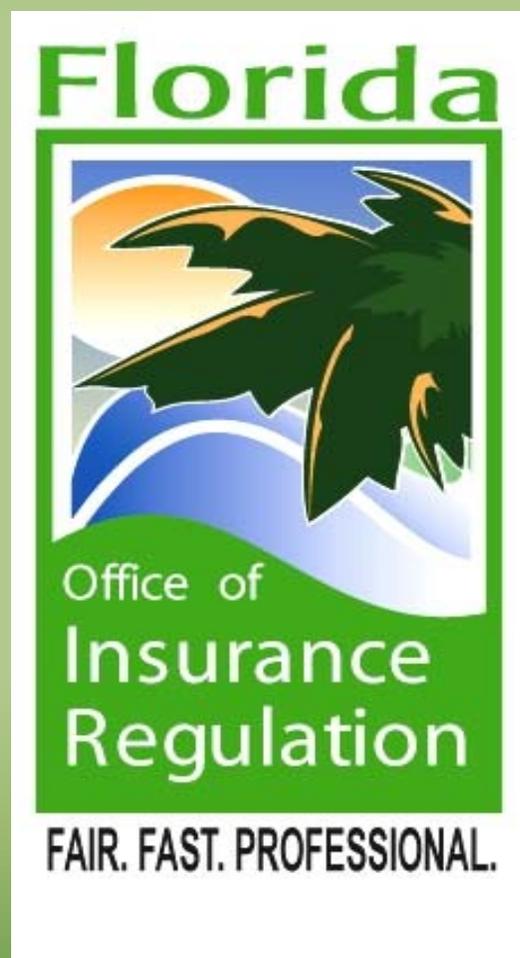


*Florida Office of Insurance
Regulation
2008 Filing and Compliance
Symposium*



*Life and Health Forms and Rates
May 22 and 23, 2008*

INTERNET WEBSITE ADDRESSES

Florida Department of Financial Services

www.fldfs.com

Office of Insurance Regulation

www.floir.com

BULLETINS

<http://www.floir.com/Bulletins/index.htm>

MEMORANDA

<http://www.floir.com/Memoranda/index.htm>

INDUSTRY LINKS

<http://www.floir.com/Links/index.htm>

Florida Statutes

<http://www.flsenate.gov/statutes>

Florida Administrative Code

<http://election.dos.state.fl.us/fac/index.shtml>

Florida Administrative Weekly

<http://faw.dos.state.fl.us/>

HIPAA Welcome Page

<http://www.cms.hhs.gov/hipaa/>

NAIC Home Page

[HTTP://WWW.NAIC.ORG](http://WWW.NAIC.ORG)

Specialty Product Administration

Telephone: (850) 413-3144

Specialty Product Administration is charged with the regulation of various insurance related industries including Auto, Home and Service Warranties, Premium Finance Companies, Legal Expense Insurance, Third Party Administrators, Continuing Care Retirement Communities, Donor Annuities and Viatical Settlements. The primary responsibility of Specialty Product Administration is to license entities, examine them for compliance with applicable laws and rules and monitor their financial condition for the protection of the public from insolvency risks and unethical business practices. Specialty Product Administration reviews the financial statement filings of licensed companies and conducts periodic on-site financial and market conduct examinations. A determination is then made to ascertain whether the condition of the company warrants continuation of its certificate of authority to operate in Florida. Specialty Product Administration currently monitors approximately 1,400 companies.

Property and Casualty Financial Oversight

Telephone: (850) 413-3148

The Property and Casualty Financial Oversight Unit is responsible for monitoring the financial condition of property and casualty, title insurers and self-insurance funds by conducting financial examinations and ongoing financial analysis. The Unit is primarily responsible for enforcing the provisions of Chapters 624 and 625, F.S., and applicable rules, as they relate to the review of Property and Casualty insurer solvency. The Unit is also responsible for the admissions process for new Property and Casualty entities as well as those proposing to expand into additional lines of business.

Property and Casualty Product Review

Telephone: (850) 413-3146

The Property and Casualty Product Review Unit enforces the provisions of Chapters 627 and 626, F.S., and applicable rules, as they relate to the review of Property and Casualty contracts and associated rates. The principle function of the Unit is to review and act upon Property and Casualty contracts and rate filings received from insurance companies and related entities. As each filing is received, it is reviewed in order to determine compliance with applicable actuarial standards, statutory provisions, and administrative rules.

The Unit is responsible for the actuarial review of insurance company rates and underwriting rules to ensure compliance with the Florida Insurance Code. Of key importance is assuring that rates are not inadequate, excessive, or unfairly discriminatory.

Company Admissions
Telephone: (850) 413-2575

The Company Admissions Section is responsible for the receipt of all company applications and the coordination of the Office's review of such applications prior to granting approval to a company to sell insurance in the state of Florida.

Life and Health Financial Oversight
Telephone: (850) 413-3153

The Life and Health Financial Oversight unit monitors the financial condition of all regulated Life and Health entities through the use of internal financial analysis and on-site examinations. The Unit is also responsible for the admissions process for new Life and Health entities as well as those proposing to expand into additional lines of business. Entities subject to the units' regulatory oversight include Life and Health insurers, fraternal benefit societies, health maintenance organizations, pre-paid limited health service organizations, pre-paid health clinics, multiple employer welfare arrangements, fiscal intermediary service organizations, discount medical plan organizations, as well as Health Flex entities that are either licensed, authorized or otherwise approved to operate in the State of Florida.

Life and Health Product Review
Telephone: (850)413-3152

The Life and Health Product Review ensures that all Life and Health policy forms and rates are in compliance with Florida Statutes and regulation. Chapters 627 and 641 are the principal statutes within the Insurance Code that govern the Unit's reviews. Applicable rules within the Florida Administrative Code also serve to guide these review processes. The primary function of the Unit is to review and act upon policy form and rate filings received from health and life insurance companies, health maintenance organizations and related entities. As each filing is received, it is reviewed to determine compliance with applicable actuarial standards, statutory provisions, and administrative rules.

The Unit is also responsible for the actuarial review of most health insurance rates to ensure that premiums are reasonable in relation to benefits as required by the Florida Insurance Code. Of key importance is assuring that rates are not inadequate, excessive, or unfairly discriminatory.

**FLORIDA OFFICE OF INSURANCE REGULATION
BUSINESS UNIT OF LIFE & HEALTH PRODUCT REVIEW**

**Telephone:(850) 413-3152
Fax: (850) 922-3866**

In Accordance with Memorandum OIR-03-008

<http://www.flair.com/memoranda/OIR-03-008M.pdf>

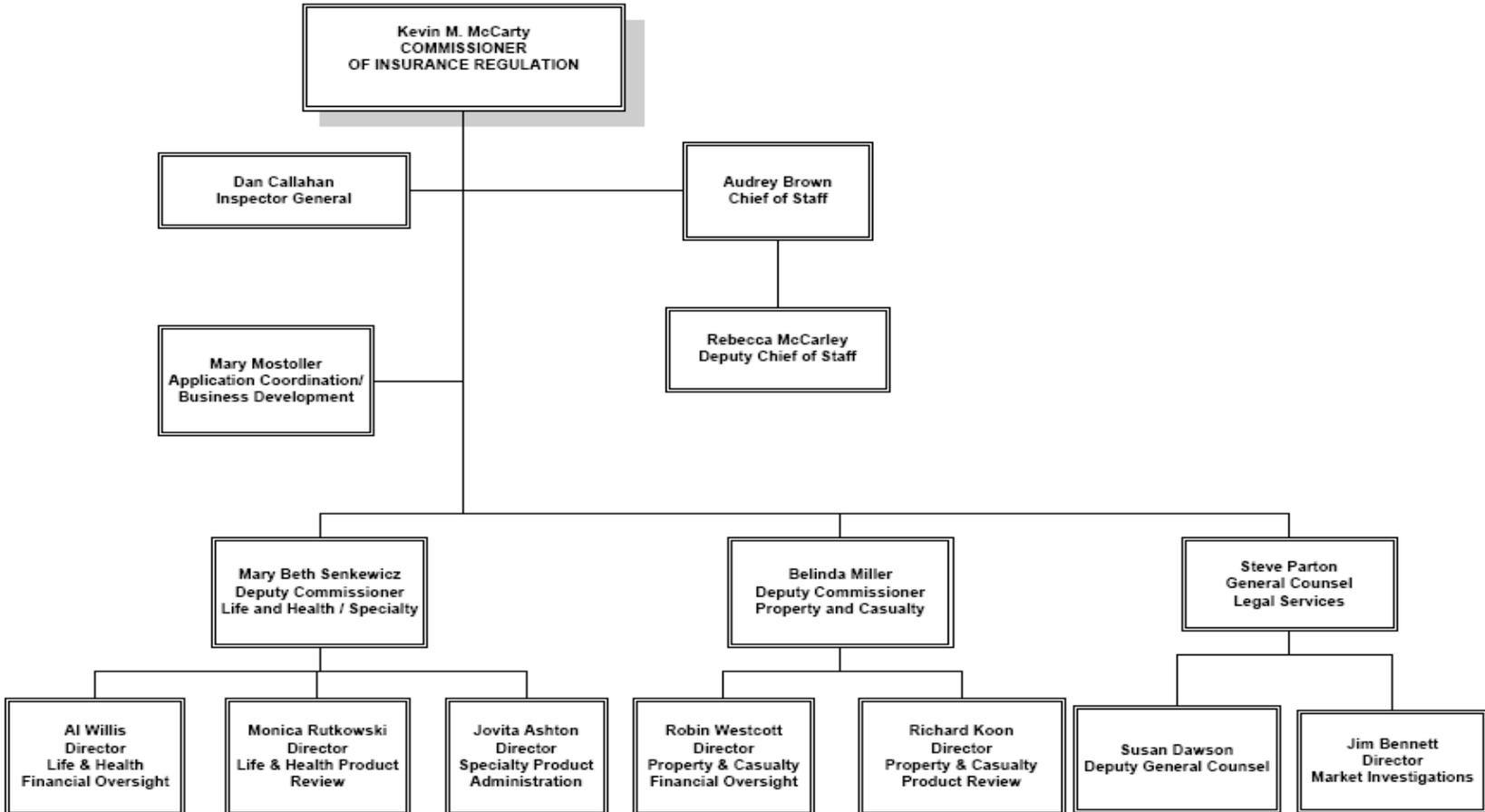
All Rate and Form filings must be submitted through the I-Portal at



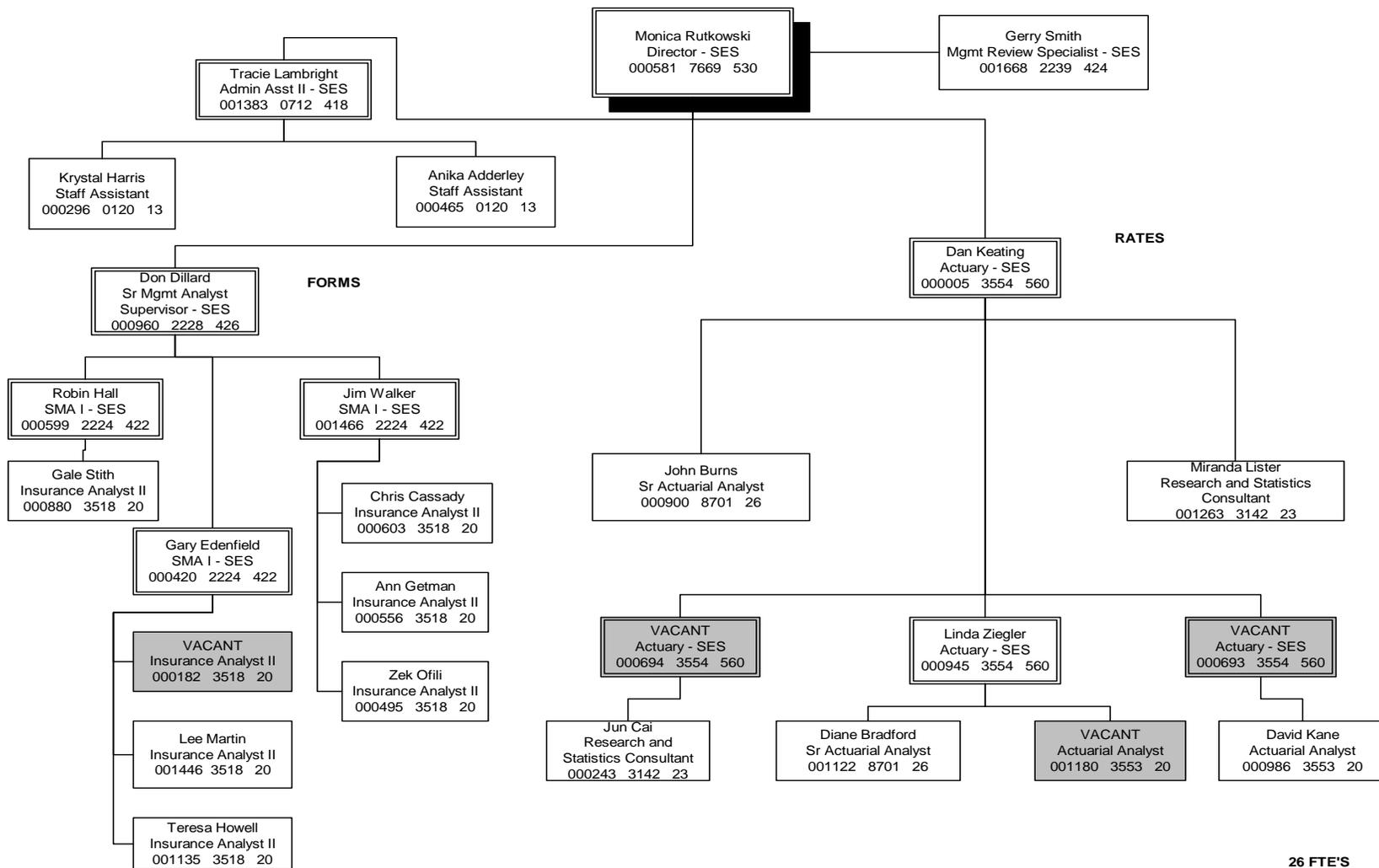
<https://iportal.fldfs.com/ifile/default.asp>

Our Office is located at:
200 East Gaines Street, Room 312
Tallahassee, FL 32399-0328

Florida Office of Insurance Regulation
Organizational Chart – March 2008



**OFFICE OF INSURANCE REGULATION
LIFE & HEALTH PRODUCT REVIEW
MAY 12, 2008**



LIFE & HEALTH PRODUCT REVIEW FILING REVIEW STAFF

FILING TYPE	FORM ANALYST	RATE ACTUARY
Accident		
<i>Individual</i>	Gary Edenfield/Lee Martin/ Teresa Howell	Miranda Lister
<i>Group</i>	Gary Edenfield/Lee Martin/ Teresa Howell	Miranda Lister
Annuities	Jim Walker/Chris Cassady/Ann Getman/ Zek Ofili	David Kane
Applications	Gary Edenfield	N/A
Assumptions/Name Changes/Merges		
<i>Life</i>	Gary Edenfield	Dan Keating
<i>Health</i>	Gary Edenfield	Dan Keating
Blanket	Gary Edenfield/Lee Martin/ Teresa Howell	Jun Cai
CCRC's	Gary Edenfield	N/A
Conversions (Non HMO)	Gary Edenfield/Lee Martin/ Teresa Howell	Dan Keating
Credit	Jim Walker/Chris Cassady/Ann Getman/ Zek Ofili	Jun Cai
Dental/Vision		
<i>Individual</i>	Gary Edenfield/Lee Martin/ Teresa Howell	Miranda Lister
<i>Group</i>	Gary Edenfield/Lee Martin/ Teresa Howell	Miranda Lister
Disability		
<i>Individual</i>	Gary Edenfield/Lee Martin/ Teresa Howell	Diane Bradford
<i>Group</i>	Gary Edenfield/Lee Martin/ Teresa Howell	Diane Bradford
Discount Medical Plans	Gary Edenfield	Miranda Lister
Health Advertisements (including MedSupp/LTC)	Robin Hall/ Gale Stith	N/A
HMO	Gary Edenfield/Lee Martin/ Teresa Howell	N/A
Large Group (Indemnity)	Gary Edenfield/Lee Martin/ Teresa Howell	David Kane
Life	Jim Walker/Chris Cassady/Ann Getman/ Zek Ofili	David Kane
Life Advertisements	Jim Walker/Chris Cassady/Ann Getman/ Zek Ofili	David Kane
Life/Annuity		
<i>Applications/Riders/Endorsements/Amendments</i>	Jim Walker/Chris Cassady/Ann Getman/ Zek Ofili	Dan Keating
Long Term Care/Nursing Home	Robin Hall	Dan Keating
Major Medical		
<i>Individual</i>	Gary Edenfield/Lee Martin/ Teresa Howell	John Burns
<i>Group</i>	Gary Edenfield/Lee Martin/ Teresa Howell	John Burns
Medical/Surgical/Hospital Expense		
<i>Individual</i>	Gary Edenfield/Lee Martin/ Teresa Howell	Linda Ziegler
<i>Group</i>	Gary Edenfield/Lee Martin/ Teresa Howell	Linda Ziegler
Medicare Supplement	Robin Hall/ Gale Stith	Linda Ziegler
Out-of-State	Gary Edenfield/Lee Martin/ Teresa Howell	Dan Keating
Point-of-Service (POS)	Gary Edenfield/Lee Martin/ Teresa Howell	Dan Keating
Prepaid Plans - dental, vision, etc.	Gary Edenfield	Dan Keating
Small Group § 627.6699 (Indemnity)	Robin Hall/ Gale Stith	Frank Dino
Specified Disease/Cancer		
<i>Individual</i>	Gary Edenfield/Lee Martin/ Teresa Howell	John Burns
<i>Group</i>	Gary Edenfield/Lee Martin/ Teresa Howell	John Burns
Stoploss	Gary Edenfield/Lee Martin/ Teresa Howell	Dan Keating
Viaticals	Jim Walker/Chris Cassady/Ann Getman/ Zek Ofili	N/A

Form Analyst Phone Numbers

Ann Getman: 850-413-2456
Chris Cassady: 850-413-5112
Zek Ofili: 850-413-5130
Gary Edenfield: 850-413-5134
Lee Martin: 850-413-5146
Jim Walker: 850-413-5148
Gale Stith: 850-413-5114
Robin Hall: 850-413-5198
Teresa Howell: 850-413-5105

Rate Actuary Phone Numbers

Dan Keating: 850-413-5144
Linda Ziegler: 850-413-5032
Miranda Lister: 850-413-5332
Jun Cai: 850-413-5036
John Burns: 850-413-5172
David Kane: 850-413-5046
Diane Bradford: 850-413-5018



OFFICE OF INSURANCE REGULATION

RATE REVIEW PROCESS

- **Regulatory Framework**

Prior approval of rates required

Large group exemption [627.410(6), FS]

Detailed review and justification

Ensure rates are not excessive, inadequate, or unfairly discriminatory

Discourage entry with low rates

Encourage adequate pricing

Require annual rate certifications

Require pooling of all similar forms

Prohibit select and ultimate rating and durational rating

Ensure all necessary components for participation in each market are met prior to submitting filings for review (i.e. if a policy includes a conversion option, the conversion plan is available in conjunction with the new form; if you are new to the small group market, the required basic and standard plans are available)

- **Procedure**

Review for complete filing

Cover Letter

Universal Data Letter completely filled out

Complete Actuarial Memorandum

Rate Pages

For any rate or rating factor change, the experience supporting the rate change must be included

Experience should be specific to the factor being revised

Aggregate experience exhibit supports aggregate rate changes only

For rate changes that are not uniform, include the effect on the Florida groups/policyholders for each significant factor that is changing

The Office will routinely issue letters during the review requesting additional information. Generally, the first request is a 14 day response and a second is 7 days

Recommendations are reviewed by chief actuary and processed through internal procedures for final determination

If we are unable to agree with the justification provided, we may indicate what we are able to approve based on the data provided

If we are unable to make any determination, the filing will be disapproved

- **Common Filing Issues**

Submit filings on an annual basis as required

Submit only one product type per filing

Choose the right type of product or the filing will be returned incomplete

Incomplete filings must be resubmitted in their entirety

Provide appropriate names for documents uploaded into a filing

Submit rate pages in a separate document

Provide Excel documents with embedded formulas [69O-149.006(3)(b)23, FAC]

Appendix A provides a sample experience exhibit [69O-149.006(3)(b)23, FAC]

Make sure all submitted documents are in a “print ready” format

The i-portal does allow for the submission of trade secret documents

Streamlined rate filings for non-credible blocks [69O-149.003, FAC]

Filing exemption for non-credible blocks [69O-149.007(7), FAC]

Florida credibility standards [69O-149.0025(6), FAC]

Definition of a claim [69O-149.0025(6)(b)2, FAC]

Large group exemption applies to forms that cover only 51 or more lives
[627.410(6)(a), FS]

- **Websites with Important Information**

Florida Administrative Code – www.flrules.org

Florida Statutes – www.leg.state.fl.us

Small Employer Sample Rate Search can be found on www.floir.com

**Appendix A
Illustrative Experience Exhibit (02/2004)**

Projection Assumptions:
 Rate Increase effective 07/01/2003 19.2%
 Claim Trend 15.0%
 Insurance Trend 1.0%
 Lapse Rate 20.0%
 Aging 1.00
 Future premium increases equal claim trend

Cal Year (a)	Earned Premium (b)	Paid Claims (c)	Change in Claim Liability & Reserve (d)	Incurred Claims (e) = (c) + (d)	Incurred Loss Ratio (f) = (e) / (b)	Expected Incurred Claims * (g)	Expected Loss Ratio * (h)	A/E Claims Ratio (i)	Active Life Reserves (j)	Earned Premium Monthly Rate Basis (k)	Earned Premium Current Rate Basis (l)
1995	56,5464	207,477	19,274	226,751	40.1%	209,222	37.0%	108.4%	-	565,464.00	715,312
1996	1,337,824	575,693	78,504	654,196	48.9%	561,946	42.0%	116.4%	-	1,337,824.20	1,692,348
1997	2,352,416	927,487	114,633	1,042,120	44.3%	1,075,107	45.7%	96.9%	-	2,352,416.18	2,975,806
1998	3,986,382	1,749,723	183,673	1,933,395	48.5%	1,896,723	47.6%	101.9%	-	3,986,381.86	5,042,773
1999	5,339,093	2,211,239	456,931	2,668,170	49.8%	2,696,178	50.3%	98.2%	-	5,339,092.79	6,753,952
2000	6,174,297	3,144,650	269,736	3,414,386	55.3%	3,308,634	53.6%	103.2%	-	6,174,296.66	7,810,485
2001	6,959,921	3,518,031	523,683	4,041,714	58.1%	3,974,882	57.1%	101.7%	-	6,959,920.78	8,394,570
2002	8,259,585	4,537,263	443,267	4,980,530	60.3%	4,812,170	58.3%	103.5%	-	8,259,584.83	8,857,418
2003	7,747,260			5,474,303	70.7%	5,392,577	69.6%	101.6%	-		
2004	7,246,233			5,057,119	78.1%	5,665,512	78.2%	99.9%	-		
2005	6,666,534			5,588,695	83.8%	5,596,987	84.0%	99.9%	-		
2006	6,133,212			5,332,842	87.0%	5,340,754	87.1%	99.9%	-		
2007	5,642,555			4,991,619	88.5%	4,999,025	88.6%	99.9%	-		
2008	5,191,150			4,638,212	89.3%	4,645,094	89.5%	99.9%	-		
2009	4,773,838			4,309,827	90.2%	4,316,221	90.4%	99.9%	-		
2010	4,393,790			4,046,691	91.1%	4,040,633	91.3%	99.9%	-		
2011	4,042,286			3,721,159	92.1%	3,726,689	92.2%	99.9%	-		
2012	3,718,903			3,457,701	93.0%	3,462,831	93.1%	99.9%	-		
2013	3,421,391			3,212,896	93.9%	3,217,663	94.0%	99.9%	-		
2014	3,147,680			2,983,423	94.8%	2,989,852	95.0%	99.9%	-		
2015	2,893,866			2,740,555	95.8%	2,778,171	95.9%	99.9%	-		
2016	2,664,196			2,577,652	96.8%	2,581,476	96.9%	99.9%	-		
2017	2,451,061			2,395,154	97.7%	2,398,708	97.9%	99.9%	-		
2018	2,254,976			2,225,577	98.7%	2,228,879	98.8%	99.9%	-		
2019	2,107,457			2,068,006	99.7%	2,071,074	99.8%	99.9%	-		
2020	1,908,611			1,921,591	100.7%	1,924,442	100.8%	99.9%	-		
2021	1,755,923			1,785,543	101.7%	1,788,192	101.8%	99.9%	-		
2022	1,613,449			1,659,126	102.7%	1,661,588	102.9%	99.9%	-		
2023	1,486,213			1,541,600	103.7%	1,543,947	103.9%	99.9%	-		
2024	1,367,316			1,432,511	104.8%	1,434,636	104.9%	99.9%	-		
2025	1,257,931			1,331,089	106.8%	1,333,064	106.0%	99.9%	-		
2026	1,157,296			1,236,848	106.9%	1,238,683	107.0%	99.9%	-		
2027	1,064,712			1,149,279	107.9%	1,150,984	108.1%	99.9%	-		
Past	34,974,581			18,943,382	54.2%	18,354,661	53.0%	102.2%	-	34,974,981	42,342,665
Future	86,080,978			77,472,577	90.0%	77,497,673	90.0%	100.0%	-		
Lifetime	121,055,960			96,415,859	79.6%	96,032,334	79.3%	100.4%	-		
Interest	5.0%										
Past	38,051,930			20,427,775	53.7%	19,986,026	52.3%	102.2%	-	38,051,930	46,163,229
Future	59,677,447			52,202,547	87.5%	52,192,316	87.3%	100.0%	-		
Lifetime	97,729,377			72,630,322	74.3%	72,178,342	73.9%	100.6%	-		

Each filing should include an exhibit with the requested increase and one without the requested increase. Formulas (and underlying assumptions) used to determine projected values should be disclosed as part of the filing. Assumptions disclosed should include the interest, medical trend, insurance trend, aging, lapse, shock, lapses, and the effectiveness of past and proposed rate increases.

* Calendar year expected claims and expected loss ratios are taken from the *directional experience exhibit 2003* expected loss ratios are taken from the *approved/developmental loss ratio slope one duration beyond the 2002 expected loss ratio*. Each additional future value follows the approved/developmental loss ratio slope.

Appendix A, continued

Premium By Duration and Calendar Year									
Ann Dur	1995	1996	1997	1998	1999	2000	2001	2002	Total
1	565,464	885,453	1,325,465	2,154,657	2,365,453	2,265,752	2,165,841	2,765,798	14,493,883
2		452,371	619,817	927,826	1,508,260	1,655,817	1,586,026	1,516,089	8,266,206
3			407,134	557,833	742,260	1,206,608	1,324,634	1,268,821	5,507,313
4				346,064	446,268	467,624	965,286	1,059,723	3,284,966
5					276,851	357,015	444,243	868,758	1,946,866
6						221,481	285,612	377,606	884,699
7							188,259	242,770	431,029
8								160,020	160,020
9									-
10									-
11									-
12									-
13									-
14									-
15									-
16									-
17									-
18									-
	565,464	1,337,824	2,352,416	3,966,382	5,339,093	6,174,297	6,959,921	8,259,783	

Durational Loss Ratio Slope									
Ann Dur	1995	1996	1997	1998	1999	2000	2001	2002	mid year durational slope
1	0.37	0.37	0.37	0.37	0.37	0.37	0.37	0.37	0.37
2	0.52	0.52	0.52	0.52	0.52	0.52	0.52	0.52	0.444
3	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.583
4	0.74	0.74	0.74	0.74	0.74	0.74	0.74	0.74	0.696
5	0.82	0.82	0.82	0.82	0.82	0.82	0.82	0.82	0.782
6	0.86	0.86	0.86	0.86	0.86	0.86	0.86	0.86	0.840
7	0.88	0.88	0.88	0.88	0.88	0.88	0.88	0.88	0.871
8	0.89	0.89	0.89	0.89	0.89	0.89	0.89	0.89	0.886
9	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.895
10	0.91	0.91	0.91	0.91	0.91	0.91	0.91	0.91	0.904
11	0.92	0.92	0.92	0.92	0.92	0.92	0.92	0.92	0.913
12	0.93	0.93	0.93	0.93	0.93	0.93	0.93	0.93	0.922
13	0.94	0.94	0.94	0.94	0.94	0.94	0.94	0.94	0.931
14	0.95	0.95	0.95	0.95	0.95	0.95	0.95	0.95	0.940
15	0.95	0.95	0.95	0.95	0.95	0.95	0.95	0.95	0.950
16	0.96	0.96	0.96	0.96	0.96	0.96	0.96	0.96	0.959
17	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.969
18	0.98	0.98	0.98	0.98	0.98	0.98	0.98	0.98	0.979

Expected Claims By Duration and Calendar Year									
Ann Dur	1995	1996	1997	1998	1999	2000	2001	2002	Total
1	209,222	327,618	490,422	797,223	875,218	838,328	801,361	1,023,345	5,362,737
2		234,328	321,065	480,614	781,279	857,713	821,562	785,334	4,281,895
3			263,619	361,198	480,614	781,279	857,713	821,562	3,565,985
4				257,688	332,303	348,205	718,776	789,096	2,446,068
5					226,765	292,426	363,874	711,389	1,594,634
6						190,483	245,638	324,757	760,878
7							165,938	214,012	379,970
8								142,475	142,475
9									-
10									-
11									-
12									-
13									-
14									-
15									-
16									-
17									-
18									-
	209,222	561,946	1,075,107	1,896,723	2,696,178	3,308,434	3,974,882	4,812,170	

Exp LR's	37.0%	42.0%	45.7%	47.6%	50.5%	53.6%	57.1%	58.3%	
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OFFICE OF INSURANCE REGULATION

FORM REVIEW PROCESS

MAKING THE MOST OF YOUR I-FILE FORMS SUBMISSION

You spend a lot of time assembling your forms filings for the various states in which your company writes business and, over the years, Florida has tried to make that easier for you. Since 2003, the Industry Portal Filing Assembly and Submission, commonly known as 'I-File' has helped by providing a tremendous advantage both in terms of time and review turnaround over the old, paper filing days. This section of your booklet is designed to give you more details concerning the assembly and submission of life and health forms. Hopefully this will assist you in making filings that will not be rejected as incomplete nor become bogged down in the review process and help you to help us speed your products off of our desks and into the marketplace.

As you get ready to assemble your filing, please remember:

- All forms must be legible and readable in an electronic format. Word or PDF documents are recommended for forms submissions. You may send annotated or 'redlined' copies of forms, but at least one clean copy should be submitted to permit stamping as approved for use in this state. If you must submit scanned copies of forms they should be clear and legible copies.
- Life policy and Annuity contract filings should be sent as 'Forms Only' and all others (Health, Long-Term Care, and Discount Medical Plans) should be sent as 'Forms and Rates'. But remember that life and annuity policy or contract filings are still required to include an actuarial memorandum as part of the filing.
- Forms should be filed for only one company and only one type of coverage should be included in each filing.
- Combo filings for products that contain both life and health coverages, should be submitted separately but simultaneously and should be clearly indicated as life or health in each cover letter with a reference to the companion filing included in the letter.
- The online Readability and Checklist Certifications must include the name and title of a company officer. A third assistant filing guru may be a key employee, but is probably not recognized by our agency as a company officer. Instructions are provided for identifying those forms that may be exempt from the readability score requirements.



SUBMIT

And don't forget to take that one last step!

We receive a lot of phone calls from filing originators who thought that uploading documents and completing online forms automatically sent them to us and, alas, such is not the case.

Types of Submissions

An original submission is one that is submitting a new form for the first time. This may be a brand new form never issued in Florida or one that is a revision of a previously approved form that is replacing the older version.

Filing Rules – Chapter 69O-149, F.A.C.

Product Codes – LOB & TOI

**UDL – Contact & general Filing
Information**

ENTER DATA CAREFULLY!

... while YOU were out....

First, as with any filing, you'll want to be sure to become familiar with and follow the filing requirements that are set out for you in Rule 69O-149.021 and .023 of the Florida Administrative Code. You will find a copy of the Rule on pages 86-88 of your Life and Health Forms and Rates booklet. Filings that do not follow these rules may be returned as incomplete.

You should also take care in selecting the Line of Business and Type of Insurance codes when assembling your filing as an incorrect code will also result in the return of your filing as Incomplete. A major cause of returns is for Life and Annuity filings that contain something other than a policy or contract but are indicated with codes for a policy or contract. These include applications, riders, endorsements and the like and there are codes designated as "Life-Other" or "Annuity-Other" for these type of form filings.

The section of the Filing Component List identified as OIR-B2-1507 L&H Universal Standardized Data Letter, what we refer to as the "UDL" is where you provide information about who is making your filing, who your contact person is and some more general information about the type of filing you are making. It is also where you complete both the readability and checklist certifications. Note that this form has replaced three separate forms – the Standardized Data Letter, and the two certifications just mentioned that were sent in individually in the old 'paper filing' days.

You will see you can copy your account information into the locations for the Filing Originator or Company Contact person – or both – but care should be taken to assure that this information is correct since this is what automatically populates our clarification and approval letters. An incorrectly entered email address means you will not receive correspondence from the Office and your filing may wind up being disapproved as a result. Sometimes we get an email error message and sometimes we don't but the responsibility to provide accurate contact information is ultimately yours. Please also enter a prefix such as Miss, Mrs., Ms. or Mr. and enter your contact information in a case-sensitive manner. All upper- or lower-case information that populates our letters will have to be revised later by our forms analyst. Your attention to these details saves us time in creating our letters to you and helps speeds the review process more than you might imagine.

One note concerning the Company Contact person; If you are preparing to submit a filing and know you will be out of your office within the review period – either 45 or 60 days depending upon your filing type - you may wish to have a different individual be the contact person or at least provide someone else in your office with access to both your email and I-File account password.



Uploading Your Forms

Filing Component List

Component	Last Updated	Status
Company Data	3/25/2008 09:35	Complete
Cover Letter	3/25/2008 09:16	Incomplete
DIR-1507 L&H Universal Standardized Data Letter	3/25/2008 14:23	Complete
Forms Checklist	3/25/2008 14:25	Complete
Forms to be Reviewed	3/25/2008 09:16	Incomplete
Certification Statement: Valuation Standards (Optional)	3/25/2008 09:16	-----
Certification Statement: Nonforfeiture Standards (Optional)	3/25/2008 09:16	-----
Supplementary Information (Optional) Supplementary Documentation	3/25/2008 09:16	-----

Now you are ready to begin uploading forms.

If you are submitting a policy or contract, please provide the Office with copies of any previously approved forms (applications, riders, etc.) that may be used with the submitted policy or contract, uploaded as supplementary information, along with the dates and Florida file numbers (i.e. FLA-01-23456) for the approval of these forms for use in this state, either in a cover letter or as a separate document

In addition, care should be taken to separate forms you are sending as supplemental information from those you are submitting for review for approval. These may be actuarial memoranda, a statement of variability, lists of previously approved forms, and the like. There is a separate area on the Filing Component List page for this purpose and not paying attention to where you upload your forms may result in errors when we are ready to approve your filing.

For life insurance and annuity filings, you'll also note a section on the Filing Component List for two certification statements. The Valuation and Nonforfeiture Standards documents are helpful in determining whether or not a filing should be reviewed by our Rates Section. In many cases, the information presented on these forms helps us to speed up the review of your submission and finalize your filing sooner. If you choose not to submit them, you should tell us this in your filing's cover letter and that will keep us from sending you a clarification letter asking for them.

Finally, please be sure the document you upload is in fact the document you meant to send to us...





How you communicate with the Office while your filing is under review also helps to speed the review process.

Please do not send additional information or revised forms that we have not requested unless you call us first. Failure to do so can lead to misunderstanding and to errors in processing the approval of your filing which, in many cases, can only be corrected through a new, time-consuming re-filing.

Also, please remember that our letters to you requesting more information about your filing or requiring changes to the forms are called ‘clarification letters’ in our office. Please do not refer to our ‘disapproval’ letters unless your filing has affirmatively been disapproved by a letter which also includes a page entitled Notice of Rights.

Suggested content for your correspondence to the office will be the subject of another presentation today, but you will be best served remember to always to address the concerns, numbered in our clarification letters, item-by-item in your response.

You use the ‘Add to a submitted filing’ feature in I-File to assemble your response. You’ll note the page entitled Filing Component List that is very similar to the one you completed when assembling your filing originally and you upload documents such as a response cover letter, supplemental information and revised forms to be reviewed in the same way.

Once again, you must click on the grey Submit button or your response will remain on your submitted filings workbench and we will not receive it.

And finally, should you have to resubmit a disapproved filing, you are reminded that our filing rules require you to identify the filing as having been previously disapproved and provide the Florida file number of the prior filing.

Your cover letter for a resubmission, should address the reasons for disapproval in an item-by-item fashion, similar to that for the previously mentioned response letter.

YOUR FILING COVER LETTER

The cover letter is often the very first thing that an analyst looks at after opening the filing in our electronic review system and what you put in – or leave out of - this important piece of correspondence can help to speed – or slow down – the review process. In an effort to help you craft an effective cover letter, this section covers some of the things that we must have and the things we need to review your filing in a timely manner and to ultimately approve it as soon as possible.

The cover letter is a required component of the Florida's electronic I-File Filing Assembly and Submission System; the level of detail however, is up to you. More is generally better but the quality of the details is more important than word-count.

At a minimum, your cover letter should:

- ✓ Clearly explain the type and nature of the filing;
- ✓ Is this a new filing, or
- ✓ A filing for revisions of previously approved forms?
- ✓ You cannot give us too much information!



Please be sure to identify all forms by form number and title.

New Policy Filings

Note, if you are submitting a new policy, provide the Office with copies of any previously approved forms (applications, riders, etc.) that may be used with the submitted contract, along with the dates and Florida file numbers (i.e. FLA-01-23456) for the approval of these forms for use in this state.

Revised Policies & Associated Forms

If you are submitting a revised policy or an associated form, such as an application or a rider, please provide the form numbers, dates of approval and Florida file numbers (i.e. FLA-01-23456) and a brief description of the type of coverage for any policies that will be issued or changed as a result of the use of the submitted form subsequent to its approval for use in this state.

Resubmission of a Previously Closed Filing

If you are resubmitting a filing that was closed by the Office, please provide us with the prior Florida file number and state whether the prior filing was disapproved, withdrawn, or returned as incomplete. Note that a resubmitted filing must include all forms and related information that was submitted in the original filing.

If the previous filing was disapproved or returned as being incomplete, address all issues which were stated in the OIR disapproval/incomplete letter which was returned with the filing.

Methods of Marketing



Please provide a detailed description of all marketing methods employed to solicit sales of the form in our state. Rule 690-149.023(4), F.A.C., requires an insurer to submit a description of distribution systems (e.g. direct marketing, marketing through agents, marketing through financial or other institutions, internet, telemarketing etc.) and the intended target population for all product filings. If you intend to solicit a policy to different markets please explain in detail any difference in the planned solicitation.

Note that we do not review advertising materials except those for Long term Care, Medicare Supplement or Small Group coverage.

Other Important Points to Consider:

- ➔ If the filing is being made on behalf of the insurer by a consultant or consulting firm, please provide a currently dated certification of authorization from the insurer to represent the company identified in the forms being filed.
- ➔ If a Third Party Administrator will be contracted to administer the policies issued, please identify the name of the TPA. Always verify that the TPA is licensed in Florida before utilizing their services.
- ➔ If the submitted forms contain variable language the language should be indicated in brackets and the filing should include an explanation for all variable language which might be used for each item. The explanation should address:
 - the need for variability;
 - the factors that determine which variables will be used in a particular contract;
 - the time at which a variable may become fixed in a contract; and
 - the anticipated range (i.e. 1 – 10 years, 5 – 10%, etc.) for variable values.
- ➔ ‘Combo’ filings for products that contain both life and health coverages, should be submitted separately but simultaneously and should be clearly indicated as life or health in each cover letter with a reference to the companion filing included in the letter.
- ➔ If a submitted application contains a question regarding foreign travel, the cover letter should indicate whether or not a response may be used to deny, limit, or charge extra for coverage. If so, your company will need to demonstrate to the Office how asking the foreign travel question is justified in actuarially determining the risk

associated with future foreign travel. Also, the letter should provide an explanation as to how asking such questions does not unfairly discriminate or violate Florida's law.

➡ If any of the forms submitted contain exclusions for war or acts of war, the cover letter should indicate whether or not the definition of war includes terrorism in determining whether or not a benefit will be paid.

➡ Be sure that the contact information in your cover letter is current and all data, names, phone numbers, E-mail addresses and the like are correct in the letter. Although this information is also required to be input for a Contact person when assembling your filing in I-File, this information should be correct in case of a problem with that information in the electronic filing system.



AND MOST IMPORTANTLY, PLEASE REVIEW THE ENTIRE COVER LETTER BEFORE SUBMITTING THE FILING.

****REMEMBER YOU CANNOT GIVE US TOO MUCH INFORMATION ****

COMMON FORMS PROBLEMS

Common Forms Problems

This section addresses common forms problems we see in the review of the various types of Life and Annuity forms and to assist you, the filing originator, in addressing them so that our mutual goal of getting your filing approved the first time is attained.

One of our common problems is the way in which forms address the issue of providing coverage for domestic partners. As society is evolving into different types of households, the life insurance industry has also had to adapt by allowing benefits for domestic partners. Although we currently have no Statutes or Rules concerning the benefits offered to these individuals, we do ask that the coverage offered to be offered to both same and opposite sex partners.



Sometimes the problems are not in the policy. An issue of discrimination may exist where a company wants to market the same policy through different distribution channels that include different benefit options in each of these distribution channels. Giving individual life policyholder “A” some benefits that may or may not be given to policyholder “B” creates a situation in which discrimination may occur. Section 626.9541 (1)(g) F.S., does not allow for discrimination between individuals in the same actuarially supportable class.

Applying varying types of underwriting – guaranteed issue, simplified and full underwriting – to issue the same individual policy form is also discriminatory. Policies issued in the workplace with the level of underwriting determined by the number of employees may be acceptable for group life insurance, but it is discriminatory in an individual policy form as it subjects individuals of the same actuarial class and expectation of life to different conditions for issuing the coverage.

Related forms such as riders, endorsements and amendments are defined under the definition of “policy” in Section 627.402, F. S., and, as such, must comply with many of the same requirements as do the policies to which they will be attached. Two areas we commonly see that are overlooked in the filing of these related forms are:

1. The name of the insurer must be prominently displayed on the form.

2. The form must be executed on behalf of the insurer by the signature of at least one company officer.



Certainly, some discretionary language is acceptable. For example, in variable life and annuity filings we see the reservation of rights as it relates to market timing...that is where certain contract holders try to time the stock market to maximize returns...but by doing so this strategy can disrupt other investors. So language which clearly allows companies to use their discretion in preempting these type activities is frequently approved.

As our population has aged, so has our concern for protecting the rights and quality of life for our seniors. When the Florida legislature enacted the secondary notice referenced in Section 627.4555, it required insurers to provide the applicant for a life insurance policy an opportunity to designate a person to receive a lapse notice when the policy is in danger of lapsing and the insured is age 64 or older. Note that language should also appear in the policy. A notice of the rights of these policyholders along with the responsibilities under the law for insurers should be included as part of a life policy's grace period provision.

No discussion on common forms problems would be complete without touching on the use of brackets to indicate variable items in a policy or related form. In an attempt to work with industry, certain bracketing is permitted. Language that is of "John Doe" type can be bracketed. However, when information such as annuity surrender charges, policy fees, and interest rates are bracketed we need an explanation, including a numerical range, for these values.



For Out-of-State group filings, please note disclosure language on the cover page concerning the governing state law must be in contrasting color. Although the contrasting color is preferred, , we recognize that not all companies have the ability to print in a contrasting color so in order to achieve maximum prominence, we do allow the language to be bolded and a box placed around it.

Another common problem seen in Out-of-State group filing is when the certification required by Section 627.5515, F.S., is not included and that results in your filing being

returned incomplete. So in order to avoid that, please be sure this form is included, properly executed by a company officer.



Unfortunately, the most common reason for disapproval is **“No response”**. So please, instead of just not responding, call us. Anyone of our staff would be glad to work with you anyway we can to get you filing approved the first time through and, if you need more time for your response, that’s generally not a problem. If you have any questions about anything in our letters, call...but please, don’t just fail to respond!

COMMON APPLICATION PROBLEMS

UNDERWRITING QUESTIONS

One of the biggest issues we face in reviewing applications filed for use with life or health insurance products is the wording used to ask underwriting questions. Health questions and activity questions should be written so as to be readily understood by the applicant and must not call for opinions that he or she may not be qualified to give in response. These responses serve as the basis for a contest under our statutes and we take them very seriously.



If you have underwriting guides for agent and applicant put the questions on application to support them. If you have agent underwriting guides for transferring information that is not on the application this not allowed.

Here is a sample of some of the health-related questions we have seen in applications:

- Here are a few of the questions we are seeing?
- Have you seen a doctor?
- Have you consulted with a doctor?
- Do you have any other medical ailments?
- Are you disabled or do you plan on being disabled?
- Have you had cancer or any symptoms?
- Do you have any medical conditions?

These types of questions are considered ambiguous and are subjective and call for further clarification and will not be accepted and you will receive a clarification letter or a disapproval letter from the Office.

Question in applications concerning medical conditions should be phrased so as to solicit responses that may be supported by the applicant's medical records. Asking an applicant if he or she has "had" or "been told" they have a medical condition calls for the applicant to provide a potentially contestable response he or she may not be qualified to provide. Medical questions should only ask for diagnosis or treatment by a licensed member of the medical profession.



When asking medical question of the applicant about someone else, begin the question with "TO THE BEST OF YOUR KNOWLEDGE"

We are also seeing group enrollment forms with health questions being asked. We know that other states **allow** health question regarding group coverage but this is not allowed in under Florida group health statutes. This also applies to coverage which is more than the guarantee issue. For example let's say you are offering a group hospital indemnity policy which has a \$100 a day benefit. You inform the group that if you can individually underwrite you will provide another \$100 to the individuals who qualify. However, the only time you can ask health question is for late enrollees. Once you accept the group everyone is entitled to the same coverage.

THE DON'TS AND THE DO'S



DON'T:

- Don't file an application with rider coverage if the rider has not been approved.
- Don't file an application with an "Other" box unless you explain what "Other" is.
- Don't file an application and state it will be used with policies approved in the future.



DO:

- Do put a space for the agent's printed name, a space for the agent's signature and a space for the agent's Florida license number on your application.
- Do put the Florida fraud statement right above the applicant's name on your application.
- Do use the Florida required AIDS question "has been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection."

ADVERTISING PROBLEMS

Advertisements

Florida Statutes require three types of product advertisement to be filed for review. They are:

- Long Term Care: Section 627.9407(2), F.S. and Rule 69O-157.115, F.A.C.
- Medicare Supplement: Section 627.6735, F.S. and Rule 69O-156.121, F.A.C.
- Small Group: Section 627.6699(12) (d) 4, F.S. and Rule 690-150.218, F.A.C.

All other Accident and health advertisements are not required to be filed for review and approval. Even though the advertisements are not filed they must comply with our advertising Rules which can be found in Chapter 69O-150 Part I, F.A.C., advertising of Health Insurance.

It is important that each ad submitted is clearly identified consistently throughout the filing as one of the types listed above.

Types of Advertising



An Institutional Advertisement is a type of advertisement that is used to introduce to readers, viewers, or listeners' to the concept of Insurance. For example, this type of advertisement could also be used as a promotional piece of the Insurer as a seller of Insurance products.



An Invitation to Inquire is a type of advertisement that creates a desire to inquire further about an insurance policy. We often see a reply card attached to a brochure or letter. Often insurance agents will use a typical business letter on the insurance company letterhead and provide a telephone number for the potential client to call back. This type of advertisement could be a pamphlet or a brochure. It includes any type of lead-generating device.

An Invitation to Contract is a type of advertisement that may state premium costs. If you have a rate or premium in the advertisement we will consider it an invitation to contract.



What Advertising is not

- Training materials from insurers for agents and employees.
- In-house materials and communications for agents and employees.
- Court-ordered communications to policyholders.
- General announcements from insurers to policyholders

The Review Process

When an Analyst reviews the advertisement(s)



You might receive a clarification letter. This type of letter is to clear up any confusion, or you might be asked to make revisions to the advertisement. You might receive a disapproval letter.

Or you might receive an approval, the ultimate goal!!

Suggestions for making effective responses:

- Always send a cover letter to explain your response.
- Refer to the Florida file number assigned to the filing.
- Respond to our objections point by point.
- Be specific as possible in your answers to our requests or objections.
- Submit all documents with revisions or corrections.

Tips to Remember:



- It will be a quicker review if you limit the number of advertisements you file in one filing.
- If you have multiple advertisements, a good rule of thumb is to submit similar types of ads, for example all institutional pieces together or group Invitation to Inquire pieces together.
- If you file brochures, single page ads, and a ninety page power point presentation in one filing, all of the ads will be held up if there is one question on page 58 of the presentation.
- Please consider filing five single page ads together, or if you have a large power point presentation file that by itself.
- We will need to research the policy that your insurance company is advertising. Please provide the policy forms that the advertisement is marketing along with the approved Florida file number. If the policy has not been approved do not submit an advertisement for review.
- Identify the different media in which the advertisement will be used (TV, Radio, Internet, or Brochure).
- Always give us the marketing and distribution methods. Identify if a call center will be used and explain the process. If a call center is used, use only Florida licensed agents.
- In advertising we commonly see a lot of bracketing, please provide a complete explanation of variability.
- Certify that the advertisement will appear exactly as you have presented it to us, if it is modified in any way it will need to be filed with the Florida Office of Insurance Regulation.
- A cover letter provides both direction and insight.
- Certify that the font size of all the disclosure language in the form is at least 10 point type
- Identify if a Third Party Administrator will be used.
- Any disclosure statement must reflect that only a licensed agent maybe contacted for further information about premium cost and coverage details. Section 626.9531(1), F.S
- Sources of statistics must be cited. Use sources that are current and valid. Industry standards currently accept sources that are less than five years old.



If you have identical advertisements for Long-Term Care, Medicare Supplement, and/or Small Group you will need to file them separately. These advertisements are governed by different statutes and rules so that requires a separate filing.

LIFE FORMS ISSUES

As the life and annuity industry has changed over the years, especially in recent times, the Office has encountered new challenges in helping industry to bring new products to market while maintaining compliance with applicable statutes and rules. This section is designed to give you some information that will help make it easier for you and our staff to address some of the more common issues we are facing. By doing so, we hope to help you get your filings approved the first time you submit them and as quickly as possible.



ANNUITY SUITABILITY

One example of the type of information we need came about as a response to numerous consumer complaints from Florida's large senior citizen population. As a result, in 2004, the Office developed 6 annuity suitability questions.

They include:

1. What is the target market for the company's annuity products?
 - the issue ages?
 - the restrictions on the annuity date?
 - how is the applicant informed of the restrictions on the annuity date for the earliest maturity date and the latest date to annuitize?
 - can the date to annuitize be changed by the owner of the annuity?
2. Is there a bonus paid to the purchaser/owner? If so,
 - what is the bonus based on?
 - how is the applicant informed of the bonus and its provisions and limitations?
 - is the bonus paid during the first year only?
 - how much is the bonus amount or percentage?
 - how is it credited to the contract?
3. What guidelines have been provided through the market distribution system to ensure that sales are aimed at the target market?
4. What procedures have been put in place to monitor solicitation and marketing practices to ensure compliance with these guidelines?
5. What procedures have been put in place to monitor business in force to ensure that the company's annuity products are reaching the target market?
6. What actions does the company put in place if annuity product sales do not track the target market?

Also, in order for your annuity contract to be approved, there should be language on the cover page indicating that the date to annuitize may be changed. We require that the owner be given the option to change the annuity payout date to a date that is not more restrictive than 12 months after contract's issue. In addition, the annuity payout and death benefit amounts must be free of surrender or withdrawal charges and certain other adjustments.

FOREIGN TRAVEL

Another important ongoing issue centers on questions in applications about a proposed insured's foreign travel. Florida's Freedom to Travel Act became effective shortly after our last symposium in 2006. A copy of Rule 69O-125.003 F.A.C. can be found on pages 78-80 of this booklet.



The freedom to travel act also added a new paragraph to subsection (1) of Florida statute 626.9541, F. S., expanding the protections against discrimination with regard to the underwriting of life insurance based upon the insured's past foreign travel or any plans he or she may have for future foreign travel. This subsection is also contained in the booklet on page 66.

If the application contains a question regarding foreign travel, it should either be deleted or, if the response may be used to deny, limit, or charge extra for coverage, your company will need to demonstrate to the Office how asking the foreign travel question is justified in actuarially determining the risk associated with future foreign travel. Also, insurers should provide an explanation as to how asking such questions does not unfairly discriminate or violate Florida's law.

An insurer may file a petition for a variance or waiver with the Office for a limited exception from the statute and rule. The petition shall contain supporting information demonstrating that the requested limited exception(s) are based upon national or international emergency conditions that affect the public health, safety, and welfare and are consistent with public policy. This petition should be submitted to our General Counsel, Mr. Steve Parton.

ELECTRONIC TRANSACTIONS

If the transmission of data or transactions is to be made electronically, the requirements of Section 668.50, F. S., may apply and you will need to provide a statement concerning an understanding of and compliance with these requirements. You can find the statute on pages 70-77 of your booklet.

In processing filings where the applicant can apply online or in another electronic format, we will ask you for the following additional marketing information.

- A detailed description of any information to be transmitted electronically
- An explanation of how the signature pad will be used
- Will the applicant be reviewing all of the health questions?
- Will the applicant see his/her signature?
- Certify that the applicant's signature will not be transmitted to any other forms
- How will the policy be delivered?
- The Office needs to be provided with print outs of every screen used in the application process

- How is replacement handled? Please demonstrate compliance with 690-151.006, F.A.C.

Also, please note that anyone taking information from the applicant over the phone must be a Florida licensed agent.

When your Internet based or telephonically solicited filing is approved, the following language will be in the approval letter:

“Electronic provision of documents is provided for in **Section 668.50**, F. S. Any such provision of insurance documents should be guided by those statutes which, among other things, require agreement between the parties. Since the Office is not in a position to require compliance with Section 668 F.S, it will not approve any reference to electronic documents that does not specifically address that it meets the intent of Section 668.50 (5)-(8)”.

PRE-NEED FUNERAL PLANNING



Filings of life and annuity policies used in the Pre-Need marketplace must certify compliance with the requirements of the applicable subsection of our Unfair Trade Practices laws and specific rules concerning these policies. A copy of the applicable subsection can be found on page 67 of this booklet. The filing should also include any forms assigning the proceeds. While the Office may approve certain types of assignment forms for use with pre-need planning, they must be revocable and make no reference to a particular funeral home or goods and services.



PRODUCT CODING

In 2005, our agency completed a project in which we adopted the NAIC’s product coding matrix for life and health insurance form filings made through the I-File system in this state. This product coding matrix, commonly referred to as the line of business code, was the result of a joint effort between the NAIC, state regulators and the insurance industry. This project resulted in a numerical coding description of each line of business offered by the insurance industry. Implementation of the codes has been underway since that time and it continues to be an issue we face daily in the filings we receive.

In 2007, for example, the Forms sections of the Division of Life and Health Product Review returned 265 filings as Incomplete for incorrect Line of Business or Type of Insurance codes. For life insurance, the single biggest issue remains incorrect coding for forms other than policies, such as applications, riders, amendments and the like. Once received by the Office, this information cannot be corrected and we must return the filing to you for re-assembly and resubmission. Care should be taken to assure that you are selecting the correct codes when assembling your filing and you can always call us if you are unsure. The NAIC has scheduled changes in the Line of Business codes for January 01, 2009

CORPORATE-, BANK- & STRANGER-OWNER LIFE INSURANCE

The issue of Corporate owned life insurance, bank owned life and stranger owned life insurance has also become more prevalent since the 2006 symposium.

The first of two major issues we face in reviewing forms filed for use in this marketplace is when the policy is filed as an employee group policy since there may be an issue with regard to naming the employer as the beneficiary, in violation of the Employee Groups statute 627.552, F. S.

In addition, group policies must provide conversion privileges that are nearly always absent in COLI or STOLI-type policies. Section 627.566 F.S. requires a right of conversion if the insured or a dependent's coverage ceases because of termination of employment or membership in the eligible class. Section 627.567 F.S., requires conversion if the master group policy terminates.

Also, when designed to cover individuals in a non-group setting, we frequently have issues arising from discrimination against insured's with an equal expectation of life in the benefits, terms or conditions of the policy form when it is also issued outside of the COLI marketplace.

MILITARY SALES PRACTICES

In an effort to support our men and women serving in the military, Florida Administrative Code Rule 690-142.200, in line with the parent Legislation- the Military Personnel Financial Services Protection Act of September 26th, 2006 and the follow up NAIC Model Regulation on Military Sales Practices, of June 4th, 2007, was designed to safeguard members of the Armed Forces from dishonest and predatory insurance sales practices while on a military installation. This rule applies to the solicitations and sales of life insurance and annuity products by insurers and insurance agents to active duty members of the United States armed forces and their families. Please note that this rule applies in addition to other statutes and rules governing the sale and solicitations of life insurance and annuity products. The complete rule can be found on pages 80-86 of this booklet.



OTHER FORMS ISSUES

- **Arbitration**



Mandatory, pre-dispute binding arbitration presents a challenge for the review of life insurance and annuity filings. We do approve arbitration as long as it is non-binding on the policyholder. Please keep in mind that we will not allow the insured's right to bring civil action in court to be reduced or eliminated in any fashion.

- **Exclusions**



Exclusions of coverage continue to remain an issue for us in our review of your forms. Often included in these exclusions is a reference to acts of war. You should tell us in your filing's cover letter whether or not the definition of war includes terrorism. And by the way, the acceptable answer to that question is "No", the war exclusion will not include terrorism.

- **Disclosures**



When filing a whole life policy, please place language on the cover page indicating to what age premiums are payable. Also, please disclose to the policyholder the value of the policy at maturity or indicate that the maturity value can be found either the cover or the schedule page of the policy.

VIATICAL BROKER FORMS

In recent years we are often asked what type forms need to be submitted to us for approval in a viatical filing made by or on behalf of brokers. Section 626.9921, F. S. requires "Related forms" to be approved prior to use in this state and a related form is defined in statute 626.9911, as a form the viator must sign or initial. Forms not meeting this definition will not be approved.

The most common mistake made in viatical form filings is terminology. Please note all terms must be consistent with statute. The term "life settlement" for example is not defined in statute and form must refer to "viatical settlements" instead. Section 626.9911 also provides a definition of other terms the Office will accept. A copy of this statute is located on pages 67-69 of this booklet.

THE MULTI-STATE REVIEW PROGRAM



And, while not an issue exactly; we are pleased to call to your attention to ongoing success of the Multi-State review program or, simply, the MSRP. Since going online in 2003, the program has reviewed many annuity form filings filed for approval in the six participating states and the District of Columbia. Of these, over 80% were approved in 60 days or less and the record for the speediest approval remains at just 7 days. More information about the MSRP, the partnering agencies and how it helps brings products to a large number of consumers in a short period of time.

Discount Medical Plan Organization (DMPO) Issues



The regulation of discount medical plan organizations (DMPOs) and discount medical plans (DMPs) is relatively new for the Office. Our Legislature passed the first law governing DMPOs in the 2003 Session. Chapter 636, Part II, Florida Statutes, originally required DMPOs to be licensed to conduct business in Florida by December 1, 2004, however, our Legislature held a Special Session in December of 2004, and the deadline for DMPOs to obtain licensure was extended through March 31, 2005.

As of March 1, 2008, there are 46 DMPOs licensed and authorized to conduct business in Florida. Also, as of March 1, 2008, the Division of Life and Health Product Review (LHPR) had received a total of 1022 filings and had approved 650 of those filings. LHPR also keeps track of the Pending, Withdrawn and Disapproved filings. Our goal is to review every filing as quickly as possible and to provide necessary feedback to the DMPO in the event any modifications are needed to make the filing approvable.

All filings should be submitted through the I-File System which is used by the Office to track all filings.

NEW FILING REQUIREMENTS

A DMPO filing should always contain a Cover Letter, a Universal Data Letter (UDL), a Member Agreement, an Enrollment form(s), and a Price Filing form that discloses the fees to be charged to the member.

The Cover Letter should clearly explain the purpose of the filing. For example:

- Is this a new filing or does this filing replace a previously submitted filing? If the filing replaces a previously submitted filing, include the previous Florida file log number and explain if the previous filing was Approved, returned Incomplete, or Disapproved.
- Specify which particular forms are being replaced and which new forms are their replacements.
- Use strike-through and underline to identify all language being changed.
- Is this filing for your DMPO or for a particular marketer or private label marketer? Identify the marketer.
- State all marketing methods that will be used.

The Cover Letter is the place to explain any and everything relevant to the filing.

The UDL form provides the Office with the contact information of the person making the filing, the type of product being filed, and the specific forms you want reviewed for approval. It also tells us if you are currently selling the plan in Florida, have current business in force or have any market restrictions for the plan.

The Member Agreement form should always contain the Elements found in Rule 69O-203.202(1)(a) through (l), F.A.C. and the Disclosures found in Section 636.212, F.S. Detailed information regarding the Member Agreement is found in the next segment. Please use the DMPO Checklist form OIR-B2-1607 to be certain each of the requirements of the Member Agreement is addressed prior to submitting.

DISCOUNT MEDICAL PLAN ORGANIZATION (DMPO) CONTRACT AND APPLICATION CHECKLIST

Statute/Rule	Description	Yes	No	N/A	Page #
69O-203.202(1)(a)	All Discount Medical Plan contracts shall include: Name and address of the DMPO.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
69O-203.202(1)(b)	All Discount Medical Plan contracts shall include: Telephone number for member assistance and plan information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
69O-203.202(1)(c)	All Discount Medical Plan contracts shall include: Name of Group if applicable and the name of the Member.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
69O-203.202(1)(d)	All Discount Medical Plan contracts shall include: Effective date and term of contract.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
69O-203.202(1)(e)	All Discount Medical Plan contracts shall include: Space for rate to be charged and any one time processing fees.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
69O-203.202(1)(f)	All Discount Medical Plan contracts shall include: Mode of payment (monthly, quarterly, etc. with provision for change of mode if applicable).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
69O-203.202(1)(g)	All Discount Medical Plan contracts shall include: Renewal, termination and cancellation conditions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
69O-203.202(1)(h)	All Discount Medical Plan contracts shall include: Description of benefits to be provided.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
69O-203.202(1)(i)	All Discount Medical Plan contracts shall include: All limitations, exclusions and exceptions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
69O-203.202(1)(j)	All Discount Medical Plan contracts shall include: Provisions for adding new family members.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
69O-203.202(1)(k)	All Discount Medical Plan contracts and application forms shall contain a unique form number in the lower left hand corner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
69O-203.202(1)(l)	All Discount Medical Plans member contracts shall include: A description of the member complaint procedure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
636.216	All Discount Medical Plan contracts shall include: The required disclosures.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

For each of the various marketing methods used to enroll members in the plan, an enrollment form should be submitted. Each enrollment form should be revised at the very beginning to make it clear to the prospective member that they are completing an application for membership in a DMP. Each enrollment form should also state the name and address of the DMPO and clearly identify the entity as the DMPO. A private label marketer may be identified as long as the licensed DMPO is also identified.

The Price Filing form should describe the packaging and pricing for each plan submitted in the filing. For example, there may be a Gold Plan, Silver Plan, and a Platinum Plan. The Price Filing form should identify which benefits are available under each plan, the monthly fee for these benefits, and the amount of any one-time processing fee, if applicable. If a fourth plan is offered as a combination of all three other plans, the charge for the fourth plan must be justified if it is over the amount identified in Rule 69O-203.204, F.A.C.

When preparing a new filing, be sure to review and revise the materials based on changes we have requested in any of your previous filings. For example, if you know we require the Disclosures, pursuant to Section 636.212, F.S., to be in a size 12-point font with a heading of Disclosures in bold, please make these changes on the new materials before submitting the new filing. This will save time and speed up the process.

If we ask you to make certain changes on a form, and the requested changes are made, but other language is also changed on the form, please bring this to our attention in your response letter. If you tell us about specific changes you have made in addition to those requested, it will speed up the process. If we note a change made that was not requested by us, and you didn't tell us about it, we have to closely review the entire form again. This slows down the process for you.

MEMBER AGREEMENT



This agreement is between the member and the DMPO - not between the member and the marketer. This agreement governs the plan. This document should be specifically titled "Member Agreement." Pursuant to Section 636.216(2), F.S. the Member Agreement must specify the services being provided in the plan. If the services descriptions are presented in an accompanying Member Guide or Handbook, this will be acceptable as long as the Member Agreement document itself contains language that incorporates the Member Guide or Handbook as a part of the Member Agreement. It is very important that the member knows exactly which documents form the Member Agreement. Rule 69O-203.202(1)(a) through (l), F.A.C. contains the specific elements that must be contained in the Member Agreement.

RULE 690-203, PART II of the F.A.C.

Element A – the plan must include the name and address of the DMPO. Some submissions have contained the name and address of the marketer or private label marketer only, but the DMPO name and address must also be included. In addition to including your name and address, you must have language that clearly identifies your entity as the “Discount Medical Plan Organization.”

Element B – include a telephone number for member assistance and Plan information. This may be the number of the DMPO or the number of the marketer, if you are allowing the marketer to administer the plan for you. This is a good place to remind you of Section 636.228, F.S. The DMPO is required to have an executed written agreement with its marketers. The DMPO is bound by the acts of its marketers, so it is very important that you are aware and mindful of activities your marketers are engaging in and the methods they are using to market and administer these plans on your behalf. As a reminder, you are responsible for reviewing and approving, in writing, all advertising or marketing materials distributed to prospective members by your marketers. We suggest that you keep a record of your written approvals and agreements.

Element C – include the name of the group, if applicable, and the name of the member. If the plan is sold to any type of group, such as an Employer or Association group, you must include their name in the Member Agreement. You must include the Member’s name in the Member Agreement.

Element D – effective date and term of contract
There must be a specific date on which a particular member’s plan becomes effective. This date must be stated in the Member Agreement. There must be a specific “term” of the contract, such as monthly, quarterly, semi-annually, or yearly.

Element E – states the Member Agreement must contain a space for the charges and any one-time processing fee that may be applicable.

Element F – the mode of payment the member has selected, whether monthly, quarterly, etc. must be stated in the Member Agreement. If the member is allowed to change their mode of payment after enrollment, you must also include a provision telling them how to do this. It can be as simple as a sentence stating, “To change your mode of payment, please call our customer service phone number.”

Element G – renewal, termination and cancellation conditions – You must explain how the plan will be renewed, how the plan may be terminated and how the member may cancel the plan. Some plans renew automatically when the payment is made, while other plan will send the member a renewal notice. Both ways are acceptable. It is the same for terminating the contract. Most plans simply state the plan will be terminated if the fee is not paid, but there could be other reasons. As far as cancellation conditions, most plans allow the member to call the 800 number to cancel or ask the member to submit a notice

in writing or via email while other plans require the return of the ID card. All of these methods are acceptable.

It is important that members know they may cancel their plan within the first 30 days after the effective date and receive a full refund of their paid member fees and **their** entire processing fee, less \$30, pursuant to Section 636.208(2), F.S. This statement is required in the Member Agreement.

Element H – a description of the benefits to be provided. The benefit descriptions are very important as they explain to the member exactly what discounted medical services benefits they have purchased and what range of discounts they can expect to receive from the contracted providers. The member should be informed of the lowest percentage they will receive and the highest percentage of a discount they will receive. For example; on Hearing services, the member may receive discounts of 5% to 50%, or 10% to 60%. By stating the range of discounts, any possible misconceptions about what the member expects may be avoided.

Element I – further requires the benefit descriptions to state any limitations, exclusions, and exceptions to what is discounted under the medical services benefits. For example, some vision plans only allow the member to purchase one pair of eyeglasses during a one-year period. Some plans do not discount all dental procedures. This is the type of information that should be included in this provision. Fee schedules which provide a detailed listing of services and the price to their members are acceptable.

Element J – the plan must have a provision for adding new family members. Many of the plans include all family members in the applicant’s immediate family or household. In this case, all you have to include is a sentence that states, “Call our customer service number to add additional family members.” Some plans are for Individual, Individual plus 1 and Individual plus 2. The fees vary based on the number of included family members. In this case, add more detailed information on how the member can add family members, including any additional fees that will be charged.

Element K – All plan forms must include a unique form number in the lower left hand corner. This is also required by Section 636.216(3), F.S. After a particular form has been approved, to make changes to that form, in addition to resubmitting the revised form to us for review and approval, keep the original form number but assign a revision date to that form. For example, if you have form 333 and then revise it, you should identify the form as 333 – 02/23/08 or 333 (02/23/08).

Element L – the plan must have a member complaint procedure. This specifically informs the member what procedure they must follow in order to file a complaint. Some plans require the member to call the 800 number while some require the complaint to be in writing. Some plans include a very detailed procedure with the specific information, certain timeframes for response and how the member will be notified of the outcome. When adding this procedure to the Member Agreement, be sure the procedure is the same as that outlined in your Application for Licensure package previously submitted.

Please be sure that the Member Agreement contains all of the required information. If the Member Agreement is composed of more than one document, such as the Handbook, be sure to include a prominent statement informing the member which documents constitute the entire agreement. This statement should be in the first paragraph of the Member Agreement. This is very important.

**REVISIONS TO CHAPTER 636, PART II, F.S.
Effective June 14, 2005**

Subsection 636.208(2), F.S. ensures that all DMPOs are reimbursing the member for periodic charges paid IF the member cancels the plan within the first 30 days. This also allows the DMPO to require the member to return the discount card in order to receive the reimbursement. Notice of this right should be included in the Member Agreement.

Subsection 636.208(3) – If the DMPO cancels a membership for any reason other than non-payment of fees by the member, the DMPO is now required to make a pro-rata reimbursement of all periodic charges to the member. The wording does not make any distinction or allowance for the term of the plan. It applies to all terms of renewal, whether the plan is renewed monthly, quarterly or annually.

Subsection 636.208(4), F.S. –The DMPO is now required to reimburse the member for any one-time processing fee that exceeds \$30 per year.

Subsection 636.210(1)(a), F.S. – This now allows the DMPO to use the word “insurance” as a disclaimer of any relationship between the DMPO benefits and insurance.

Subsection 636.210(1)(b), F.S. – This is a very important subsection. This prohibits the use of terms that could reasonably mislead a person into believing the DMP is health insurance. This was changed to include the verbiage “in a manner” that could reasonably mislead the prospective member. You can now use some of the terminology that is associated with health insurance - you just have to be very careful not to use them in a manner that could reasonably mislead a prospective member into believing the plan is health insurance.

Pursuant to Section 636.212, F.S., the Disclosures are required to be on the first page of all advertisements, marketing materials and brochures. Always be sure to state the Disclosures in a font size of 12-point, or more. It is important that Disclosures have a heading of “Disclosures” in a bold font.



Subsection 636.216(2), F.S., also requires the Disclosures be in the Member Agreement. These Disclosures should be included on the first page of the Member Agreement. Always be sure the Disclosures are in a font size of at least 12-point.

The fifth disclosure requires the name and address of the DMPO and language identifying your company as a Discount Medical Plan Organization. Please do not use the acronym of DMPO when identifying your company, as most prospective members will not be familiar with this term.

A new provision was added under the Disclosures statute. If the initial contract is completed by telephone, such as telemarketing, phone inquiries from TV, radio or newspaper advertisements, the DMPO is required to read the Disclosures to the member and provide the Disclosures in writing in the initial materials sent to the prospective or new member. Add these Disclosures to your telemarketing scripts as soon as possible. Telemarketing scripts used for contracting members should be filed for approval.

Section 636.216, F.S., requires that all forms used with the DMP be filed with and approved by our Office. Subsection (4) has been added to allow a 60-day timeframe for review of the forms. We hold ourselves to an initial 14-day review time, as we know how important it is to you to have your filings processed as quickly as possible.

Subsection 636.216(4), F.S., also added language that allows the Office to disapprove any form that is unreasonable, discriminatory, misleading or unfair. If the Office disapproves any of your filings, you will be notified by email and certified mail and given the specific reasons why it was disapproved.

REVISIONS TO RULE 690-203, PART II, F.A.C. Effective November 1, 2007

Rule 690-203.202(3)(a), F.A.C. requires all charges to members must be filed with the Office, and the Office must approve any periodic charge exceeding \$30 per month, or \$50 per month as provided by paragraph 690-203.204(1)(b), F.A.C. for the contract issued and not per member covered in the contract. Rule 690-203.204(1)(b), F.A.C. allows certain plans to charge \$50 per month, if the plan contains at least the following services: physician services (as licensed pursuant to Florida law), dental services, vision services, chiropractic services, and podiatric services, but does not include hospital services.

This rule revision places the burden of proof that periodic charges bear a reasonable relationship to the benefits received by the member on the DMPO. If the DMPO uses member savings as the basis of demonstrating the benefits received by the member, the benefit must be benefits and savings that care be reasonable anticipated by an average Floridian who may purchase a plan. Rule 690-203.202(3)(b) and (c), F.A.C. provides detailed information on meeting the standards of proof.

Rule 690-203.204(2), F.A.C. addresses free plans. The plan contracts and charges of a plan that is purchased from a DMPO and subsequently provided at no charge to individuals by an insurer, bank, credit union, or employer are exempt from Rule 690-203.202(1)(e) and (f), F.A.C. This allows the DMPO to remove the fields for the “space

for charges and one-time processing fee” and “mode of payment” from the Member Agreement.

BUNDLING WITH NON-MEDICAL SERVICES AND INSURANCE PRODUCTS

The provisions of Section 636.230, F.S., recognize that a DMP may be combined together with other products. Bundling is when another product is sold together with and marketed with a DMP. These other products are “non-medical services” and “insurance.” If the medical services and non-medical services, when bundled, are over \$30 per month, the DMPO must disclose the medical services charges to the member in writing.



The insurance product, however, is also a regulated product; therefore, additional information is required. All insurance products with which a DMP is bundled must first be filed with the Office in the appropriate manner before selling the product with a DMP. The Office holds the DMPO responsible for verifying the insurance product has been approved to be sold in Florida prior to submitting a bundled filing. The insurance carrier should be able to provide you with specific information needed by the Office to verify such filing. Your Cover Letter should contain a description of the insurance product, with all required information contained in Rule 690-203.205, F.A.C. When submitting a bundled product, the filing must include the following:

1. Name of the licensed insurance carrier (the carrier must be licensed to do business in Florida);
2. The specific policy form number providing the insurance coverage;
3. The Florida filing number under which the insurance product was approved or filed with the Office. This is the same type of number assigned to your filings and you can obtain this from the insurance carrier. Also required is a copy of the rate schedule from the carrier on the carrier’s paper or letterhead identifying the product and the rates for the coverage being bundled with the DMP;
4. Explain how the DMP member is applying for the insurance coverage, i.e., on the same application as the DMP, on a separate application, etc. If the insurance coverage is provided under a group policy – provide the identity of the group policyholder and the state in which the group policy was issued to the group policyholder.

Rule 690-203.205(3), F.A.C. provides that when the bundled product contains insurance or other products subject to regulation and approval by the Office, a DMPO may submit for approval a combined application. Each product that is involved in the sale of the bundled product, combined application, and the charges relating to each component of the bundled product must be filed in accordance with the laws and regulations applicable to each component.

SENIOR ISSUES

LONG-TERM CARE PARTNERSHIP IN FLORIDA

The development and implementation of the program.

Federal legislative changes initiated with the passing of the Deficit Reduction Act of 2005, which became law on February 8, 2006, tightened Medicaid eligibility by changing the look-back period for qualification from three years to five years, changed the treatment of financial assets, and altered the treatment of individuals with substantial home equity to further restrict Medicaid eligibility. This legislation also clarified Medicaid transfer rules.

In 2005, the Florida Legislature passed Senate Bill 1208 to establish the foundation for development of the LTCPP. The bill directed the Agency for Health Care Administration (AHCA) to establish a LTCPP which would provide incentives for an individual to purchase coverage and establish standards and eligibility, in consultation with OIR. AHCA was also charged with, in consultation with OIR, providing and approving LTCPP information that would be distributed to individuals through insurance companies offering approved partnership policies. AHCA was further responsible for presenting a plan in the form of recommended legislation to the Legislature in the 2006 session.



House Bill 947 was unanimously passed in the Florida House of Representatives and in the Florida Senate and directed the Agency for Health Care Administration (AHCA) to amend the Medicaid state plan that established the Florida Long-Term Care Partnership Program for the purposes of compliance with the provision so the Social Security Act.

In addition to providing program requirements, the bill also provided that for purposes of determining Medicaid eligibility, assets in an amount equal to the insurance benefit payments made to, or on behalf of, an individual who is a beneficiary under a qualified state LTCPP in Florida shall be disregarded. Total countable assets for determining Medicaid long-term care eligibility are reduced by \$1 for each \$1 in paid out insurance benefits. Determining eligibility for Medicaid benefits is complex and determined separately from the LTCP policy. The asset disregard is exempted from the lien placed on the beneficiary's estate.

As implemented, the Partnership will:

- Provide incentives for persons to obtain long-term care insurance
- Review and approve, in consultation with the Office of Insurance Regulation (OIR), long-term care insurance policies for inclusion within the program
- Provide a mechanism to qualify for Medicaid long-term care coverage without being required to spend down personal resources, using a dollar for dollar model

- Provide counseling on planning for long-term care needs
- Encourage the use of private initiatives to alleviate the financial burden on the state's medical assistance programs.

To clarify and define insurer responsibility under the provisions found in House Bill 947, the OIR adopted amendments to Chapter 690-157, F.A.C. Effective August 1, 2007, the following applies to new and existing Long-Term Care insurance policies under the LTCPP: All of the following provisions apply to LTCP policies.

HB947 provides a limit on the amount of premium increase that may be applied to closed blocks of Long Term Care policies. The rate on those policies cannot exceed the rate a company charges for its open block of similar policies. If the company is not currently selling any similar plans, the rate is capped at the average new business rate for similar plans currently available for sale in Florida. Insurer's are required to pool the claims experience of all affiliated carriers when calculating rates rather than only the policy forms providing similar benefits of the insured. The bill also amended several laws governing long term care insurance as follows:



- A long term care policy is incontestable after being in force for 2 years, except in instances of non-payment of premium; seniors know their insurer did a thorough job of reviewing their application and they will be protected from post-claim underwriting or any frivolous allegations of fraud when they apply for benefits.
- Prohibits an insurer from imposing a new waiting period when a policy is replaced through an affiliated insurer;
- Eliminates the current minimum nursing home benefit of 24 months of coverage; This allows a person of modest means or of middle income the ability to afford a policy which offers a shorter benefit period. A person may purchase the amount of coverage they can afford.
- Requires that any long-term care insurance policy or certificate issued or renewed, at the policyholder's option, shall make available to the insured the contingent benefit upon lapse as approved in the LTC Insurance Model Regulation adopted by the NAIC;

August 2007, OIR implemented Part III of the LTC rule requires an insurer to offer policyholders or certificate holders (hereafter "policyholders") the option of exchanging an existing Long-Term Care contract for a new qualified partnership contract, if the existing policy was issued after March 1, 2003. The policyholder does not have to accept the offer.

For those policyholders with policies issued prior to March 1, 2003, the insurer will issue a new partnership contract if the policyholder makes such a request; however, the insurer is not required to notify them of the exchange option. If the policyholder exchanges a product for the same product, there is no underwriting, however, if the policyholder exchanges a policy and increases or add benefits, they will be charged for the additional

benefits and underwritten. This should allow persons who previously purchased a qualified LTC policy to exchange their contract for one with the benefits of owning a LTCP policy.



An insurer must provide necessary and sufficient training for its producers in understanding Long-Term Care and Long-Term Care Partnership policies prior to any solicitations, sales or negotiations, and maintain records of such training. Appointing insurers bear the responsibility of confirming that this training requirement has been met by their agents. All health insurers are required to make certain their appointed agents have acquired the training necessary and sufficient to fully understand the provisions of these partnership policies.

In order to solicit and sell LTC or LTCP insurance in Florida, agents must initially complete eight hours of training. Two of the eight hours should be Florida specific training on FL long term care law, partnership and Medicaid. During the next 24-month period 4 additional hours are required.

Florida is not opting out and is committed to reciprocity and has agreed to apply asset disregard provisions on a dollar for dollar basis for all Medicaid applicants who purchased qualified partnership policies outside of Florida. Reciprocity standards only apply to asset disregard and estate recovery provisions.

Establishes standards for Inflation protection and defines Inflation coverage limitations; the opportunity for the insured to increase benefit levels every year until the insured reached attained age 76. The partnership policy is issued with and retains inflation coverage which meets inflation standards based on the insured's then attained age.

The issued policy shall meet the following inflation coverage criteria:

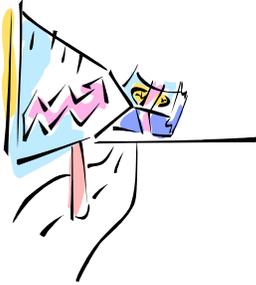
Must be bought when the policy is issued and retained;

No set levels are required;

No guaranteed future purchase options;

- (a) Individual who has not yet attained age 61 shall buy annual compound inflation coverage;
- (b) Individual who has attained age 61 but has not attained age 76 shall buy annual inflation coverage;
- (c) for policies issued with inflation coverage, the policyholders must have the inflation coverage at a level based upon the insured's current age. Florida law is silent on over age 76. This refers to Florida requiring

compound inflation up to attained age 60, any type of inflation coverage between 61 and 75, and no requirement for inflation at 76 or higher.



If a consumer buys a policy before age 60, with a compound annual inflation, some states require the insured to maintain the same level of protection, however, Florida allows the consumer to change inflation coverage from compound to simple. Some policy filings show this will happen automatically. At 76, the consumer may choose not to have inflation coverage altogether, however, some states require the consumer keep the inflation coverage. Compound inflation would be more expensive.

Partnership Status Disclosure Notice - Florida developed and adopted by reference Form OIR-B2-1786 (1/2007) for the selling company's convenience. The company does not have to use this form, but if they modify the verbiage, the disclosure notice must be filed for approval with the Office. The disclosure form explains asset disregard, Partnership policy status and what would disqualify the policy as a Partnership policy and the state agency to contact with questions.

Long-Term Care Partnership Program Policy Summary - Establishes requirement that insurers provide to any insured requesting such information a copy of Form OIR-B2-1781 (12/06).

Florida does not require a state certification from companies offering LTCP policies.



NEW LEGISLATION

You should be aware of any new legislation that might affect your forms. The Office sends out a memorandum each year after the legislative session advising of any new laws or changes in the laws that have an affect on form filings.

In 2006 there were changes in the statutes that affect forms.

Chapter 627.9407(3), F.S. – “Restrictions-A Long Term Care insurance policy may not”

This statute was amended to remove the restriction of providing coverage for less than 24 consecutive months for nursing home care for each covered person.

Policies no longer need to provide coverage for a minimum of 24 consecutive months of nursing home care.

Chapter 627.94075, F.S. – “A qualified state Long-Term Care Insurance Partnership Program in Florida”

This statute provides rulemaking authority to the Office regarding determination of eligibility for certain services to implement applicable provisions of a qualified state Long-Term Care Insurance Partnership Program in Florida.

Chapter 627.94076, F.S. – “Time limit on certain defenses”

This statute was amended to require a two-year incontestability period.

All policies must have a two-year contestable period. Any challenges the insurer has to the policy must be raised during the first two years. After two years, the only reason the policy can be cancelled by the insurer is for non-payment of premium.



In 2007 there were changes in the Florida Administrative Code for the Long-Term Care Insurance Partnership Program.

Rule 69O-157.1100, F.A.C. – Requirements for Exchange of Coverage.

An insurer may offer policyholders the option of exchanging an existing Long-Term Care contract for a new Long-Term care contract.

Rule 69O-157.1155, F.A.C. – Producer Training.

An insurer must maintain records provide necessary and sufficient training for its producers in understanding Long-Term Care Partnership policies prior to any solicitations, sales or negotiations, and maintain records of such training.



Part III Long-Term Care Insurance Partnership Plans

This establishes standards for approved Long-Term Care Partnership Program policies and certificates with an effective date of on or after January 1, 2007.

- Requires that Partnership policy forms and rates be filed and approved;
- Requires that the policy be a qualified long-term care insurance policy under the provisions of Section 627.9404(12), F.S.;
- Establishes eligibility for reciprocal agreements for policies purchased outside of Florida;
- Establishes standards for inflation protection;
- Requires insurers to provide a partnership disclosure notice. The insurer may use Form OIR-B2-1786 (1/2007). Important Information Regarding Your Policy's Long-Term care Insurance Partnership Status;
- Requires insurers to notify policyholders, in writing, when an action will result in the loss of Partnership status, how this action will impact their policy and advise how to retain Partnership status, if possible;
- Requires that any insurer issuing or marketing policies that qualify as Partnership policies notify all of its policyholders with existing Long-Term Care coverage issued on or after March 1, 2003, of the benefits associated with a Partnership policy and offer the optional exchange, along with required disclosures;
- Defines inflation coverage limitations;
- Establishes insurer reporting requirements to the Health and Human Services Secretary;
- Establishes requirement that insurers provide to any insured requesting such information a copy of Form OIR-B2-1781 (12/06), Approved Long-Term Care Partnership Program Policy Summary.



ACCELERATED DEATH BENEFITS WITH LTC-TYPE COVERAGE

A life insurance rider that accelerates benefits for long term care must be filed as a LTC rider with an Outline of Coverage, application, and any other applicable appendices



This must be a separate filing from the filing made with the Life Section and the filing must comply with Chapter 627, Part Eighteen, in the Florida Statutes and Rule 690-157, Part II, in the Florida Administrative Code, applicable to long term care policies.

AVOIDING COMMON PITFALLS IN HEALTH FORMS

The health insurance industry in Florida is constantly changing and, as a result, there are more issues that need to be addressed. This section will help you to anticipate some of the issues we face in reviewing your forms filings and to make the appropriate revisions to your forms before you submit them to the Office. IUN this way, you are assured that your forms are in compliance with our statutes and rules and that the review period will be as brief as possible.

Since our last symposium in 2006, we have received an increase in hospital indemnity policies and major medical type policies with inside caps and yearly caps, sometimes called Mini Meds or limited benefit plans. In most cases this type policy falls under the basic hospital, medical, surgical expense policy as outlined in Rule 690-154.106(1),(2)and(3),F.A.C. which can be found on pages 88-92 of this booklet.

From the information we are receiving, the increase in these types of filings is being made in an effort to provide some coverage for the under insured and uninsured market.

For some background, Florida adopted Rule 690-154 in 1974; the Rule provides for 11 Categories of coverage. The Rule also provides minimum standards for these coverages.



Limited Benefit Policies

Rule 690-154.106(8), F.A.C., defines “limited benefit policy” as a policy which provides coverage for each person insured under the policy for a specifically named disease, specifically named accident, or specifically named limited market fulfilling an experimental or reasonable need.

One of the main problems we are seeing with these policies is that some companies are inaccurately naming these policies. On the face page of the policy, the policy is titled “Limited Benefit”. These policies do not qualify as Limited Benefit Policies; they are policies that have limited benefits. Therefore, when a company files a policy containing limited benefits, the company should use the correct title, such as “Medical/Surgical Expense Policy”. Additionally, the face page of the policy should contain the following statement: This policy has “Limited Benefits.”

Mandated Benefits

Another problem that has surfaced is some confusion in some companies regarding which mandated benefits are to be included in these filings. If the filing is an indemnity type

policy, there are 11 mandates that do not apply. These 11 mandates are: Diabetes, Newborn coverage, Child health supervision services, Mastectomy, length of stay and out patient post surgical care, Mammograms, Ambulatory surgical center, conversion, Osteoporosis, and Cleft Lip and Cleft Palate. The 11 mandates and the corresponding statutes can be found on page 107 of this booklet.

Cancer Policies



Cancer policies, true limited benefit policies also have some issues that need to be addressed. When a cancer policy provides Chemotherapy, the policy **MUST** provide all secondary benefits that accompany the chemo drug, such as administration of the drug; anti-nausea drugs; and use of the facility where the chemo drug is administered. If secondary benefits do not accompany coverage, the policy must state that it covers the chemo drug only. The same applies to radiation therapy and immunotherapy.

You should also be careful that your sales brochures not use phrases and terms that may mislead the consumer to think the policy may pay for expenses that are not covered.

Newborn Coverage

One problem area that applies to most health policies is Newborn Coverage. Florida statute allows up to 60 days for the insured to notify the company of the birth of a newborn. We continue to find in the newborn provision, however, that companies require notification of a birth within 30 days. Such a requirement does not comply with Florida statute; thus, the company must amend the policy to bring it into compliance.

Another problem deals with a company requiring premium from the date of birth. Florida's newborn statute states that if notification of birth is given within the first 30 days, there will be no premium due. Obviously, requiring premium from the date of birth does not apply if notification was given within the first 30 days. However, if notification is given after 30 days and before 60 days, premium can be charged from the date of birth.

Legal Action

Section 627.616, F. S., states that legal action may be brought until the expiration of the applicable statute of limitation. Although it is not defined here, Florida law defines the statute of limitation to be 5 years. The most common mistake we find in this provision is that companies use a three year limitation for bringing a legal action. This is not acceptable. The wording "applicable statute of limitation" is the correct wording. However, we will accept "five years," in place of "applicable statute of limitations"



Definition of Disability

Section 627.4233, F. S., defines total disability during the first twelve months as follows: “a person is unable to perform the material and substantial duties of the person’s regular occupation.” Often, the company’s definition is not in compliance with this statute. The mistake made most often is that companies inappropriately restrict this definition - requiring the individual to be unable to work in any occupation. Again, the Florida statute here applies to the inability of the insured to perform the material and substantial duties of his or her regular occupation – not any and all occupations. Obviously, these kinds of interpretations of the statute cause delays in the approval process.

Survivorship Benefits



Florida Statute Section 627.603 allows for a death benefit of a maximum of \$1,000.00 in a health policy. The Department views a survivor benefit as a death benefit. In most cases, the amount of the survivor benefit to be awarded is based on the total monthly premium for the policy, ranging from 3 to 6 months. Our problem occurs when the benefit exceeds \$1,000. In order to alleviate this problem; the survivor benefit could be worded so that it is equal to a sum of the monthly premiums, not to exceed \$1,000. A copy of the statute can be found on page 70 of this booklet.

Florida Fraud Warning

The fraud statement used with applications has to be the exact state found in Section 817.234(1)(b). The Office will not accept any other version. For your future reference a copy of the fraud statement and statute can be found on pages 77-78.

Out-of-State Group Health Policies

We are continuing to find that the certification required by Section 627.6515, F. S., for Out-of-State health forms missing from the filing of these forms or that some of the forms that are in the filing are not listed on the certification. We are also finding that companies are certifying the forms have been approved in the situs state and have only been filed in that state. Our out of state statute is very clear in that it states the policy has to be approved in the state where it is issued.

One other issue with out of state filings is that third party administrators are used and their name and address is shown on the certificate. We have found in a lot of cases these third party administrators are not licensed to do business in Florida. This causes the company to contract with another third party and re-file the forms.

Other Important Filings

Assumption Filings

In making an assumption filing the Office requires that along with the assumption certificate that you file a copy of the assumption agreement and copies of the domiciliary states' approval.



Name Change Filings

Once you file your name change endorsement and get approval and get your new certificate of authority, you will need to re-file all of your forms with the new company name or you may sign a consent order with the Office stating that the only thing that has change on your forms is the company. By using the consent order method you will not have to re-file the forms. On page 106, you will see a copy of the letter that advises you about the consent order approach.

Merger Filings

In making a merger filing, you will have to file the merger endorsement along with the domiciliary states' approval. Once your merger is approved by the Office you will need to file the non surviving company's forms in the surviving company's name, if you are going to use any of the non-surviving company's forms. The consent order approach as used in the assumption filing cannot be used here.



OFFICE OF INSURANCE REGULATION

APPENDIX