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

August 6, 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 June 25, 2013.

   (ATTACHMENT 1) **FOR APPROVAL**

2. Request for Approval for Final Adoption of Proposed 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 FINAL ADOPTION**

3. Request for Approval for Final Adoption of Proposed 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 FINAL ADOPTION**

4. Request for Approval for Final Adoption of Proposed Rule 69O-149.022 Forms Adopted

   The purpose of this rule amendment is to adopt 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 FINAL ADOPTION**

5. Request for Approval for Final Adoption of Proposed Rule 69O-149.003 Rate Filing Procedures

   The current version of Rule 69O-149.003(6), Florida Administrative Code, includes tables which display the applicable maximum annual medical trend for Major Medical and Medicare Supplement policies. Companies with 1,000 or fewer policies in Florida have the option to submit a streamlined annual rate filing by utilizing the medical trend. The proposed amendment deletes the aforementioned maximum annual medical trend tables from the text of the rule and adds a link to the Office's website where the tables will be updated.

   (ATTACHMENT 5) **APPROVAL FOR FINAL ADOPTION**

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. I'm here on behalf of Kevin McCarty, who sends his regrets. He usually makes these meetings, but he was called to a meeting that he had to attend. So I am a poor substitute, but I'll try to get through these items.

First I would like to ask for the minutes to be approved from the March 7th board meeting, March 7th, 2013, of the Financial Services Commission.

GOVERNOR SCOTT: Is there a motion to approve?

CFO ATWATER: So moved.

GOVERNOR SCOTT: Is there a second?

ATTORNEY GENERAL BONDI: Second.

GOVERNOR SCOTT: Any comments or objections?

(No audible response.)

GOVERNOR SCOTT: Hearing none, the motion carries.

MS. MILLER: Thank you. Next I would like to request approval for publication of a rule for amending Rule 690-137.001, which defines the annual and quarterly reporting requirements for insurance

companies. The Office is proposing to amend this rule to adopt the more current versions of the NAIC annual and quarterly statement instructions and manuals.

Section 624.424 of the Florida Statutes requires insurers to file these statements with the Office and allows the Office and the Financial Services Commission to adopt rules setting standards for these reports. This enables companies to file one statement nationally and to have all of the states use the same statement.

GOVERNOR SCOTT: All right. Is there a motion to approve?

ATTORNEY GENERAL BONDI: So moved.

GOVERNOR SCOTT: Is there a second?

COMMISSIONER PUTNAM: Second.

GOVERNOR SCOTT: Any comments or objections?

(No audible response.)

GOVERNOR SCOTT: Hearing none, the motion carries.

MS. MILLER: Thank you. Next, I would request approval for publication of the proposed amendments to Rule 690-138.001, the NAIC Financial Condition Examiners Handbook adopted. The Office is proposing to amend this rule to adopt the NAIC 2013

Financial Condition Examiners Handbook.

Section 624.316 of the Florida Statutes requires the Office to examine the financial condition of insurance companies using generally accepted accounting and auditing 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, the rule enables the procedures used by the Office to be in line with the accepted accounting principles.

GOVERNOR SCOTT: Is there a motion to approve?

ATTORNEY GENERAL BONDI: So moved.

GOVERNOR SCOTT: Is there a second?

COMMISSIONER PUTNAM: Second.

GOVERNOR SCOTT: Any comments or objections?

(No audible response.)

GOVERNOR SCOTT: Hearing none, the motion carries.

MS. MILLER: Thank you. And finally, I would like to request approval for publication of proposed amendments to Rule 690-149.022. The purpose of this rule is to develop a notice of estimated premium impacts from the federal Patient Protection and Affordable Care Act required by

Committee Substitute for Senate Bill 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 and to individuals insured by HMOs.

GOVERNOR SCOTT: Is there a motion to approve?

ATTORNEY GENERAL BONDI: So moved.

COMMISSIONER PUTNAM: So moved.

GOVERNOR SCOTT: Is there a second?

CFO ATWATER: Second.

GOVERNOR SCOTT: Any comments or objections?

(No audible response.)

GOVERNOR SCOTT: Hearing none, the motion carries.

MS. MILLER: Thank you. That concludes the agenda for the Office of Insurance Regulation.

GOVERNOR SCOTT: Thank you, Belinda.

ATTORNEY GENERAL BONDI: And she was a very good substitute.

GOVERNOR SCOTT: Yes. Good job.

M E M O R A N D U M

DATE: July 9, 2013

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

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Kelly McGrath

SUBJECT: Cabinet Agenda for August 6, 2013
Request for Final Approval to Adopt Amendments to
Rule 69O-137.001
Annual and Quarterly Reporting Requirements
Assignment # 129087-12

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before July 31, 2013 and to the Financial Services Commission on August 6, 2013, with a request for Final Approval to Adopt the proposed rules. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on July 10, 2013.

The notice of proposed rules was published on June 27, 2013 in Volume 39, No. 125, of the *Register*. The hearing was not requested, therefore, the hearing was not held.

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.

The Legal Services Office has communicated with the Joint Administrative Procedures Committee, and ascertained that their review of the rules has been completed.

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

Approved for signature:

by
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, 2012~~2011~~;

2. The NAIC's Annual Statement Instructions, Life, Accident and Health, 2012~~2011~~;

3. The NAIC's Annual Statement Instructions, Health, 2012~~2011~~;

4. The NAIC's Annual Statement Instructions, Title, 2012~~2011~~; and

5. The NAIC's Accounting Practices and Procedures Manual, as of March 2012~~2011~~.

(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, 2013~~2012~~;

2. The NAIC's Quarterly Statement Instructions, Life, Accident and Health, 2013~~2012~~;

3. The NAIC's Quarterly Statement Instructions, Health, 2013~~2012~~;

4. The NAIC's Quarterly Statement Instructions, Title, 2013~~2012~~; and

5. The NAIC's Accounting Practices and Procedures Manual, as of March 2013~~2012~~.

(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: July 9, 2013

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

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Kelly McGrath

SUBJECT: Cabinet Agenda for August 6, 2013
Request for Final Approval to Adopt Amendments to
Rule 69O-138.001
NAIC Financial Condition Examiners Handbook Adopted
Assignment # 130907-13

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before July 31, 2013 and to the Financial Services Commission on August 6, 2013, with a request for Final Approval to Adopt the proposed rules. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on July 10, 2013.

The notice of proposed rules was published on June 27, 2013 in Volume 39, No. 125, of the *Register*. The hearing was not requested, therefore, the hearing was not held.

Section 624.316, Florida Statutes, requires the Office to examine insurer's 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.

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

The Legal Services Office has communicated with the Joint Administrative Procedures Committee, and ascertained that their review of the rules has been completed.

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

Approved for signature:

for 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: July 22, 2013

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

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Kelly McGrath

SUBJECT: Cabinet Agenda for August 6, 2013
Request for Final Approval to Adopt Amendments to
Rule 69O-149.022
Forms Adopted
Assignment #134012-13

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before July 31, 2013 and to the Financial Services Commission on August 6, 2013, with a request for Final Approval to Adopt the proposed rules. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on July 10, 2013.

The notice of proposed rules was published on June 27, 2013 in Volume 39, No. 125, of the *Register*. A hearing was not held.

The amendment to rule 69O-149.022 adopts by reference the "Notice of Estimated Premium Impacts from the Federal Patient Protection and Affordable Care Act" and the related instructions to insurers.

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.

The Legal Services Office has communicated with the Joint Administrative Procedures Committee, and ascertained that their review of the rules has been completed.

Stephen Fredrickson is the attorney handling this rule. Attached are: 1) the proposed rule(s); 2) any incorporated materials, such as forms; 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.

Notice of Estimated Premium Impact Due to the Federal Patient Protection and Affordable Care Act (PPACA)

Please enter information in all the data fields below (highlighted in red).

Insurer Name:	{Insurer Name}
Insurer NAIC Code:	*****
New Plan Name:	{Name, *new health care plan*}
New Metal Level:	Silver
Most Popular Plan Name (for comparison):	{Name, *most popular plan*}
Medical Trend:	***

	Monthly Premiums					
	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!

Validations

TRUE
TRUE

TRUE
TRUE

TRUE

FALSE

FALSE FALSE FALSE FALSE FALSE FALSE

FALSE FALSE FALSE FALSE FALSE FALSE

FALSE FALSE FALSE FALSE FALSE FALSE
FALSE FALSE FALSE FALSE FALSE FALSE

FALSE FALSE FALSE FALSE FALSE FALSE

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.*

69O-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.—

M E M O R A N D U M

DATE: June 20, 2013

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

THROUGH: Belinda Miller, General Counsel

FROM: Dennis Threadgill
Kelly McGrath

SUBJECT: Cabinet Agenda for August 6, 2013
Request for Final Approval to Adopt Amendments to
Rule 69O-149.003
Rate Filing Procedures
Assignment 123776-12

The Office of Insurance Regulation requests that this proposed rule amendment be presented to the Cabinet aides on or before July 31, 2013 and to the Financial Services Commission on August 6, 2013, with a request for Final Approval to Adopt the proposed rule amendment. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on January 11, 2013.

The notice of proposed rule was published on July 20, 2012 in Volume 38, No. 29, of the *Register.* A hearing was held. A notice of Change was published on December 26, 2012 in Volume 38, No.97.

The current version of Rule 69O-149.003(6), Florida Administrative Code, includes tables which display the applicable maximum annual medical trend. The proposed amendment to Rule 69O-149.003 deletes the aforementioned maximum annual medical trend tables from the text of the rule and provides the URL of the Office's website on which the Office will update the tables as needed.

Sections 624.308(1), 624,424(1)(c), 627.410(6)(b), (e), 119.07(1)(b), 624.307(1), 626.9541(1), 627.410, F.S., provide rulemaking authority and laws implemented for this rule.

The Legal Services Office has communicated with the Joint Administrative Procedures Committee, and ascertained that their review of the rule has been completed.

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

Approved for signature:

by

Belinda Miller, General Counsel

Approved for submission to Financial Services Commission:

Kevin M. McCarty, Commissioner
Office of Insurance Regulation

69O-149.003 Rate Filing Procedures.

(1) – (2) – No Changes.

(3) Filings shall be submitted electronically to https://iportal.fldfs.com/.

(4) No Changes.

(5)(a) Insurers with fewer than 1,000 Florida policyholders, under any form or pooled group of Medicare supplement, or medical expense forms with coverage meeting the definition of Section 627.6561(5)(a)2., F.S., may, at their option, file a streamlined rate increase filing not exceeding medical trend as provided in subsection (6) below.

(b) –(f) No changes.

(6)(a) The ~~following~~ tables found at www.floir.com shall apply to filings made pursuant to subsection (5) above. They contain the maximum medical trend for medical expense coverage described in Section 627.6561(5)(a)2.F.S. and the maximum medical trend for Medicare Supplement coverage.

(b) A company without fully credible data may, at its option, use an annual medical trend assumption not to exceed the values in the ~~following~~ tables referenced in (a) for the medical trend assumption used in a complete filing made pursuant to paragraph 69O-149.003(2)(b), F.A.C., including the actuarial memorandum required by Rule 69O-149.006, F.A.C., without providing explicit trend justification.

(c) Use of an annual medical trend assumption exceeding the maximum medical trend in the ~~following~~ tables referenced in (a) shall be filed pursuant to subparagraph 69O-149.006(3)(b)18., F.A.C.

~~(d) The maximum medical trend for medical expense coverage described in Section 627.6561(5)(a)2., F.S., is:~~

~~Category~~	~~Individual Without Rx~~	~~Individual With Rx~~	~~Group Without Rx~~	~~Group With Rx~~
~~Major Medical~~	~~11.5%~~	~~12.0%~~	~~13.0%~~	~~13.5%~~
~~Health Maintenance Organizations~~	~~10.5%~~	~~11.0%~~	~~13.0%~~	~~13.5%~~

~~(e) The maximum medical trend for Medicare supplement coverage is:~~

~~Medicare supplement~~	~~5.5%~~	~~10%~~	~~5.5%~~	~~10%~~

Rulemaking ~~Specific~~ Authority 624.308(1), 624.424(1)(c), 627.410(6)(b), (e) FS. Law Implemented 119.07(1)(b), 624.307(1), 626.9541(1), 627.410 FS. History–New 7-1-85, Formerly 4-58.03, 4-58.003, Amended 8-23-93, 4-18-94, 8-22-95, 4-4-02, 10-27-02, 6-19-03, Formerly 4-149.003, Amended 5-18-04, 12-22-05, 1-16-08, 10-2-08.

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) (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.

627.410 Filing, approval of forms.—

(6) (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.

(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.

119.07 Inspection and copying of records; photographing public records; fees; exemptions.—

(1) (b) A custodian of public records or a person having custody of public records may designate another officer or employee of the agency to permit the inspection and copying of public records, but must disclose the identity of the designee to the person requesting to inspect or copy public records.

624.307 General powers; duties.—

(1) The department and office shall enforce the provisions of this code and shall execute the duties imposed upon them by this code, within the respective jurisdiction of each, as provided by law.

626.9541 Unfair methods of competition and unfair or deceptive acts or practices defined.—

(1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS.—The following are defined as unfair methods of competition and unfair or deceptive acts or practices:

(a) Misrepresentations and false advertising of insurance policies.—Knowingly making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison which:

1. Misrepresents the benefits, advantages, conditions, or terms of any insurance policy.
2. Misrepresents the dividends or share of the surplus to be received on any insurance policy.
3. Makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy.
4. Is misleading, or is a misrepresentation, as to the financial condition of any person or as to the legal reserve system upon which any life insurer operates.
5. Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof.
6. Is a misrepresentation for the purpose of inducing, or tending to induce, the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy.
7. Is a misrepresentation for the purpose of effecting a pledge or assignment of, or effecting a loan against, any insurance policy.
8. Misrepresents any insurance policy as being shares of stock or misrepresents ownership interest in the company.
9. Uses any advertisement that would mislead or otherwise cause a reasonable person to believe mistakenly that the state or the Federal Government is responsible for the insurance sales activities of any person or stands behind any person's credit or that any person, the state, or the Federal Government guarantees any returns on insurance products or is a source of payment of any insurance obligation of or sold by any person.

(b) False information and advertising generally.—Knowingly making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public:

1. In a newspaper, magazine, or other publication,
2. In the form of a notice, circular, pamphlet, letter, or poster,
3. Over any radio or television station, or
4. In any other way,

an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance, which is untrue, deceptive, or misleading.

(c) Defamation.—Knowingly making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of, any oral or written statement, or any pamphlet, circular, article, or literature, which is false or maliciously critical of, or derogatory to, any person and which is calculated to injure such person.

(d) Boycott, coercion, and intimidation.—Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion, or intimidation resulting in, or tending to result in, unreasonable restraint of, or monopoly in, the business of insurance.

(e) False statements and entries.—

1. Knowingly:
   a. Filing with any supervisory or other public official,
   b. Making, publishing, disseminating, circulating,
   c. Delivering to any person,
   d. Placing before the public,
   e. Causing, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public,

any false material statement.

2. Knowingly making any false entry of a material fact in any book, report, or statement of any person, or knowingly omitting to make a true entry of any material fact pertaining to the business of such person in any book, report, or statement of such person.

(f) Stock operations and advisory board contracts.—Issuing or delivering, promising to issue or deliver, or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns or profits as an inducement to insurance.

(g) Unfair discrimination.—

1. Knowingly making or permitting any unfair discrimination between individuals of the same actuarially supportable class and equal expectation of life, in the rates charged for any life insurance or annuity contract, in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

2. Knowingly making or permitting any unfair discrimination between individuals of the same actuarially supportable class, as determined at the original time of issuance of the coverage, and essentially the same hazard, in the amount of premium, policy fees, or rates charged for any policy or contract of accident, disability, or health insurance, in the benefits payable thereunder, in any of the terms or conditions of such contract, or in any other manner whatever.

3. For a health insurer, life insurer, disability insurer, property and casualty insurer, automobile insurer, or managed care provider to underwrite a policy, or refuse to issue, reissue, or renew a policy, refuse to pay a claim, cancel or otherwise terminate a policy, or increase rates based upon the fact that an insured or applicant who is also the proposed insured has made a claim or sought or should have sought medical or psychological treatment in the past for abuse, protection from abuse, or shelter from abuse, or that a claim was caused in the past by, or might occur as a result of, any future assault, battery, or sexual assault by a family or household member upon another family or household member as defined in s. 741.28. A health insurer, life insurer, disability insurer, or managed care provider may refuse to underwrite, issue, or renew a policy based on the applicant's medical condition, but shall not consider whether such condition was caused by an act of abuse. For purposes of this section, the term "abuse" means the occurrence of one or more of the following acts:

a. Attempting or committing assault, battery, sexual assault, or sexual battery;
b. Placing another in fear of imminent serious bodily injury by physical menace;
c. False imprisonment;
d. Physically or sexually abusing a minor child; or
e. An act of domestic violence as defined in s. 741.28.

This subparagraph does not prohibit a property and casualty insurer or an automobile insurer from excluding coverage for intentional acts by the insured if such exclusion does not constitute an act of unfair discrimination as defined in this paragraph.

(h) Unlawful rebates.—

1. Except as otherwise expressly provided by law, or in an applicable filing with the office, knowingly:

a. Permitting, or offering to make, or making, any contract or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon;
b. Paying, allowing, or giving, or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance contract, any unlawful rebate of premiums payable on the

contract, any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract;

c. Giving, selling, or purchasing, or offering to give, sell, or purchase, as inducement to such insurance contract or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the insurance contract.

2. Nothing in paragraph (g) or subparagraph 1. of this paragraph shall be construed as including within the definition of discrimination or unlawful rebates:

a. In the case of any contract of life insurance or life annuity, paying bonuses to all policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance; provided that any such bonuses or abatement of premiums is fair and equitable to all policyholders and for the best interests of the company and its policyholders.

b. In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses.

c. Readjustment of the rate of premium for a group insurance policy based on the loss or expense thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

d. Issuance of life insurance policies or annuity contracts at rates less than the usual rates of premiums for such policies or contracts, as group insurance or employee insurance as defined in this code.

e. Issuing life or disability insurance policies on a salary savings, bank draft, preauthorized check, payroll deduction, or other similar plan at a reduced rate reasonably related to the savings made by the use of such plan.

3.a. No title insurer, or any member, employee, attorney, agent, or agency thereof, shall pay, allow, or give, or offer to pay, allow, or give, directly or indirectly, as inducement to title insurance, or after such insurance has been effected, any rebate or abatement of the premium or any other charge or fee, or provide any special favor or advantage, or any monetary consideration or inducement whatever.

b. Nothing in this subparagraph shall be construed as prohibiting the payment of fees to attorneys at law duly licensed to practice law in the courts of this state, for professional services, or as prohibiting the payment of earned portions of the premium to duly appointed agents or agencies who actually perform services for the title insurer. Nothing in this subparagraph shall be construed as prohibiting a rebate or abatement of an attorney's fee charged for professional services, or that portion of the premium that is not required to be retained by the insurer pursuant to s. 627.782(1), or any other agent charge or fee to the person responsible for paying the premium, charge, or fee.

c. No insured named in a policy, or any other person directly or indirectly connected with the transaction involving the issuance of such policy, including, but not limited to, any mortgage broker, real estate broker, builder, or attorney, any employee, agent, agency, or representative thereof, or any other person whatsoever, shall knowingly receive or accept, directly or indirectly, any rebate or abatement of any portion of the title insurance premium or of any other charge or fee or any monetary consideration or inducement whatsoever, except as set forth in sub-subparagraph b.; provided, in no event shall any portion of the attorney's fee, any portion of the premium that is not required to be retained by the insurer pursuant to s. 627.782(1), any agent charge or fee, or any other monetary consideration or inducement be paid directly or indirectly for the referral of title insurance business.

(i) Unfair claim settlement practices.—

1. Attempting to settle claims on the basis of an application, when serving as a binder or intended to become a part of the policy, or any other material document which was altered without notice to, or knowledge or consent of, the insured;

2. A material misrepresentation made to an insured or any other person having an interest in the proceeds payable under such contract or policy, for the purpose and with the intent of effecting settlement of such claims, loss, or damage under such contract or policy on less favorable terms than those provided in, and contemplated by, such contract or policy; or

3. Committing or performing with such frequency as to indicate a general business practice any of the following:

a. Failing to adopt and implement standards for the proper investigation of claims;

b. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

c. Failing to acknowledge and act promptly upon communications with respect to claims;

d. Denying claims without conducting reasonable investigations based upon available information;

e. Failing to affirm or deny full or partial coverage of claims, and, as to partial coverage, the dollar amount or extent of coverage, or failing to provide a written statement that the claim is being investigated, upon the written request of the insured within 30 days after proof-of-loss statements have been completed;

f. Failing to promptly provide a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a claim or for the offer of a compromise settlement;

g. Failing to promptly notify the insured of any additional information necessary for the processing of a claim; or

h. Failing to clearly explain the nature of the requested information and the reasons why such information is necessary.

4. Failing to pay undisputed amounts of partial or full benefits owed under first-party property insurance policies within 90 days after an insurer receives notice of a residential property insurance claim, determines the amounts of partial or full benefits, and agrees to coverage, unless payment of the undisputed benefits is prevented by an act of God, prevented by the impossibility of performance, or due to actions by the insured or claimant that constitute fraud, lack of cooperation, or intentional misrepresentation regarding the claim for which benefits are owed.

(j) Failure to maintain complaint-handling procedures.—Failure of any person to maintain a complete record of all the complaints received since the date of the last examination. For purposes of this paragraph, "complaint" means any written communication primarily expressing a grievance.

(k) Misrepresentation in insurance applications.—

1. Knowingly making a false or fraudulent written or oral statement or representation on, or relative to, an application or negotiation for an insurance policy for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, agent, broker, or individual.

2. Knowingly making a material omission in the comparison of a life, health, or Medicare supplement insurance replacement policy with the policy it replaces for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, agent, broker, or individual. For the purposes of this subparagraph, a material omission includes the failure to advise the insured of the existence and operation of a preexisting condition clause in the replacement policy.

(l) Twisting.—Knowingly making any misleading representations or incomplete or fraudulent comparisons or fraudulent material omissions of or with respect to any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse,

forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance in another insurer.

(m) Advertising gifts permitted.—No provision of paragraph (f), paragraph (g), or paragraph (h) shall be deemed to prohibit a licensed insurer or its agent from giving to insureds, prospective insureds, and others, for the purpose of advertising, any article of merchandise having a value of not more than $25.

(n) Free insurance prohibited.—

1. Advertising, offering, or providing free insurance as an inducement to the purchase or sale of real or personal property or of services directly or indirectly connected with such real or personal property.

2. For the purposes of this paragraph, "free" insurance is:

a. Insurance for which no identifiable and additional charge is made to the purchaser of such real property, personal property, or services.

b. Insurance for which an identifiable or additional charge is made in an amount less than the cost of such insurance as to the seller or other person, other than the insurer, providing the same.

3. Subparagraphs 1. and 2. do not apply to:

a. Insurance of, loss of, or damage to the real or personal property involved in any such sale or services, under a policy covering the interests therein of the seller or vendor.

b. Blanket disability insurance as defined in s. 627.659.

c. Credit life insurance or credit disability insurance.

d. Any individual, isolated, nonrecurring unadvertised transaction not in the regular course of business.

e. Title insurance.

f. Any purchase agreement involving the purchase of a cemetery lot or lots in which, under stated conditions, any balance due is forgiven upon the death of the purchaser.

g. Life insurance, trip cancellation insurance, or lost baggage insurance offered by a travel agency as part of a travel package offered by and booked through the agency.

4. Using the word "free" or words which imply the provision of insurance without a cost to describe life or disability insurance, in connection with the advertising or offering for sale of any kind of goods, merchandise, or services.

(o) Illegal dealings in premiums; excess or reduced charges for insurance.—

1. Knowingly collecting any sum as a premium or charge for insurance, which is not then provided, or is not in due course to be provided, subject to acceptance of the risk by the insurer, by an insurance policy issued by an insurer as permitted by this code.

2. Knowingly collecting as a premium or charge for insurance any sum in excess of or less than the premium or charge applicable to such insurance, in accordance with the applicable classifications and rates as filed with and approved by the office, and as specified in the policy; or, in cases when classifications, premiums, or rates are not required by this code to be so filed and approved, premiums and charges collected from a Florida resident in excess of or less than those specified in the policy and as fixed by the insurer. This provision shall not be deemed to prohibit the charging and collection, by surplus lines agents licensed under part VIII of this chapter, of the amount of applicable state and federal taxes, or fees as authorized by s. 626.916(4), in addition to the premium required by the insurer or the charging and collection, by licensed agents, of the exact amount of any discount or other such fee charged by a credit card facility in connection with the use of a credit card, as authorized by subparagraph (q)3., in addition to the premium required by the insurer. This subparagraph shall not be construed to prohibit collection of a premium for a universal life or a variable or indeterminate value insurance policy made in accordance with the terms of the contract.

3.a. Imposing or requesting an additional premium for a policy of motor vehicle liability, personal injury protection, medical payment, or collision insurance or any combination

thereof or refusing to renew the policy solely because the insured was involved in a motor vehicle accident unless the insurer's file contains information from which the insurer in good faith determines that the insured was substantially at fault in the accident.

b. An insurer which imposes and collects such a surcharge or which refuses to renew such policy shall, in conjunction with the notice of premium due or notice of nonrenewal, notify the named insured that he or she is entitled to reimbursement of such amount or renewal of the policy under the conditions listed below and will subsequently reimburse him or her or renew the policy, if the named insured demonstrates that the operator involved in the accident was:

(I) Lawfully parked;

(II) Reimbursed by, or on behalf of, a person responsible for the accident or has a judgment against such person;

(III) Struck in the rear by another vehicle headed in the same direction and was not convicted of a moving traffic violation in connection with the accident;

(IV) Hit by a "hit-and-run" driver, if the accident was reported to the proper authorities within 24 hours after discovering the accident;

(V) Not convicted of a moving traffic violation in connection with the accident, but the operator of the other automobile involved in such accident was convicted of a moving traffic violation;

(VI) Finally adjudicated not to be liable by a court of competent jurisdiction;

(VII) In receipt of a traffic citation which was dismissed or nolle prossed; or

(VIII) Not at fault as evidenced by a written statement from the insured establishing facts demonstrating lack of fault which are not rebutted by information in the insurer's file from which the insurer in good faith determines that the insured was substantially at fault.

c. In addition to the other provisions of this subparagraph, an insurer may not fail to renew a policy if the insured has had only one accident in which he or she was at fault within the current 3-year period. However, an insurer may nonrenew a policy for reasons other than accidents in accordance with s. 627.728. This subparagraph does not prohibit nonrenewal of a policy under which the insured has had three or more accidents, regardless of fault, during the most recent 3-year period.

4. Imposing or requesting an additional premium for, or refusing to renew, a policy for motor vehicle insurance solely because the insured committed a noncriminal traffic infraction as described in s. 318.14 unless the infraction is:

a. A second infraction committed within an 18-month period, or a third or subsequent infraction committed within a 36-month period.

b. A violation of s. 316.183, when such violation is a result of exceeding the lawful speed limit by more than 15 miles per hour.

5. Upon the request of the insured, the insurer and licensed agent shall supply to the insured the complete proof of fault or other criteria which justifies the additional charge or cancellation.

6. No insurer shall impose or request an additional premium for motor vehicle insurance, cancel or refuse to issue a policy, or refuse to renew a policy because the insured or the applicant is a handicapped or physically disabled person, so long as such handicap or physical disability does not substantially impair such person's mechanically assisted driving ability.

7. No insurer may cancel or otherwise terminate any insurance contract or coverage, or require execution of a consent to rate endorsement, during the stated policy term for the purpose of offering to issue, or issuing, a similar or identical contract or coverage to the same insured with the same exposure at a higher premium rate or continuing an existing contract or coverage with the same exposure at an increased premium.

8. No insurer may issue a nonrenewal notice on any insurance contract or coverage, or require execution of a consent to rate endorsement, for the purpose of offering to issue, or

issuing, a similar or identical contract or coverage to the same insured at a higher premium rate or continuing an existing contract or coverage at an increased premium without meeting any applicable notice requirements.

9. No insurer shall, with respect to premiums charged for motor vehicle insurance, unfairly discriminate solely on the basis of age, sex, marital status, or scholastic achievement.

10. Imposing or requesting an additional premium for motor vehicle comprehensive or uninsured motorist coverage solely because the insured was involved in a motor vehicle accident or was convicted of a moving traffic violation.

11. No insurer shall cancel or issue a nonrenewal notice on any insurance policy or contract without complying with any applicable cancellation or nonrenewal provision required under the Florida Insurance Code.

12. No insurer shall impose or request an additional premium, cancel a policy, or issue a nonrenewal notice on any insurance policy or contract because of any traffic infraction when adjudication has been withheld and no points have been assessed pursuant to s. 318.14(9) and (10). However, this subparagraph does not apply to traffic infractions involving accidents in which the insurer has incurred a loss due to the fault of the insured.

(p) Insurance cost specified in "price package".—

1. When the premium or charge for insurance of or involving such property or merchandise is included in the overall purchase price or financing of the purchase of merchandise or property, the vendor or lender shall separately state and identify the amount charged and to be paid for the insurance, and the classifications, if any, upon which based; and the inclusion or exclusion of the cost of insurance in such purchase price or financing shall not increase, reduce, or otherwise affect any other factor involved in the cost of the merchandise, property, or financing as to the purchaser or borrower.

2. This paragraph does not apply to transactions which are subject to the provisions of part I of chapter 520, entitled "The Motor Vehicle Sales Finance Act."

3. This paragraph does not apply to credit life or credit disability insurance which is in compliance with s. 627.681(4).

(q) Certain insurance transactions through credit card facilities prohibited.—

1. Except as provided in subparagraph 3., no person shall knowingly solicit or negotiate any insurance; seek or accept applications for insurance; issue or deliver any policy; receive, collect, or transmit premiums, to or for any insurer; or otherwise transact insurance in this state, or relative to a subject of insurance resident, located, or to be performed in this state, through the arrangement or facilities of a credit card facility or organization, for the purpose of insuring credit card holders or prospective credit card holders. The term "credit card holder" as used in this paragraph means any person who may pay the charge for purchases or other transactions through the credit card facility or organization, whose credit with such facility or organization is evidenced by a credit card identifying such person as being one whose charges the credit card facility or organization will pay, and who is identified as such upon the credit card either by name, account number, symbol, insignia, or any other method or device of identification. This subparagraph does not apply as to health insurance or to credit life, credit disability, or credit property insurance.

2. Whenever any person does or performs in this state any of the acts in violation of subparagraph 1. for or on behalf of any insurer or credit card facility, such insurer or credit card facility shall be held to be doing business in this state and, if an insurer, shall be subject to the same state, county, and municipal taxes as insurers that have been legally qualified and admitted to do business in this state by agents or otherwise are subject, the same to be assessed and collected against such insurers; and such person so doing or performing any of such acts shall be personally liable for all such taxes.

3. A licensed agent or insurer may solicit or negotiate any insurance; seek or accept applications for insurance; issue or deliver any policy; receive, collect, or transmit premiums, to or for any insurer; or otherwise transact insurance in this state, or relative to

a subject of insurance resident, located, or to be performed in this state, through the arrangement or facilities of a credit card facility or organization, for the purpose of insuring credit card holders or prospective credit card holders if:

a. The insurance or policy which is the subject of the transaction is noncancelable by any person other than the named insured, the policyholder, or the insurer;

b. Any refund of unearned premium is made directly to the credit card holder; and

c. The credit card transaction is authorized by the signature of the credit card holder or other person authorized to sign on the credit card account.

The conditions enumerated in sub-subparagraphs a.-c. do not apply to health insurance or to credit life, credit disability, or credit property insurance; and sub-subparagraph c. does not apply to property and casualty insurance so long as the transaction is authorized by the insured.

4. No person may use or disclose information resulting from the use of a credit card in conjunction with the purchase of insurance, when such information is to the advantage of such credit card facility or an insurance agent, or is to the detriment of the insured or any other insurance agent; except that this provision does not prohibit a credit card facility from using or disclosing such information in any judicial proceeding or consistent with applicable law on credit reporting.

5. No such insurance shall be sold through a credit card facility in conjunction with membership in any automobile club. The term "automobile club" means a legal entity which, in consideration of dues, assessments, or periodic payments of money, promises its members or subscribers to assist them in matters relating to the ownership, operation, use, or maintenance of a motor vehicle; however, the definition of automobile clubs does not include persons, associations, or corporations which are organized and operated solely for the purpose of conducting, sponsoring, or sanctioning motor vehicle races, exhibitions, or contests upon racetracks, or upon race courses established and marked as such for the duration of such particular event. The words "motor vehicle" used herein shall be the same as defined in chapter 320.

(r) Interlocking ownership and management.—

1. Any domestic insurer may retain, invest in, or acquire the whole or any part of the capital stock of any other insurer or insurers, or have a common management with any other insurer or insurers, unless such retention, investment, acquisition, or common management is inconsistent with any other provision of this code, or unless by reason thereof the business of such insurers with the public is conducted in a manner which substantially lessens competition generally in the insurance business.

2. Any person otherwise qualified may be a director of two or more domestic insurers which are competitors, unless the effect thereof is substantially to lessen competition between insurers generally or materially tend to create a monopoly.

3. Any limitation contained in this paragraph does not apply to any person who is a director of two or more insurers under common control or management.

(s) Prohibited arrangements as to funerals.—

1. No life insurer shall designate in any life insurance policy the person to conduct the funeral of the insured, or organize, promote, or operate any enterprise or plan to enter into any contract with any insured under which the freedom of choice in the open market of the person having the legal right to such choice is restricted as to the purchase, arrangement, and conduct of a funeral service or any part thereof for any individual insured by the insurer. No life insurer shall designate in any life insurance policy the person to conduct the funeral of the insured as the owner of the policy.

2. No insurer shall contract or agree to furnish funeral merchandise or services in connection with the disposition of any person upon the death of any person insured by such insurer.

3. No insurer shall contract or agree with any funeral director or direct disposer to the effect that such funeral director or direct disposer shall conduct the funeral of any person insured by such insurer.

4. No insurer shall provide, in any insurance contract covering the life of any person in this state, for the payment of the proceeds or benefits thereof in other than legal tender of the United States and of this state, or for the withholding of such proceeds or benefits, all for the purpose of either directly or indirectly providing, inducing, or furthering any arrangement or agreement designed to require or induce the employment of a particular person to conduct the funeral of the insured.

(t) Certain life insurance relations with funeral directors prohibited.—

1. No life insurer shall permit any funeral director or direct disposer to act as its representative, adjuster, claim agent, special claim agent, or agent for such insurer in soliciting, negotiating, or effecting contracts of life insurance on any plan or of any nature issued by such insurer or in collecting premiums for holders of any such contracts except as prescribed in s. 626.785(3).

2. No life insurer shall:

a. Affix, or permit to be affixed, advertising matter of any kind or character of any licensed funeral director or direct disposer to such policies of insurance.

b. Circulate, or permit to be circulated, any such advertising matter with such insurance policies.

c. Attempt in any manner or form to influence policyholders of the insurer to employ the services of any particular licensed funeral director or direct disposer.

3. No such insurer shall maintain, or permit its agent to maintain, an office or place of business in the office, establishment, or place of business of any funeral director or direct disposer in this state.

(u) False claims; obtaining or retaining money dishonestly.—

1. Any agent, physician, claimant, or other person who causes to be presented to any insurer a false claim for payment, knowing the same to be false; or

2. Any agent, collector, or other person who represents any insurer or collects or does business without the authority of the insurer, secures cash advances by false statements, or fails to turn over when required, or satisfactorily account for, all collections of such insurer,

shall, in addition to the other penalties provided in this act, be guilty of a misdemeanor of the second degree and, upon conviction thereof, shall be subject to the penalties provided by s. 775.082 or s. 775.083.

(v) Proposal required.—If a person simultaneously holds a securities license and a life insurance license, he or she shall prepare and leave with each prospective buyer a written proposal, on or before delivery of any investment plan. "Investment plan" means a mutual funds program, and the proposal shall consist of a prospectus describing the investment feature and a full illustration of any life insurance feature. The proposal shall be prepared in duplicate, dated, and signed by the licensee. The original shall be left with the prospect, the duplicate shall be retained by the licensee for a period of not less than 3 years, and a copy shall be furnished to the department upon its request. In lieu of a duplicate copy, a receipt for standardized proposals filed with the department may be obtained and held by the licensee.

(w) Soliciting or accepting new or renewal insurance risks by insolvent or impaired insurer prohibited; penalty.—

1. Whether or not delinquency proceedings as to the insurer have been or are to be initiated, but while such insolvency or impairment exists, no director or officer of an insurer, except with the written permission of the office, shall authorize or permit the insurer to solicit or accept new or renewal insurance risks in this state after such director or officer

knew, or reasonably should have known, that the insurer was insolvent or impaired. "Impaired" includes impairment of capital or surplus, as defined in s. 631.011(12) and (13).

2. Any such director or officer, upon conviction of a violation of this paragraph, is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(x) Refusal to insure.—In addition to other provisions of this code, the refusal to insure, or continue to insure, any individual or risk solely because of:

1. Race, color, creed, marital status, sex, or national origin;

2. The residence, age, or lawful occupation of the individual or the location of the risk, unless there is a reasonable relationship between the residence, age, or lawful occupation of the individual or the location of the risk and the coverage issued or to be issued;

3. The insured's or applicant's failure to agree to place collateral business with any insurer, unless the coverage applied for would provide liability coverage which is excess over that provided in policies maintained on property or motor vehicles;

4. The insured's or applicant's failure to purchase noninsurance services or commodities, including automobile services as defined in s. 624.124;

5. The fact that the insured or applicant is a public official; or

6. The fact that the insured or applicant had been previously refused insurance coverage by any insurer, when such refusal to insure or continue to insure for this reason occurs with such frequency as to indicate a general business practice.

(y) Powers of attorney.—Except as provided in s. 627.842(2):

1. Requiring, as a condition to the purchase or continuation of an insurance policy, that an applicant for insurance or an insured execute a power of attorney in favor of an insurance agent or agency or employee thereof; or

2. Presenting to the applicant or the insured, as a routine business practice, a form that authorizes the insurance agent or agency to sign the applicant's or insured's name on any insurance-related document or application for the purchase of motor vehicle services as described in s. 624.124. To be valid, a power of attorney must be an act or practice other than as described in this paragraph, must be a separate writing in a separate document, must be executed with the full knowledge and consent of the applicant or insured who grants the power of attorney, must be in the best interests of the insured or applicant, and a copy of the power of attorney must be provided to the applicant or insured at the time of the transaction.

(z) Sliding.—Sliding is the act or practice of:

1. Representing to the applicant that a specific ancillary coverage or product is required by law in conjunction with the purchase of insurance when such coverage or product is not required;

2. Representing to the applicant that a specific ancillary coverage or product is included in the policy applied for without an additional charge when such charge is required; or

3. Charging an applicant for a specific ancillary coverage or product, in addition to the cost of the insurance coverage applied for, without the informed consent of the applicant.

[1](aa) Churning.—

1. Churning is the practice whereby policy values in an existing life insurance policy or annuity contract, including, but not limited to, cash, loan values, or dividend values, and in any riders to that policy or contract, are directly or indirectly used to purchase another insurance policy or annuity contract with that same insurer for the purpose of earning additional premiums, fees, commissions, or other compensation:

a. Without an objectively reasonable basis for believing that the replacement or extraction will result in an actual and demonstrable benefit to the policyholder;

b. In a fashion that is fraudulent, deceptive, or otherwise misleading or that involves a deceptive omission;

c. When the applicant is not informed that the policy values including cash values, dividends, and other assets of the existing policy or contract will be reduced, forfeited, or used in the purchase of the replacing or additional policy or contract, if this is the case; or
d. Without informing the applicant that the replacing or additional policy or contract will not be a paid-up policy or that additional premiums will be due, if this is the case.

Churning by an insurer or an agent is an unfair method of competition and an unfair or deceptive act or practice.

2. Each insurer shall comply with sub-subparagraphs 1.c. and 1.d. by disclosing to the applicant at the time of the offer on a form designed and adopted by rule by the commission if, how, and the extent to which the policy or contract values (including cash value, dividends, and other assets) of a previously issued policy or contract will be used to purchase a replacing or additional policy or contract with the same insurer. The form must include disclosure of the premium, the death benefit of the proposed replacing or additional policy, and the date when the policy values of the existing policy or contract will be insufficient to pay the premiums of the replacing or additional policy or contract.
3. Each insurer shall adopt written procedures to reasonably avoid churning of policies or contracts that it has issued, and failure to adopt written procedures sufficient to reasonably avoid churning shall be an unfair method of competition and an unfair or deceptive act or practice.
(bb) Deceptive use of name.—Using the name or logo of a financial institution, as defined in s. 655.005(1), or its affiliates or subsidiaries when marketing or soliciting existing or prospective customers if such marketing materials are used without the written consent of the financial institution and in a manner that would lead a reasonable person to believe that the material or solicitation originated from, was endorsed by, or is related to or the responsibility of the financial institution or its affiliates or subsidiaries.
(cc) Unfair rate increases for persons in military service.—Charging an increased premium for reinstating a motor vehicle insurance policy that was canceled or suspended by the insured solely for the reason that he or she was transferred out of this state while serving in the United States Armed Forces or on active duty in the National Guard or United States Armed Forces Reserve. It is also an unfair practice for an insurer to charge an increased premium for a new motor vehicle insurance policy if the applicant for coverage or his or her covered dependents were previously insured with a different insurer and canceled that policy solely for the reason that he or she was transferred out of this state while serving in the United States Armed Forces or on active duty in the National Guard or United States Armed Forces Reserve. For purposes of determining premiums, an insurer shall consider such persons as having maintained continuous coverage.
(dd) Life insurance limitations based on past foreign travel experiences or future foreign travel plans.—
1. An insurer may not refuse life insurance to; refuse to continue the life insurance of; or limit the amount, extent, or kind of life insurance coverage available to an individual based solely on the individual's past lawful foreign travel experiences.
2. An insurer may not refuse life insurance to; refuse to continue the life insurance of; or limit the amount, extent, or kind of life insurance coverage available to an individual based solely on the individual's future lawful travel plans unless the insurer can demonstrate and the Office of Insurance Regulation determines that:
a. Individuals who travel are a separate actuarially supportable class whose risk of loss is different from those individuals who do not travel; and
b. Such risk classification is based upon sound actuarial principles and actual or reasonably anticipated experience that correlates to the risk of travel to a specific destination.

3. The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 necessary to implement this paragraph and may provide for limited exceptions that are based upon national or international emergency conditions that affect the public health, safety, and welfare and that are consistent with public policy.

4. Each market conduct examination of a life insurer conducted pursuant to s. 624.3161 shall include a review of every application under which such insurer refused to issue life insurance; refused to continue life insurance; or limited the amount, extent, or kind of life insurance issued, based upon future lawful travel plans.

5. The administrative fines provided in s. 624.4211(2) and (3) shall be trebled for violations of this paragraph.

6. The Office of Insurance Regulation shall report to the President of the Senate and the Speaker of the House of Representatives by March 1, 2007, and on the same date annually thereafter, on the implementation of this paragraph. The report shall include, but not be limited to, the number of applications under which life insurance was denied, continuance was refused, or coverage was limited based on future travel plans; the number of insurers taking such action; and the reason for taking each such action.

[1](ee) Fraudulent signatures on an application or policy-related document.—Willfully submitting to an insurer on behalf of a consumer an insurance application or policy-related document bearing a false or fraudulent signature.

[1](ff) Unlawful use of designations; misrepresentation of agent qualifications.—

1. A licensee may not, in any sales presentation or solicitation for insurance, use a designation or title in such a way as to falsely imply that the licensee:

a. Possesses special financial knowledge or has obtained specialized financial training; or

b. Is certified or qualified to provide specialized financial advice to senior citizens.

2. A licensee may not use terms such as "financial advisor" in such a way as to falsely imply that the licensee is licensed or qualified to discuss, sell, or recommend financial products other than insurance products.

3. A licensee may not, in any sales presentation or solicitation for insurance, falsely imply that he or she is qualified to discuss, recommend, or sell securities or other investment products in addition to insurance products.

4. A licensee who also holds a designation as a certified financial planner (CFP), chartered life underwriter (CLU), chartered financial consultant (ChFC), life underwriter training council fellow (LUTC), or the appropriate license to sell securities from the Financial Industry Regulatory Authority (FINRA) may inform the customer of those licenses or designations and make recommendations in accordance with those licenses or designations, and in so doing does not violate this paragraph.

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.