office to review such applications; amending s. 651.026, F.S.; revising requirements for annual reports filed by providers of continuing care; providing requirements for quarterly reports; amending s. 651.0261, F.S.; providing additional requirements for quarterly reports filed by continuing care facilities; amending s. 651.033, F.S.; requiring office approval before execution of an agreement for establishing an escrow account; defining the terms "emergency" and "business day"; specifying circumstances under which providers of continuing care may withdraw a specified percentage of the required minimum liquid reserve; revising the timeframe for the office to deny petitions for emergency withdrawals; providing duties of escrow agents; amending s. 651.034, F.S.; revising duties of

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

collection and distribution of funds by residents of continuing care facilities; providing duties of providers relating to such funds; providing requirements for providers who borrow or solicit funds from residents; providing that failure to comply with specified collection and distribution provisions is a violation of minimum liquid reserve requirements; authorizing the commission to require certain statements or filing to be submitted by electronic means; amending s. 651.091, F.S.; requiring continuing care facilities to post notices of bankruptcy proceedings; providing requirements for such notices; requiring continuing care facilities to maintain certain records; requiring providers of continuing care to make certain records available for review and to deliver copies of specified disclosure statements; providing liability and penalties; providing applicability; prohibiting persons from filing or maintaining actions under certain circumstances; creating s. 651.104, F.S.; prohibiting persons from acting or holding themselves out as management companies for continuing care retirement communities without a certificate of authority; providing requirements for certificate of authority applications; prohibiting the office from issuing

certificates of authority under certain circumstances; creating s. 651.1041, F.S.; providing applicability of specified insurer provisions to acquisitions of management companies; creating s. 651.1043, F.S.; providing requirements for management company annual and quarterly financial statements; requiring acquisition application filings under certain circumstances; requiring monthly statement filings under certain circumstances; providing fines for noncompliance; providing rulemaking authority; creating s. 651.1045, F.S.; providing grounds for the office to refuse, suspend, and revoke management company certificates of authority; providing that revocation of a management company's certificate of authority does not relieve a provider from specified obligations to residents and from annual statement filings and license fees; authorizing the office to seek enforcement actions; amending s. 651.105, F.S.; authorizing the office to examine the businesses of management companies and their parents, subsidiaries, and affiliates under certain circumstances; requiring the office to notify management companies of compliance deficiencies and to require corrective actions or plans; requiring management companies to respond to such notices; amending s. 651.1065, F.S.;

prohibiting management companies from engaging in certain acts if delinquency proceedings have been or are to be initiated; providing penalties; creating s. 651.1068, F.S.; prohibiting officers and directors of insolvent providers or management companies from serving as officers and directors of providers and management companies and from having control over the selection of officers and directors under certain circumstances; amending s. 651.107, F.S.; requiring management companies to file annual statements and pay license fees during periods of certificate of authority suspension; providing for automatic reinstatement or revocation of certificates of authority; amending s. 651.108, F.S.; providing administrative fines for management companies for certain violations; creating s. 651.113, F.S.; defining the term "negative fund balance"; providing guidelines for the commissioner to determine whether a provider or facility is insolvent or in imminent danger of becoming insolvent; requiring providers and facilities determined to be insolvent or in danger of insolvency to prepare a plan; authorizing the office to issue an order requiring a provider or facility to engage in certain acts under certain circumstances; authorizing the office to issue immediate final orders

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

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

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

48.151 Service on statutory agents for certain persons.—

(3) The Chief Financial Officer is the agent for service of process on all insurers applying for authority to transact insurance in this state, all licensed nonresident insurance agents, all nonresident disability insurance agents licensed

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

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

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

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

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

624.4085 Risk-based capital requirements for insurers.—

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

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

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

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

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

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

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

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

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

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

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

624.610 Reinsurance.—

(3)

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

state. An accredited reinsurer is one that:

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

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

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

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

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

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

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

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

a. Its financial stability;

b. The lawfulness and quality of its investments;

c. The competency, character, and integrity of its management;

d. The competency, character, and integrity of persons who own or have a controlling interest in the assuming insurer; and

e. Whether claims under its contracts are promptly and fairly adjusted and are promptly and fairly paid in accordance with the law and the terms of the contracts.

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

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

(12)

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

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

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

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

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

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

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

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

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

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

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

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

office; and

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

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

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

627.062 Rate standards.—

(2) As to all such classes of insurance:

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

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

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

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

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

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

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

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

627.0621 Transparency in rate regulation.—

(2) RATE TRANSPARENCY REPORT.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Contact information for the office.

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

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

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

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

INFORMATION.—

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

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

2. Tools that aid consumers in finding insurers.

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

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

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

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

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

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

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

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

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

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

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

provided in s. 119.0715 or s. 624.4213.

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

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

627.0645 Annual filings.—

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

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

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

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

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

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

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

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

627.4554 Suitability in annuity transactions.—

(5) DUTIES OF INSURERS AND AGENTS.—

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

interest, and documentation:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

recommended.

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

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

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

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

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

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

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

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

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

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

(A) Fixed annuities.

(B) Fixed indexed annuities.

(C) Variable annuities.

(D) Life insurance.

(E) Mutual funds.

(F) Stocks and bonds.

(G) Certificates of deposit.

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

(A) From one insurer;

(B) From two or more insurers; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. Obtain a consumer-signed statement on a form

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

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

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

627.6699 Employee Health Care Access Act.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~specific authority to:~~

~~1. Enter into contracts as necessary or proper to carry out the provisions and purposes of this act, including the authority to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions.~~

~~2. Sue or be sued, including taking any legal action necessary or proper for recovering any assessments and penalties for, on behalf of, or against the program or any carrier.~~

~~3. Take any legal action necessary to avoid the payment of improper claims against the program.~~

~~4. Issue reinsurance policies, in accordance with the requirements of this act.~~

~~5. Establish rules, conditions, and procedures for reinsurance risks under the program participation.~~

~~6. Establish actuarial functions as appropriate for the operation of the program.~~

~~7. Assess participating carriers in accordance with paragraph (j), and make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~Specifically, the board shall:~~

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

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

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

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

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

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

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

(2)

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

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

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

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

627.7152 Assignment agreements.—

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

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

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

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

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

(3) Coverages, deductibles, and exclusions.

(4) Mitigation discounts.

(5) Claims reporting requirements.

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

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

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

627.915 Insurer experience reporting.—

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

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

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

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

(c) Claims reporting requirements.

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

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

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

~~(a) Direct premiums written.~~

~~(b) Direct premiums earned.~~

~~(c) Loss reserves for all known claims:~~

~~1. At beginning of the year.~~

~~2. At end of the year.~~

~~(d) Reserves for losses incurred but not reported:~~

~~1. At beginning of the year.~~

~~2. At end of the year.~~

~~(e) Allocated loss adjustment expense:~~

~~1. Reserve at beginning of the year.~~

~~2. Reserve at end of the year.~~

~~3. Paid during the year.~~

~~(f) Unallocated loss adjustment expense:~~

~~1. Reserve at beginning of the year.~~

~~2. Reserve at end of the year.~~

~~3. Paid during the year.~~

~~(g) Direct losses paid.~~

~~(h) Underwriting income or loss.~~

~~(i) Commissions and brokerage fees.~~

~~(j) Taxes, licenses, and fees.~~

~~(k) Other acquisition costs.~~

~~(l) General expenses.~~

~~(m) Policyholder dividends.~~

~~(n) Net investment gain or loss and other income gain or loss allocated pro rata by earned premium to Florida business~~

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

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

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

628.081 Incorporation of domestic insurer.—

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

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

628.091 Filing, approval of articles of incorporation.—

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

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

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

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

628.111 Amendment of articles of incorporation; mutual insurer.—

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

(b) The office shall promptly examine the certificate of

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

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

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

628.461 Acquisition of controlling stock.—

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

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

the insurer and controlling company a letter of notification regarding the transaction or proposed transaction within 5 days after any form of tender offer or exchange offer is proposed, or within 5 days after the acquisition of the securities if no tender offer or exchange offer is involved. The notification must be provided on forms prescribed by the commission containing information determined necessary to understand the transaction and identify all purchasers and owners involved;

A filing required under this subsection must be made for any acquisition that equals or exceeds 10 percent of the outstanding voting securities.

(4)

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

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

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

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

(5)

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

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

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

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

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

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

628.717 Filing of articles of incorporation.—

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

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

628.719 Amendment of articles of incorporation.—

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

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

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

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

628.910 Incorporation options and requirements.—

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

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

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

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

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

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

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

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

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

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

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

629.071 Surplus funds required.—

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

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

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

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

629.081 Organization of reciprocal insurer.—

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

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

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

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

629.1015 Affiliate fees.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

629.162 Subscriber contributions.—

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

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

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

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

629.163 Subscriber savings accounts.—

(1) Reciprocal insurers may establish subscriber savings accounts.

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

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

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

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

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

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

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

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

629.164 Subscriber distributions.—

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

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

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

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

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

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

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

629.171 Annual statement.—

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

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

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

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

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

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

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

Section 37. Section 629.201, Florida Statutes, is amended

to read:

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

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

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

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

(a) Supervise the finances of the insurer.~~;~~

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

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

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

as may be conferred by the subscribers' agreement.

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

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

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

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

(b) Terms of not more than 5 years.

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

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

Section 38. Section 629.271, Florida Statutes, is

repealed.

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

629.291 Merger or conversion.—

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

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

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

629.301 Impaired reciprocal insurers.—

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

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

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

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

Section 41. Section 629.401, Florida Statutes, is

repealed.

Section 42. Section 629.520, Florida Statutes, is repealed.

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

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

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

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

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

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

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

Section 45. Section 641.2012, Florida Statutes, is created to read:

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

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

641.26 Annual and quarterly reports.—

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

(a) A financial statement of the health maintenance

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

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

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

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

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

(f) An actuarial certification that:

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

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

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

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

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

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

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

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

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

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

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

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

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

organizations.

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

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

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

(a) Equity ownership of voting securities;

(b) Common managerial control; or

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

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

(a) The spouse of the other person;

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

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

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

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

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

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

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

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

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

(9)~~(7)~~ "Continuing care at-home" means, pursuant to a contract other than a contract described in subsection (7) ~~(5)~~, 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.

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

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

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

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

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

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

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

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

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

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

(b) The provider's days cash on hand is less than the greater of the minimum number of days cash on hand specified in the provider's bond covenants or lending agreement for long-term financing or 100 days. 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 pursuant to s. 651.026 or s. 651.0261. If the provider is a member of an obligated group having cross-collateralized debt, the days cash on hand of the obligated group must be used as the provider's days cash on hand.

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

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

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

(1) The facility is insolvent or impaired.

(2) The facility is at a regulatory action level, pursuant

to s. 651.034.

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

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

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

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

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

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

651.019 New financing, additional financing, or refinancing.—

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

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

651.0212 General eligibility requirements to operate in this state.—

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

(a) They are incompetent or untrustworthy.

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

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

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

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

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

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

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

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

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

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

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

(4) Within 30 ~~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 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. If a certificate of authority is denied, the office shall 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.~~

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

651.022 Provisional certificate of authority; application.—

(3) In addition to the information required in subsection (2), an applicant for a provisional certificate of authority shall submit a feasibility study, prepared by an independent consultant, 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) An identification and 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.

(f) 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.

(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.

(5)~~(a)~~ Within 30 days after receipt of an application for a provisional certificate of authority, 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 shall be refunded to the applicant.

~~(b) 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 the application is deemed to be complete as of the date of~~

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

~~(6) Within 45 days after the date an application is deemed complete as set forth in paragraph (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. 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.~~

Section 54. Subsections (4) through (9) of section 651.023, Florida Statutes, are renumbered as subsections (3) through (8), respectively, and paragraphs (c) and (h) of subsection (1), subsection (2), and present subsections (3) and (7) of that section 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:

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

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

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.

(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 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. If denied, the holder of the provisional certificate is entitled to an administrative hearing pursuant to chapter 120.~~

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

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

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

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

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

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

651.024 Acquisition.—

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

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

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

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

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

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

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

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

651.0246 Expansions.—

(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, the size, the 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 revenues, 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.

5. A projected balance sheet of the applicant.

6. The expectations for 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 rates, 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 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.

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

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

If any material change occurs in the facts set forth in an application filed with the office pursuant to this section, 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.

(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 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 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.~~ 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 stating that the application as received is substantially incomplete and, therefore, is unacceptable for filing without further action required by the office. Any filing fee received must be refunded to the applicant.

(6) Within 45 ~~30~~ days after the date on which an application is deemed complete as provided 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, citing the specific failures to meet the requirements of this chapter. The denial entitles the applicant to a hearing pursuant to chapter 120.

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

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

651.026 Annual and quarterly reports.—

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

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

(e) ~~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 commission.

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

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

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

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

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

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

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

Section 58. Subsections (2), (3), and (4) of section 651.0261, Florida Statutes, are renumbered as subsections (3), (4), and (5), respectively, subsection (1) and present subsection (3) are amended, and a new subsection (2) is added to that section, 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 commission rule and days cash on hand, occupancy, debt service coverage ratio, and a detailed listing of the assets maintained in the liquid reserve as required under s. 651.035. The last quarterly statement for a fiscal year is not required if a provider does not have pending a regulatory action level event, impairment, or a corrective action plan. If a provider falls below two or more of the thresholds set forth in s. 651.011(29) ~~s. 651.011(26)~~ at the end of any fiscal quarter,

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

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

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

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

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

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

(a) The provider is:

1. Subject to administrative supervision proceedings;

2. Subject to a corrective action plan resulting from a regulatory action level event and for up to 2 years after the factors that caused the regulatory action level event have been corrected; or

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

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

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

(d) The provider is found to be impaired.

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

651.033 Escrow accounts.—

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

(c) Any agreement establishing an escrow account required under this chapter is subject to approval by the office before execution. The agreement must be in writing and 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) and (b), (5)(a), and subsection (6).

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

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

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

(3) When entrance fees are required to be deposited in an escrow account pursuant to s. 651.0215, s. 651.022, s. 651.023, s. 651.0246, 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 be deposited with the escrow agent or as provided in paragraph (c). The escrow agent must 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. 651.0215(7) ~~s. 651.0215(8)~~, s. 651.023(5) ~~s. 651.023(6)~~, or s. 651.0246. However, if the resident rescinds the contract within the 7-day period, the escrow agent must release the escrowed fees to the resident.

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

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

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

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

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

651.034 Financial and operating requirements for providers.—

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

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

Section 61. Subsections (1) and (3), paragraph (b) of subsection (7), and subsection (8) of section 651.035, Florida Statutes, are amended 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. Each established account must be separate and unique to a facility, unencumbered, and not commingled with any other funds from any other account, facility, affiliate, or obligated group. Funds held in escrow under paragraphs (a), (c), and (d) must be held completely separate from any funds held by a trustee under paragraph (b), meaning the debt service, operating, and renewal and replacement reserves must have their own distinct account number:

(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

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 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 provided pursuant to s. 197.322(3), and must annually pay property taxes out of such escrow.

(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 reserve 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. In addition, the trust indenture, loan agreement, or escrow agreement must provide that the provider, trustee, lender, escrow agent, or a person designated to act in its place shall notify the office in writing at least 10 days before the withdrawal of any portion of the debt service reserve funds required to be held in escrow as described in this paragraph. The notice must include an affidavit sworn to by the provider, the trustee, or a person designated to act in its place which includes the amount of the scheduled debt service payment, the payment due date, the amount of the withdrawal, the accounts from which the withdrawal will be made, and a plan with a schedule for replenishing the withdrawn funds. If the plan is revised by a consultant that is retained as prescribed in the provider's financing documents, the revised plan must be submitted to the office within 10 days after the approval by the lender or trustee. If a debt service reserve is transferred from one financial institution or lender to another, the provider must provide notice to the office at least 10 days before the transfer takes place. The notice must include an affidavit sworn to by the provider and include the name of the institution where the debt service reserve is being transferred, the date of transfer, the amount being transferred, a copy of the agreement requiring the transfer to the new

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

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

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

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

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

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

a. Is insolvent or financially impaired.

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

c. Is placed under administrative supervision.

d. Is in a hazardous financial condition under s. 651.113.

e. Entered into a forbearance agreement with a lender.

f. Filed or has notified the office of its intent to file for bankruptcy.

g. Failed to maintain minimum liquid reserve requirements under subsections (10) and (11).

Upon notice from the office that a condition identified in this subparagraph exists, the provider has 10 days within which to fund the operating reserve at 50 percent and provide evidence of the funding to the office.

(d) Before reducing the operating reserve required under paragraph (c), the provider must obtain written approval from the office ~~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~~.

(e) If a provider has been in operation for more than 12 months, the total annual operating expenses must 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 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 be included in the total operating expenses in an amount not to exceed the premium paid during the first 12 months of facility operation. The operating reserves required under this subsection must 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 in compliance with this subsection.

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

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

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

(7)

(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 provider may not withdraw funds until the office provides such written notice. 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, or if the facility fails to fund the minimum liquid reserve required by subsection (10) or subsection (11). 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.

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

651.043 Approval of change in management.—

(2) A provider or management company shall notify the

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

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

651.055 Continuing care contracts; right to rescind.—

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

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

Section 64. 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 deemed preferred claims against all assets owned by the provider.~~; however,~~ Such claims are not subordinate to any secured claim and must be treated with higher priority over all other claims, except Class 1 claims. For purposes of s. 631.271, such contracts are deemed Class 2 claims.

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

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

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

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

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

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

651.087 Resident funds for charitable or operational purposes.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Maintain a 50 percent operating reserve pursuant to s. 651.035(1)(c)4. for the duration of the repayment period. Following the repayment period, the provider must obtain the office's prior written approval to reduce the operating reserve amount.

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

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

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

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

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

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

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

(8) 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.

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

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

(2) Every continuing care facility shall:

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

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

residents' council and make supporting documentation available upon request.

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

(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, obtain written acknowledgment of receipt, 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:

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

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

3. Any known legal impediments to the plans disclosed in subparagraphs 1. and 2., including, but not limited to, pending legal action to stop or modify the plans, the denial of building permits, or a failure to secure financing~~, to the extent that the availability of such plans does not put at risk real estate, financing, acquisition, negotiations, or other implementation of operational plans and thus jeopardize the success of~~

~~negotiations, operations, and development~~.

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

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

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

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

651.104 Certificate of authority to act as a management company.—

(1) It is unlawful for any person to act as or hold himself or herself out to be management company for a continuing care retirement community in this state without a valid certificate of authority issued by the office pursuant to this section. A management company that was operating in this state as of June 30, 2025, may continue to operate until January 1, 2026, as a management company without a certificate of authority and is not in violation of the requirement to possess a valid certificate of authority as a management company during that period of time. To qualify for and hold authority to act as a management company in this state, a management company must otherwise be in compliance pursuant to this section and with its organizational agreement. A person who, on or after January 1, 2026, does not hold a certificate of authority to act as a management company while operating as a management company is subject to a fine of $10,000 per violation per day.

(2) A management company shall file with the office an application for a certificate of authority on a form adopted by the commission and furnished by the office. The application must include or have attached the following information and documents:

(a) All basic organizational documents of the management company, such as the articles of incorporation, articles of

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

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

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

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

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

1. Amounts shown on the consolidated audited financial report must be shown on the worksheet;

2. Amounts for each entity must be stated separately; and

3. Explanations of consolidating and eliminating entries must be included.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(9) 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.

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

651.1045 Management company grounds for discretionary denial, suspension, or revocation of certificate of authority.—

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

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

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

the certificate of authority under this chapter.

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

(d) Demonstrating a lack of fitness or trustworthiness.

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

(f) Misappropriating, converting, or withholding moneys.

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

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

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

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

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

(l) Failing 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 failing to honor its continuing care or continuing care at-home contracts, if responsible for the day-to-day operations of the provider.

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

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

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

(p) Demonstrating a pattern of bankrupt enterprises.

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

1. Is not reputable and of responsible character;

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

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

4. 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, contract holders, investors, or creditors; by manipulation of assets, finances, or accounts; or by bad faith; or

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

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

(2) Revocation of a management company's certificate of authority under this section does not relieve a provider of 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 residents or this chapter. The management company 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 management company may not issue any new contracts on behalf of a provider.

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

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

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

651.105 Examination.—

(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 or management company 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. For a provider or management company as deemed accredited under s. 651.028, such examinations must take place at least once every 5 years. An examination covering the preceding 3 or 5 fiscal years of the provider or management company, as applicable, must be commenced within 12 months after the end of the most recent fiscal year covered by the examination. Such examination may include events subsequent to the end of the most recent fiscal year and the events of any prior period which relate to possible violations of this chapter or which affect the present financial condition of the provider or management company. At least once every 3 or 5 fiscal years, as applicable, the office shall conduct an interview in person, telephonically, or through electronic communication with the current president or chair of the residents' council, or another designated officer of the council

if the president or chair is not available, as part of the examination process. The examinations must 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 or management company 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 or management company, whether in connection with a formal examination or not.

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

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

(5) A provider or management company shall respond to written correspondence from the office and provide data, financial statements, and pertinent information as requested by the office. The office has standing to petition a circuit court for mandatory injunctive relief to compel access to and require the provider or management company to produce the documents, data, records, and other information requested by the office. 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.

(6) ~~Unless a provider 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, or management company relies on a contractual or financial relationship with a parent, a subsidiary, or an affiliate in order to meet the financial requirements of this chapter, the office may examine any parent, subsidiary, or affiliate that has a contractual or financial relationship with the provider, ~~or~~

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

Section 73. Section 651.1065, Florida Statutes, is amended 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 facility have been or are to be initiated, a proprietor, a general partner, a member, an officer, a director, a trustee, ~~or~~ a manager, or a management company of a continuing care facility 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, or a management company knew, or reasonably should have known, that the continuing care facility was impaired or insolvent except with the written permission of the office. If the facility has declared bankruptcy, 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, a general partner, a member, an officer, a director, a trustee, ~~or~~ a manager, or a management company that ~~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 74. Section 651.1068, Florida Statutes, is created to read:

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

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

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

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

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

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

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

651.108 Administrative fines.—

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

Section 77. Section 651.113, Florida Statutes, is created

to read:

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

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

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

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

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

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

potential decline in operations, working capital, or equity.

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

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

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

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

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

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

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

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

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

(a) Obtain additional financing or revenues to maintain solvency.

(b) Reduce expenses by specified methods or amounts.

(c) Increase the operating reserve.

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

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

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

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

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

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

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

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

(5) This section may not be interpreted to limit the

powers granted to the office by any laws of this state, nor may it be interpreted to supersede any laws of this state.

Section 78. Subsection (11) of section 651.114, Florida Statutes, is amended to read:

651.114 Delinquency proceedings; remedial rights.—

~~(11)(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 paragraph (c), may 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 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) If the office determines, at any time during the suspension of its remedial rights as provided in paragraph (a), that:~~

~~1. The trustee or lender is not in compliance with paragraph (a);~~

~~2. 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;~~

~~3. The provider engaged in the misappropriation, conversion, or illegal commitment or withdrawal of minimum liquid reserve or escrowed funds required under this chapter;~~

~~4. The provider refused to be examined by the office pursuant to s. 651.105(1); or~~

~~5. The provider refused to produce any relevant accounts, records, and files requested as part of an examination,~~

~~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 79. Section 651.1165, Florida Statutes, is created to read:

651.1165 Recording of lien by the office.—

(1) The office shall, as a condition to granting a provisional certificate of authority to an applicant, record with the county recorder of any county a notice of lien against the facility's properties on behalf of all residents and contract holders who enter into life care contracts with the applicant to secure performance of the provider's obligations to residents and contract holders pursuant to life care contracts.

(2) From the time of the recording under subsection (1), there exists a lien for an amount equal to the reasonable value of services to be performed under a life care contract in favor of each resident and contract holder on the land and improvements of the facility's properties owned by the provider, not exempt from execution, which are listed in the notice of lien filed pursuant to subsection (3) and which are located in the county in which the notice of lien is recorded.

(3) The lien shall be perfected by the office by executing by affidavit the notice and claim of lien, which must contain:

(a) The legal description of the lands and improvements to be charged with a lien.

(b) The name of the owner of the property affected.

(c) A statement that the lien has been filed by the office pursuant to this section.

(4) The lien may be released or partially released at the request of the applicant if, in the judgment of the director, such release or partial release inures to the benefit of the residents and contract holders and the performance of the provider's obligations to the residents and contract holders.

(5) The lien may be foreclosed by civil action. Any number of persons claiming liens against the same property pursuant to this section may join in the same action. If separate actions are commenced, the court may consolidate such actions. The court shall, as part of the costs, allow reasonable attorney fees for each claimant who is a party to the action.

(6) In a civil action filed pursuant to this section, the judgment must be entered in favor of each resident and contract holder having a lien who has joined in the foreclosure action for the amount equal to the reasonable value of services to be performed under a life care contract in favor of each resident and contract holder. The court shall order the sheriff to sell any property subject to the lien at the time judgment is given, in the same manner as real and personal property is sold on execution. The lien for the reasonable value of services to be performed under a life care contract must be on equal footing with claims of other residents and contract holders. If a sale

is ordered and the property sold and the proceeds of the sale are not sufficient to discharge all liens of residents and contract holders against the property, the proceeds must be prorated among the respective residents and contract holders.

(7) The lien provided for in this section is preferred to all liens, mortgages, or other encumbrances upon the property attaching subsequently to the time the lien is recorded and is preferred to all unrecorded liens, mortgages, and other encumbrances. The amount secured by any lien having priority to the lien filed pursuant to this section may not be increased without prior approval of the office.

(8) The office shall file a release of the lien upon proof of complete performance of all obligations to residents and contract holders pursuant to life care contracts.

(9) The office may subordinate any lien filed pursuant to this section to the lien of a first mortgage or other long-term financing obtained by the provider, regardless of the time at which the subsequent lien attaches.

Section 80. Subsection (3) of section 627.642, Florida Statutes, is amended to read:

627.642 Outline of coverage.—

(3) In addition to the outline of coverage, a policy as specified in s. 627.6699(3)(j) ~~s. 627.6699(3)(k)~~ must be accompanied by an identification card that contains, at a minimum:

(a) The name of the organization issuing the policy or the name of the organization administering the policy, whichever applies.

(b) The name of the contract holder.

(c) The type of plan only if the plan is filed in the state, an indication that the plan is self-funded, or the name of the network.

(d) The member identification number, contract number, and policy or group number, if applicable.

(e) A contact phone number or electronic address for authorizations and admission certifications.

(f) A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the policy may obtain benefits verification and information in order to estimate patient financial responsibility, in compliance with privacy rules under the Health Insurance Portability and Accountability Act.

(g) The national plan identifier, in accordance with the compliance date set forth by the federal Department of Health and Human Services.

The identification card must present the information in a readily identifiable manner or, alternatively, the information may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided

through other electronic technology.

Section 81. Paragraph (a) of subsection (2), paragraphs (a), (e), and (g) of subsection (7), and paragraph (a) of subsection (8) of section 627.6475, Florida Statutes, are amended to read:

627.6475 Individual reinsurance pool.—

(2) DEFINITIONS.—As used in this section:

(a) ~~"Board,"~~ "Carrier~~,~~" and "health benefit plan" have the same meaning ascribed in s. 627.6699(3).

(7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.—

(a) The individual health reinsurance program shall operate subject to the supervision and control of the board of the small employer health reinsurance program ~~established pursuant to s. 627.6699(11)~~. The board shall establish a separate, segregated account for eligible individuals reinsured pursuant to this section, which account may not be commingled with the small employer health reinsurance account.

(e)1. Before March 1 of each calendar year, the board shall determine and report to the office the program net loss in the individual account for the previous year, including administrative expenses for that year and the incurred losses for that year, taking into account investment income and other appropriate gains and losses.

2. Any net loss in the individual account for the year shall be recouped by assessing the carriers as follows:

a. The operating losses of the program shall be assessed in the following order subject to the specified limitations. The first tier of assessments shall be made against reinsuring carriers in an amount that may not exceed 5 percent of each reinsuring carrier's premiums for individual health insurance. If such assessments have been collected and additional moneys are needed, the board shall make a second tier of assessments in an amount that may not exceed 0.5 percent of each carrier's health benefit plan premiums.

b. Except as provided in paragraph (f), risk-assuming carriers are exempt from all assessments authorized pursuant to this section. The amount paid by a reinsuring carrier for the first tier of assessments shall be credited against any additional assessments made.

c. The board shall equitably assess reinsuring carriers for operating losses of the individual account based on market share. The board shall annually assess each carrier a portion of the operating losses of the individual account. The first tier of assessments shall be determined by multiplying the operating losses by a fraction, the numerator of which equals the reinsuring carrier's earned premium pertaining to direct writings of individual health insurance in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of all such premiums earned by reinsuring carriers in the state during that calendar

year. The second tier of assessments shall be based on the premiums that all carriers, except risk-assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments against reinsuring carriers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to be paid in the operation of the plan for the calendar year prior to the association's anticipated receipt of annual assessments for that calendar year. Any interim assessment is due and payable within 30 days after receipt by a carrier of the interim assessment notice. Interim assessment payments shall be credited against the carrier's annual assessment. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining assessments.

d. Subject to the approval of the office, the board shall adjust the assessment formula for reinsuring carriers that are approved as federally qualified health maintenance organizations by the Secretary of Health and Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent, if any, that restrictions are placed on them which are not imposed on other carriers.

3. Before March 1 of each year, the board shall determine and file with the office an estimate of the assessments needed to fund the losses incurred by the program in the individual account for the previous calendar year.

4. If the board determines that the assessments needed to fund the losses incurred by the program in the individual account for the previous calendar year will exceed the amount specified in subparagraph 2., the board shall evaluate the operation of the program and report its findings and recommendations to the office ~~in the format established in s. 627.6699(11) for the comparable report for the small employer reinsurance program~~.

(g) Except as otherwise provided in this section, the board and the office shall have all powers, duties, and responsibilities with respect to carriers that issue and reinsure individual health insurance, ~~as specified for the board and the office in s. 627.6699(11) with respect to small employer carriers,~~ including, but not limited to~~, the provisions of s. 627.6699(11) relating to~~:

1. Use of assessments that exceed the amount of actual losses and expenses.

2. The annual determination of each carrier's proportion of the assessment.

3. Interest for late payment of assessments.

4. Authority for the office to approve deferment of an assessment against a carrier.

5. Limited immunity from legal actions or carriers.

6. Development of standards for compensation to be paid to agents. Such standards shall be limited to those specifically

enumerated in s. 627.6699(11)(d) ~~s. 627.6699(12)(d)~~.

7. Monitoring compliance by carriers with this section.

(8) STANDARDS TO ASSURE FAIR MARKETING.—

(a) Each health insurance issuer that offers individual health insurance shall actively market coverage to eligible individuals in the state. The provisions of s. 627.6699(11) ~~s. 627.6699(12)~~ that apply to small employer carriers that market policies to small employers shall also apply to health insurance issuers that offer individual health insurance with respect to marketing policies to individuals.

Section 82. Subsection (2) of section 627.657, Florida Statutes, is amended to read:

627.657 Provisions of group health insurance policies.—

(2) The medical policy as specified in s. 627.6699(3)(j) ~~s. 627.6699(3)(k)~~ must be accompanied by an identification card that contains, at a minimum:

(a) The name of the organization issuing the policy or name of the organization administering the policy, whichever applies.

(b) The name of the certificateholder.

(c) The type of plan only if the plan is filed in the state, an indication that the plan is self-funded, or the name of the network.

(d) The member identification number, contract number, and policy or group number, if applicable.

(e) A contact phone number or electronic address for authorizations and admission certifications.

(f) A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the policy may obtain benefits verification and information in order to estimate patient financial responsibility, in compliance with privacy rules under the Health Insurance Portability and Accountability Act.

(g) The national plan identifier, in accordance with the compliance date set forth by the federal Department of Health and Human Services.

The identification card must present the information in a readily identifiable manner or, alternatively, the information may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided through other electronic technology.

Section 83. Subsection (1) of section 627.66997, Florida Statutes, is amended to read:

627.66997 Stop-loss insurance.—

(1) A self-insured health benefit plan established or maintained by a small employer, as defined in s. 627.6699(3)(s) ~~s. 627.6699(3)(v)~~, is exempt from s. 627.6699 and may use a stop-loss insurance policy issued to the employer. For purposes of this subsection, the term "stop-loss insurance policy" means

an insurance policy issued to a small employer which covers the small employer's obligation for the excess cost of medical care on an equivalent basis per employee provided under a self-insured health benefit plan.

(a) A small employer stop-loss insurance policy is considered a health insurance policy and is subject to s. 627.6699 if the policy has an aggregate attachment point that is lower than the greatest of:

1. Two thousand dollars multiplied by the number of employees;

2. One hundred twenty percent of expected claims, as determined by the stop-loss insurer in accordance with actuarial standards of practice; or

3. Twenty thousand dollars.

(b) Once claims under the small employer health benefit plan reach the aggregate attachment point set forth in paragraph (a), the stop-loss insurance policy authorized under this section must cover 100 percent of all claims that exceed the aggregate attachment point.

Section 84. Reciprocal insurers licensed before July 1, 2025, have until July 1, 2026, to comply with the changes made to subscribers' advisory committees in s. 629.201, Florida Statutes. Reciprocal insurers licensed before July 1, 2025, have until July 1, 2027, to comply with the changes made to unearned premium reserve requirements imposed under s. 629.56, Florida

Statutes.

Section 85. 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, 2025.