FINANCIAL SERVICES COMMISSION
Office of Insurance Regulation
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December 6, 2016

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

Contact: **Caitlin Murray**
(850-413-5005)

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

ITEM	SUBJECT	RECOMMENDATION

1. Minutes of the Financial Services Commission for September 20, 2016.
   http://www.myflorida.com/myflorida/cabinet/agenda16/0920/transcript.pdf

   (ATTACHMENT 1) **FOR APPROVAL**

2. Request for Approval for Publication of Repeal of Rules 69P-5.001 through 69P-5.012

   The rules address the procedures applicable to Surplus Lines insurers and agents related to collection of taxes. This function is now governed by the Florida Surplus Lines Service Office. The rules are now obsolete and should be repealed.

   (ATTACHMENT 2) **APPROVAL FOR PUBLICATION**

3. Request for Approval for Final Adoption of Amendments to Rule 69O-161.001,.009,.010, .011; Prior Authorization Forms

   Section 627.42392, Florida Statutes, requires the Financial Services Commission to develop a standard Prior Authorization Form as well as guidelines for prior authorization forms. The rule will establish guidelines for all prior authorization forms which ensure the general uniformity of such forms, and to adopt a prior authorization form for use by health insurance issuers which do not provide an electronic prior authorization process for use by its contracted providers.

   (ATTACHMENT 3) **APPROVAL FOR FINAL ADOPTION**

4. Office of Insurance Regulation 1st Quarter Report FY 2016-17

   (ATTACHMENT 4) **FOR APPROVAL**

STATE OF FLORIDA

IN RE: MEETING OF THE GOVERNOR AND CABINET
_____/

CABINET MEMBERS: GOVERNOR RICK SCOTT
ATTORNEY GENERAL PAM BONDI
CHIEF FINANCIAL OFFICER
JEFF ATWATER
COMMISSIONER OF AGRICULTURE
ADAM PUTNAM

DATE: TUESDAY, SEPTEMBER 20, 2016

LOCATION: CABINET MEETING ROOM
LOWER LEVEL, THE CAPITOL
TALLAHASSEE, FLORIDA

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OFFICE OF INSURANCE REGULATION

GOVERNOR SCOTT: Next I would like to recognize David Altmaier with the Office of Insurance Regulation.

Good morning, David.

COMMISSIONER ALTMAIER: Good morning, Governor. Good morning, Cabinet. It's great to be here this morning.

So what I thought that I would do before I get started into our actual agenda is just give quick updates on the claims experience that we're seeing with Hurricane Hermine.

As you all are likely aware, immediately following landfall of the storm, we initiated a data call to our industry and began to collect information about the experience that they were having with claims.

That information is up to date. As of this past Friday, we've had 205 companies submit information to us. At this point in time we have 14,890 claims that have been filed. The industry expects that those will cost approximately $80 million.

So those are numbers that we expect to

fluctuate over the next several weeks to months as the claims adjustment process unfolds, but at the moment we've been in contact with most of our industry. And as you would expect after a Category 1 storm, those numbers don't appear to put any particular company in any kind of financial duress. So we're encouraged by the response of our industry, encouraged by the numbers that we're seeing. It does appear everyone was prepared.

We've been staying in close communication, CFO, with your Division of Consumers Services and keeping an eye on call volume that might indicate a need for us to spring into action; but thus far, that seems to be minimal.

So at this point, I'll take any questions about that, but at the moment, it's playing out somewhat as we expected.

GOVERNOR SCOTT: Commissioner, is it the typical policy that has business interruption insurance, is it clear what's covered and what's not covered?

MR. ALTMAIER: It certainly should be clear what's covered under business interruption. There is a percentage for mean claims that we expect will be related to business interruption. In fact, the

modeling agency, RMS, just released a publication a couple of hours ago. They estimate in the southeast where the storm was impacting not just in Florida, but there will be approximately $400 million in claims; and a large part of that will be related to business interruption.

GOVERNOR SCOTT: I had one person -- one business owner say that their insurance company said to them that because the -- how did they say it? Because the outage was not on their property, it was caused by a tree on some other property, their business wouldn't be covered for a business interruption.

MR. ALTMAIER: I understand. It gets --

GOVERNOR SCOTT: It seems hard to believe, but I've never read the policy, so --

COMMISSIONER ALTMAIER: We're happy to take a look at any particular situation that seems strange. It gets a little nuance when there's a tree in somebody's yard that falls on someone else's yard. I think probably some of the calls that have come in have been related to that very situation. It does get a little nuance, but if there's a situation that doesn't seem to make sense, we're happy to take a closer look at it.

GOVERNOR SCOTT: Thanks, and I know your office has -- everybody we've referred, your office has done a great job.

COMMISSIONER ALTMAIER: Well, glad to hear.

So we will just jump right into the agenda. The first item up is a request for approval for the final adoption of our minutes from the April 26th, 2016, Financial Services Commission.

GOVERNOR SCOTT: Is there a motion on the item?

ATTORNEY GENERAL BONDI: So move.

GOVERNOR SCOTT: Is there a second?

CFO ATWATER: Second.

GOVERNOR SCOTT: Comments or objection?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion carries.

COMMISSIONER ALTMAIER: Thank you very much.

The next three items, Items 2, 3, and 4 of the agenda are all the final adoption of the repeal of several rules. Since they are up for final adoption, my plan is to address each individually; but if you'd like for me to do that differently, I'm happy to lump them together.

GOVERNOR SCOTT: Okay. That's fine.

MR. ALTMAIER: Lump them together? Agenda Items 2 --

GOVERNOR SCOTT: Please lump them together.

COMMISSIONER ALTMAIER: I'm sorry?

GOVERNOR SCOTT: Lump them together unless anybody has a problem with it.

COMMISSIONER ALTMAIER: Okay. Perfect.

Agenda Item Number 2 covers two rules that govern the public records request that we receive, as well as indexing of final orders. These rules have become obsolete because most of the guidance in those rules is now governed by statute or in our policies and procedures.

Agenda Item Number 3 is seven total rules that govern our smoking policy, and the statutory authority for setting rules related to the smoking policy is no longer with the OIR, it's with other state agencies and so those have become obsolete.

And then Agenda Item Number 4 is the repeal of a rule that had in it hardwired the form that certain title insurance companies and agents used for their closing protection letter forms. In our form review process now, we don't like to put the forms directly into a rule. We have more of a back-and-forth approval process with the companies,

and so this rule is also obsolete.

So I'd respectfully request your approval for the final adoption for the repeal of those three items.

GOVERNOR SCOTT: Items 2, 3, and 4, is there a motion?

COMMISSIONER PUTNAM: So moved.

GOVERNOR SCOTT: Is there a second?

ATTORNEY GENERAL BONDI: Second.

GOVERNOR SCOTT: Comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion carries.

We're going to Item 5 now.

COMMISSIONER ALTMAIER: Thank you very much.

Item Number 5 is request for final adoption of amendments to Rule 69O1-37.001. As you're aware, insurance companies file with us quarterly and annual financial statements, and the statute gives us the authority to set the standard by which those are received.

What we have historically done is adopted the National Association of Insurance Commissioners' blanks. This amendment would just simply update those blanks to the current year, 2015 annual and

2016 quarterly. So I'd respectfully request your approval of that agenda item.

GOVERNOR SCOTT: For Item 5 is there a motion?

ATTORNEY GENERAL BONDI: So move.

GOVERNOR SCOTT: Second?

COMMISSIONER PUTNAM: Second.

GOVERNOR SCOTT: Comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion carries.

COMMISSIONER ALTMAIER: Thank you very much.

And our last -- excuse me, Agenda Item Number 6 is the final adoption for final approval for amendments to Rule 69O-138.001, similar to the rule that we just adopted, this is a rule that adopts the financial condition examiner's handbook. That's guidance that our field examiners utilize when they do examinations of insurance companies.

This update would simply amend the rule to include the most recent year of 2016. So respectfully request your approval of that item.

GOVERNOR SCOTT: Item 6, is there a motion on the item?

COMMISSIONER PUTNAM: So move.

GOVERNOR SCOTT: Is there a second?

ATTORNEY GENERAL BONDI: Second.

GOVERNOR SCOTT: Comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion carries.

COMMISSIONER ALTMAIER: Okay. Thank you very much.

One last rule-related item is Agenda Item Number 7. This is a request for a publication of amendments to Rule 69O-161.001, 010, and 011. This is related to the recently-passed statute that requires the adoption of a standard prior authorization form, as well as guidance in how to submit that. And these are the forms that physicians utilize when requesting services from insurance companies.

The statute requires that we consult with the Agency for Healthcare Administration on this, which we have done throughout our process. So far they have been very helpful, as well as listing feedback from any other stakeholder.

So I would respectfully request your approval of --

GOVERNOR SCOTT: Item 7, is there a motion?

ATTORNEY GENERAL BONDI: So move.

GOVERNOR SCOTT: Is there a second?

CFO ATWATER: Second.

GOVERNOR SCOTT: Comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion carries.

COMMISSIONER ALTMAIER: All right. Perfect.

So we'll get into the meatier part of our agenda. This is the 2006 -- fiscal year 2016/17 performance measures, our 2017/18 legislative budget request, and our 2017 legislative session priorities.

So this is a great conversation for us to have. I like the way that we have them together. I think when we go through our performance measures internally, it gives us a better picture of how we're responding to evolving market conditions in the insurance industry and gives us a frame of reference for what be might need to look at from a legislative standpoint, and also from a budget standpoint.

It's certainly always helpful to start that conversation by centering in on the mission of the office in which this is a slide that you have seen before. Our mission continues to be promoting the

proper balance between consumer centric protections and market stability. And so as you hear our legislative budget requests, and legislative priorities, as well as we do our performance measures, this will hopefully come through in that discussion.

This is our performance measure detail. These are the ten performance measures that the Office attempts to comply with. We have two columns there. The second to the last is the total fiscal year. I'm very proud that we achieved a 4.9 overall score. Our staff continues to go above and beyond their expectations and do a very good job getting their filings done, staying in communication with our insurance companies, getting our rate filings reviewed in a timely fashion.

You can see on the last column, that is the most recent quarter, the fourth quarter, very proud that we achieved all fives in that particular column, and so very pleased with the effort that our staff has put in over the last quarter.

So as a new agency head, these are standards that I've inherited from my predecessor. That being said, as one of his deputies, I was significantly involved in the development of these

standards. I still believe that they accurately measure the day-to-day operations of the Office.

But since it is the end of a fiscal year and since I am new to the position, we're going to take a look at these and just make sure that if there is any room to update those, to continue challenging our staff, to continue challenging the Agency to meet the demands of the insurance-buying public, we will have that review and have that conversation internally.

COMMISSIONER PUTNAM: Governor?

GOVERNOR SCOTT: Yes, Commissioner.

COMMISSIONER PUTNAM: I'm glad to hear you say that. I think when we had another new agency head, I said, you know, you're inheriting these standards so feel free to take a look at them since you're going to be judged by them; and so I'm glad to hear you say that you're going to do that.

And while you're doing that, I would congratulate you on practically being perfect in every way, but I would encourage you to evaluate the standards on whether they're asking you to stretch enough.

As much as I want to see excellence, I want to see an accurate reflexion of where our strengths

are and where our gaps are. And, you know, these are very process-oriented metrics, and the evidence is clear that y'all are very efficient, and that's outstanding; but when you align your mission and your objectives with your metrics, I think that there's probably an opportunity under your leadership to put your imprint on it and to identify some additional areas for evaluation that will give us a complete picture of the challenges that you face and the needs of your Agency.

COMMISSIONER ALTMAIER: Thank you, Commissioner. I will certainly take those comments to heart.

My personal philosophy is that in our business and in our personal lives, there's always room for improvement. So we will make sure that we design performance measures that accurately measure our day-to-day operations and our mission but also challenge us to seek out ways in which we can be better and more streamlined and efficient.

So thank you for that feedback.

COMMISSIONER PUTNAM: Thank you. And congratulations on a 4.9.

COMMISSIONER ALTMAIER: Thank you very much. That goes to my staff.

So to the Commissioner's point, there are a lot of things that we deal with on a regular basis that doesn't tend to come through in the numbers, and these are just some of those selected activities and accomplishments, as well as opportunities that we see coming up. We have a couple of slides for the P&C segment and a couple of slides for the life and health segment. This is where we really look at the performance of our office with respect to the evolving conditions in the marketplace and try to parlay that performance into developing our legislative budget request and our 2017 legislative priorities. And so you're probably going to hear, as we talk through this, some overlap into those conversations.

I'm not going to go through everything on this slide. There are just a couple that I want to highlight, most of which you are very familiar with. The first one that I do want to mention, of course, are the Supreme Court decisions related to workers' compensation insurance. Of course I'm talking about the Castellanos decision and the Westlaw decision. Those are rate filings that our Office has worked very hard on over the past six to eight weeks when those decisions were rendered and

those filings were made.

So a couple of key things there: We're getting very close to being finished with those reviews and putting those rate filings out into the public so that our business owners and community can respond to that and plan effectively.

More so than that though, these decisions raise the question about what our workers' compensation system should look like in Florida going forward. I know that there have been a lot of stakeholders that have raised concerns about the nature of these decisions. There are a lot of stakeholders that raised concerns about the concerns that have been raised from this decision, so there's going to be a very, I'm sure, passionate discussion on workers' compensation insurance.

And so one of the goals for our Office is to make sure that we're prepared to act as a resource for those folks when they're interested in going down that path, and we'll talk about that in just a few moments; but this has occupied a significant amount of our time on the P&C side.

I want to mention the personal injury protection, the PIP reports that we commissioned several months ago. It was issued last week. It's

a dense 400-page actuarial report, and so we're still going through that.

I want to share with you just a couple of high-level comments: First of all, it does appear that HB 119 was effective as a cost-saving tool in the PIP marketplace. When you look at the cost of PIP since the passage of HB 119 in Florida compared to nationwide, there was about a 20% decline in costs related to that Bill.

That being said, the report also goes on to suggest that if PIP were repealed, there would be an approximate 9.7% savings in premium. That comes with an important caveat, that that assumption is that PIP is repealed and not replaced with anything which, of course, is a very important public policy decision that we'll be interested in being a part of that discussion.

For the consumers -- that if we were to go down the path of repealing PIP, for the consumers that choose to replace PIP with a comparable coverage, to maintain that, depending on the level of coverage that they select, those cost savings become very negligible; in some cases, even almost wash completely out.

And so the PIP report is something that we'll

be spending a substantial amount of time with over the next several weeks as we formulate precisely what it says from an actuarial standpoint and how those actuarial assumptions would impact the industry.

And then the final thing that I want to draw your attention to on this slide is an issue I'm sure you're all very familiar with, which is a rise in water loss trends that we're seeing on property and the property market. You may hear this characterized by other folks as a problem with the assignment of benefits. And the story goes that homeowners, insurers -- homeowners, insureds have water losses or roof losses, they assign their benefits to a third party, and then the third party -- the allegation is that they ramp up the costs to the insurance company.

We are seeing this -- and I want to show a slide here -- we are seeing this reflected in the rate filings that we are receiving at the Office, and so this is an important tale of two years.

On the left-hand side, the pie chart are the rate filings that we received for our property writers between January and July of 2015. You can see the big chunk of dark blue there are the number

of filings that were submitted to us that requested a rate decrease, and so those were substantially more than the rate filings that we received that requested a rate increase.

On the right-hand side is the same time period for 2016 as opposed to 2015, and you can see the script has flipped. Not only are we receiving many more rate filings that are requesting an increase, it's almost 75% of the total filings that we're receiving; but many of those increases range from 8 to 9, up to 12%.

So there are substantial rate increases -- when we have conversations with the companies about this, they attribute the need for rates to increased water loss trends that they are seeing; and so it's certainly very frustrating for me as an insurance regulator, and I'm sure for you as well, to have a period of time -- I used to be able to say a period of no storm activity, but now I have to say a period of minimal storm activity, to see rates going up in this nature when really reinsurance costs are coming down and things in the market are very favorable.

Another area that we're --

Yes, I'm sorry.

CFO ATWATER: Commissioner, to that point, I take it that you're finding that embedded within the filing is the evidence of the increases and losses that they're experiencing?

COMMISSIONER ALTMAIER: Yes.

CFO ATWATER: Would that be accurate to say?

COMMISSIONER ALTMAIER: That is an accurate statement.

CFO ATWATER: Okay. So, and I know that you would not obviously approve a rate that was not justified by the evidence, so not only is this what you're saying they're coming in the door sharing with you, but you're actually seeing the evidence internally within the filing of the losses themselves?

COMMISSIONER ALTMAIER: That's correct, yes.

CFO ATWATER: Have you begun to see any of these players suggest to you or begin to take action on non-renewing any of their policies within some of these geographic areas where there seems to be significant --

COMMISSIONER ALTMAIER: What we're hearing currently is some underwriting actions that are coming at the moment in the form of closing down certain zip codes throughout the state, as opposed

to a mass number of non-renewals. Now we have heard of a case here and there of a company that is looking at a block of business and determining that the risk is not something that is up to their appetite, it doesn't fit well in their portfolio, so they may take those non-renewal actions.

But what we're hearing more widespread than that are companies looking at certain regions of the state and determining that given the rising water losses in those regions, it's just not a good idea for them to be writing in those regions.

CFO ATWATER: Which would then impact future takeouts, I would take it, as well as the potential of non-renewals in the future?

COMMISSIONER ALTMAIER: That is correct, and that actually is a great segue into this slide. You can see here that already -- a lot of this is due to the fact that Citizens is below 500,000 policies, and so the pool of risk that's there available to take is beginning to dry up. You can see that in the chart on the right-hand side. The number of approved takeouts so far this year is 570,000; however, only 47,000 of those have gone out.

What's going to complicate that, CFO, is

exactly the point that you just raised, which the 570,000 number is going to begin to shrink significantly because of the fact that companies are going to be looking at their underwriting, the risks that they currently have, and they're going to determine more than likely that it may not be in their best interest to pursue taking on additional risk through the takeout policy.

So you will hear Barry Gilway talk about a repopulation of Citizens over time if this were to continue, which certainly would undo a lot of great progress that's been made over the past several years with reducing the policies in Citizens.

CFO ATWATER: You know, we all knew, at a point when you're at one and a half million policies, that at some point when the depopulation reaches at some stage of where we're at, 490, 493 --

COMMISSIONER ALTMAIER: Yes, sir.

CFO ATWATER: -- somewhere in that range now, that obviously the percentage movement would slow just on the bare mathematics of that. But I just would say to you, what I'd be really concerned about is if the behavior in the marketplace is not addressed or continues to put cost pressures, that

marketplace players decide we're exiting, we're non-renewing and that cost be moved back to Citizens, that house will be moved back to Citizens, that we just have to be sure that historically where Citizens became a place where anyone could go, such as in some of the sinkhole issues and they weren't getting adequate rate, well, then, you know, this was all falling eventually on an innocent homeowner and so that our public policy making has to stay ahead of this.

And so I just would appreciate -- I know you have access to us at any time, but if you begin to see some movement on non-renewals and the point is that their public policies -- they believe is causing harm to the business model that can't keep rates low enough for households, then I think that's just a real alarm for all of us.

COMMISSIONER ALTMAIER: Certainly.

CFO ATWATER: Okay.

COMMISSIONER ALTMAIER: Certainly. Thank you.

So we'll transition now to the life and health side, and two key issues that I want to highlight on the life and health marketplace that our staff has spent some time dealing with. And you are all aware a couple of weeks ago, we did announce the

approval of the rate filings for ACA compliant products, and so we had 15 individual -- 15 small group compliant health insurance rates.

The story here is a significant contraction in our health insurance marketplace. I think you're likely aware of the two very large health insurance companies that have completely withdrawn from the market here in Florida, as well as a third very large carrier that has withdrawn from 31 of the 37 counties that they operated in; so they'll now only be operating in six counties.

What that means for Floridians is, first of all, there are 47 of our 67 counties in which only one health insurance company is offering plans, which significantly, obviously, reduces the competition that consumers have access to.

The second thing is that the people that were insured by those plans that are now withdrawing, that's about 500,000 Floridians, they are going to have to proactively go onto the enrollment website and choose a new plan during this open enrollment period. If they do not do that, then they will be auto enrolled into a plan with similar costs and so that they maintain some semblance of health insurance coverage.

So there are a couple of challenges there for us. We are working with CMS at a federal level to talk through their methodology for how consumers are going to be mapped into new plans, but also we are looking at, and this will come up in just a few moments, we are looking at the condition of our -- of the remaining carriers in the marketplace. We have no solvency concerns with those carriers, but we do believe that their leverage ratios, their profitability ratios, and their capital ratios are going to come under a little bit more stress than they might have originally anticipated because of the uptick in membership that they will likely see as a result of these withdrawals.

COMMISSIONER PUTNAM: Governor?

GOVERNOR SCOTT: Yes, Commissioner.

COMMISSIONER PUTNAM: Could you elaborate on this a little bit? I mean this is pretty startling. How many players did you say were pulling out of Florida and the other player that's pulling out of a substantial number of counties and --

COMMISSIONER ALTMAIER: Sure.

There are three carriers that have made significant reductions in their presence in

Florida, two of those carriers have completely withdrawn from the market. One of those carriers that withdrew from the market last year, they had a presence in all 67 counties in Florida. And so that was a substantial loss in terms of a company that was willing to write in all areas of the state.

The third company that's significantly reducing their presence, they were -- they had a presence in 37 counties in Florida last year. They have dropped that down to six counties in the State of Florida, and so they have withdrawn from a substantial number.

COMMISSIONER PUTNAM: My goodness. So what would be causing such a huge contraction of healthcare coverage in Florida from the Feds?

COMMISSIONER ALTMAIER: There is an uncertainty from the insurance carrier's perspective about the risk pool that they will ultimately be insuring, and that is a dynamic that is changing. The law has been in place for several years now, but it's still a changing dynamic when you have people that historically have not had insurance in the past, now they are becoming insured.

Most of the folks that are getting insured are achieving a subsidy. Most of these folks that are getting insurance may not have passed the underwriting standards in place prior to the enactment of the Affordable Care Act, and so that is causing challenges for insurance companies in setting their appropriate price points because they are having difficulty gauging how healthy the risk pool will be when they ultimately get to the insurance.

And so without changes to a portion of the program called the risk adjustment portion, which is supposed to help compensate companies if they are adversely selected, if they get an unhealthier population than they suspect, we are hearing from companies that that is not working as effectively as it could; and so we're hearing from companies that without changes to that particular mechanism, they view this as an unviable business plan. And so that's causing some to pull out, and it's causing others to significantly reduce their footprint.

And this is a nationwide phenomenon. There are some states -- I've talked with fellow commissioners. There are some states that have one

plan operating in the entire state. There are some counties in some states that don't have any plans at all and so consumers have zero choice in terms of who to get their health insurance with.

And so it is a nationwide thing that has captured the attention of state regulators to determine what is the best way to identify the hurdles in the program and put our resources to use in an attempt to address those in a manner that we can bring some competition back to the market for the benefit of our consumers.

COMMISSIONER PUTNAM: So --

GOVERNOR SCOTT: -- money.

COMMISSIONER PUTNAM: So how many Floridians did you say are going to be automatically reenrolled if they don't select on their own?

COMMISSIONER ALTMAIER: The number of insureds that were with one of those three plans that will have to find a new one is approximately 500,000. So we are going to engage with as many stakeholders as possible.

If you're watching on TV and you have a plan, you need to maybe check on that; but we're also going to engage with the agency forces, FAHO, FAIA. We're going to talk to as many people as we can

that will have contact with some of those consumers because the best thing that they can do, of course, is to log into the website, check their coverage, and make a selection that is suitable to their needs as opposed to letting somebody else do it for them.

COMMISSIONER PUTNAM: So how many Florida counties will only have one carrier?

COMMISSIONER ALTMAIER: Forty-seven.

COMMISSIONER PUTNAM: Forty-seven of 67 counties will only have one option for health insurance?

COMMISSIONER ALTMAIER: That is correct. An additional ten counties will only have two; and the most we have in any one county is four plans.

COMMISSIONER PUTNAM: So it doesn't sound like it's working out like they planned it.

COMMISSIONER ALTMAIER: It certainly -- from a competitive standpoint, it is not. There is certainly -- there's just not a robust number of carriers that are offering these products, and that causes challenges on a number of fronts.

COMMISSIONER PUTNAM: And what about the upward price pressure, what's the rate increase look like?

GOVERNOR SCOTT: Yeah, what's the range, David, on the prices that went up?

COMMISSIONER ALTMAIER: So the average rate increase in the individual market was 19.1%. That is a couple of points higher actually than what carriers actually requested. The average rate request was approximately 17.6%.

We wound up signing off on 19.1 for a few of these reasons: For the change in risk pool, for the lack of competition; and just a general aggressive nature in the price of these products, we've ticked it up a few points to try to compensate for some of the challenges here.

Other states are seeing rate increases even higher than that. I think the state of Tennessee, hopefully I quote this correctly, they have two plans in their state and they both had rate needs of over 30%, so the theme nationwide or that the carriers are having to raise rates substantially in order to address this uncertainty with the risk pool that they're ultimately insuring.

COMMISSIONER PUTNAM: So rates are going up 19 percent consistently. At what point do you reach -- at what point do the insureds reach a level where they're better off just paying the

penalty instead of absorbing these enormous double-digit rate increases?

COMMISSIONER ALTMAIER: A lot of that is dependent a little bit on the insureds and how much they were paying in insurance. That is also on an escalating trajectory as well, and so in many cases it may not actually be cost effective to drop the coverage.

A lot of the consumers that are looking at these rate increases because of the subsidies that they receive, they won't actually see a significant rate increase because that part will be in the subsidy; but as we all know, somebody has to pay the subsidy. And so, you know, the cost to the entire population generally goes up. But the actual payers of the insurance product may not necessarily see 19.1% because of the interaction that they have with the subsidies.

COMMISSIONER PUTNAM: Thank you.

COMMISSIONER ALTMAIER: You're welcome.

So the other issue that I was going to highlight on this particular slide is our long-term care marketplace, and this is a slide that sort of helps underscore the point I'd like to make here.

There are -- speaking of rate increases, the

long-term care business model is starting to show some cracks. This is a list of the top 25 long-term care companies. You can see in the very last column that the majority of those have requested significant rate increases, oftentimes rate increases over a hundred percent; and in many cases, impacting a large number of Floridians and sometimes tens of thousands of Floridians subjected to these rate increases.

And, of course, the nature of long-term care is that these are products that many people bought many, many years ago. Now these individuals are on fixed income and just don't have the flexibility in their budget to afford long-term care increases of this nature.

The other factor complicating this is that the companies that are bold and italicized on this chart are the only companies that are still offering their products in Florida, and so in addition to the significant rate increases, we are seeing of the companies begin to -- similar to the point Commissioner Putnam was making about the ACA, some companies are looking at this and saying, you know, this business model is just not viable for us any more so we're going to have to stop

offering our products.

It is a significant product. Most people, according to a study, will have to utilize long-term care services at some point in their lives. In most of those cases, those costs can exceed a hundred thousand dollars; and without a robust private long-term care industry, much of that cost will go to programs like Medicaid and Medicare.

So these are the -- oh, and I almost forgot one of our other important issues, and this was related a little bit to what we were just discussing. You know, when you have the conversation about the Affordable --

CFO ATWATER: Commissioner, on the previous slide for a second, I know that -- I appreciate the fact that you've included it here. I don't -- I'm not sure that people have come to grips with how serious an issue this is.

Have there been conversations with your peers or at NAIC, any movement towards a collection of ideas that could be placed into the arena of public policy making that could help address this?

COMMISSIONER ALTMAIER: Yes.

There are actually a number of work streams

ongoing, both with my colleagues across the country, as well as here in Florida we have some ideas as well, which we'll discuss when we get to our legislative agenda. But just the ideas that we have about this, it's a complicated balance, because when we look at the performance of these books of business, it's clear that there likely is some significant rate need for these books.

That being said, there's a balance between making sure the product is viable and making good on your promises to your consumers. And so we have looked at ways in which consumers can have some options as opposed to just simply paying the higher premium or canceling their policy. We've looked at options.

A lot of these policies have what they call an inflation benefit rider so the daily benefit that you get under the policy goes up as inflation goes up. So there could be some options with making adjustments to that endorsement that could help mitigate the increased rates.

It would be a reduction in coverage in some cases, but it would still be an option for consumers if they chose to go down that path, as opposed to just the black-and-white pay-the-rate

increase or cancel the policy.

So it's ideas of that nature that we're having conversations with internally with our companies and with our colleagues nationwide to see what we could potentially implement so the con --

CFO ATWATER: Do you have the data that would provide the Florida population that is participating today in such coverage and the decisions that are taking place each quarter as to which ones are giving up and just not staying current with their policy?

COMMISSIONER ALTMAIER: I'm sure that that is information that we can get our hands on, if we don't already have it; so I will circle back with my team and track that down and circulate that for you.

CFO ATWATER: I think us understanding the significance here in our own state, I -- you try to imagine someone who has been paying these premiums knowing -- doing the responsible thing, that they were going to take care of their own needs and not place that burden on family or neighbors or their government but taken care of; and then it gets to a point after paying premiums year after year, that now as they're getting closer to the actual date

where it may, in fact, be necessary, they can't afford to go on, and --

COMMISSIONER ALTMAIER: Right. That's exactly right. And actually we had two public rate hearings in Miami in August, and we heard that sentiment repeated over and over again, and sometimes through tears of some of the insureds.

CFO ATWATER: I'm sure you did.

COMMISSIONER ALTMAIER: It's certainly a very big issue for the insureds, and we want to make sure that we are, as we mentioned in our mission statement, finding that balance between making sure this market stays viable, but also making sure that consumers that are relying on these products have some options to continue being insured under them.

CFO ATWATER: But you could create a data call that could help us understand the significance of those who have now -- who have been responsible, have now had -- had no chance but to go bare.

COMMISSIONER ALTMAIER: Yes, sir, we can -- if we don't already have the data, we can certainly construct a data call to look for it.

CFO ATWATER: Thank you.

COMMISSIONER ALTMAIER: And so I'll just touch on this slide for just a quick moment because I

think we covered many of the key takeaways as we discussed the rate filings and the ACA.

But we have, in light of that particular rate filing, looked at our domestic marketplace, and I just want to reiterate that it's a healthy marketplace. But you can see the green line in the box on the right, that's the profit margin for these companies, and it's coming under some stress.

And so what we'd like to do is -- and we'll talk about this more when we get to the legislative portion of the presentation, talk about ways that we can look at the standards that these HMOs comply with and make sure that they are modernizing as the marketplace that they operate in is changing.

So I want to transition then, those items that we've talked about, as we look at those issues that we have dealt with over the past several months, we use that as a baseline for when we go into our discussions about our budget and our legislative needs and have a conversation about how those change in conditions in the market might impact our budgetary needs. This -- what you see is our current budget for 2016/2017.

We have a team of 292 outstanding employees. That's down from a peak of 315 from several years

ago. Our budget is 30.9 million. It's exclusively funded by the Insurance Regulatory Trust Fund, so there's no general revenue used for our budget. And we do recognize a substantial amount of efficiency by being administratively housed within DFS and relying on them for certain administrative, HR, and technological support.

So this slide shows a comparison between that budget that I just gave at a very quick high level and the proposal that we plan to hopefully make for 2017 and 2018. I just want to identify a couple of the key differences. First of all, the only substantial increase that we're asking for is in the salaries and benefits. I'll talk about that in just a quick moment, but we are looking for an increase in salaries and benefits.

Offsetting that a little bit, the Florida Public Hurricane Model is in its fourth and final year of enhancements this year. So that $850,000 expense will roll off for 2017 and 2018, and so you can see there that the proposed legislative budget request would be $31.6 million after taking into consideration some of those changes.

So I want to go into a little bit more detail about what we have discovered after we've had

conversations about our budget needs. As I mentioned, we have an outstanding staff at the Office. One of the biggest challenges that we face is that outstanding staff realizing how outstanding they are and leaving and going to work in the private sector.

The entry level positions that we have, especially in our solvency business units, we have looked at the statistics. And we have anywhere between a 50% to 80% turnover ratio in some of those lower level positions. And those are the positions that when we get the financial statements, the rate filings, and those key documents, those are the folks that we rely on to do the first analysis of those to keep the senior level people informed on trends in the marketplace.

And so what we are trying to do with this legislative budget request is reclassify a lot of those lower level positions into positions that, Number 1, are a little bit more competitive with the private market, but also create some semblance of a career track for these employees that we hire generally from Florida State or FAMU, that work for us for a year or two and then move on. One thing that we did that I thought was very helpful is we

conducted a survey of our supervisory staff, and we asked them how much time and resources they commit to training new employees as a result of this turnover.

And we got a great response from our supervisory team. It appears that we are spending a significant amount of resources, and so this could actually represent some efficiencies in the long run by saving costs and resources on the time that our supervisory staff is spending training new employees as we have our entry level folks working out.

Because we're funded through the Insurance Regulatory Trust, this increase in our budget, it's a minimal increase in our budget, but it would not affect the general revenue of the state, it would just be a little bit extra allocation from the Insurance Regulatory Trust.

As I mentioned, these are the significant changes from last year's budget, but I'm happy to take any questions on this before we move on to our legislative items.

(NO RESPONSE).

COMMISSIONER ALTMAIER: Okay. And we have actually, I should note, prepared a document that

goes through a little bit more comprehensively our legislative budget request. It talks a little bit more about the survey, our turnover ratio, and things of that nature. We've shared that with your staff. We unfortunately did not do it timely enough to do a thorough review before this meeting, but as they work through that, if they have questions for us, we'd be happy to chat with you about that.

GOVERNOR SCOTT: Commissioner.

COMMISSIONER PUTNAM: Is the turnover a new problem, or has the Department always acted as sort of the training ground for actuaries, similar to a public defender's office or a state attorney's office?

I mean you're never going to be competitive on salary, but it's kind of understood that you're taking talent, introducing them to the real world; and after a couple of years, they move on to the private sector. Is it your vision that you should be the career path for actuaries, or is it more akin to the legal model.

COMMISSIONER ALTMAIER: Well, it actually is -- it's a historical problem. We have historically struggled with the turnover in the

lower parts of our organizational chart. The new dynamic that has led to the development of this LBR is the change in dynamics in the insurance marketplace. It has changed so much in the past four to five years, not only from a solvency review standpoint, there are -- companies are becoming more global, companies are evolving in terms of their risk appetite and the things that they want to be involved with.

So that requires additional expertise and additional resources for our staff to analyze and truly understand the ramifications that has for the consumers who rely on those.

And so what we have discovered is that when we have employees that leave, as they have historically done, we have to spend a substantial more time training new employees on not only what we've historically done for companies, but also making sure that their education evolves along with the insurance industry that they are charged with overseeing.

I certainly don't anticipate that people have to come and sign a lifetime contract with the OIR and work there forever, but I certainly would like to create the path that those that are interested,

so that we can maintain some consistency from year to year; so that we can keep up and make sure that as the market evolves, we are also evolving.

COMMISSIONER PUTNAM: Am I reading the data right, that your base is 75 and your average is 131 on P&C, and 110 on -- 111 on life and health?

COMMISSIONER ALTMAIER: Is that number from our document?

COMMISSIONER PUTNAM: It's a summary of your document.

COMMISSIONER ALTMAIER: Okay. That's -- I will check into it to confirm that. The statistic that was convincing to me, Commissioner, is when we looked at the entry-level positions that we're really trying to focus on keeping. Our entry-level financial examiner positions are typically -- the base salary for those is about $38,000.

We looked at jobs in the private sector that have the same type of degree expectations and experience expectations, and the average salary for those are anywhere between 62 and $78,000.

The salaries that you just mentioned are probably offset. We do have some actuaries that we're not -- the senior actuaries, that we're not interested in adjusting salaries in those

situations. They seem to be competitive and are long-term.

Some of the actuarial analysts that we hope to develop into being the bench, so to speak, that can step into those roles when the senior actuaries leave something that we are interested in looking to adjust. And so the averages that you read -- and I will do a little bit more research to better respond to your question, but it may be skewed upwards by some of the positions that we're not interested in addressing. It's really the bottom levels of the organizational chart that we're interested in.

COMMISSIONER PUTNAM: Yeah, I'm referring to your reclass of actuary to senior actuary, and your reclass of eight positions to senior actuarial analyst.

COMMISSIONER ALTMAIER: Okay.

COMMISSIONER PUTNAM: I mean just for -- just so we're on the same page.

COMMISSIONER ALTMAIER: Sure. Okay.

COMMISSIONER PUTNAM: I don't expect you to --

COMMISSIONER ALTMAIER: Yeah, I will note that and certainly find a better answer for you and come back to you or your staff and fill you in on that.

But really what we're trying to address is the lower parts of the organizational chart, but we'll make sure we have an explanation for that as well.

COMMISSIONER PUTNAM: Thank you.

COMMISSIONER ALTMAIER: You're welcome.

Additional questions on the LBR or --

(NO RESPONSE).

COMMISSIONER ALTMAIER: Okay. So I'll switch then to the legislative issues, and this should go relatively quickly because we've already kind of laid the groundwork for most of them.

But one of the things that I'm committed to playing a leadership role in during the 2017 legislative session is the third party property claims, the water losses, the assignment of benefits. Whatever you would like to characterize it as, that is an issue that I am going to be committed to being at the table and taking a leadership role in that issue.

This is an issue that we discussed during the appointment process, and one of the things that I said to you at that point, was that the assignment of benefits mechanism is a mechanism that has some benefit for consumers. So it's my viewpoint that legislatively the fix needs to be very surgical so

the consumers can still rely upon that mechanism, but that we identify loopholes that could be potential cost drivers and try to close them down so that it works the way that it was historically meant to work. And so we're going to do a considerable amount of outreach to stakeholders on that particular issue to make sure we have some consensus on how that issue is addressed.

We did discuss a little bit HMOs and looking at the capital standards that those health plans operate under and making sure that we look at the regulations that those companies abide by and make sure that those are modernized to reflect the change in market conditions that they are operating in.

One of the things that we haven't spent a lot of time discussing this morning are continuing care retirement communities. These are communities that insureds pay a significant amount of money to for entrance fees, oftentimes their life savings.

And so we feel as if this statute could stand a little bit of modernizing to make sure that the regulations overseeing those, Number 1, are consumer centric; and Number 2, reflect the business practices of this day and age. So we're

going to take a look at looking at ways in which we could be helpful in that arena.

And then we did discuss long-term care. And, CFO, to your point, one of the goals that we have legislatively is to look at ways that we might be able to put options in for consumers that are faced with these exorbitant rate increases.

We believe that there's got to be an option other than cancel your policy or pay the rate hike. So we're going to be looking at ways that we might be able to establish other options that consumers have that they can continue this coverage and mitigate the increased rates.

And then, finally, we are going to spend some time looking at any redundant or obsolete statutory language that we might have on the books. We're also going to -- it won't be a legislative effort, but we're also going to look at the rules that we have in place and make sure that there's nothing that's redundant or inefficient and try to get some of the -- and try to get some of that cleaned up.

So those are really the issues that I envision the Office taking a leadership role on this upcoming legislative session. I have two others on here: Workers' compensation and PIP.

The reason that they're on the slide is that I will anticipate that those issues will come up legislatively, and we want to make sure that we are well positioned to act as a resource to stakeholders that are interested in taking on those issues and making sure that we have a voice at the table and providing our input to how those work streams progress.

So a lot of this will involve a substantial amount of stakeholder engagement, which we're committed to doing, as we flesh out what this language might actually look like as we get close to session. But that's at a high level our legislative agenda, and I'm happy to take any questions on that.

GOVERNOR SCOTT: Are there any questions?

(NO RESPONSE).

GOVERNOR SCOTT: Okay. Is there a motion on the legislative budget request and the legislative initiatives?

ATTORNEY GENERAL BONDI: So moved.

GOVERNOR SCOTT: Is there a second?

CFO ATWATER: Second.

GOVERNOR SCOTT: Florida law requires the Governor to independently review legislation and

the budget upon passage. Accordingly, I am abstaining from the vote on this item. The record should reflect my abstention.

Any other comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion is approved with one abstention.

Thank you, David.

COMMISSIONER ALTMAIER: Thank you for your time.

GOVERNOR SCOTT: We're going to take a break until 12:45.

(WHEREUPON, THERE WAS A BRIEF RECESS).

* * * *

M E M O R A N D U M

DATE: November 21, 2016

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Virginia Christy
Stephen Fredrickson

SUBJECT: Cabinet Agenda for December 6, 2016
Request for Approval to Publish Repeal of
Rules 69P-5.002,.003,.004,.005,.006,.008,.012
Assignment # 182316-15

The Office of Insurance Regulation requests that this proposed repeal be presented to the Cabinet aides on or before December 1, 2016 and to the Financial Services Commission on December 6, 2016, with a request to approve for publication the proposed rules.

The rules address the procedures applicable to Surplus Lines insurers and agents related to collection of taxes. This function is now governed by the Florida Surplus Lines Service Office. The rules are now obsolete and should be repealed.
Sections 624.308, 624.307(1), 626.914, 626.915, 626.916, 626.924, 626.930, 626.913(2), 626.929(1), 626.931, 626.938, 626.944(3), 627.949(1), 626.918(2)(d)4, 626.621(7), 627.736(1) F.S., provide rulemaking authority and laws implemented for these rules.

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

Approved for signature:

Anoush Brangaccio
Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier
David Altmaier, Commissioner
Office of Insurance Regulation

CHAPTER 69P-5

UNAUTHORIZED INSURERS AND SURPLUS LINES

69P-5.002 Private Passenger Automobile Physical Damage Insurance.

Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.307(1), 626.914(4), 626.916, 626.924, 626.930 FS. History–New 3-10-92, Formerly 4-11.003, 4J-5.002, Repealed _____.

69P-5.003 Statement of Diligent Effort.

Rulemaking ~~Specific~~ Authority 624.308, 626.916(2) FS. Law Implemented 624.307(1), 626.913(2), 626.916(1)(a), 626.930(1) FS. History–New 10-1-91, Formerly 4-11.005, Amended 8-28-94, Formerly 4J-5.003, Repealed _____.

69P-5.004 Quarterly Report Required.

Rulemaking ~~Specific~~ Authority 624.308(1) FS. Law Implemented 624.307(1), 626.914(4), 626.916(1), 626.929(1), 626.931 FS. History–New 5-15-90, Amended 4-1-91, Formerly 4-11.006, 4J-5.004, Repealed _____.

69P-5.005 Report and Tax of Independently Procured Coverages.

Rulemaking ~~Specific~~ Authority 624.308(1) FS. Law Implemented 624.307(1), 626.938, 627.944(3), 627.949(1) FS. History–New 5-15-90, Formerly 4-11.007, 4J-5.005, Repealed _____.

69P-5.006 Surplus Lines Insurers: Quarterly and Annual Reporting Requirements.

Rulemaking ~~Specific~~ Authority 624.308(1) FS. Law Implemented 624.307(1), 626.916, 626.931 FS. History–New 6-12-94, Formerly 4J-5.006, Repealed _____.

69P-5.008 Surplus Lines Surplus Requirement Election Form.

Rulemaking ~~Specific~~ Authority 626.918(2)(d)4. FS. Law Implemented 626.918 FS. History–New 4-26-98, Formerly 4J-5.008, Repealed _____.

69P-5.012 Prohibitions.

Rulemaking ~~Specific~~ Authority 624.308 FS. Law Implemented 624.307(1), 626.621(7), 626.914, 626.915, 626.916, 627.736(1) FS. History–New 7-6-94, Formerly 4-176.012, 4J-5.012, Repealed _____.

CHAPTER 69P-5

UNAUTHORIZED INSURERS AND SURPLUS LINES

69P-5.002 Private Passenger Automobile Physical Damage Insurance.

(1) This rule is applicable only to the placement of private passenger automobile physical damage insurance as defined in Section 627.066, Florida Statutes, pursuant to the Surplus Lines Law, as established in Sections 626.913 through 626.937, Florida Statutes.

(2) "Records of surplus lines agent," as required by Section 626.930, Florida Statutes, shall include, as a part of the record on every private passenger automobile physical damage only risk placed with an eligible surplus lines insurer, complete documentation of the diligent effort the producing agent has made to place the risk with an authorized insurer. The documentation shall include, but not be limited to, the following:

(a) Name of the authorized insurers directly or indirectly contacted;

(b) Persons contacted, telephone number, and relationship to the authorized insurers, or a copy or printout of any information from a computer data base or other medium of publication which communicates an insurer's declination of the risk;

(c) Dates of contact; and

(d) Reason(s) for declination.

(3) An unwillingness or refusal on the part of an insurer to do business with a particular producing agent shall not be considered a valid insurer declination for purposes of satisfying the declination requirement in Section 626.914(4), Florida Statutes.

(4) The diligent effort made by the producing agent shall include declinations by:

(a) The authorized insurer writing the insured's primary mandatory automobile liability coverages; and

(b) At least three authorized insurers actually writing private passenger automobile physical damage only coverage. The insurer described in paragraph (a) may be one of the three insurers required by this subparagraph, if that insurer is actually writing physical damage only coverage in Florida.

(5) Private passenger automobile physical damage only coverage is not eligible for export unless the producing agent has verified that the prospective insured has procured the mandatory automobile liability coverage required by Florida law.

(6) Private passenger automobile physical damage only coverage is not eligible for export when the surplus lines market is detrimental to the applicant's best interests and when the producing agent is aware of the availability of markets more beneficial to the applicant.

(7) Each private passenger automobile physical damage only policy issued by a surplus lines insurer shall contain a notification stamped on the front of the policy in a contrasting color of ink, in 12-point boldface type, to the effect that the policy is physical damage only and that the policy does not provide the mandatory automobile liability coverages required under Florida law and that any policy issued by a surplus lines insurer is not protected by the Florida Insurance Guaranty Association.

Specific Authority 624.308 FS. Law Implemented 624.307(1), 626.914(4), 626.916, 626.924, 626.930 FS. History–New 3-10-92, Formerly 4-11.003, 4J-5.002.

69P-5.003 Statement of Diligent Effort.

(1) When placing coverage with an eligible surplus lines insurer, the surplus lines agent must verify that a diligent effort has been made by requiring from the retail or producing agent a properly documented statement of diligent effort on form DI4-1153 (7/94), "Statement of Diligent Effort", which is hereby adopted and incorporated by reference. Copies of form DI-1153 may be obtained from the Bureau of Property and Casualty Insurer Solvency, 200 East Gaines Street, Tallahassee, Florida 32399-0329.

(2) Declinations must be documented on a risk-by-risk basis.

Specific Authority 624.308, 626.916(2) FS. Law Implemented 624.307(1), 626.913(2), 626.916(1)(a), 626.930(1) FS. History–New 10-1-91, Formerly 4-11.005, Amended 8-28-94, Formerly 4J-5.003.

69P-5.004 Quarterly Report Required.

(1) Each surplus lines agent shall on or before the end of the month next following each calendar quarter file with the department a verified report in duplicate of all surplus lines insurance transacted by him during such calendar quarter. The report shall be submitted on Form DI4-SL1, "Quarterly Report, Affidavit and Tax Return Required by the Surplus Lines Law," rev. 8-90 which is hereby adopted and incorporated by reference. This form may be obtained from the Surplus Lines Section, Bureau of Data Control, Surplus Lines, Department of Insurance, 200 East Gaines Street,

Tallahassee, FL 32399-0300. The form, with the check for any required tax, shall be submitted to: The Department of Insurance and State Treasurer, Surplus Lines Section, Revenue Processing Section, P. O. Box 6100, Tallahassee, FL 32314-6100. All checks shall be made payable to the 'Florida Insurance Department." If no business was transacted in the reporting quarter, Form DI4-SL1 shall be submitted to the Bureau of Data Control, Billing and Surplus Lines Tax Section, Department of Insurance, 200 East Gaines Street, Tallahassee, FL 32399-0300.

(2)(a) In addition to the form adopted in subsection (1), above, all surplus lines agents shall submit quarterly report information in computer readable form using the diskette medium for business written only. The information shall be sent to the Bureau of Data Control, Billing and Surplus Lines Tax Section, Department of Insurance, 200 East Gaines Street, Tallahassee, FL 32399-0300, on any standard 3 1/2" diskette or 5 1/4" floppy disk produced by an IBM-compatible personal computer. The outside of the diskette shall be labeled with the agent's name, social security number, quarterly reporting date, telephone number (including area code), and certification that the diskette is virus-free (using a detector). All information on the disk should be saved in Text or ASCII format. Any agent creating a disk using a word processor (such as WordPerfect or Microsoft Word) should save the report file in Text or ASCII mode. A carriage return (CR) should be entered at the end of each line. The Quarterly Report file saved on the diskette shall be named with the agent's three initials, the last four digits of his/her social security number, the year, the reporting quarter in the following format: FML9999D.YYQ. If the agent has no middle initial, use the format: F L9999D.YYQ.

(b) If there is no surplus lines business transacted in the reporting quarter, an affidavit (on Form DI4-SL1) is all that is required to be submitted to the Department.

(c) All lines in the Quarterly Report File will begin with an identification number and colon. The

disk format is as follows:

1. First Eight Lines:

a. Line #1: Agent's social security number formatted as 1: 999-99-9999 (CR).

b. Line #2: Agent's full name formatted as: 2: FIRST NAME, MIDDLE NAME, LAST NAME (CR).

c. Line #3: Name of person who prepared the diskette formatted as: 3: FIRST NAME, MIDDLE NAME, LAST NAME (CR).

d. Line #4: Telephone number of person who prepared the diskette formatted as: 4: (999) 999-9999 ext 9999 (CR); or if there is no extension, then 4: (999) 999-9999 (CR).

e. Line #5: Name of the agency (if any) for which the agent works formatted as: 5: AGENCY NAME (CR). The name is limited to 50 characters and shall not contain any abbreviations. If the agent does not work for an agency, then enter: 5: NONE (CR).

f. Line #6: Federal Employer Identification Number (FEIN) of the agency formatted as: 6: 99-9999999 (CR) or the Social Security Number (SSN) of the agent if no agency formatted as 6: 999-99-9999 (CR).

g. Line #7: quarterly reporting date formatted as: 7: MM/DD/YYYY (CR). Example: 7: 03/30/1990.

h. Line #8 starts the Surplus Lines Company (SLC) information and is repeated for each Surplus Lines Company represented in the report. Data will be separated by commas. Each company will occupy one line beginning with row identification number 8 followed by a colon. Example: 8:

i. The first data item in the company information line will be the SLC's FEIN in the format: 99-9999999.

ii. The second data item will be the SLC's Name in the format: ABC . . . (limit of 30 characters with no abbreviations).

i. Line #9 starts the policy data. Repeat this line of data once for each policy reported. Delineate by commas on lines where more than one item of data is present. All dollar amounts shall contain the dollar sign ($) and a decimal point; the number of characters provided in the format example does not indicate a limit on the size of the data item. All percentages shall contain the amount followed by a percent sign (%). Each line of policy data shall begin with the row identification number 9 followed by a colon. Example: 9:

i. Insured's name as shown on the policy in the format: JOHN QUE PUBLIC (limit of 30 characters with no abbreviations).

ii. Policy number in the format: xxxx . . . etc.

iii. County Code (the two-digit Florida County Code) in the format: 99.

iv. Tax status: enter the appropriate one-digit code as follows: 0 = all risks; 1 = aviation/nontaxable; 2 = political subdivision; 3 = ocean marine/nontaxable; 4 = aviation/taxable; 5 = ocean marine/taxable. Format: 9.

v. Transaction number in the format: 9.

vi. Policy actions: enter the appropriate one-digit code as follows: 1 = renewed or new; 2 = additional premium; 3 = return or cancellation. Format: 9.

vii. Gross Premium: enter the total premium of the policy in the following format: $999999.99.

viii. 5% premium tax: enter 5% of the gross premium in the format: $999.99.

ix. Content of policy information line: 9: NAMED INSURED, POLICY #, County Code, Non-resident Agent Status, Tax Status, Transaction #, Policy Action, Gross Premium, 5% Premium Tax.

x. Example of policy information line: 9: BILL SMITH,cn123,43,Y,0,1,1,$6000.00,$300.00 (CR).

j. Line #10 contains policy detail information. This is repeated once for each code relating to the previous line #9 entry. The information is separated with commas and each row begins with row

identification number 10 and a colon. Example: 10:

i. Coverage Code: enter the 3-digit code for the surplus lines class of coverage in the format: 999.

ii. Total Premium: enter the total premium by class for this coverage in the format: $999999.99.

iii. Number of Surplus Lines Companies: enter the number of different SLC's covering the above code for this policy in the format: 99.

iv. FEIN of the SLC in the format: 99-9999999.

v. Percentage of Coverage: enter the percentage of policy coverage for this company for this code in the format: 99%.

vi. Dollar amount which this SLC is covering in the format: $9999999.99 (CR).

vii. Data items iv, v, and vi will repeat once for each SLC covering the above code.

viii. Content of Policy Detail Information Line #10: 10: Coverage Code, Total Premium by Class, # of SLC's, FEIN of SLC, % of Coverage by SLC, $ of Coverage (CR).

ix. Example of Policy Detail Information Line #10: 10:

595,$3000.00,2,11-2222222,40%,$1200.00,33-4444444,60%,$1800.00.

(d) Content of a completed diskette:

Line #	Data
1:	Agent's Social Security Number
2:	Agent's Full Name
3:	Person Creating Disk: Full Name
4:	Person Creating Disk: Phone Number
5:	Agency's Name or NONE

6: FEIN or SSN

7: End of Quarter Report Date

8: SLC's FEIN, SLC's NAME: repeat for each company

9: Policy Information: repeat for each policy number

10: Policy Detail Information: repeat for each policy number

(e) Example of a completed diskette:

1: 213-99-1234

2: DOE,JOHN,NATHAN

3: SMITH,JOAN,SUE

4: (555) 123-1234

5: THE AGENT ASSOCIATES

6: 99-1234567

7: 09/30/1990

8: 11-2222222, SURPLUS LINES COMPANY ONE

8: 22-3333333, SURPLUS LINES COMPANY TWO

8: 33-4444444, SURPLUS LINES COMPANY THREE

9: BILL SMITH,cn12333,43,Y,0,1,1,$60000.00,$300.00

10: 290,$20000.00,1,11-2222222,100%,$2000.00

10: 595,$4000.00,2,11-2222222,65%,$2600.00,22-3333333,35%,$1400.00

9: NANCY JONES,ABC124,62,NO,1,2,$5000.00,$250.00

10: 199,$5000.00,3,33-4444444,70%,$3500.00,11-2222222,20%,$1000.00,22-3333333,10%,$500.00

Specific Authority 624.308(1) FS. Law Implemented 624.307(1), 626.914(4), 626.916(1), 626.929(1), 626.931 FS. History–New 5-15-90, Amended 4-1-91, Formerly 4-11.006, 4J-5.004.

69P-5.005 Report and Tax of Independently Procured Coverages.

(1) Every insured who in this state procures or causes to be procured or continues or renews insurance with an unauthorized foreign or alien insurer, or any self-insurer who in this state so procures or continues excess loss, catastrophe, or other insurance, upon a subject of insurance resident, located, or to be performed within this state, other than insurance procured through a surplus lines agent pursuant to the Surplus Lines Law of this state or exempted from tax under Section 626.932(4), Florida Statutes, shall, within 30 days after the date such insurance was so procured, continued, or renewed, file both of the following forms: Form DI4-SL3, "Tax Report of I.P.C.," rev. 9-89, and Form DI4-SI4 (TL-2), "Transmittal of Surplus Lines Premium Taxes – I.P.C.", rev. 2-88, both of which are hereby adopted and incorporated by reference. Both forms may be obtained from the Surplus Lines Section, Bureau of Compliance, Department of Insurance, 200 East Gaines Street, Tallahassee, FL 32399-0300. Both forms shall be mailed to the Surplus Lines Section, Revenue Processing Section, P. O. Box 6100, Tallahassee, FL 32314-6100. All checks shall be made payable to the Florida Insurance Department.

(2) A risk retention group which itself insures or a purchasing group which procures or causes to be procured or continues or renews insurance, with an eligible surplus lines insurer or risk retention group, upon a subject of insurance resident, located, or to be performed in this state, other than insurance procured through a surplus lines agent pursuant to the Surplus Lines Law of this state

shall request Form DI4-SL5(TL-2), "Transmittal of Surplus Lines Premium Taxes – I.P.C., Risk Retention Groups – Purchasing Groups," rev. 2-88, which is hereby adopted and incorporated by reference from the Surplus Lines Section, Bureau of Compliance, Department of Insurance, 200 East Gaines Street, Tallahassee, FL 32399-0300 and shall submit the form accompanied by a check for the taxes due to: The Department of Insurance and State Treasurer, Surplus Lines Section, Revenue Processing Section, P. O. Box 6100, Tallahassee, FL 32314-6100. All checks shall be made payable to the Florida Insurance Department.

Specific Authority 624.308(1) FS. Law Implemented 624.307(1), 626.938, 627.944(3), 627.949(1) FS. History–New 5-15-90, Formerly 4-11.007, 4J-5.005.

69P-5.006 Surplus Lines Insurers: Quarterly and Annual Reporting Requirements.

(1) Each foreign eligible surplus lines insurer accepting premiums which are subject to taxes shall, on or before the end of the month next following each calendar quarter, file with the Department a report of all surplus lines insurance transacted by the insurer for risks located in this state during such calendar quarter. The first such report shall be for the calendar quarter ending December 31, 1993.

(2) Each alien eligible surplus lines insurer accepting premiums which are subject to taxes shall, on or before June 30 of each year, file with the Department a report of all surplus lines insurance transacted by the insurer for insurance risks located in this state during the preceding calendar year. The first such report shall be for calendar year 1994.

(3)(a) The quarterly report shall be submitted on the form adopted in paragraph (b), below, accompanied by the computer diskette described in paragraph (d), below. The annual report shall be submitted on the form adopted in paragraph (c), below, accompanied by the computer diskette

described in paragraph (d), below. Both of the forms may be obtained from and the forms and the computer diskettes shall be submitted to: Surplus Lines Section, Bureau of Property and Casualty Insurer Solvency and Market Conduct, Division of Insurer Services, Department of Insurance, 200 East Gaines Street, Tallahassee, FL 32399-0329.

(b) The quarterly report shall be submitted on Form DI4-SLQ, "Florida Department of Insurance/Surplus Lines Insurers/Quarterly Report Affidavit," rev. 11/93, which is hereby adopted and incorporated by reference.

(c) The annual report shall be submitted on Form DI4-SLA, "Florida Department of Insurance/Surplus Lines Insurers/Annual Report Affidavit," rev. 11/93, which is hereby adopted and incorporated by reference.

(d)1. The computer diskette shall contain the following information:

a. Name and address of the Florida surplus lines insurer;

b. Aggregate gross Florida premiums charged;

c. Aggregate returned Florida premiums;

d. Aggregate net Florida premiums;

e. A listing of all policies, certificates, cover notes, or other forms of confirmation of insurance coverage or any substitutions thereof or endorsements thereto and the identifying number.

2. All the information required by subparagraph 1., above, shall be submitted on an IBM-compatible 3.5" or 5.25" diskette which has been saved in Text or ASCII format. The outside of the diskette shall be labeled with the surplus lines insurer's name; the insurer's Federal Employer Identification Number (FEIN), and the dates covered by the report.

Specific Authority 624.308(1) FS. Law Implemented 624.307(1), 626.916, 626.931 FS. History–New 6-12-94, Formerly 4J-5.006.

69P-5.008 Surplus Lines Surplus Requirement Election Form.

Section 626.918(2)(d)4., Florida Statutes, requires a form be filed by surplus lines insurers making an election of alternate minimum surplus requirements. Form DI4-1280 (rev. 12/97) is hereby incorporated by reference to be the form specified in Section 626.918(2)(d)4., Florida Statutes, for making such election.

Specific Authority 626.918(2)(d)4. FS. Law Implemented 626.918 FS. History–New 4-26-98, Formerly 4J-5.008.

69P-5.012 Prohibitions.

(1) Stand-alone Private Passenger Auto Physical Damage Coverage Prohibited.

(a) Private passenger auto physical damage coverage for motorized vehicles cannot be issued as a stand-alone policy by a surplus lines carrier unless the coverage is unavailable from the Joint Underwriting Association and:

1. The automobile is valued at $40,000 (actual cash value) or more, or

2. The automobile qualifies as an ancient motor vehicle pursuant to Section 320.086, Florida Statutes.

(b) Such coverage, when issued by a surplus lines carrier other than as allowed in paragraph (a) above, must be issued in combination with mandatory PIP and property damage liability coverages.

(2) Requiring Auto Physical Damage Coverage Prohibited. Private passenger auto physical damage coverage is not a required coverage and is not to be considered a condition for providing required coverages.

(3) Duplicate Coverage Prohibited. No insurance agent shall sell and no insurer shall issue any

motor vehicle insurance policy on a vehicle which is covered by an existing policy if coverages would overlap with the existing policy coverages.

Specific Authority 624.308 FS. Law Implemented 624.307(1), 626.621(7), 626.914, 626.915, 626.916, 627.736(1) FS. History–New 7-6-94, Formerly 4-176.012, 4J-5.012.

69P-5.002 thru .012
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.

626.916 Eligibility for export.—

(1) No insurance coverage shall be eligible for export unless it meets all of the following conditions:

(a) The full amount of insurance required must not be procurable, after a diligent effort has been made by the producing agent to do so, from among the insurers authorized to transact and actually writing that kind and class of insurance in this state, and the amount of insurance exported shall be only the excess over the amount so procurable from authorized insurers. Surplus lines agents must verify that a diligent effort has been made by requiring a properly documented statement of diligent effort from the retail or producing agent. However, to be in compliance with the diligent effort requirement, the surplus lines agent's reliance must be reasonable under the particular circumstances surrounding the export of that particular risk. Reasonableness shall be assessed by taking into account factors which include, but are not limited to, a regularly conducted program of verification of the information provided by the retail or producing agent. Declinations must be documented on a risk-by-risk basis. If it is not possible to obtain the full amount of insurance required by layering the risk, it is permissible to export the full amount.

(b) The premium rate at which the coverage is exported shall not be lower than that rate applicable, if any, in actual and current use by a majority of the authorized insurers for the same coverage on a similar risk.

(c) The policy or contract form under which the insurance is exported shall not be more favorable to the insured as to the coverage or rate than under similar contracts on file and in actual current use in this state by the majority of authorized insurers actually writing similar coverages on similar risks; except that a coverage may be exported under a unique form of policy designed for use with respect to a particular subject of insurance if a copy of such form is filed with the office by the surplus lines agent desiring to use the same and is subject to the disapproval of the office within 10 days of filing such form exclusive of Saturdays, Sundays, and legal holidays if it finds that the use of such special form is not reasonably necessary for the principal purposes of the coverage or that its use would be contrary to the purposes of this Surplus Lines Law with respect to the reasonable protection of authorized insurers from unwarranted competition by unauthorized insurers.

(d) Except as to extended coverage in connection with fire insurance policies and except as to windstorm insurance, the policy or contract under which the insurance is exported shall not provide for deductible amounts, in determining the existence or extent of the insurer's liability, other than those available under similar policies or contracts in actual and current use by one or more authorized insurers.

(e) For personal residential property risks, the retail or producing agent must advise the insured in writing that coverage may be available and may be less expensive from Citizens Property Insurance Corporation. The notice must include other information that states that assessments by Citizens Property Insurance Corporation are higher and the coverage provided by Citizens Property Insurance Corporation may be less than the property's existing coverage. If the notice is signed by the insured, it is presumed that the insured has been informed and knows that policies from Citizens Property Insurance Corporation may be less expensive, may provide less coverage, and will be accompanied by higher assessments.

(2) The commission may by rule declare eligible for export generally, and notwithstanding the provisions of paragraphs (a), (b), (c), and (d) of subsection (1), any class or classes of insurance coverage or risk for which it finds, after a hearing, that there is no reasonable or adequate market among authorized insurers. Any such rules shall continue in effect during the existence of the conditions upon which predicated, but subject to termination by the commission.

(3)(a) Subsection (1) does not apply to wet marine and transportation or aviation risks which are subject to s. 626.917.

(b) Paragraphs (1)(a)-(d) do not apply to classes of insurance which are subject to s. 627.062(3)(d)1. These classes may be exportable under the following conditions:

1. The insurance must be placed only by or through a surplus lines agent licensed in this state;

2. The insurer must be made eligible under s. 626.918; and

3. The insured must sign a disclosure that substantially provides the following: "You are agreeing to place coverage in the surplus lines market. Superior coverage may be available in the admitted market and at a lesser cost. Persons insured by surplus lines carriers are not protected under the Florida Insurance Guaranty Act with respect to any right of recovery for the obligation of an insolvent unlicensed insurer." If the notice is signed by the insured, the insured is presumed to have been informed and to know that other coverage may be available, and, with respect to the diligent-effort requirement under subsection (1), there is no liability on the part of, and no cause of action arises against, the retail agent presenting the form.

(4) A reasonable per-policy fee, not to exceed $35, may be charged by the filing surplus lines agent for each policy certified for export.

626.918 Eligible surplus lines insurers.—

(1) A surplus lines agent may not place any coverage with any unauthorized insurer which is not then an eligible surplus lines insurer, except as permitted under subsections (5) and (6).

(2) An unauthorized insurer may not be or become an eligible surplus lines insurer unless made eligible by the office in accordance with the following conditions:

(a) Eligibility of the insurer must be requested in writing by the Florida Surplus Lines Service Office.

(b) The insurer must be currently an authorized insurer in the state or country of its domicile as to the kind or kinds of insurance proposed to be so placed and must have been such an insurer for not less than the 3 years next preceding or must be the wholly owned subsidiary of such authorized insurer or must be the wholly owned subsidiary of an already eligible surplus lines insurer as to the kind or kinds of insurance proposed for a period of not less than the 3 years next preceding. However, the office may waive the 3-year requirement if the insurer provides a product or service not readily available to the consumers of this state or has operated successfully for a period of at least 1 year next preceding and has capital and surplus of not less than $25 million.

(c) Before granting eligibility, the requesting surplus lines agent or the insurer shall furnish the office with a duly authenticated copy of its current annual financial statement in the English language and with all monetary values therein expressed in United States dollars, at an exchange rate (in the case of statements originally made in the currencies of other countries) then-current and shown in the statement, and with such additional information relative to the insurer as the office may request.

(d)1.a. The insurer must have and maintain surplus as to policyholders of not less than $15 million; in addition, an alien insurer must also have and maintain in the United States a trust fund for the protection of all its policyholders in the United States under terms deemed by the office to be reasonably adequate, in an amount not less than $5.4 million. Any such

surplus as to policyholders or trust fund shall be represented by investments consisting of eligible investments for like funds of like domestic insurers under part II of chapter 625 provided, however, that in the case of an alien insurance company, any such surplus as to policyholders may be represented by investments permitted by the domestic regulator of such alien insurance company if such investments are substantially similar in terms of quality, liquidity, and security to eligible investments for like funds of like domestic insurers under part II of chapter 625. Clean, irrevocable, unconditional, and evergreen letters of credit issued or confirmed by a qualified United States financial institution, as defined in subparagraph 2., may be used to fund the trust.

b. For those surplus lines insurers that were eligible on January 1, 1994, and that maintained their eligibility thereafter, the required surplus as to policyholders shall be:

(I) On December 31, 1994, and until December 30, 1995, $2.5 million.
(II) On December 31, 1995, and until December 30, 1996, $3.5 million.
(III) On December 31, 1996, and until December 30, 1997, $4.5 million.
(IV) On December 31, 1997, and until December 30, 1998, $5.5 million.
(V) On December 31, 1998, and until December 30, 1999, $6.5 million.
(VI) On December 31, 1999, and until December 30, 2000, $8 million.
(VII) On December 31, 2000, and until December 30, 2001, $9.5 million.
(VIII) On December 31, 2001, and until December 30, 2002, $11 million.
(IX) On December 31, 2002, and until December 30, 2003, $13 million.
(X) On December 31, 2003, and thereafter, $15 million.

c. The capital and surplus requirements as set forth in sub-subparagraph b. do not apply in the case of an insurance exchange created by the laws of individual states, where the exchange maintains capital and surplus pursuant to the requirements of that state, or maintains capital and surplus in an amount not less than $50 million in the aggregate. For an insurance exchange which maintains funds in the amount of at least $12 million for the protection of all insurance exchange policyholders, each individual syndicate shall maintain minimum capital and surplus in an amount not less than $3 million. If the insurance exchange does not maintain funds in the amount of at least $12 million for the protection of all insurance exchange policyholders, each individual syndicate shall meet the minimum capital and surplus requirements set forth in sub-subparagraph b.

d. A surplus lines insurer which is a member of an insurance holding company that includes a member which is a Florida domestic insurer as set forth in its holding company registration statement, as set forth in s. 628.801 and rules adopted thereunder, may elect to maintain surplus as to policyholders in an amount equal to the requirements of s. 624.408, subject to the requirement that the surplus lines insurer shall at all times be in compliance with the requirements of chapter 625.

The election shall be submitted to the office and shall be effective upon the office's being satisfied that the requirements of sub-subparagraph d. have been met. The initial date of election shall be the date of office approval. The election approval application shall be on a form adopted by commission rule. The office may approve an election form submitted pursuant to sub-subparagraph d. only if it was on file with the former Department of Insurance before February 28, 1998.

2. For purposes of letters of credit under subparagraph 1., the term "qualified United States financial institution" means an institution that:

a. Is organized or, in the case of a United States office of a foreign banking organization, is licensed under the laws of the United States or any state.

b. Is regulated, supervised, and examined by authorities of the United States or any state having regulatory authority over banks and trust companies.

c. Has been determined by the office or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and

standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit are acceptable to the office.

(e) The insurer must be of good reputation as to the providing of service to its policyholders and the payment of losses and claims.

(f) The insurer must be eligible, as for authority to transact insurance in this state, under s. 624.404(3).

(g) This subsection does not apply as to unauthorized insurers made eligible under s. 626.917 as to wet marine and aviation risks.

(3) The office shall from time to time publish a list of all currently eligible surplus lines insurers and shall mail a copy thereof to each licensed surplus lines agent at his or her office of record with the office.

(4) This section shall not be deemed to cast upon the office any duty or responsibility to determine the actual financial condition or claims practices of any unauthorized insurer; and the status of eligibility, if granted by the office, shall indicate only that the insurer appears to be sound financially and to have satisfactory claims practices and that the office has no credible evidence to the contrary.

(5) When it appears that any particular insurance risk which is eligible for export, but on which insurance coverage, in whole or in part, is not procurable from the eligible surplus lines insurers, after a search of eligible surplus lines insurers, then the surplus lines agent may file a supplemental signed statement setting forth such facts and advising the office that such part of the risk as shall be unprocurable, as aforesaid, is being placed with named unauthorized insurers, in the amounts and percentages set forth in the statement. Such named unauthorized insurer shall, however, before accepting any risk in this state, deposit with the department cash or securities acceptable to the office and department of the market value of $50,000 for each individual risk, contract, or certificate, which deposit shall be held by the department for the benefit of Florida policyholders only; and the surplus lines agent shall procure from such unauthorized insurer and file with the office a certified copy of its statement of condition as of the close of the last calendar year. If such statement reveals, including both capital and surplus, net assets of at least that amount required for licensure of a domestic insurer, then the surplus lines agent may proceed to consummate such contract of insurance. Whenever any insurance risk, or any part thereof, is placed with an unauthorized insurer, as provided herein, the policy, binder, or cover note shall contain a statement signed by the insured and the agent with the following notation: "The insured is aware that certain insurers participating in this risk have not been approved to transact business in Florida nor have they been declared eligible as surplus lines insurers by the Office of Insurance Regulation of Florida. The placing of such insurance by a duly licensed surplus lines agent in Florida shall not be construed as approval of such insurer by the Office of Insurance Regulation of Florida. Consequently, the insured is aware that the insured has severely limited the assistance available under the insurance laws of Florida. The insured is further aware that he or she may be charged a reasonable per policy fee, as provided in s. 626.916(4), Florida Statutes, for each policy certified for export." All other provisions of this code shall apply to such placement the same as if such risks were placed with an eligible surplus lines insurer.

(6) When any particular insurance risk subject to subsection (5) is eligible for placement with an unauthorized insurer and not more than 12.5 percent of the risk is so subject, the office may, at its discretion, permit the agent to obtain from the insured a signed statement as indicated in subsection (5). All other provisions of this code apply to such placement the same as if such risks were placed with an eligible surplus lines insurer.

624.307 General powers; duties.—

69P-5.002 thru .012
Rulemaking Authority

(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.

626.914 Definitions.—As used in this Surplus Lines Law, the term:
(1) "Surplus lines agent" means an individual licensed as provided in this part to handle the placement of insurance coverages with unauthorized insurers and to place such coverages with authorized insurers as to which the licensee is not licensed as an agent.
(2) "Eligible surplus lines insurer" means an unauthorized insurer which has been made eligible by the office to issue insurance coverage under this Surplus Lines Law.
(3) "To export" means to place, in an unauthorized insurer under this Surplus Lines Law, insurance covering a subject of insurance resident, located, or to be performed in this state.
(4) "Diligent effort" means seeking coverage from and having been rejected by at least three authorized insurers currently writing this type of coverage and documenting these rejections. However, if the residential structure has a dwelling replacement cost of $1 million or more, the term means seeking coverage from and having been rejected by at least one authorized insurer currently writing this type of coverage and documenting this rejection.

626.913 Surplus Lines Law; short title; purposes.—
(2) It is declared that the purposes of the Surplus Lines Law are to provide orderly access for the insuring public of this state to insurers not authorized to transact insurance in this state, through only qualified, licensed, and supervised surplus lines agents resident in this state, for insurance coverages and to the extent thereof not procurable from authorized insurers; to protect such authorized insurers, who under the laws of this state must meet certain standards as to policy forms and rates, from unwarranted competition by unauthorized insurers who, in the absence of this law, would not be subject to similar requirements; and for other purposes as set forth in this Surplus Lines Law.

626.915 Surplus lines insurance authorized.—If certain insurance coverages of subjects resident, located, or to be performed in this state cannot be procured from authorized insurers, such coverages, hereinafter designated "surplus lines," may be procured from unauthorized insurers, subject to the following conditions:
(1) The insurance must be eligible for export under s. 626.916 or s. 626.917;
(2) The insurer must be an eligible surplus lines insurer under s. 626.917 or s. 626.918;
(3) The insurance must be so placed through a licensed Florida surplus lines agent; and
(4) The other applicable provisions of this Surplus Lines Law must be met.

626.924 Information required on contract.—
(1) Each surplus lines agent through whom a surplus lines coverage is procured shall write or print on the outside of the policy and on any certificate, cover note, or other confirmation of the insurance his or her name, address, and identification number and the name and address of the producing agent through whom the business originated and shall have stamped or written upon the first page of the policy or the certificate, cover note, or confirmation of insurance the words: THIS INSURANCE IS ISSUED PURSUANT TO THE FLORIDA SURPLUS LINES LAW. PERSONS INSURED BY SURPLUS LINES CARRIERS DO NOT HAVE THE PROTECTION OF THE FLORIDA INSURANCE GUARANTY ACT TO THE EXTENT OF ANY RIGHT OF RECOVERY FOR THE OBLIGATION OF AN INSOLVENT UNLICENSED INSURER.
(2) Surplus lines policies issued on or after October 1, 2009, shall have stamped or printed on the face of the policy in at least 14-point, boldface type, the following statement: SURPLUS LINES INSURERS' POLICY RATES AND FORMS ARE NOT APPROVED BY ANY FLORIDA REGULATORY AGENCY.

626.930 Records of surplus lines agent.—
(1) Each surplus lines agent shall keep in his or her office in this state, or in the agent's state of residence for a nonresident who does not have an office in this state, a full and true record for a period of 5 years of each surplus lines contract, including applications and all certificates, cover notes, and other forms of confirmation of insurance coverage and any substitutions thereof or endorsements thereto relative to said contract procured by the agent and showing such of the following items as may be applicable:
(a) Amount of the insurance and perils insured against;
(b) Brief general description of property insured and where located;
(c) Gross premium charged;
(d) Return premium paid, if any;
(e) Rate of premium charged upon the several items of property;
(f) Effective date of the contract, and the terms thereof;
(g) Name and post office address of the insured;
(h) Name and home-office address of the insurer;
(i) Amount collected from the insured; and
(j) Other information as may be required by the department.
(2) The record shall at all times be open to examination by the department or the Florida Surplus Lines Service Office without notice and shall be so kept available and open for 5 years next following expiration or cancellation of the contract.
(3) Each surplus lines agent shall maintain all surplus lines business records in his or her general lines agency office, if licensed as a general lines agent, or in his or her managing general agency office, if licensed as a managing general agent or the full-time salaried employee of such general agent.

626.929 Origination, acceptance, placement of surplus lines business.—
(1) A general lines agent while licensed and appointed as a surplus lines agent under this part may originate surplus lines business and may accept surplus lines business from any other originating Florida-licensed general lines agent appointed and licensed as to the kinds of insurance involved and may compensate such agent therefor.

626.931 Agent affidavit and insurer reporting requirements.—
(1) Each surplus lines agent shall on or before the 45th day following each calendar quarter file with the Florida Surplus Lines Service Office an affidavit, on forms as prescribed and furnished by the Florida Surplus Lines Service Office, stating that all surplus lines insurance transacted by him or her during such calendar quarter has been submitted to the Florida Surplus Lines Service Office as required.
(2) The affidavit of the surplus lines agent shall include efforts made to place coverages with authorized insurers and the results thereof.
(3) Each foreign insurer accepting premiums shall, on or before the end of the month following each calendar quarter, file with the Florida Surplus Lines Service Office a verified report of all surplus lines insurance transacted by such insurer for insurance risks located in this state during such calendar quarter.
(4) Each alien insurer accepting premiums shall, on or before June 30 of each year, file with the Florida Surplus Lines Service Office a verified report of all surplus lines insurance transacted by such insurer for insurance risks located in this state during the preceding calendar year.
(5) The department may waive the filing requirements described in subsections (3) and (4).
(6) Each insurer's report and supporting information shall be in a computer-readable format as determined by the Florida Surplus Lines Service Office or shall be submitted on

forms prescribed by the Florida Surplus Lines Service Office and shall show for each applicable agent:

(a) A listing of all policies, certificates, cover notes, or other forms of confirmation of insurance coverage or any substitutions thereof or endorsements thereto and the identifying number; and

(b) Any additional information required by the department or Florida Surplus Lines Service Office.

626.938 Report and tax of independently procured coverages.—

(1) Every insured who in this state procures or causes to be procured or continues or renews insurance from another state or country with an unauthorized foreign or alien insurer legitimately licensed in that jurisdiction, or any self-insurer who in this state so procures or continues excess loss, catastrophe, or other insurance, upon a subject of insurance resident, located, or to be performed within this state, other than insurance procured through a surplus lines agent pursuant to the Surplus Lines Law of this state or exempted from tax under s. 626.932(4), shall, within 30 days after the date such insurance was so procured, continued, or renewed, file a report of the same with the Florida Surplus Lines Service Office in writing and upon forms designated by the Florida Surplus Lines Service Office and furnished to such an insured upon request, or in a computer readable format as determined by the Florida Surplus Lines Service Office. The report shall show the name and address of the insured or insureds, the name and address of the insurer, the subject of the insurance, a general description of the coverage, the amount of premium currently charged therefor, and such additional pertinent information as is reasonably requested by the Florida Surplus Lines Service Office.

(2) Any insurance on a risk located in this state in an unauthorized insurer legitimately licensed in another state or country procured through solicitations, negotiations, or an application occurring or made outside this state shall be deemed to be insurance procured, continued, or renewed in this state within the intent of subsection (1).

(3) For the general support of the government of this state, there is levied upon the obligation, chose in action, or right represented by the premium charged for such insurance a tax at the rate of 5 percent of the gross amount of such premium and a 0.3 percent service fee pursuant to s. 626.9325. If the policy covers risks or exposures only partially in this state and this state is the home state as defined by the federal Nonadmitted and Reinsurance Reform Act of 2010 (NRRA), the tax and service fee payable shall be computed on the gross premium. The tax must not exceed the tax rate where the risk or exposure is located. The insured shall withhold the amount of the tax and service fee from the amount of premium charged by and otherwise payable to the insurer for such insurance. On or before the 45th day following each calendar quarter after the insurance is procured, continued, or renewed, the insured shall make payable to the department the amount of the tax and make payable to the Florida Surplus Lines Service Office the amount of the service fee. The insured shall remit the tax and the service fee to the Florida Surplus Lines Service Office. The Florida Surplus Lines Service Office shall forward to the department the taxes, and any interest collected pursuant to subsection (5), within 10 days after receipt.

(4) If the insured fails to withhold from the premium the amount of tax and the service fee herein levied, the insured shall be liable for the amount thereof and shall pay that amount to the Florida Surplus Lines Service Office within the time stated in subsection (3).

(5) The tax imposed hereunder, if delinquent, shall bear interest at the rate of 6 percent per year, compounded annually.

(6) The tax shall be collectible from the insured by civil action brought by the department or by distraint.

[1](7) Taxes and interest collected under this section shall be deposited into the General Revenue Fund.

(8) This section does not abrogate or modify, and shall not be construed or deemed to abrogate or modify, any provision of s. 626.901, s. 626.902, s. 626.903, or any other provision of this code.

(9) This section does not authorize independent procurement of workers' compensation insurance, life insurance, or health insurance.

(10) Each report and supporting information shall be in a computer-readable format as determined by the Florida Surplus Lines Service Office or shall be submitted on forms prescribed by the Florida Surplus Lines Service Office.

History.—s. 377, ch. 59-205; s. 9, ch. 63-86; s. 16, ch. 65-269; ss. 13, 35, ch. 69-106; s. 2, ch. 81-318; ss. 316, 318, 807, ch. 82-243; s. 47, ch. 90-132; ss. 181, 206, 207, ch. 90-363; s. 4, ch. 91-429; s. 35, ch. 92-146; s. 12, ch. 2001-213; s. 1026, ch. 2003-261; s. 9, ch. 2003-395; s. 9, ch. 2006-305; s. 5, ch. 2008-132; ss. 8, 9, ch. 2009-70; s. 5, ch. 2011-46.

[1]Note.—Section 9, ch. 2009-70, provides that "[t]he amendments to ss. 626.932(5) and 626.938(7), Florida Statutes, made by this act expire July 1, 2014, and the text of those subsections shall revert to that in existence on June 30, 2009, except that any amendments to such text enacted other than by this act shall be preserved and continue to operate to the extent that such amendments are not dependent upon the portions of such text which expire pursuant to this section." Effective July 1, 2014, subsection (7), as amended by s. 9, ch. 2009-70, will read:

(7) The department shall deposit 15.74 percent of all taxes and interest collected under this section to the credit of the Insurance Regulatory Trust Fund. Eighty-four and twenty-six hundredths percent of all taxes and interest collected under this section shall be deposited into the General Revenue Fund.

626.621 Grounds for discretionary refusal, suspension, or revocation of agent's, adjuster's, customer representative's, service representative's, or managing general agent's license or appointment.—The department may, in its discretion, deny an application for, suspend, revoke, or refuse to renew or continue the license or appointment of any applicant, agent, adjuster, customer representative, service representative, or managing general agent, and it may suspend or revoke the eligibility to hold a license or appointment of any such person, if it finds that as to the applicant, licensee, or appointee any one or more of the following applicable grounds exist under circumstances for which such denial, suspension, revocation, or refusal is not mandatory under s. 626.611:

(7) Willful overinsurance of any property or health insurance risk.

627.949 Restrictions on insurance purchased by purchasing groups.—

(1) In order to purchase insurance or coverage for a risk located in this state, which risk is a subject of insurance of a member of the purchasing group, a purchasing group shall only purchase insurance or coverage from:

(a) A risk retention group that is certificated or licensed in one of the states of the United States;

(b) An authorized insurer; or

(c) An eligible surplus lines insurer.

627.736 Required personal injury protection benefits; exclusions; priority; claims.—

(1) REQUIRED BENEFITS.—Every insurance policy complying with the security requirements of s. 627.733 shall provide personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in such motor vehicle, and other persons struck by such motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to the provisions of subsection (2) and paragraph (4)(e), to a limit of $10,000 for loss sustained

by any such person as a result of bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

(a) Medical benefits.—Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices, and medically necessary ambulance, hospital, and nursing services. However, the medical benefits shall provide reimbursement only for such services and care that are lawfully provided, supervised, ordered, or prescribed by a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, or a chiropractic physician licensed under chapter 460 or that are provided by any of the following persons or entities:

1. A hospital or ambulatory surgical center licensed under chapter 395.

2. A person or entity licensed under ss. 401.2101-401.45 that provides emergency transportation and treatment.

3. An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, or dentists licensed under chapter 466 or by such practitioner or practitioners and the spouse, parent, child, or sibling of that practitioner or those practitioners.

4. An entity wholly owned, directly or indirectly, by a hospital or hospitals.

5. A health care clinic licensed under ss. 400.990-400.995 that is:

a. Accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, or the Accreditation Association for Ambulatory Health Care, Inc.; or

b. A health care clinic that:

(I) Has a medical director licensed under chapter 458, chapter 459, or chapter 460;

(II) Has been continuously licensed for more than 3 years or is a publicly traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and

(III) Provides at least four of the following medical specialties:

(A) General medicine.

(B) Radiography.

(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

The Financial Services Commission shall adopt by rule the form that must be used by an insurer and a health care provider specified in subparagraph 3., subparagraph 4., or subparagraph 5. to document that the health care provider meets the criteria of this paragraph, which rule must include a requirement for a sworn statement or affidavit.

(b) Disability benefits.—Sixty percent of any loss of gross income and loss of earning capacity per individual from inability to work proximately caused by the injury sustained by the injured person, plus all expenses reasonably incurred in obtaining from others ordinary and necessary services in lieu of those that, but for the injury, the injured person would have performed without income for the benefit of his or her household. All disability benefits payable under this provision shall be paid not less than every 2 weeks.

(c) Death benefits.—Death benefits equal to the lesser of $5,000 or the remainder of unused personal injury protection benefits per individual. The insurer may pay such benefits to the executor or administrator of the deceased, to any of the deceased's relatives by blood or legal adoption or connection by marriage, or to any person appearing to the insurer to be equitably entitled thereto.

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and no such insurer shall require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such required benefits. Insurers may not require that property damage liability insurance in an amount greater than $10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. Any insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice shall be deemed to have violated part IX of chapter 626, and such violation shall constitute an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance; and any such insurer committing such violation shall be subject to the penalties afforded in such part, as well as those which may be afforded elsewhere in the insurance code.

627.944 Risk retention groups not certificated in this state.—Risk retention groups certificated or licensed in states other than this state and seeking to do business as a risk retention group in this state must observe and abide by the laws of this state as follows:
(3) TAXATION.—All premiums paid for insurance or coverages on risks located within this state to a risk retention group shall be subject to taxation at the same rate and subject to the same interest, fines, and penalties for nonpayment as that applicable to eligible surplus lines insurers. Each agent utilized in any transaction shall report and pay the taxes for the premiums for risks which they have placed with or on behalf of a risk retention group not certificated in this state. In the event that an agent fails to pay the tax, each risk retention group shall pay the tax for insured or covered risks located within this state. Further, each risk retention group shall report all premiums paid to it for insured or covered risks located within this state.

M E M O R A N D U M

DATE: November 8, 2016

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Virginia Christy
Stephen Fredrickson

SUBJECT: Cabinet Agenda for December 6, 2016
Request for Final Approval to Adopt Amendments to
Rule 69O-161.001,.009,.010,.011
Assignment # 189052-16

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before December 1, 2016 and to the Financial Services Commission on December 6, 2016, with a request for Final Approval to Adopt the proposed rules. A notice of the Final Rule Hearing was published in the *Florida Administrative Register* on November 9, 2016.

The notice of proposed rules was published on September 29, 2016 in Volume 42, No. 190, of the *Register*. A hearing was held. Changes were made to rule 69O-161.010 as published in Vol. 41, No. 129, on November 9, 2016.

The statute requires the FSC to adopt the form and guidelines in consultation with the Agency for Health Care Administration. Improves the position of the Office in implementing the statutory mandate.

Sections 624.308(1), 627.647, 627.42392, 624.307(1), 627.510(2) F.S., provide rulemaking authority and laws implemented for these rules.

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 these rules. 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:

Anoush Brangaccio

Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

David Altmaier

David Altmaier, Commissioner
Office of Insurance Regulation

UNIFORM INSURANCE CLAIM FORMS AND PRIOR AUTHORIZATION FORMS

69O-161.001 – Purpose

The purpose of this chapter is to establish uniform claim forms for claims relating to health insurance and industrial life insurance policies, to establish guidelines for all prior authorization forms which ensure the general uniformity of such forms, and to adopt a prior authorization form for use by health insurance issuers which do not provide an electronic prior authorization process for use by its contracted providers.

Rulemaking ~~Specific~~ Authority 624.308(1), 627.647, 627.42392 FS. Law Implemented 624.307(1), 627.42392, 627.510(2), 627.647 FS. History–New 4-25-88, Formerly 4-74.001, Amended 6-8-94, Formerly 4-161.00, Amended _____.

69O-161.009 Form Availability.

All forms referenced in this rule chapter may be obtained at www.floir.com ~~by writing to: Office of Insurance Regulation, Bureau of Life and Health Forms, Rates and Reserve Analysis, Larson Building, Tallahassee, Florida 32399-0328.~~

Rulemaking ~~Specific~~ Authority 624.308(1), 627.647 FS. Law Implemented 624.307(1), 627.510(2), 627.647 FS. History–New 6-8-94, Formerly 4-161.009, Amended_____.

69O-161.010 – Guidelines for Prior Authorization Forms

(1) No Change

(2) Definitions: As used in this Rule:

(4) All prior authorization forms must contain information where a provider may find a health insurer's ~~insurance issuer's step therapy or fail first protocol requirements and quantity limits for all~~ list of services subject to prior authorization.

(5) The prior authorization form must contain the direct contact information for the health insurer ~~utilization review entity.~~

(6) No Change

(7) Disclosure and review of prior authorization requirements.

(a) A health insurer ~~utilization review entity or issuer~~ shall make any current prior authorization ~~requirements, restrictions and~~ forms, directions as to when to use such forms, and instructions for filling out such forms, readily accessible on its website and in written ~~or electronic~~ form upon request for beneficiaries and health care providers~~, and the general public. Requirements shall be described in detail but also in clear, easily understandable language. Clinical criteria shall be described in language easily understandable by a health care provider.~~

~~(b) If a utilization review entity or issuer intends either to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the utilization review entity shall ensure that the new or amended requirement is not implemented unless the utilization review entity's website has been updated to reflect the new or amended requirement or restriction. This shall not extend to expansion of coverage for new health care services.~~

~~(c) If a utilization review entity or issuer intends either to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the utilization review entity shall provide beneficiaries who are currently using the affected health care service and all contracted health care physicians who provide affected health care service or services of written notice of the new or amended requirement or amendment no less than 60 days before the requirement or restriction is implemented. Such notice may be delivered electronically or by other means as agreed to by the receiving entity.~~

Rulemaking Authority 624.308(1), 627.42392 FS. Law Implemented 624.307(1), 627.42392 FS. History–New _____.

69O-161.011 – Use of Prior Authorization Form

All authorized insurers offering health insurance as defined in s. 624.603, F.S. managed care plans as defined in s. 409.962(9), F.S. and health maintenance organizations as defined in s.641.19(12), F.S. which do not provide an electronic prior authorization process for use by its contracted providers shall use only the Prior Authorization Form for Medical Procedures, Courses of Treatment, or Prescription Drug Benefits (OIR Form OIR-B2-2180) (12/16) http://www.flrules.org/Gateway/reference.asp?No=Ref-07606 which is hereby incorporated and made part of this rule chapter by reference.

Rulemaking Authority 624.308(1), 627.42392 FS. Law Implemented 624.307(1), 627.42392, FS. History–New _____.

[Name/Logo of Authorizing Entity]

Prior Authorization Form for Medical Procedures, Courses of Treatment, or Prescription Drug Benefits

If you have questions about our prior authorization requirements, please refer to [contact information]

All of the applicable information and documentation is required. Incomplete forms will be returned for additional information.

1. PRIORITY:

[ ]	a. Standard	
[ ]	b. Date of Service	Services scheduled for this date:
[ ]	c. Urgent	Provider certifies that applying the standard review time frame may seriously jeopardize the life or health of the member

2. PATIENT INFORMATION:

a. Name (First):	b. Last:	c. MI:	d. DOB(mm/dd/yyyy):
e. Gender: [ ] Male [ ] Female	f. Height:	g. Weight:	
h. Address:	i. City, State, Zip:	j. Phone:	
k. Health Plan ID #:	l. Group #:		

3. ORDERING PHYSICIAN/CLINIC INFORMATION:

a. Name:	b. TIN/NPI#:	c. Specialty:	d. Contact Name:
e. Clinic Name:		f. Clinic Address:	
g. City, State, Zip:		h. Phone:	i. Fax or email:

4. RENDERING PHYSICIAN/CLINIC/FACILITY/PHARMACY INFORMATION: [ ] Check if same as 3.

a. Name:	b. TIN/NPI#:	c. Specialty:	d. Contact Name:
e. Physician/Clinic/Facility/Pharmacy Name:		f. Address:	
g. City, State, Zip:		h. Phone:	i. Fax or email:

5. REQUESTED MEDICAL PROCEDURE/COURSE OF TREATMENT/DEVICE INFORMATION:

a. Service Type:
b. Setting/CMS POS Code: Outpatient [ ] Inpatient [ ] Home [ ] Office [ ] *Other [ ]
c. *Please specify if other:

6. HCPCS/CPT/CDT CODES

a. Latest ICD Code	b. HCPCS/CPT/CDT Code	c. Code Description	d. Medical Reason

Other Clinical Information – Include/attach clinical/office notes, laboratory information, imaging reports, and any guiding documentation to support medical necessity. If this is an out-of-network request, please provide an explanation.

[Name/Logo of Authorizing Entity]

Prior Authorization Form for Medical Procedures, Courses of Treatment, or Prescription Drug Benefits

If you have questions about our prior authorization requirements, please refer to [contact information]

7. OTHER SERVICES (SEE INSTRUCTIONS)

a. Type of Service:	b. Name of Therapy/Agency:	
c. Units/Volume/Visits Requested:	d. Frequency/Length of Time Needed:	e. Initial [ ] Extension [ ] Previous Authorization #:
f. Additional Comments:		

8. PRESCRIPTION DRUG

a. Diagnosis name and code:			
b. Medication Requested	c. Strength	d. Dosing Schedule (including length of therapy)	e. Quantity Per Month or Quantity Limits
f. Is the patient currently treated with requested medication(s): [ ] Yes [ ] No If yes, When was treatment with the requested medication started?			
g. Explain the medical reasons for the requested medications, including an explanation for selecting these medications over alternatives:			
h. List any other medications patient will use in combination with requested medication:			

9. PREVIOUS SERVICES/THERAPY (INCLUDING DRUG, DOSE, DURATION, AND REASON FOR DISCONTINUING PREVIOUS THERAPY)

a.	Date Discontinued
b.	Date Discontinued
c.	Date Discontinued

Additional Information – Please attach and submit any progress notes, lab data, discharge summaries, or other guiding documentation to support discontinuation of previous therapy and initiation of therapy with the requested medication along with a copy of the prescription.

10. ATTESTATION

I hereby certify and attest that all information provided as part of this prior authorization request is true and accurate.

Provider Signature:_____ Date:_____

[Name/Logo of Authorizing Entity]

Prior Authorization Form for Medical Procedures, Courses of Treatment, or Prescription Drug Benefits

If you have questions about our prior authorization requirements, please refer to [contact information]

DO NOT WRITE BELOW THIS LINE: FIELDS TO BE COMPLETED BY PLAN

Authorization #_____ Contact Name: _____

Instructions for OIR-B2-2180

1. Priority: Only one of the following options should be marked.
    a. Standard should be marked if the prior authorization request is not an urgent request or the medical service has not been scheduled.
    b. Date of Service should be chosen if the requested medical service has been scheduled for a future date. The scheduled date should be written in the corresponding box to the right of the Date of Service label. Note that this is for informational purposes only and that the health insurance issuer is not obligated to provide authorization prior to the scheduled date.
    c. Urgent should be marked if the patient's life may be seriously jeopardized by applying the standard review time frame.
2. Patient Information: All boxes should be completed.
    a. Fill in the patient's first name
    b. Fill in the patient's last name
    c. Fill in the patient's middle initial.
    d. Fill in the patient's date of birth beginning with the two-digit numerical representation for the month, followed by the two-digit numerical representation for the day, followed by the four digit year.
    e. Check the patient's applicable gender.
    f. Fill in the patient's height in inches.
    g. Fill in the patient's weight in pounds.
    h. Fill in the patient's current address if available.
    i. Fill in city, state, and zip code of the patient's address if available.
    j. Fill in the patient's phone number if available.
    k. Fill in the patient's unique health plan identification number.
    l. If available, fill in the patient's group identification number.
3. Ordering Physician or Clinic Information. In this section, complete all of the applicable boxes for the physician who is requesting the medical service.

    b. Fill in the provider's unique tax identification number or national provider identification number.

4. Rendering Physician. In this section, complete all of the applicable boxes for the physician who is being requested to perform or administer the medical service. If the ordering physician is the same as the rendering physician, mark the box next to the title. The section will not need to be completed unless any information differs from section 3.

    b. Fill in the provider's unique tax identification number or national provider identification number.

5. Requested medical Procedure, Course of Treatment, or medical Device information.
    a. In this box, explain with sufficient accuracy the nature of the requested medical service.

b. Write the Setting or CMS Place of Service Code. Additionally, mark the box to the right of where the requested medical service will be performed or given.
c. If Other was marked in 5.a., write where the requested medical service or device will be given.

6. HCPCS/CPT/CDT CODES. In this section you should explain the CMS Healthcare Common Procedure Coding System Code, Current Procedural Terminology Code, and or the Current Dental Terminology Code, whichever are applicable and necessary to determine which medical services or procedures are being requested.
    a. Enter the most current International Classification of Disease Code used to classify and code the diagnoses, symptom, or procedure applicable to the patient's condition.
    b. Explain the CMS Healthcare Common Procedure Coding System Code, Current Procedural Terminology Code, and or the Current Dental Terminology Code, whichever are applicable and necessary to determine which medical services or procedures are being requested.
    c. Provide a description of the code used in 6.b.
    d. Provide a medical reason for requesting the medical service.

    Other Clinical Information – If necessary attach other relevant guiding documentation to the request. This does not call for the submission of all documents, just those necessary to make a decision on the request. If this is an out of network request, provide an explanation and attach it to the request.

7. This section should be completed in the event the requested medical service does not fall within the other sections. A description of the nature of the medical service requested and corresponding details should be completed to fully convey what is being requested. Examples of other services may include, but are not limited to, rehabilitation services and home health care services.
8. This section should be completed if prescription medication is being requested.
    a. Fill in the diagnosis name and code of the condition the prescription drug will be used to treat.
    b. Detail the medication requested.
    c. Detail the strength of the medication requested.
    d. Detail the dosing schedule of the medication requested, including the length of therapy.
    e. Detail the quantity per month or quantity limit of the medication requested.
    f. Check the appropriate box and explain if necessary.
9. Previous Services or Therapy (Including Drug, Dose, Duration, and Reason for Discontinuing Previous Therapy). This section should be completed if the patient has had previous therapy relating to the medical service being requested. All relevant previous services or therapy should be explained. If there is not enough space, attach another sheet to explain other therapies. If additional guiding documentation is necessary to explain the previous therapy or treatment, that should be attached as well. Include any reason for discontinuing the previous services or therapy.

10. The requesting provider must truthfully certify that all information provided as part of the prior authorization request is true and accurate.

69O-161.001
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.

627.647 Standard health claim form.—
(1) The commission shall prescribe a standard health claim form to be used by all hospitals and a standard health claim form to be used by all physicians, dentists, and pharmacists. Such forms shall be in a format that allows for the use of generally accepted coding systems by providers in order to facilitate the processing of claims. Such forms shall provide for the disclosure by the claimant of the name, policy number, and address of every insurance policy which may cover the claimant with respect to the submitted claim except those policies specified in s. 627.4235(5). The required information on diagnosis, dental procedures, medical procedures, services, date of service, supplies, and fees may also be met by an attachment to the appropriate physician claim form. However, for the purpose of filing Medicaid claims, such attachments shall be prohibited. Such standard health claim forms shall be accepted by all insurers and all agencies, departments, and divisions of the state.
(2) This section does not apply to claims submitted by electronic or electromechanical means, except that such claims must include disclosure of every insurance policy which may cover the claimant with respect to the submitted claim.

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.

627.510 Settlement on proof of death.—
(2) Insurers transacting industrial life insurance business in the state who require a claim form to be filed by a claimant for settlement of a policy shall allow the claimant to file the claim using the uniform life insurance claim form developed by the commission. The commission shall establish by rule a uniform life insurance claim form to be used by claimants for settlement of any industrial life insurance policy issued by an insurer transacting life insurance business in this state.

627.42392 Prior authorization.—

(1) As used in this section, the term "health insurer" means an authorized insurer offering health insurance as defined in s. 624.603, a managed care plan as defined in s. 409.962(9), or a health maintenance organization as defined in s. 641.19(12).

(2) Notwithstanding any other provision of law, effective January 1, 2017, or six (6) months after the effective date of the rule adopting the prior authorization form, whichever is later, a health insurer, or a pharmacy benefits manager on behalf of the health insurer, which does not provide an electronic prior authorization process for use by its contracted providers, shall only use the prior authorization form that has been approved by the Financial Services Commission for granting a prior authorization for a medical procedure, course of treatment, or prescription drug benefit. Such form may not exceed two pages in length, excluding any instructions or guiding documentation, and must include all clinical documentation necessary for the health insurer to make a decision. At a minimum, the form must include: (1) sufficient patient information to identify the member, date of birth, full

name, and Health Plan ID number; (2) provider name, address and phone number; (3) the medical procedure, course of treatment, or prescription drug benefit being requested, including the medical reason therefor, and all services tried and failed; (4) any laboratory documentation required; and (5) an attestation that all information provided is true and accurate.

(3) The Financial Services Commission in consultation with the Agency for Health Care Administration shall adopt by rule guidelines for all prior authorization forms which ensure the general uniformity of such forms.

(4) Electronic prior authorization approvals do not preclude benefit verification or medical review by the insurer under either the medical or pharmacy benefits.

Presentation to the Florida Financial Services Commission

Florida Office of Insurance Regulation (Office)

Commissioner David Altmaier

December 6, 2016

Presentation Agenda

Market Developments	• Hurricanes Hermine & Matthew • Property & Casualty Market • Life & Health Market
OIR Industry Conference	• Attendance • Industry Feedback
Performance Measures	• First Quarter of Fiscal Year 2016-2017

Property & Casualty

Activities, Accomplishments, and Opportunities

Selected Activities & Accomplishments

- Hurricane Hermine and Matthew disaster reporting data calls providing claims and exposure data
- Established 2017 personal and commercial rates for Citizens Property Insurance Corporation
- 2016 Pinnacle Report found a 23.2% reduction in total Personal Injury Protection (PIP) costs attributable to HB 119

Estimated Statewide Average Change: Repeal of No-Fault		
Scenario	**Impact on Liability Coverages**	**Impact on All Major Coverages**
Without Purchasing Med Pay	-9.60%	-6.70%
Optional $2,500 Med Pay	-4.90%	-3.40%
Optional $5,000 Med Pay	-1.00%	-0.70%

Note: Changes are representative of an average policyholder that purchases a full coverage policy

Opportunities

- Continuing to monitor the statewide impact of third-party claims on homeowners insurance rates
- Fostering a private flood insurance market
- Adapting to new business models (e.g. ridesharing, home-sharing)
- Trade secret protections preventing the public's access to company information available through the Quarterly & Supplemental Reporting (QUASR) system online
- Continued soft reinsurance market

Property & Casualty

Hurricane Claims Tracking

Hurricane Hermine

As of November 22:

- 18,275 statewide claims reported
- $95 million est. insured losses
- 69.3% claims closed
- Final reporting due December 7

Hurricane Matthew

As of October 28:

- 100,589 statewide claims reported
- $606 million est. insured losses
- 42.7% of claims closed
- Final reporting due January 6

***The Office has developed an interactive Excel workbook where Florida consumers and stakeholders can download and view claims on the county level and by various lines of business. Visit www.floir.com and select "Hurricane Claims Data"**

Property & Casualty

Hurricane Claims Tracking Workbook (e.g. Matthew as of October 28, 2016)

Reporting from the Matthew Catastrophe Reporting Form

as of October 28, 2016

Lines of Business	Sub-Lines	Number of Claims	Closed Claims (paid)	Closed Claims (not paid)	Number Claims Open	Percent Claims Closed
Residential Property		85,473	19,101	19,588	46,784	45.3%
	Homeowners	69,935	15,125	16,990	37,820	45.9%
	Dwelling	9,313	2,236	1,840	5,237	43.8%
	Mobile Homeowners	5,854	1,732	717	3,405	41.8%
	Commercial Residential	371	8	41	322	13.2%
Commercial Property		4,872	222	551	4,099	15.9%
Flooding		4,245	105	320	3,820	10.0%
	Private Flood	106	63	25	18	83.0%
	Federal Flood	4,139	42	295	3,802	8.1%
Business Interruption		163	19	25	119	27.0%
Other Lines of Business		5,836	2,424	629	2,783	52.3%
TOTALS		100,589	21,871	21,113	57,605	42.7%

The Excel workbooks give current and previous overall market summaries, county summaries and allows users to search any Florida county for individual claim details.

Visit www.floir.com

County Summary Report from the Matthew Catastrophe Reporting Form

as of October 28, 2016

VOLUSIA - Return to County Overview

Sub-Lines	Number of Claims	Closed Claims (paid)	Closed Claims (not paid)	Number Claims Open	Percent Claims Closed
Homeowners	20,075	4,577	3,876	11,622	42.1%
Dwelling	3,099	857	481	1,761	43.2%
Mobilehome	2,674	620	222	1,832	31.5%
Commercial Residential	156	1	18	137	12.2%
Commercial Property	1,614	78	136	1,400	13.3%
Private Flood	36	23	10	3	91.7%
Federal Flood	215	0	24	191	11.2%
Business Interruption	45	5	7	33	26.7%
Other LOBs	1,180	536	100	544	53.9%
Total	**29,094**	**6,697**	**4,874**	**17,523**	**39.8%**

Life & Health

Activities, Accomplishments, and Opportunities

Selected Activities & Accomplishments

- The Office has approved Small Group and Individual PPACA compliant health plans for 2017.
- An ambitious and innovative approach to help reduce the impact of rising Long-Term Care premiums:
  - Extended rate guarantees
  - Multi-year phase-in of rate increases
  - Rate increase alternatives (flexible benefit periods, reduced inflation coverage)
  - Lapse protection
- The Office is preparing to implement SB 1308, effective on 1/1/2017, which modernized Life Insurer solvency regulation

Opportunities

- Establish proper reserving requirements for CCRC's to improve protections for Florida seniors.
- Working with the health insurance industry to navigate through significant shifts in market and regulatory dynamics
- Assessing consumer protection concerns in the face of a contracting health insurance market.
- Working to create consumer choice in the face of rising Long-Term Care premiums and reduce obstacles to innovation for Long-Term Care insurers.
- Modernization of HMO solvency regulation.

Life & Health

ACA Individual Market Average Monthly Premiums

Individual PPACA Market Monthly Premiums for Plan Year 2017

	Company	Network Type[1]	Offering Plans On the Federal Exchange[2]	Florida File Log Number	Average 2016 Monthly Premium[3] per Person for Actual 2016 Enrollment	Average 2017 Monthly Premium[3] per Person for Actual 2016 Enrollment	Average Percentage Change Requested[4]	Average Percentage Change Approved[4]
On Exchange								
1	Blue Cross and Blue Shield of Florida, Inc.	EPO	On and Off	16-10386	$457	$544	14.5%	19.0%
2	Celtic Insurance Company	EPO	On and Off	16-10375	$337	$404	4.3%	20.0%
3	FLORIDA HEALTH CARE PLAN, INC.	HMO	On and Off	16-10365	$525	$606	12.3%	15.4%
4	Health First Commercial Plans, Inc.	HMO	On and Off	16-10155	$433	$484	8.4%	11.7%
5	Health Options, Inc.	HMO	On and Off	16-10387	$406	$483	13.8%	18.9%
6	Humana Medical Plan, Inc.	HMO	On and Off	16-10143	$340	$465	43.6%	36.8%
7	Molina Healthcare of Florida, Inc.	HMO	On and Off	16-10201	$340	$399	10.6%	17.4%
8	Harken Health Insurance Company	HMO	On and Off	16-10241	N/A	N/A	N/A	Withdrawn
Off Exchange Only								
9	Aetna Health Inc. (a FL corp.)	HMO	Off-Exchange	16-09992	$350	$427	20.8%	22.0%
10	Aetna Life Insurance Company	PPO	Off-Exchange	16-09799	$385	$481	28.9%	25.0%
11	AvMed, Inc.	HMO	Off-Exchange	16-10389	$389	$495	27.5%	27.3%
12	Cigna Health and Life Insurance Company	EPO	Off-Exchange	16-10328	$486	$479	-0.6%	-1.5%
13	Coventry Health Care of Florida, Inc.	HMO	Off-Exchange	16-10164	$336	$376	14.1%	11.8%
14	Freedom Life Insurance Company of America	PPO	Off-Exchange	16-10424	$543	$637	17.4%	17.4%
15	Sunshine State Health Plan	HMO	Off-Exchange	16-10361	$636	$636	0.0%	0.0%
	Weighted Average using Actual Membership[5]:				**$385**	**$458**	**17.7%**	**19.1%**

(1) Network types available are Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), and an Exclusive Provider Organization (EPO).
(2) A plan available through the Federally Facilitated Exchange (FFE) may or may not be available outside of the FFE.
(3) Average Monthly Premiums do not include the impact of potential premium subsidies. As of 03/31/2016.
(4) Percent changes are based on actual 2016 enrollment and do not represent the percent difference for a single policyholder.
(5) Weighted averages give more weight to companies with larger membership.

General Information
This information has not been reviewed or finalized by the Department of Health & Human Services; therefore, it is subject to change.
Florida file log numbers can be used to search the Office of Insurance Regulation's "I-File Forms & Rates Filing Search" system.

OIR Industry Conference

October 25-26, 2016

More than 230 insurance industry professionals, stakeholders, and special guests from all over the country attended the 2016 Industry Conference at the Florida State Conference Center.

The Conference spanned two days with 30 members of the Office staff either giving presentations or participating in roundtable discussions.

Attendees this year included forms analysts, compliance officers, product development managers, and attorneys. The attendees had access to general session presentations and multiple break-out sessions.

Topics Included:

- Applications Process
- I-File Form & Rate Filing System
- Affordable Care Act (ACA)
- Disaster Reporting
- Homeowners Insurance
- Private Passenger Auto Insurance
- Long-Term Care Insurance
- Continuing Care Retirement Communities
- Wall of Wind & Florida Public Loss Model
- Trade Secret Overview
- Legislative Update
- Market Investigations
- Solvency Issues & Updates

Performance Measures Detail

First Quarter Fiscal Year 2016-2017 (July – September)

OIR Performance Measures

		1st Quarter FY 2016-2017	
	Objective	**Result**	**Score**
1	Applications for a new certificate of authority and new types of insurance added to an existing certificate of authority within 90 days	*100%*	5
2	Life and health form and rate filing reviews completed within 45 days	*100%*	5
3	Property and casualty form filing reviews completed within 45 days	*98.9%*	5
4	Property and casualty rate filing reviews completed within 90 days	*99.7%*	5
5	Market conduct exams with violations in which the Office requires companies to remediate	*100%*	5
6	Financial exams of domestic insurers completed within 18 months of the "as of" exam date	-	*
7	Life and health priority financial examinations of domestic insurers completed within 18 months of the "as of" exam date	-	*
8	Property and casualty priority financial examinations of domestic insurers completed within 18 months of the "as of" exam date	-	*
9	Priority financial analyses completed within 60 days	*99.0%*	4
10	Non-priority financial analyses completed within 90 days	*99.6%*	4
	Overall Score		**4.71**

Note: Scoring is based on the scale adopted by the Financial Services Commission, with 1 being lowest and 5 being highest, and each measure of equal weight.

** Financial examinations are generally cyclical over long-periods of time and, while several are currently in progress, none were due in the first quarter.*