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

December 13, 2017

MEMBERS
Governor Rick Scott
Attorney General Pam Bondi
Chief Financial Officer Jimmy Patronis
Commissioner Adam Putnam

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

8:00 A.M.
LL-03, The Capitol
Tallahassee, Florida

ITEM	SUBJECT	RECOMMENDATION

1. Minutes of the Financial Services Commission for October 17, 2017.

   http://www.myflorida.com/myflorida/cabinet/agenda17/1017/transcript.pdf

   (ATTACHMENT 1) **FOR APPROVAL**

2. Request for Approval of Appointment to the Florida Workers' Compensation Joint Underwriting Association Board of Governors, Foreign Seat No. 2.

   Pursuant to Section 627.311(5)(b), F.S., there are nine members of the Florida Workers' Compensation Joint Underwriting Association (FWCJUA) Board of Governors; eight of the members shall be appointed by the Financial Services Commission.

   (ATTACHMENT 2) **FOR APPROVAL**

3. Request for Approval for Publication of Rule 69O-150.206; Marketing Communications of Benefits Payable, Losses Covered, and Premiums Payable

   Amends rule to remove marketing requirements due to statutory change that removed requirement for insurers to offer Basic and Standard Health benefit plans.

   (ATTACHMENT 3) **APPROVAL FOR PUBLICATION**

4. Request for Approval for Publication of Rule 69O-191.029; Maintaining Eligibility for Certificate of Authority

   The current rule requires an HMO to be operational within six months of licensure. This creates a conflict with the changes to Section 641.221, Florida Statutes, which allows an

HMO limited to Medicare Advantage plans up to 24 months after licensure to become operational. The rule will be updated to conform to the statutory changes.

(ATTACHMENT 4) **APPROVAL FOR PUBLICATION**

5. Office of Insurance Regulation 1st Quarter Report FY 2017-18

(ATTACHMENT 5) **FOR APPROVAL**

OFFICE OF INSURANCE REGULATION

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

Hey, David.

COMMISSIONER ALTMAIER: Good morning, Governor. Members of the Cabinet, good morning. It's great to be with you this morning.

Item Number 1 of our agenda is the adoption of the minutes from the FSC meeting on August the 16th. We'd respectfully request for your approval of those minutes.

GOVERNOR SCOTT: Is there a motion on the item?

ATTORNEY GENERAL BONDI: So move.

GOVERNOR SCOTT: Is there a second?

CFO PATRONIS: Second.

GOVERNOR SCOTT: Comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion carries.

COMMISSIONER ALTMAIER: Thank you.

Item Number 2 is a brief update on Hurricane Irma related insurance claims. We're collecting

this information every Friday at this point.

As of this past Friday, we've had 747,534 insurance claims, and companies that have reported those to us have estimated that those will cost $4.9 billion. Those are both numbers that we expect to increase over the next several weeks as the claims process continues to play out.

We're using that information to assess the financial condition of the companies that are insuring against that risk, as well as to detect against any market conduct activity that might need our attention. I'm pleased to report that even though it is early in the process, we haven't seen either of those two items at this point in time that would warrant additional action from our office; but as we continue to monitor this, we'll keep you apprised of that.

I'd be happy to answer any questions about Irma related claims.

GOVERNOR SCOTT: Does anybody have any questions?

CFO PATRONIS: No, sir.

GOVERNOR SCOTT: All right. Thanks, David.

COMMISSIONER ALTMAIER: Thank you.

Item Number 3 is request for approval of the

OIR to contract with EVP Advisors, Inc. to conduct a workers' compensation peer review of NCCI. And this is a peer review that is statutorily required to take place every two years. We've conducted the RFQ process, and EVP Advisors emerged as the proposed contractor, so respectfully request your approval of that item.

GOVERNOR SCOTT: Is there a motion?

ATTORNEY GENERAL BONDI: So move.

GOVERNOR SCOTT: Is there a second?

CFO PATRONIS: Second.

GOVERNOR SCOTT: Comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, Item 3 carries.

COMMISSIONER ALTMAIER: Thank you very much.

And Governor and Cabinet, if it's appropriate, I think Agenda Items 4, 5, and 6 could probably be done together.

Agenda Items Number 4 and 5 are requests for approval for final adoption of the repeal of rules that are no longer necessary because of statutory changes. And Agenda Item Number 6 is simply requesting approval of the final adoption of a rule -- two rules that are amended to reference updated annuity mortality tables.

And so with your permission, we'd respectfully request your approval for all three of those items.

GOVERNOR SCOTT: So 4, 5 and 6, is there a motion?

CFO PATRONIS: So move.

GOVERNOR SCOTT: Second?

ATTORNEY GENERAL BONDI: Second.

GOVERNOR SCOTT: Comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion carries.

COMMISSIONER ALTMAIER: Thank you very much.

And then finally, Governor and Cabinet, Agenda Item Number 7 is our fourth quarter of the most recent fiscal year performance review. Those are included in your meeting materials. The only comment that I'll make about those is that this is the first quarter under our new performance measures, and that has gone smoothly.

I'd be happy to answer any questions that you might have about that information.

GOVERNOR SCOTT: Are there any questions?

COMMISSIONER PUTNAM: Not about that.

GOVERNOR SCOTT: Okay. Okay. Is there a

motion to accept the report?

ATTORNEY GENERAL BONDI: So moved.

GOVERNOR SCOTT: Is there a second?

CFO PATRONIS: Second.

GOVERNOR SCOTT: Comments or objections?

(NO RESPONSE).

GOVERNOR SCOTT: Hearing none, the motion carries.

Commissioner, did you have another question?

COMMISSIONER PUTNAM: Thank you, Governor.

You haven't seen any evidence of companies exiting as a result of the storm, have you?

COMMISSIONER ALTMAIER: Thank you for the question, Commissioner.

No, as a result of the storm, we have not heard of any company that is interested in exiting the state as a result of Irma related losses.

COMMISSIONER PUTNAM: And you haven't seen any financial weakness in the takeout companies either, have you?

COMMISSIONER ALTMAIER: No, sir. At this point in time, we have been very diligent in assessing the impact to each company. We haven't seen any company, takeout or otherwise, that seem to be having trouble with the volume of claims that

they're receiving, either from a financial standpoint or a logistical standpoint in terms of servicing the consumers; but that is something that we're very diligently monitoring over the course of the next several weeks and months as this plays out.

COMMISSIONER PUTNAM: That's good news.

COMMISSIONER ALTMAIER: Yes, sir.

COMMISSIONER PUTNAM: What's the chatter in the industry about the collective impact of California, Puerto Rico, Harvey, Nate, Irma, Maria in terms of upward pressure on rates?

COMMISSIONER ALTMAIER: Yes, sir, that's actually a very good question. It was a significant catastrophic year, especially for the second half of 2017.

Where we're going to see that play out mostly is in the reinsurance markets, and we're monitoring a lot of the different reinsurance gatherings. They were actually in -- one of the larger ones is in Monte Carlo. They were all there as Irma was impacting our state, so it was a very hot topic for them.

At the moment in time -- and of course, we have several months of 2017 left to play out -- it

seems as if these catastrophes are going to represent an earnings event for the reinsurance companies as opposed to a capital event. In other words, they've made enough money throughout 2017 to, in general, with some specific exceptions, to handle these catastrophic events.

We would expect some upward pressure on reinsurance rates that might impact the direct rates that Floridians pay. But at this point in time, the precise number is a little bit early to predict.

COMMISSIONER PUTNAM: Thank you.

GOVERNOR SCOTT: Anything else, Commissioner?

COMMISSIONER PUTNAM: No, sir.

GOVERNOR SCOTT: Thanks, David.

COMMISSIONER ALTMAIER: Always a pleasure. Thank you.

* * * *

Florida Workers' Compensation Joint Underwriting Association, Inc. (FWCJUA)
Board of Governors
Appointments for Consideration

FWCJUA Board Nominee for Consideration for Foreign Insurer Seat 2
(Office Recommendation)

Foreign Insurer Seat 2 Robert deViere, ICW Group Insurance Companies

Background Summary

- The operation of the FWCJUA, a non-profit entity, is subject to the supervision of a nine-member Board of Governors.
- Eight board members are appointed by, and serve at the pleasure of the Financial Services Commission pursuant to section 627.311(5), Florida Statutes. These include three at-large members, two domestic insurer representatives, two foreign insurer representatives, and one representative from the largest property and casualty insurance agents' association in Florida (this is the Florida Association of Insurance Agents).
- The ninth board member is the insurance consumer advocate appointed by the Chief Financial Officer, or his designee, under section 627.0613, Florida Statutes.
- Each Board member serves a term of four years, with the most recent term expiring on June 30, 2019.
- The Foreign Insurer Seat 2 vacancy opened on April 25, 2017.

Current Board Members Appointed by the Financial Services Commission

Domestic Insurer Seat 1 Thomas A. Koval, FCCI Insurance Group
Domestic Insurer Seat 2 Steven T. Solomon, WorkComp Partners
Foreign Insurer Seat 1 James P. Ward, The Hartford Insurance Company
Foreign Insurer Seat 2 Vacant
FAIA Seat Robert T. Moore, Corporate Insurance Advisors, LLC
At Large Seat 1 Charlie Clary, DAG Architects
At Large Seat 2 Claude Revels, Claude Revels & Associates, LLC
At Large Seat 3 Cynthia Howard, C3WCS Consulting, LLC

M E M O R A N D U M

DATE: November 20, 2017

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Sarah Berner, Assistant General Counsel
Stephen Fredrickson, Assistant General Counsel

SUBJECT: Cabinet Agenda for December 13, 2017
Request for Approval to Publish Amendments to
Rule 69O-150.206
Assignment # 207465-17

The Office of Insurance Regulation requests that this proposed rule amendment be presented to the Cabinet aides on or before December 6, 2017, and to the Financial Services Commission on December 13, 2017, with a request to approve for publication the proposed rules.

This rule amendment removes requirements for insurers offering Basic and Standard Health benefit plan due to change in statute.

Sections 624.308(1); 626.9611; 627.6699(9)(d)1., 4., (12); 624.307(1); 626.9541(1)(a), (b), (e), (k), (l); 626.9641(1), F.S., are the rulemaking authority and laws implemented for this rule.

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

69O-150.206 Marketing Communications of Benefits Payable, Losses Covered, and Premiums Payable.

(1) Deceptive Words, Phrases, or Illustrations Prohibited.

(a) through (f) No Change

~~(g) A marketing communication that is an invitation to contract and is intended to be used in the marketing of a standard, basic, or limited health benefit plan in this state must contain the disclosures stated in Section 627.6699(9)(d)1., F.S.~~

~~(h)1. A marketing communication for a plan providing benefits for either a basic or standard health benefit plan shall state clearly and conspicuously in a prominent type the kind of plan marketed.~~

~~2. A marketing communication for a health benefit plan providing limited benefits, such as specified diseases or specified accidents, shall state clearly and conspicuously in prominent type the limited nature of the plan.~~

~~3. The statement shall be worded in language identical to, or substantially similar to the following: "THIS IS A LIMITED SMALL EMPLOYER HEALTH BENEFIT PLAN", "THIS IS A BASIC SMALL EMPLOYER HEALTH BENEFIT PLAN", "THIS IS A STANDARD SMALL EMPLOYER HEALTH BENEFIT PLAN", whichever is applicable.~~

(g) ~~(i)~~ A marketing communication of a health benefit plan sold by direct response shall not use in a misleading manner the phrases, "no salesman will call", "no agent will call", "by eliminating the agent and/or commission, we can offer this low cost plan" or similar wording.

Rulemaking Authority 624.308(1), 626.9611, 627.6699(12) FS. Law Implemented 624.307(1), 626.9541(1)(a), (b), (e), (k), (l), 626.9641(1), 627.6699(9)(d)1., 4. FS. History–New 2-25-93, Formerly 4-150.206, Amended _____.

69O-150.206
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.

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

626.9611 Rules.—
(1) The department or commission may, in accordance with chapter 120, adopt reasonable rules as are necessary or proper to identify specific methods of competition or acts or practices which are prohibited by s. 626.9541 or s. 626.9551, but the rules shall not enlarge upon or extend the provisions of ss. 626.9541 and 626.9551.
(2) The department and the commission shall, in accordance with chapter 120, adopt rules to protect members of the United States Armed Forces from dishonest or predatory insurance sales practices by insurers and insurance agents. The rules shall identify specific false, misleading, deceptive, or unfair methods of competition, acts, or practices which are prohibited by s. 626.9541 or s. 626.9551. The rules shall be based upon model rules or model laws adopted by the National Association of Insurance Commissioners which identify certain insurance practices involving the solicitation or sale of insurance and annuities to members of the United States Armed Forces which are false, misleading, deceptive, or unfair.

627.6699 Employee Health Care Access Act.—

(9) SMALL EMPLOYER CARRIER'S ELECTION TO BECOME A RISK-ASSUMING CARRIER OR A(d) A small employer carrier that elects to cease participating as a reinsuring carrier and to become a risk-assuming carrier is prohibited from reinsuring or continuing to reinsure any small employer health benefits plan under subsection (11) as soon as the carrier becomes a risk-assuming carrier and must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured. A small employer carrier that elects to cease participating as a risk-assuming carrier and to become a reinsuring carrier is permitted to reinsure small employer health benefit plans under the terms set forth in subsection (11) and must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured. REINSURING CARRIER.—

(12) STANDARDS TO ASSURE FAIR MARKETING.—
(a) Each small employer carrier shall actively market health benefit plan coverage, including any subsequent modifications or additions to those plans, to eligible small employers in the state. Small employer carriers must offer and issue all plans on a guaranteed-issue basis.
(b) A small employer carrier or agent shall not, directly or indirectly, engage in the following activities:
1. Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

2. Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.
(c) Paragraph (a) does not apply with respect to information provided by a small employer carrier or agent to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.
(d) A small employer carrier shall not, directly or indirectly, enter into any contract, agreement, or arrangement with an agent that provides for or results in the compensation paid to an agent for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer except if the compensation arrangement provides compensation to an agent on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.
(e) A small employer carrier shall not terminate, fail to renew, or limit its contract or agreement of representation with an agent for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the agent with the small employer carrier unless the agent consistently engages in practices that violate this section or s. 626.9541.
(f) A small employer carrier or agent shall not induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.
(g) Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.
(h) The commission may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.
(i) A violation of this section by a small employer carrier or an agent is an unfair trade practice under s. 626.9541 or ss. 641.3903 and 641.3907.
(j) If a small employer carrier enters into a contract, agreement, or other arrangement with a third-party administrator to provide administrative, marketing, or other services relating to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section.

626.9541 Unfair methods of competition and unfair or deceptive acts or practices defined.—
(1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS.—The following are defined as unfair methods of competition and unfair or deceptive acts or practices:
(a) Misrepresentations and false advertising of insurance policies.—Knowingly making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, statement, sales presentation, omission, comparison, or property and casualty certificate of insurance altered after being issued, which:
1. Misrepresents the benefits, advantages, conditions, or terms of any insurance policy.
2. Misrepresents the dividends or share of the surplus to be received on any insurance policy.
3. Makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy.
4. Is misleading, or is a misrepresentation, as to the financial condition of any person or as to the legal reserve system upon which any life insurer operates.
5. Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof.

6. Is a misrepresentation for the purpose of inducing, or tending to induce, the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy.
7. Is a misrepresentation for the purpose of effecting a pledge or assignment of, or effecting a loan against, any insurance policy.
8. Misrepresents any insurance policy as being shares of stock or misrepresents ownership interest in the company.
9. Uses any advertisement that would mislead or otherwise cause a reasonable person to believe mistakenly that the state or the Federal Government is responsible for the insurance sales activities of any person or stands behind any person's credit or that any person, the state, or the Federal Government guarantees any returns on insurance products or is a source of payment of any insurance obligation of or sold by any person.
(b) False information and advertising generally.—Knowingly making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public:
1. In a newspaper, magazine, or other publication,
2. In the form of a notice, circular, pamphlet, letter, or poster,
3. Over any radio or television station, or
4. In any other way,
an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance, which is untrue, deceptive, or misleading.

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

any false material statement.

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

(k) Misrepresentation in insurance applications.—
1. Knowingly making a false or fraudulent written or oral statement or representation on, or relative to, an application or negotiation for an insurance policy for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, agent, broker, or individual.
2. Knowingly making a material omission in the comparison of a life, health, or Medicare supplement insurance replacement policy with the policy it replaces for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, agent, broker, or individual. For the purposes of this subparagraph, a material omission includes the failure to advise the insured of the existence and operation of a preexisting condition clause in the replacement policy.
(l) Twisting.—Knowingly making any misleading representations or incomplete or fraudulent comparisons or fraudulent material omissions of or with respect to any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse,

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

626.9641 Policyholders, bill of rights.—
(1) The principles expressed in the following statements shall serve as standards to be followed by the department, commission, and office in exercising their powers and duties, in exercising administrative discretion, in dispensing administrative interpretations of the law, and in adopting rules:
(a) Policyholders shall have the right to competitive pricing practices and marketing methods that enable them to determine the best value among comparable policies.
(b) Policyholders shall have the right to obtain comprehensive coverage.
(c) Policyholders shall have the right to insurance advertising and other selling approaches that provide accurate and balanced information on the benefits and limitations of a policy.
(d) Policyholders shall have a right to an insurance company that is financially stable.
(e) Policyholders shall have the right to be serviced by a competent, honest insurance agent or broker.
(f) Policyholders shall have the right to a readable policy.
(g) Policyholders shall have the right to an insurance company that provides an economic delivery of coverage and that tries to prevent losses.
(h) Policyholders shall have the right to a balanced and positive regulation by the department, commission, and office.

M E M O R A N D U M

DATE: November 20, 2017

TO: David Altmaier, Commissioner, Office of Insurance Regulation

THROUGH: Anoush Brangaccio, General Counsel

FROM: Sarah Berner, Assistant General Counsel
Matt Sirmans, Assistant General Counsel

SUBJECT: Cabinet Agenda for December 13, 2017
Request for Approval to Publish Amendments to
Rule 69O-191.029
Assignment # 216048-17

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before December 6, 2017, and to the Financial Services Commission on December 13, 2017, with a request to approve for publication the proposed rules.

The current rule requires an HMO to be operational within six months of licensure. This creates a conflict with the changes to Section 641.221, Florida Statutes, which allows an HMO limited to Medicare Advantage plans up to 24 months after licensure to become operational. The rule will be updated to conform to the statutory changes.

Sections 641.36; 641.19(7); 641.2015; 641.221, F.S., are the rulemaking authority and laws implemented for this rule.

Matt Sirmans 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

69O-191.029 Maintaining Eligibility for Certificate of Authority.

The HMO place of business shall be located in this state and shall be actively engaged in managed care within six months of licensure except as provided in Section 641.221(2), F.S. The HMO shall maintain a place of business, the location of which is identifiable by and accessible to the public as determined by the Office. Any HMO holding an existing Certificate of Authority which has not become operational as of the effective date of this rule shall be required to comply within one (1) year of this date.

Rulemaking ~~Specific~~ Authority 641.36 FS. Law Implemented 641.19(7), 641.2015, 641.221 FS. History–New 5-28-92, Formerly 4-191.029, Amended_____.

69O-191.029
Rulemaking Authority

641.36 Adoption of rules; penalty for violation.—The commission shall adopt rules necessary to carry out the provisions of this part. The office shall collect and make available all health maintenance organization rules adopted by the commission. Any violation of a rule adopted under this section shall subject the violating entity to the provisions of s. 641.23.

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

(7) "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

641.2015 Incorporation required.—On or after October 1, 1985, any entity that has not yet obtained a certificate of authority to operate a health maintenance organization in this state shall be incorporated or shall be a division of a corporation formed under the provisions of either part I of chapter 607 or chapter 617 or shall be a public entity that is organized as a political subdivision. In the case of a division of a corporation, the financial requirements of this part shall apply to the entire corporation. Incorporation shall not be required of any entity which has already been issued an initial certificate of authority prior to this date and which is not a corporation on October 1, 1985, or which is incorporated in any other state on October 1, 1985; nor shall incorporation be required on renewal of any certificate of authority by such an organization or be required of a public entity that is organized as a political subdivision.

641.221 Continued eligibility for certificate of authority.—
(1) In order to maintain its eligibility for a certificate of authority, a health maintenance organization shall continue to meet all conditions required to be met under this part and the rules promulgated thereunder for the initial application for and issuance of its certificate of authority under s. 641.22.
(2) In order to maintain eligibility for a certificate of authority, a health maintenance organization authorized under the Florida Insurance Code to exclusively market, sell, or offer to sell Medicare Advantage plans in this state shall be actively engaged in managed care within 24 months after licensure, shall designate and maintain at least one primary anti-fraud employee, and shall adopt an anti-fraud plan. The Office of Insurance Regulation may extend the period of eligibility upon written request.

FY 2017-2018 Q1

Number	Description	Weight	Bench-mark	Scale	Result	Counts	Score
1	Average* number of days to process applications with a benchmark** score of 3.	8%	35.42	5 = 34.71 4 = 35.07 3 = 35.42 2 = 35.77 1 =36.13	35.86	85	2
2	Average* number of days to complete life and health form and rate filing reviews with a benchmark** score of 3.	8%	22.09	5 = 21.65 4 = 21.87 3 = 22.09 2 = 22.31 1 =22.53	22.07	1249	3
3	Average* number of days to complete property and casualty form and rate filing reviews with a benchmark** score of 3.	8%	20.90	5 = 20.48 4 = 20.69 3 = 20.90 2 = 21.11 1 =21.32	20.83	1891	3
4	Weighted average of the percentages for completed applications/filings within: 90 days for COA's and new types of insurance; 45 days for L&H; 90 days for P&C rates and 45 days for forms; 60/90 days for priority/non-priority financial analyses; and total market conduct violations requiring remediation.	8%	100%	5 = 98 -100% 4 = 95 - 97% 3 = 92 - 94% 2 = 90 - 92% 1 = 87-89%	99.6%		5
5	Average* number of days to complete market conduct exams and investigations with a benchmark** score of 3.	8%	88.7	5 = 86.93 4 = 87.81 3 = 88.70 2 = 89.57 1 = 90.47	89.5	26	3
6	Percentage of financial exams of domestic insurers completed within 18 months of the "as of" exam date.	8%	100%	5 = 100% 4 = 98-99% 3 = 97-98% 2 = 95-96% 1 = 93 - 94%	◊		5
7	Percentage of life and health priority financial examinations of domestic insurers completed within 18 months of the "as of" exam date.	8%	100%	5 = 100% 4 = 98-99% 3 = 97-98% 2 = 95-96% 1 = 93 - 94%	◊		5
8	Percentage of property and casualty priority financial examinations of domestic insurers completed within 18 months of the "as of" exam date.	8%	100%	5 = 100% 4 = 98-99% 3 = 97-98% 2 = 95-96% 1 = 93 - 94%	◊		5
9	Average* number of days to complete priority financial analyses with a benchmark** score of 3.	8%	8.64	5 = 8.47 4 = 8.55 3 = 8.64 2 = 8.73 1 = 8.81	8.57	93	3
10	Average* number of days to complete non-priority financial analyses with a benchmark** score of 3.	8%	42.24	5 = 41.40 4 = 41.82 3 = 42.24 2 = 42.66 1 = 43.08	40.54	1868	5
						Avg.	3.9

** Average refers to an eight-quarter moving weighted average to reduce the effects of seasonality and create a stable dataset.*

◊ Due to the long cycle of financial exams, none were due during the period.