AGENDA
FINANCIAL SERVICES COMMISSION
Office of Insurance Regulation
Materials Available on the Web at:
http://www.floir.com/Sections/GovAffairs/FSC.aspx

June 25, 2013

MEMBERS
Governor Rick Scott
Attorney General Pam Bondi
Chief Financial Officer Jeff Atwater
Commissioner Adam Putnam

Contact: **Karen Kees**
(850-413-2474)

9:00 A.M.
LL-03, The Capitol
Tallahassee, Florida

ITEM	SUBJECT	RECOMMENDATION

1. Minutes of the Financial Services Commission for March 7, 2013.

   (ATTACHMENT 1) **FOR APPROVAL**

2. Request for Approval for Publication of Proposed Amendments to Rule 69O-137.001; Annual and Quarterly Reporting Requirements.

   The Office is proposing to amend this rule to adopt the current versions of these NAIC instructions and manuals. Section 624.424, Florida Statutes, requires insurers to file quarterly and annual financial reports with the Office and allows the Office to enact rules setting the standards for those reports. By adopting the current versions of these NAIC instructions and manuals, the Office is establishing up-to-date, uniform standards for annual and quarterly reports which will provide the information necessary for the Office to evaluate insurers' financial conditions.

   (ATTACHMENT 2) **APPROVAL FOR PUBLICATION**

3. Request for Approval for Publication of Proposed Amendments to Rule 69O-138.001; NAIC Financial Condition Examiners Handbook Adopted.

   The Office is proposing to amend this rule to adopt the 2013 NAIC Financial Condition Examiners Handbook. Section 624.316, Florida Statutes, requires the Office to examine insurers' financial condition using generally accepted accounting procedures. This statute also allows the Office to adopt the NAIC Financial Condition Examiners Handbook to facilitate these exams. By adopting the newest version of the handbook, this rule ensures that the procedures used by the Office to examine insurers are the current generally accepted accounting practices.

   (ATTACHMENT 3) **APPROVAL FOR PUBLICATION**

4. Request for Approval for Publication of Proposed Amendments to Rule 69O-149.022 Forms Adopted.

The purpose of this rule development is to develop the "Notice of Estimated Premium Impacts from the Federal Patient Protection and Affordable Care Act" required by CS/SB 1842 which amended Section 627.410, Florida Statutes. This notice will be required to be sent to all individual and small group nongrandfathered health plans or health maintenance organizations.

(ATTACHMENT 4) **APPROVAL FOR PUBLICATION**

T H E C A B I N E T

S T A T E O F F L O R I D A

Representing:

STATE BOARD OF ADMINISTRATION

ADMINISTRATION COMMISSION

BOARD OF TRUSTEES OF THE INTERNAL IMPROVEMENT TRUST FUND

FINANCIAL SERVICES COMMISSION, INSURANCE REGULATION

The above agencies came to be heard before THE FLORIDA CABINET, the Honorable Governor Scott presiding, in the Cabinet Meeting Room, LL-03, The Capitol, Tallahassee, Florida, on Thursday, March 7, 2013, commencing at approximately 9:15 a.m.

Reported by:

MARY ALLEN NEEL
Registered Professional Reporter
Florida Professional Reporter
Notary Public

ACCURATE STENOTYPE REPORTERS, INC.
2894 REMINGTON GREEN LANE
TALLAHASSEE, FLORIDA 32308
850.878.2221

APPEARANCES:

Representing the Florida Cabinet:

RICK SCOTT
Governor

PAM BONDI
Attorney General

JEFF ATWATER
Chief Financial Officer

ADAM PUTNAM
Commissioner of Agriculture

* * *

GOVERNOR SCOTT: Now I would like to recognize Belinda Miller, general counsel of the Office of Insurance Regulation. Good morning.

MS. MILLER: Good morning. Thank you, Governor and members of the Financial Services Commission.

This morning I would like to request approval of the minutes from the December 11, 2012 meeting of the Financial Services Commission.

GOVERNOR SCOTT: Is there a motion to approve the item?

CFO ATWATER: So moved.

COMMISSIONER PUTNAM: Second.

GOVERNOR SCOTT: Any comments or objections? Hearing none, the motion carries.

MS. MILLER: Thank you. Items Number 2 and 3 on our list today are requests to do a rule for annual and quarterly statements for financial -- insurance companies and for amendments to the Examiners Handbook. And with your indulgence, we would request that those rules be withdrawn and reconsidered at the next available opportunity.

GOVERNOR SCOTT: Is there a motion to withdraw these two items?

CFO ATWATER: So moved.

GOVERNOR SCOTT: Is there a second?

ATTORNEY GENERAL BONDI: Second.

GOVERNOR SCOTT: Any comments or objections? The items are withdrawn.

MS. MILLER: Thank you.

GOVERNOR SCOTT: Thanks, Belinda.

This concludes our Cabinet meeting. Our next meeting will be Tuesday, March 19th at 9:00 a.m. in Tallahassee. We are adjourned.

(Proceedings concluded at 10:47 a.m.)

CERTIFICATE OF REPORTER

STATE OF FLORIDA:

COUNTY OF LEON:

I, MARY ALLEN NEEL, Registered Professional Reporter, do hereby certify that the foregoing proceedings were taken before me at the time and place therein designated; that my shorthand notes were thereafter translated under my supervision; and the foregoing pages numbered 1 through 49 are a true and correct record of the aforesaid proceedings.

I FURTHER CERTIFY that I am not a relative, employee, attorney or counsel of any of the parties, nor relative or employee of such attorney or counsel, or financially interested in the foregoing action.

DATED THIS 19th day of March, 2013.

MARY ALLEN NEEL, RPR, FPR
MaryAllenNeel@gmail.com
ACCURATE STENOTYPE REPORTERS, INC.
2894-A Remington Green Lane
Tallahassee, Florida 32308
Telephone: 850.878.2221

M E M O R A N D U M

DATE: May 14, 2013

TO: Kevin M. McCarty, Commissioner, Office of Insurance Regulation

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Jason Nelson

SUBJECT: Cabinet Agenda for June 25, 2013
Request for Approval to Publish Amendments to
Rule 69O-137.001
Annual and Quarterly Reporting Requirements
Assignment # 129087-12

The Office of Insurance Regulation requests that this proposed rule amendment be presented to the Cabinet aides on or before June 19, 2013 and to the Financial Services Commission on June 25, 2013, with a request to approve for publication the proposed rules.

This rule is being amended to adopt the 2012 NAIC Annual Statement Instructions Manuals.

Sections 624.308(1), 624.424(1), F.S., provide rulemaking authority and laws implemented for this rule.

Will Spicola is the attorney handling this rule. Attached are: 1) the proposed rule(s), 2) any incorporated materials, such as forms; and 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:

Belinda Miller, General Counsel

Approved for submission to Financial Services Commission:

Kevin M. McCarty, Commissioner
Office of Insurance Regulation

69O-137.001 Annual and Quarterly Reporting Requirements.

(1) through (3) No change.

(4) Manuals Adopted.

(a) Annual statements shall be prepared in accordance with the following manuals, which are hereby adopted and incorporated by reference:

1. The NAIC's Annual Statement Instructions, Property and Casualty, 20122~~011~~;

2. The NAIC's Annual Statement Instructions, Life, Accident and Health, 20122~~011~~;

3. The NAIC's Annual Statement Instructions, Health, 20122~~011~~;

4. The NAIC's Annual Statement Instructions, Title, 20122~~011~~; and

5. The NAIC's Accounting Practices and Procedures Manual, as of March 20122~~011~~.

(b) Quarterly statements shall be prepared in accordance with the following manuals, which are hereby adopted and incorporated by reference:

1. The NAIC's Quarterly Statement Instructions, Property and Casualty, 20132~~012~~;

2. The NAIC's Quarterly Statement Instructions, Life, Accident and Health, 20132~~012~~;

3. The NAIC's Quarterly Statement Instructions, Health, 20132~~012~~;

4. The NAIC's Quarterly Statement Instructions, Title, 20132~~012~~; and

5. The NAIC's Accounting Practices and Procedures Manual, as of March 20132~~012~~.

(c) No change

~~(5) Adoption of revised Actuarial Guideline 38.~~

~~(a) Revised NAIC Accounting Practices and Procedures Manual Actuarial Guideline 38 which is Attachment Three in the agenda for the September 12, 2012 Executive (Ex) Committee and Plenary conference call at http://www.naic.org/documents/jt_ex_plenary_120912_agenda_materials.pdf is hereby~~

~~adopted and incorporated by reference and replaces the Guideline published in the Manual for annual and quarterly statements submitted to the Office on and after December 31, 2012.~~

~~(b) Sections of the draft version of the Valuation Manual, adopted by NAIC Life Insurance and Annuities (A) Committee on August 17, 2012, referenced in Revised Actuarial Guideline 38 which is Attachment One in the agenda for the September 12, 2012 Executive (Ex) Committee and Plenary conference call at http://www.naic.org/documents/jt_ex_plenary_120912_agenda_materials.pdf are hereby adopted and incorporated by reference.~~

~~(c) Reserves reported in the 2012 annual and subsequent quarterly and annual statements to which Accounting Practices and Procedures Manual Actuarial revised Guideline 38 applies will not be based upon future versions of a draft Valuation Manual unless adopted by statute or amendment to this rule.~~

~~(d) A printed copy of the NAIC Executive (Ex) Committee and Plenary conference call agenda including attachments is available for inspection at the Office at its headquarters in Tallahassee, Florida, during regular business hours.~~

Specific Authority 624.308(1), 624.424(1) FS. Law Implemented 624.424(1) FS. History–New 3-31-92, Amended 8-24-93, 4-9-95, 4-9-97, 4-4-99, 11-30-99, 2-11-01, 4-5-01, 12-4-01, 12-25-01, 8-18-02, 7-27-03, Formerly 4-137.001, *Amended 1-6-05, 9-15-05, 1-25-07, 3-16-08, 3-4-09, 1-4-10, 9-28-11,1-28-13,*_____.

624.308 Rules.--

(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.

624.424 Annual statement and other information.--

(1)(a) Each authorized insurer shall file with the office full and true statements of its financial condition, transactions, and affairs. An annual statement covering the preceding calendar year shall be filed on or before March 1, and quarterly statements covering the periods ending on March 31, June 30, and September 30 shall be filed within 45 days after each such date. The office may, for good cause, grant an extension of time for filing of an annual or quarterly statement. The statements shall contain information generally included in insurers' financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally utilized by insurers for financial statements, sworn to by at least two executive officers of the insurer or, if a reciprocal insurer, by the oath of the attorney in fact or its like officer if a corporation. To facilitate uniformity in financial statements and to facilitate office analysis, the commission may by rule adopt the form for financial statements approved by the National Association of Insurance Commissioners in 2002, and may adopt subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each insurer to submit to the office or such organization as the office may designate all or part of the information contained in the financial statement in a computer-readable form compatible with the electronic data processing system specified by the office.

(b) Each insurer's annual statement must contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or by a qualified loss reserve specialist, under criteria established by rule of the commission. In adopting the rule, the commission must consider any criteria established by the National Association of Insurance Commissioners. The office may require semiannual updates of the annual statement of opinion as to a particular insurer if the office has reasonable cause to believe that such reserves are understated to the extent of materially misstating the financial position of the insurer. Workpapers in support of the statement of opinion must be provided to the office upon request. This paragraph does not apply to life insurance or title insurance.

(c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.

M E M O R A N D U M

DATE: May 14, 2013

TO: Kevin M. McCarty, Commissioner, Office of Insurance Regulation

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Jason Nelson

SUBJECT: Cabinet Agenda for June 25, 2013
Request for Approval to Publish Amendments to
Rule 69O-138.001
NAIC Financial Condition Examiners Handbook Adopted
Assignment # 130907-13

The Office of Insurance Regulation requests that this proposed rule amendment be presented to the Cabinet aides on or before June 19, 2013 and to the Financial Services Commission on June 25, 2013, with a request to approve for publication the proposed rules.

This rule is being amended to adopt the 2013 NAIC Financial Condition Examiners Handbook. The current rule adopted the 2011 version.

Sections 624.308(1), 624.316(1)(c), F.S., provide rulemaking authority and laws implemented for this rule.

WMS Will Spicola is the attorney handling this rule. Attached are: 1) the proposed rule(s), 2) any incorporated materials, such as forms; and 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:

Belinda Miller, General Counsel

Approved for submission to Financial Services Commission:

Kevin M. McCarty, Commissioner
Office of Insurance Regulation

69O-138.001 NAIC Financial Condition Examiners Handbook Adopted.

(1)(a) The National Association of Insurance Commissioners Financial Condition Examiners Handbook 2013 ~~2011~~ is hereby adopted and incorporated by reference.

(b) No change

(2) – (3) No change.

Rulemaking Authority 624.308(1), 624.316(1)(c) FS. Law Implemented 624.316(1)(c) FS. History–New 3-30-92, Amended 4-9-97, 4-4-99, 11-30-99, 2-11-01, 12-25-01, 8-18-02, 7-27-03, Formerly 4-138.001, Amended 1-6-05, 9-15-05, 1-25-07, 3-16-08, 3-4-09, 1-4-10, 11-2-11, 1-28-13,_____.

624.308 Rules.--

(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.

624.316 Examination of insurers.--

(1)(c) The office shall examine each insurer according to accounting procedures designed to fulfill the requirements of generally accepted insurance accounting principles and practices and good internal control and in keeping with generally accepted accounting forms, accounts, records, methods, and practices relating to insurers. To facilitate uniformity in examinations, the commission may adopt, by rule, the Market Conduct Examiners Handbook and the Financial Condition Examiners Handbook of the National Association of Insurance Commissioners, 2002, and may adopt subsequent amendments thereto, if the examination methodology remains substantially consistent.

M E M O R A N D U M

DATE: June 7, 2013

TO: Kevin M. McCarty, Commissioner, Office of Insurance Regulation

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Jason Nelson JN

SUBJECT: Cabinet Agenda for June 25, 2013
Request for Approval to Publish Amendments to
Rule 69O-149.022
Forms Adopted
Assignment # 134012-13

The Office of Insurance Regulation requests that this proposed rule amendment be presented to the Cabinet aides on or before June 19, 2013 and to the Financial Services Commission on June 25, 2013, with a request to approve for publication the proposed rule amendment.

The purpose of this rule development is to develop the "Consumer Notice Health Plan Cost Changes From Federal Health Care Reform" required by CS/SB 1842 which amended Section 627.410, Florida Statutes. This notice will be required to be sent to all individual and small group nongrandfathered health plans or health maintenance organizations.

Sections 624.308, 627.410(9), 624.424(1)(c),627.410,636.216, F.S., provide rulemaking authority and laws implemented for this rule.

Steve Fredrickson is the attorney handling this rule. Attached are: 1) the proposed rule(s), 2) any incorporated materials, such as forms; and 3) copies of the rulemaking statutory authority and law implemented.

Approved for signature:

Belinda Miller, General Counsel

Approved for submission to Financial Services Commission:

Kevin M. McCarty, Commissioner
Office of Insurance Regulation

69O-149.022 Forms Adopted.

(1) The forms adopted in subsection (2), below, shall be used, as applicable, by insurers making form filings for life and accident insurance, annuities, and health insurance. All the forms in subsections (2) and (3), below, are hereby adopted and incorporated by reference. All forms are available and may be printed from the Office's website: www.floir.com.

(2) No Change.

(3) Form OIR-B2-2112 "Consumer Notice The Impact of Federal Health Care Reform on Your Health Plan Costs* (New 9/13)

Rulemaking Authority 624.308, 627.410(9) FS. Law Implemented 624.424(1)(c), 627.410, 636.216, 627.410(9), FS. History–New 10-29-91, Amended 5-15-96, 4-4-02, 5-2-02, 6-19-03, Formerly 4-149.022, Amended 4-7-05, 1-12-06, 1-28-13, _____.

Instructions

Please read the instructions below which explain the information required for the Data sheet. This entire spreadsheet template must be submitted electronically to the Office of Insurance Regulation. Insurers may provide additional consumer disclosures by a separate addendum(s).

Insurer Name:	Enter the operating name of the company issuing the policy
Insurer NAIC Code:	Enter the 5 digit NAIC code of the company issuing the policy
New Plan Name:	Enter the plan name (marketing name) of the policy which is being issued
New Metal Level:	Choose the metal level which applies to the policy being issued
Most Popular Plan Name (for comparison):	The policy or contract that has the highest enrollment in the individual or small group market (whichever is applicable) on July 1, 2013 *When issuing new individual policies this should be the largest individual plan *When issuing new small group policies this should be the largest small group plan
Medical Trend:	Enter the 2014 projected medical trend as defined in 69O-149.006(3)(b)18, F.A.C.
Monthly Health Plan Cost ***before*** Federal Health Care Reform:	The statewide average premiums as of 7/1/ 2013, brought forward to 1/1/2014 cost levels, for the plan that has the highest enrollment in the applicable market (individual/small group). The enrollment must include all policyholders, including those that have health conditions that increase the standard premium. For example: Cell D19 should be the average premium for males between the ages of 30 and 54.
Cost of **new benefits** we must offer:	The dollar amount which is attributable to the requirement that essential health benefits be provided and to meet the required actuarial value for the product, as compared to the statewide average premium for the policy or contract for the plan issued by that insurer or organization that has the highest enrollment in the individual or small group market on July 1, 2013, whichever is applicable.
Cost to **cover everyone**, even those with preexisting medical conditions:	The dollar amount of the premium which is attributable to the impact of guaranteed issuance of coverage. This estimate must include, but is not required to itemize, the impact of the requirement that rates be based on factors unrelated to health status, how the individual coverage mandate and subsidies provided in the health insurance exchange established in this state pursuant to PPACA affect the impact of guaranteed issuance of coverage, and estimated reinsurance credits.
New **taxes and fees** we must pay:	The dollar amount of the premium which is attributable to fees, taxes, and assessments associated with PPACA.
Cost to charge the same for **men and women** and to limit how **age** can affect plan costs:	The dollar amount of the premium increase or decrease from the premium that would have otherwise been due which is attributable to the combined impact of the requirement that rates for age be limited to a 3-to-1 ratio and the prohibition against using gender as a rating factor.

Consumer Notice
The Impact of Federal Health Care Reform on Health Plan Costs*

Federal health care reform may change health plan benefits and costs. **After January 1, 2014**, health insurers and HMOs:

- Must offer new benefits.
- Must cover everyone even if they have preexisting medical conditions.
- Must pay new taxes and fees which add to health plan costs.
- Must charge same health plan costs to men and women.
- Must limit how much your age can affect health plan costs.

Below is an **example** using one of our company's most popular plans and the cost of a new plan showing the impact of federal health care reform. This is an example only and it does not show differences in co-payments and deductibles. Your health plan costs may not change in the same way. Your health plan costs may be reduced if you qualify for federal tax credits or subsidies.

This example compares the health plan monthly cost for {Name, most popular plan} before federal health care reform to the health plan monthly cost for the new {Name, new health care plan} health plan offered after health care reform.

	Ages 21-29		Ages 30-54		Ages 55-64	
	Males	Females	Males	Females	Males	Females
{Name, most popular plan} Monthly Health Plan Cost ***before*** Federal Health Care Reform	$ ***	$ ***	$ ***	$ ***	$ ***	$ ***
{Name, new health care plan} Monthly Health Plan Cost ***after*** Federal Health Care Reform	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!
Portion of Monthly Health Plan Cost due to federal health care reform:						
Cost of **new benefits** we must offer	$ ***	$ ***	$ ***	$ ***	$ ***	$ ***
Cost to **cover everyone**, *even those with preexisting medical conditions*	$ ***	$ ***	$ ***	$ ***	$ ***	$ ***
New taxes and fees we must pay	$ ***	$ ***	$ ***	$ ***	$ ***	$ ***
Cost to charge the same for **men and women** and to limit how **age** can affect plan costs	$ ***	$ ***	$ ***	$ ***	$ ***	$ ***
Dollar Difference in Health Plan Costs	$ -	$ -	$ -	$ -	$ -	$ -
Percentage Difference in Health Plan Costs	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!

**The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and regulations adopted pursuant to these acts.*

690-149.022
Rulemaking Authority

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.
(2) In addition to any other penalty provided, willful violation of any such rule shall subject the violator to such suspension or revocation of certificate of authority or license as may be applicable under this code as for violation of the provision as to which such rule relates.

627.410 Filing, approval of forms.—
(1) No basic insurance policy or annuity contract form, or application form where written application is required and is to be made a part of the policy or contract, or group certificates issued under a master contract delivered in this state, or printed rider or endorsement form or form of renewal certificate, shall be delivered or issued for delivery in this state, unless the form has been filed with the office by or in behalf of the insurer which proposes to use such form and has been approved by the office. This provision does not apply to surety bonds or to policies, riders, endorsements, or forms of unique character which are designed for and used with relation to insurance upon a particular subject (other than as to health insurance), or which relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or health insurance policies and are used at the request of the individual policyholder, contract holder, or certificateholder. As to group insurance policies effectuated and delivered outside this state but covering persons resident in this state, the group certificates to be delivered or issued for delivery in this state shall be filed with the office for information purposes only.
(2) Every such filing must be made not less than 30 days in advance of any such use or delivery. At the expiration of such 30 days, the form so filed will be deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the office. The approval of any such form by the office constitutes a waiver of any unexpired portion of such waiting period. The office may extend by not more than an additional 15 days the period within which it may so affirmatively approve or disapprove any such form, by giving notice of such extension before expiration of the initial 30-day period. At the expiration of any such period as so extended, and in the absence of such prior affirmative approval or disapproval, any such form shall be deemed approved.
(3) The office may, for cause, withdraw a previous approval. No insurer shall issue or use any form disapproved by the office, or as to which the office has withdrawn approval, after the effective date of the order of the office.
(4) The office may, by order, exempt from the requirements of this section for so long as it deems proper any insurance document or form or type thereof as specified in such order, to which, in its opinion, this section may not practicably be applied, or the filing and approval of which are, in its opinion, not desirable or necessary for the protection of the public.
(5) This section also applies to any such form used by domestic insurers for delivery in a jurisdiction outside this state if the insurance supervisory official of such jurisdiction informs the office that such form is not subject to approval or disapproval by such official, and upon the order of the office requiring the form to be submitted to it for the purpose. The applicable same standards apply to such forms as apply to forms for domestic use.
(6)(a) An insurer shall not deliver or issue for delivery or renew in this state any health insurance policy form until it has filed with the office a copy of every applicable rating manual, rating schedule, change in rating manual, and change in rating schedule; if rating manuals and rating schedules are not applicable, the insurer must file with the office applicable premium rates and any change in applicable premium rates. This paragraph does not apply to group health insurance policies, effectuated and delivered in this state, insuring groups of 51 or more persons, except for Medicare supplement insurance, long-term care

insurance, and any coverage under which the increase in claim costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.
(b) The commission may establish by rule, for each type of health insurance form, procedures to be used in ascertaining the reasonableness of benefits in relation to premium rates and may, by rule, exempt from any requirement of paragraph (a) any health insurance policy form or type thereof (as specified in such rule) to which form or type such requirements may not be practically applied or to which form or type the application of such requirements is not desirable or necessary for the protection of the public. With respect to any health insurance policy form or type thereof which is exempted by rule from any requirement of paragraph (a), premium rates filed pursuant to ss. 627.640 and 627.662 shall be for informational purposes.
(c) Every filing made pursuant to this subsection shall be made within the same time period provided in, and shall be deemed to be approved under the same conditions as those provided in, subsection (2).
(d) Every filing made pursuant to this subsection, except disability income policies and accidental death policies, shall be prohibited from applying the following rating practices:
1. Select and ultimate premium schedules.
2. Premium class definitions which classify insured based on year of issue or duration since issue.
3. Attained age premium structures on policy forms under which more than 50 percent of the policies are issued to persons age 65 or over.
(e) Except as provided in subparagraph 1., an insurer shall continue to make available for purchase any individual policy form issued on or after October 1, 1993. A policy form shall not be considered to be available for purchase unless the insurer has actively offered it for sale in the previous 12 months.
1. An insurer may discontinue the availability of a policy form if the insurer provides to the office in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the office, the insurer shall no longer offer for sale the policy form or certificate form in this state.
2. An insurer that discontinues the availability of a policy form pursuant to subparagraph 1. shall not file for approval a new policy form providing similar benefits as the discontinued form for a period of 5 years after the insurer provides notice to the office of the discontinuance. The period of discontinuance may be reduced if the office determines that a shorter period is appropriate.
3. The experience of all policy forms providing similar benefits shall be combined for all rating purposes.
(7)(a) Each insurer subject to the requirements of subsection (6) shall make an annual filing with the office no later than 12 months after its previous filing, demonstrating the reasonableness of benefits in relation to premium rates. The office, after receiving a request to be exempted from the provisions of this section, may, for good cause due to insignificant numbers of policies in force or insignificant premium volume, exempt a company, by line of coverage, from filing rates or rate certification as required by this section.
(b) The filing required by this subsection shall be satisfied by one of the following methods:
1. A rate filing prepared by an actuary which contains documentation demonstrating the reasonableness of benefits in relation to premiums charged in accordance with the applicable rating laws and rules promulgated by the commission.
2. If no rate change is proposed, a filing which consists of a certification by an actuary that benefits are reasonable in relation to premiums currently charged in accordance with applicable laws and rules promulgated by the commission.
(c) As used in this section, "actuary" means an individual who is a member of the Society of Actuaries or the American Academy of Actuaries. If an insurer does not employ or otherwise retain the services of an actuary, the insurer's certification shall be prepared by

insurer personnel or consultants with a minimum of 5 years' experience in insurance ratemaking. The chief executive officer of the insurer shall review and sign the certification indicating his or her agreement with its conclusions.
(d) If at the time a filing is required under this section an insurer is in the process of completing a rate review, the insurer may apply to the office for an extension of up to an additional 30 days in which to make the filing. The request for extension must be received by the office no later than the date the filing is due.
(e) If an insurer fails to meet the filing requirements of this subsection and does not submit the filing within 60 days following the date the filing is due, the office may, in addition to any other penalty authorized by law, order the insurer to discontinue the issuance of policies for which the required filing was not made, until such time as the office determines that the required filing is properly submitted.
(8)(a) For the purposes of subsections (6) and (7), benefits of an individual accident and health insurance policy form, including Medicare supplement policies as defined in s. 627.672, when authorized by rules adopted by the commission, and excluding long-term care insurance policies as defined in s. 627.9404, and other policy forms under which more than 50 percent of the policies are issued to individuals age 65 and over, are deemed to be reasonable in relation to premium rates if the rates are filed pursuant to a loss ratio guarantee and both the initial rates and the durational and lifetime loss ratios have been approved by the office, and such benefits shall continue to be deemed reasonable for renewal rates while the insurer complies with such guarantee, provided the currently expected lifetime loss ratio is not more than 5 percent less than the filed lifetime loss ratio as certified to by an actuary. The office shall have the right to bring an administrative action should it deem that the lifetime loss ratio will not be met. For Medicare supplement filings, the office may withdraw a previously approved filing which was made pursuant to a loss ratio guarantee if it determines that the filing is not in compliance with ss. 627.671-627.675 or the currently expected lifetime loss ratio is less than the filed lifetime loss ratio as certified by an actuary in the initial guaranteed loss ratio filing. If this section conflicts with ss. 627.671-627.675, ss. 627.671-627.675 shall control.
(b) The renewal premium rates shall be deemed to be approved upon filing with the office if the filing is accompanied by the most current approved loss ratio guarantee. The loss ratio guarantee shall be in writing, shall be signed by an officer of the insurer, and shall contain at least:
1. A recitation of the anticipated lifetime and durational target loss ratios contained in the actuarial memorandum filed with the policy form when it was originally approved. The durational target loss ratios shall be calculated for 1-year experience periods. If statutory changes have rendered any portion of such actuarial memorandum obsolete, the loss ratio guarantee shall also include an amendment to the actuarial memorandum reflecting current law and containing new lifetime and durational loss ratio targets.
2. A guarantee that the applicable loss ratios for the experience period in which the new rates will take effect, and for each experience period thereafter until new rates are filed, will meet the loss ratios referred to in subparagraph 1.
3. A guarantee that the applicable loss ratio results for the experience period will be independently audited at the insurer's expense. The audit shall be performed in the second calendar quarter of the year following the end of the experience period, and the audited results shall be reported to the office no later than the end of such quarter. The commission shall establish by rule the minimum information reasonably necessary to be included in the report. The audit shall be done in accordance with accepted accounting and actuarial principles.
4. A guarantee that affected policyholders in this state shall be issued a proportional refund, based on the premium earned, of the amount necessary to bring the applicable experience period loss ratio up to the durational target loss ratio referred to in subparagraph 1. The refund shall be made to all policyholders in this state who are insured

under the applicable policy form as of the last day of the experience period, except that no refund need be made to a policyholder in an amount less than $10. Refunds less than $10 shall be aggregated and paid pro rata to the policyholders receiving refunds. The refund shall include interest at the then-current variable loan interest rate for life insurance policies established by the National Association of Insurance Commissioners, from the end of the experience period until the date of payment. Payments shall be made during the third calendar quarter of the year following the experience period for which a refund is determined to be due. However, no refunds shall be made until 60 days after the filing of the audit report in order that the office has adequate time to review the report.
5. A guarantee that if the applicable loss ratio exceeds the durational target loss ratio for that experience period by more than 20 percent, provided there are at least 2,000 policyholders on the form nationwide or, if not, then accumulated each calendar year until 2,000 policyholder years is reached, the insurer, if directed by the office, shall withdraw the policy form for the purposes of issuing new policies.
(c) As used in this subsection:
1. "Loss ratio" means the ratio of incurred claims to earned premium.
2. "Applicable loss ratio" means the loss ratio attributable solely to this state if there are 2,000 or more policyholders in the state. If there are 500 or more policyholders in this state but less than 2,000, it is the linear interpolation of the nationwide loss ratio and the loss ratio for this state. If there are less than 500 policyholders in this state, it is the nationwide loss ratio.
3. "Experience period" means the period, ordinarily a calendar year, for which a loss ratio guarantee is calculated.

624.424 Annual statement and other information.—
(1) (c) The commission may by rule require reports or filings required under the insurance code to be submitted by electronic means in a computer-readable form compatible with the electronic data processing equipment specified by the commission.

636.216 Charge or form filings.—
(1) All charges to members must be filed with the office and any charge to members greater than $30 per month or $360 per year must be approved by the office before the charges can be used. The discount medical plan organization has the burden of proof that the charges bear a reasonable relation to the benefits received by the member.
(2) There must be a written agreement between the discount medical plan organization and the member specifying the benefits under the discount medical plan and complying with the disclosure requirements of this part.
(3) All forms used, including the written agreement pursuant to subsection (2), must first be filed with and approved by the office. Every form filed shall be identified by a unique form number placed in the lower left corner of each form.
(4) A charge or form is considered approved on the 60th day after its date of filing unless it has been previously disapproved by the office. The office shall disapprove any form that does not meet the requirements of this part or that is unreasonable, discriminatory, misleading, or unfair. If such filings are disapproved, the office shall notify the discount medical plan organization and shall specify in the notice the reasons for disapproval.

~~(2)~~ The term ~~word~~ "certificate" as used in this subsection ~~section~~ does not include certificates as to group life or health insurance or as to group annuities issued to individual insureds.

(4) "PPACA" means the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and regulations adopted pursuant to those acts.

Section 15. Subsections (2), (6), and (7) of section 627.410, Florida Statutes, are amended, and subsection (9) is added to that section, to read:

627.410 Filing, approval of forms.—

(2) Every such filing must be made at least ~~not less than~~ 30 days in advance of any such use or delivery. At the expiration of the ~~such~~ 30 days, the form ~~so~~ filed will be deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the office. The approval of ~~any~~ such form by the office constitutes a waiver of any unexpired portion of such waiting period. The office may extend ~~by not more than an additional 15 days~~ the period within which it may ~~so~~ affirmatively approve or disapprove ~~any~~ such form by up to 15 days~~,~~ by giving notice of such extension before expiration of the initial 30-day period. At the expiration of ~~any~~ such extended period ~~as so extended~~, and in the absence of ~~such~~ prior affirmative approval or disapproval, ~~any~~ such form shall be deemed approved.

(6)(a) An insurer may ~~shall~~ not deliver~~,~~ ~~or~~ issue for delivery~~,~~ or renew in this state any health insurance policy form until it has filed with the office a copy of every applicable rating manual, rating schedule, change in rating manual, and change in rating schedule; if rating manuals and rating schedules are not applicable, the insurer must file with the office applicable premium rates and any change in applicable premium rates. This paragraph does not apply to group health insurance policies, effectuated and delivered in this state, insuring groups of 51 or more persons, except for Medicare supplement insurance, long-term care insurance, and any coverage under which the increase in claim costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.

(b) The commission may establish by rule, for each type of health insurance form, procedures to be used in ascertaining the reasonableness of benefits in relation to premium rates and may, by rule, exempt from any requirement of paragraph (a) any health insurance policy form or type thereof, ~~(~~as specified in such rule,~~)~~ to which form or type such requirements may not be practically applied or to which form or type the application of such requirements is not desirable or necessary for the protection of the public. With respect to any health insurance policy form or type thereof which is exempted by rule from any requirement of paragraph (a), premium rates filed pursuant to ss. 627.640 and 627.662 are ~~shall be~~ for informational purposes.

(c) Every filing made pursuant to this subsection shall be made within the same time period ~~provided in~~, and shall be deemed to be approved under the same conditions, as ~~those~~ provided in~~,~~ subsection (2).

(d) Every filing made pursuant to this subsection, except disability income policies and accidental death policies, are ~~shall be~~ prohibited from applying the following rating practices:

1. Select and ultimate premium schedules.

2. Premium class definitions that ~~which~~ classify insured based on year of issue or duration since issue.

3. Attained age premium structures on policy forms under which more than 50 percent of the policies are issued to persons age 65 or over.

(e) Except as provided in subparagraph 1., an insurer shall continue to make available for purchase any individual policy form issued on or after October 1, 1993. A policy form is ~~shall~~ not ~~be~~ considered to be available for purchase unless the insurer has actively offered it for sale during ~~in~~ the previous 12 months.

1. An insurer may discontinue the availability of a policy form if the insurer provides its decision to the office in writing ~~its decision~~ at least 30 days before ~~prior to~~ discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the office, the insurer may ~~shall~~ no longer offer ~~for sale~~ the policy form or certificate form for sale in this state.

2. An insurer that discontinues the availability of a policy form pursuant to subparagraph 1. may ~~shall~~ not file for approval a new policy form providing ~~similar~~ benefits similar to ~~as~~ the discontinued form for ~~a period of~~ 5 years after the insurer provides notice to the office of the discontinuance. The period of discontinuance may be reduced if the office determines that a shorter period is appropriate. The requirements of this subparagraph do not apply to the discontinuance of a policy form because it does not comply with PPACA.

3. The experience of all policy forms providing similar benefits shall be combined for all rating purposes, except that the experience of grandfathered health plans and nongrandfathered health plans shall be separated.

(7)~~(a)~~ Each insurer subject to ~~the requirements of~~ subsection (6) shall make an annual filing with the office within ~~no later than~~ 12 months after its previous filing, demonstrating the reasonableness of benefits in relation to premium rates. ~~The office,~~ After receiving a request to be exempted from the provisions of this section, the office may, for good cause due to insignificant numbers of policies in force or insignificant premium volume, exempt a company, by line of coverage, from filing rates or rate certification as required by this section.

(a)~~(b)~~ The filing ~~required by this subsection~~ shall be satisfied by one of the following methods:

1. A rate filing prepared by an actuary which contains documentation demonstrating the reasonableness of benefits in relation to premiums charged in accordance with the applicable rating laws and rules adopted ~~promulgated~~ by the commission.

2. If no rate change is proposed, a filing that ~~which~~ consists of a certification by an actuary that benefits are reasonable in relation to premiums currently charged in accordance with applicable laws and rules promulgated by the commission.

(b)~~(c)~~ As used in this section, the term "actuary" means an individual who is a member of the Society of Actuaries or the American Academy of Actuaries. If an insurer does not employ or otherwise retain the services of an actuary, the insurer's certification shall be prepared by insurer personnel or consultants who have ~~with~~ a minimum of 5 years' experience in insurance ratemaking. The chief executive officer of the insurer shall review and sign the certification indicating his or her agreement with its conclusions.

(c)~~(d)~~ If at the time a filing is required ~~under this section~~ an insurer is in the process of completing a rate review, the insurer may apply to the office for an extension of up to an additional 30 days in which to make the filing. The request for extension must be received by the office by ~~no later than~~ the date the filing is due.

(d)~~(e)~~ If an insurer fails to meet the filing requirements of this subsection and does not submit the filing within 60 days after ~~following~~ the date the filing is due, the office may, in addition to any other penalty authorized by law, order the insurer to discontinue the issuance of policies for which the required filing was not made, until such time as the office determines that the required filing is properly submitted.

(9) For plan years 2014 and 2015, nongrandfathered health plans for the individual or small group market are not subject to rate review or approval by the office. An insurer or health maintenance organization issuing or renewing such health plans shall file rates and any change in rates with the office as required by paragraph (6)(a), but the filing and rates are not subject to subsection (2), paragraphs (b), (c), or (d) of subsection (6), or subsection (7).

(a) For each individual and small group nongrandfathered health plan, an insurer or health maintenance organization shall include a notice describing or illustrating the estimated impact of PPACA on monthly premiums with the delivery of the policy or contract or, upon renewal, the premium renewal notice. The notice must be in a format established by rule of the commission. The format must specify how the information required under paragraph (b) is to be described or illustrated, and may allow for specified variations from such requirements in order to provide a more accurate and meaningful disclosure of the estimated impact of PPACA on

monthly premiums, as determined by the commission. All notices shall be submitted to the office for informational purposes by September 1, 2013. The notice is required only for the first issuance or renewal of the policy or contract on or after January 1, 2014.

(b) The information provided in the notice shall be based on the statewide average premium for the policy or contract for the bronze, silver, gold, or platinum level plan, whichever is applicable to the policy or contract, and provide an estimate of the following effects of PPACA requirements:

1. The dollar amount of the premium which is attributable to the impact of guaranteed issuance of coverage. This estimate must include, but is not required to itemize, the impact of the requirement that rates be based on factors unrelated to health status, how the individual coverage mandate and subsidies provided in the health insurance exchange established in this state pursuant to PPACA affect the impact of guaranteed issuance of coverage, and estimated reinsurance credits.

2. The dollar amount of the premium which is attributable to fees, taxes, and assessments.

3. For individual policies or contracts, the dollar amount of the premium increase or decrease from the premium that would have otherwise been due which is attributable to the combined impact of the requirement that rates for age be limited to a 3-to-1 ratio and the prohibition against using gender as a rating factor. This estimate must be displayed for the average rates for male and female insureds, respectively, for the following three age categories: age 21 years to 29 years, age 30 years to 54 years, and age 55 years to 64 years.

4. The dollar amount which is attributable to the requirement that essential health benefits be provided and to meet the required actuarial value for the product, as compared to the statewide average premium for the policy or contract for the plan issued by that insurer or organization that has the highest enrollment in the individual or small group market on July 1, 2013, whichever is applicable. The statewide average premiums for the plan that has the highest enrollment must include all policyholders, including those that have health conditions that increase the standard premium.

(c) The office, in consultation with the department, shall develop a summary of the estimated impact of PPACA on monthly premiums as contained in the notices submitted by insurers and health maintenance organizations, which must be available on the respective websites of the office and department by October 1, 2013.

(d) This subsection is repealed on March 1, 2015.

Section 16. Subsection (4) is added to section 627.411, Florida Statutes, to read:

627.411 Grounds for disapproval.—