THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: William Buckhalt, Executive Director, Board of Osteopathic Medicine/MQA, 2020 Capital Circle, S. E., Bin #C06, Tallahassee, Florida 32399-3256

THE FULL TEXT OF THE PROPOSED RULE IS:

64B15-12.003 Applications for Licensure.

(1) Applications for licensure by examination must include a completed application form and appropriate fee as set forth in Section 459.0055, Florida Statutes, and Rule 59W-10.001(1), Florida Administrative Code. The instructions and application form, DH-MQA 1029, 1/00, effective _____, entitled "Examination & Initial Licensure Application: (Section II: Application Form) ~~DPR/OST/003, effective 6-4-91, entitled "Application for Osteopathic Licensure"~~ are hereby incorporated by reference, and may be obtained from the Board office. Such application and fee shall expire one year from the date on which the application is initially received by the Board. After a period of one year a new application and fee must be submitted.

(2) No change.

(3) Applications for licensure by endorsement must include a completed application form and appropriate fee as set forth in Section 459.0055, Florida Statutes, and Rule 64B15-10.002(1), Florida Administrative Code. The application form, shall be the same form as referenced in subsection (1) above. ~~DPR/OST/003, effective 6-4-91, entitled "Application for Osteopathic Licensure" is hereby incorporated by reference, and may be obtained from the Board office.~~ Such application and fee shall expire one year from the date on which the application is initially received by the Board. After a period of one year, a new application and fee must be submitted.

Specific Authority 459.005 FS. Law Implemented 459.0055, 459.006, 459.007 FS. History–New 6-4-91, Formerly 21R-12.003, 61F9-12.003, Amended 10-15-95, Formerly 59W-12.003, Amended_____.

NAME OF PERSON ORIGINATING PROPOSED RULE: Board of Osteopathic Medicine

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Board of Osteopathic Medicine

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: June 4, 1999

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: February 18, 2000

Section III
Notices of Changes, Corrections and Withdrawals

DEPARTMENT OF INSURANCE

RULE NOS.: RULE TITLES:

PART V – FILING OF RATES FOR HEALTH INSURANCE

4-149.101	Purpose
4-149.102	Scope and Applicability
4-149.103	Definitions
4-149.104	Rate Filing Procedures
4-149.105	Health Rate Filing Standards
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PART VI – FILING OF FORMS

4-149.120	Purpose and Scope
4-149.121	Form Filing Procedures
4-149.122	Review
4-149.123	Prohibited Policies

THIRD NOTICE OF CHANGE

Notice is hereby given that the following changes have been made to the proposed rule in accordance with subparagraph 120.54(3)(d)1., Florida Statutes, published in Volume 23, No. 45, November 7, 1997 and Vol. 24, No. 46, November 13, 1998, of the Florida Administrative Weekly: Notices of change were published in Vol. 24, No. 20, May 15, 1998 and Vol. 24, No. 31, July 31, 1998.

Rules 4-149.101 through 4-149.123 are changed to read as follows:

RULE CHAPTER 4-149
FILING OF FORMS AND RATES FOR LIFE AND HEALTH INSURANCE

Part V Filing of Rates for Health Insurance

4-149.101 Purpose.

(1) The purpose of Part V of this rule chapter is to establish procedures for the filing of premium schedules for health insurance contract forms, as required by section 627.410, Florida Statutes. This Part provides the standards to be used in approving or disapproving health insurance premium schedules and rates pursuant to section 627.411, Florida Statutes.

(2) Rule 4-149.111 establishes the procedures for annual rate certification filing, pursuant to section 627.410(7), Florida Statutes.

(3) Rule 4-149.112 establishes procedures for the filing of premium schedules for health insurance contract forms with a loss ratio guarantee pursuant to section 627.410(8), Florida Statutes.

(4) Underpricing health insurance products ultimately results in rate increases to insureds. Underpricing provides a misleading attraction by selling coverage at low rates that are inevitably increased because they are not sustainable by the company. Section 627.411(1)(e), Florida Statutes, prohibits rating practices that result in premium escalations that are not viable for the policyholder market. Underpricing is a rating practice that results in rate increases that are not viable for the policyholder market and unfair and deceptive methods of competition. The purpose of Part V is to prevent this conduct, to the extent possible, and to provide protection to insureds when this conduct may occur.

(5) When a company no longer makes a contract form available for sale, the experience under the form may deteriorate at a faster rate than if the form were still available for sale. This results in an aging group of insureds, in that there are no new lives entering the plan, which have higher claim costs than younger lives. If rate increases occur and healthy lives terminate coverage at a rate greater than expected in the pricing of the form, an accelerated need for additional larger rate increases will occur. This is generally referred to as a death spiral. Death spirals result in rate increases that are not viable to the policyholder market. The purpose of Part V is to prevent death spirals, to the degree possible, and to provide protection to insureds when this situation may occur.

Specific Authority 624.308, 627.410 FS. Law Implemented 624.307(1), 627.410, 627.411 FS. History–New _____.

4-149.102 Scope and Applicability.

(1) Any premium schedule and change in premium schedule to be used with any health insurance contract form must be filed with the Department for approval. All filings shall be in accordance with the provisions of this Part for:

(a) Individual health insurance contract forms issued to Florida residents, including contract forms filed pursuant to a loss ratio guarantee permitted by section 627.410(8), Florida Statutes;

(b) Group health insurance contract forms where the master contract is issued in the State of Florida;

(c) Franchise health insurance contract forms issued to Florida residents;

(d) Certificates insuring residents of Florida where the group contract is issued outside the State of Florida and the insurance is provided:

1. For Medicare supplement coverage; or

2. For long term care coverage to the extent permitted by section 627.9406, Florida Statutes; and,

(e) Group contract forms subject to section 627.6515(2)(a), Florida Statute, issued outside the State of Florida where the group is formed primarily for the purposes of providing insurance must provide benefits that are reasonable in relation to the premiums charged. The standards of rules 4-149.107 and 4-149.108 shall be met to satisfy the provisions of section 627.6515(2)(a), Florida Statutes.

(2) For purposes of this Part, health insurance shall include any coverage as defined in section 624.603, Florida Statutes, including coverage issued supplementary to life insurance policies.

(3) This Part shall not apply to:

(a) Credit disability insurance as defined in section 627.677, Florida Statutes;

(b) Contract forms that are defined by section 627.601(3), Florida Statutes;

(c) Forms which provide for the acceleration of death benefits of a life insurance policy if:

1. The acceleration of benefits is incidental to the life insurance coverage purchased;

2. The cost of the acceleration benefit is less than 10% of the cost of the life insurance coverage; and

3. The cost of the acceleration benefit may not be increased without the prior written approval of the Department pursuant to section 627.410, Florida Statutes, and this rule chapter.

(d) Coverage issued by any Health Maintenance Organization (HMO) not subject to the provisions of section 627.6699, Florida Statutes;

(e) Coverage issued through Group A products. These products shall remain subject to the rules in effect immediately prior to this rule chapter revision.

Specific Authority 624.308, 627.410 FS. Law Implemented 624.307(1), 627.410, 627.411, 627.6515(1)(a), 627.6699(6)(d) FS. History–New _____.

4-149.103 Definitions.

For purposes of this Part, the following terms shall be defined as follows:

(1) Actuary or Qualified Actuary – A member of the American Academy of Actuaries or the Society of Actuaries.

(2) Actual or Incurred Loss Ratio – The ratio of the incurred claims to earned premiums.

(3) Adequately Justified – The supporting documentation, used and relied upon by the company and provided to the Department, that substantiates the assumptions used, determined by using generally accepted actuarial principles and complying with actuarial standards of practice.

(4) Anticipated Loss Ratio – The present value of future incurred claims divided by the present value of future earned premiums computed over the entire lifetime of the contract form.

(5) Annual Rate Certification (ARC) – A certification made by an actuary, in compliance with section 627.410(7)(b)2., Florida Statutes, that certifies that the current premium schedule is in compliance with the standards of this rule chapter.

(6) ARC Filing – An ARC or an annual rate filing made pursuant to section 627.410(7), Florida Statutes and rule 4-149.111, including all information required therein or by Actuarial Standards of Practice. This includes filings made with a certification with a rate change and a certification made where no rate change is proposed.

(7) Attained Age Premium Schedule – A premium schedule whereby the individual policyholder's premium is dependent upon his or her age at contract renewal, or next premium due date subsequent to the insureds birthday. The aging component of the claim cost is not pre-funded. The premium schedule increases by age reflecting the increased claim cost at the higher age.

(8) Common Morbidity – A set of values for the frequency and intensity of claims from which claim costs for a set of benefits may be calculated.

(9) CPI-U, Year N-1 – The consumer price index for all urban consumers, for all items and for all regions of the U.S. combined, as determined by the U.S. Department of Labor, Bureau of Statistics as of September of each year. Year N-1 is the calendar year immediately preceding the calendar year (N) in which the ARC filing is submitted in Florida.

(10) Cumulative Expected Claims – The expected claims for each year from the original effective date of the contract form, accumulated with interest, to the date of the evaluation.

(11) Defined Network of Providers – A provider network under contract with the company under which oversight and control of utilization are provided and where the use of the network by insureds is encouraged.

(12) Durational Loss Ratio – The ratio of incurred claims divided by earned premiums by policy duration. For the original filing of a new form, this is represented by column "e" of the projection table in rule 4-149.110(3)(r)5.

(13)(a) Earned Premium – The portion of the total premium paid by the insured attributable to the period of coverage elapsed. This includes all modal loading, fees, or charges which are part of the premium paid by the insured included in the premium charged by the company for the insurance coverage.

(b) For future periods in a projection, the earned premium is the projected premium based on the actuary's best estimate of future experience.

(14)(a) Entire Lifetime – The maximum period over which the contract form would be in effect if not terminated by action of the company or the insured.

(b) The period is, at minimum, the number of years until fewer than 5% of the original policyholders remain inforce. This period is determined using the anticipated termination rates, attributed to lapse and mortality decrements, for the form. Forms which have had rate filings prior to April 19, 1994, with a projection period shorter than the entire lifetime of the policy shall, for the purposes of computing loss ratios, continue to use the same number of years in the projection period for future rate revisions. This projection period length may be increased by five years at a time for each approved rate filing after the effective date of this rule until the entire lifetime is achieved.

(15)(a) Expected Claims – The actual earned premium times the appropriate policy durational loss ratio by pricing cell or category, not including active life reserves. Aggregate original pricing durational loss ratios may be used if they produce similar results.

(b) For a pooled group of forms, the expected claims are the sum of the expected claims by form. A company, at its option, may use a restated aggregate durational loss ratio table determined from the pooled group of forms if it produces similar results.

(16) Expected Loss Ratio – The ratio of the expected claims to earned premiums.

(17) Expenses – The administration and acquisition costs, costs of adjusting and settling an incurred claim, overhead and risk and contingency margin of the company exclusive of incurred claims and profit margin.

(18) Form, Policy Form or Contract Form – All health insurance contracts whether referred to as a policy, contract, rider, endorsement or other term, and corresponding premium schedule. Where forms are pooled the term shall refer to the pooled group of forms.

(19) Group Size –

(a) For group insurance contract forms insuring employer/employee relationships, the average number of certificates per employer.

(b) For other types of groups, the average number of certificates per master contract.

(c) The number of certificates is determined at the beginning of the rating period for existing forms and the average number expected for new forms.

(20)(a) Incurred Claims – Claims occurring within a fixed period, whether or not paid during the same period, under the terms of the contract form. Claims include payments for scheduled benefit payments, reimbursement benefit payments, or services provided by a provider or through a provider network for medical, dental, vision, disability and similar benefits. Where a company has contractual arrangements with providers to provide health care services, the incurred claims are the amounts paid under the terms of the provider contract for the healthcare services provided.

(b) Claims do not include active life reserves or any expense incurred by the company for the cost of adjusting and settling a claim, including the, review, qualification, oversight, management or monitoring of a claim or incentives or compensation to providers for other than the providing of health care services.

(c) For future periods in a projection, the incurred claims shall be based on the actuary's best estimate of future experience.

(21) Insurance Trend – The combined effect of underwriting wearoff, anti-selection resulting from rate increases, discontinuance of new sales, and the increase in expected claim cost due to the aging of the inforce population.

(22) Insurer Conduct – The following actions or inactions of the company with respect to a policy form which have resulted in inadequate rates and the need for large rate increases:

(a) Failure to file an ARC or failure to make a filing in compliance with section 627.6745(2), Florida Statutes, meeting the standards of Florida laws and rule chapters 4-149 and 4-156, after January 1, 1999. The Department will not look prior to January 1, 1998 in determining such violation for purposes of this definition.

(b) Failure to correct a rate filing when the Department presents information to the company that suggests that rates are inadequate and the company does not adequately resolve the Department concerns;

(c) Violation of applicable actuarial standards of practice at the time of a filing;

(d) Failure to implement the underwriting standards assumed in the pricing assumptions of the form; or

(e) The use of pricing assumptions that has resulted in a demonstrated pattern of product underpricing.

(23) Issue Age Premium Schedule – A premium schedule whereby the individual insured's premium is determined based on the insured's age at the time of issue of the contract. The aging component of the claim cost is prefunded. The insured's premium is not changed due to advancing age.

(24) Lifetime Loss Ratio –

(a) This loss ratio is derived by dividing A by B where:

1. "A" is the sum of:

a. The incurred claims, accumulated with interest, from the original effective date of the contract form to the effective date of the evaluation, and

b. The present value of future incurred claims over the entire remaining lifetime of the contract form; and

2. "B" is the sum of:

a. The earned premiums, accumulated with interest, from the original effective date of the contract form to the effective date of the evaluation, and

b. The present value of future earned premiums over the entire remaining lifetime of the contract form.

(b) The lifetime loss ratio is equal to the anticipated loss ratio at the inception of the contract form.

(c) This is the portion of the total premium dollars paid by all insureds under a form that is paid out by the company in health benefits over the entire lifetime of the form. This is a measure of the amount of premium dollars paid to consumers in the form of benefits.

(25) Limited Pay Contracts – Limited pay contracts are contracts that provide for a premium payment period that is shorter than the benefit coverage period of the contract, such as a five-pay long term care insurance contract.

(26) Medical Expense Contract Forms – Contract forms that provide benefits for medical, surgical and hospital expenses incurred. These forms do not prefund medical trend but re-rate the policy for medical trend.

(27) Medical Indemnity Contract Forms – Contract forms that pay a predetermined, specified, fixed benefit for services provided. Claim costs under these forms are prefunded and are not re-rated for medical trend, although they may be subject to utilization changes.

(28) Medical Trend – For medical expense contract forms, and the portion of Group B products subject to medical trend, the trend attributed to the combined effect on medical costs of:

(a) Medical provider price increases;

(b) Utilization changes;

(c) Medical cost shifting;

(d) New medical procedures and technology; and

(e) Deductible leveraging.

(29) Modified Lifetime Loss Ratio –

(a) This loss ratio is derived by dividing A by B where:

1. "A" is the sum of:

a. The lesser of the actual incurred claims, accumulated with interest, and the cumulative expected claims from the original effective date of the contract form to the effective date of the evaluation, and

b. The present value of future incurred claims over the entire remaining lifetime of the contract form; and

2. "B" is the sum of:

a. The earned premiums, accumulated with interest, from the original effective date of the contract form to the effective date of the evaluation, and

b. The present value of future earned premiums over the entire remaining lifetime of the contract form.

(b) The difference between this definition and lifetime loss ratio is found in the first term. Modified lifetime loss ratio uses the lesser of the actual and expected claims for the past period where the lifetime loss ratio uses the actual claims.

(30) Policy/certificate Anniversary – The date when coverage was initially effective, as indicated by the policy or other evidence of coverage for a group, and every subsequent year thereafter on the same date.

(31) Premium Schedule – The collection of rates to be charged for a form, including base rates, any modifying factors (this includes any experience rating method, formula and standards to be used) or fees, and any change to the premium schedule being charged. Premium increases to affected insureds as used in this rule shall be due to a change to the

premium schedule and do not include changes due to age, geographic area, family composition or experience resulting from the application of the schedule that has not changed.

(32) Product Group:

Group A – These are products that are funded on a one-year basis to satisfy loss ratio requirements. These products are expected to be repriced annually based on trend and demographic change assumptions. Effects of underwriting, if any, are part of the composite assumptions and claims experience is not durational. These include annually rated group products.

Group B – These are products that are funded over the entire lifetime of the form to satisfy loss ratio requirements. These products are expected to have no changes to the premium schedule (except that where a portion, less than 30%, of the coverage is subject to medical trend, some periodic premium schedule increases may be expected). The rates are based on the insured's demographics and on the underwriting status of the insureds at issue. Effects of underwriting and other aspects of insurance trend are recognized in the pattern of expected loss ratios by duration. These include long term care, home health care, and medical indemnity contract forms.

Group C – These are products that are funded over the entire lifetime of the form to satisfy loss ratio requirements. These products are expected to be repriced annually to reflect medical trend. The rates are based on the insured's demographics and on the underwriting status of the insured at issue. Effects of underwriting and other aspects of insurance trend are recognized in the pattern of expected loss ratios by duration. These include Medicare supplement and individual medical expense contract forms.

(33) Projection – A determination of future values based on a set of formulas, methods and assumptions. Except in the event of legislative changes, any changes to the set of formulas, methods or assumptions must be based on credible data, which shall include experience if credible as defined by this rule chapter. Future rate change assumptions in determining projected premium values, subsequent to a proposed increase in a current ARC filing, shall not exceed the medical trend assumption, if applicable, used in determining future claim costs.

(34) Renewal Clauses – The contract terms and conditions regarding the renewal conditions of a contract. Clauses include:

(a) Optionally Renewable – Renewal of the contract can be declined at the option of the company.

(b) Conditionally Renewable –

1. Renewal of the contract can be declined by the company by class, by geographic area, or for stated reasons other than deterioration of health.

2. The company may revise rates on a class basis.

(c) Guaranteed Renewable –

1. Renewal of a contract cannot be declined by the company for any reason other than fraud, misrepresentation as may be limited by any applicable statute, or failure to pay the premium when due.

2. The company may revise rates on a class basis.

(d) Non-Cancelable –

1. Renewal of the contract cannot be declined by the company for any reason other than fraud, misrepresentation as may be limited by any applicable statute, or failure to pay the premium when due.

2. Rates cannot be revised by the company.

(e) Non-Renewable – The contract must be for a specific duration, but shall not exceed one year.

(35)(a) Stop-Loss Coverage – A contract form sold to a self-insured employer with an ERISA qualified employee welfare benefit plan or a church plan, and where the contract form does not directly cover any underlying employee but rather the employer's obligation under the benefit Plan. The stop loss contract obligation may not pass directly to the employees.

(b) Stop-Loss Reinsurance – Reinsurance that pays incurred claims in excess of a specified amount on an insured individual. This is limited to protection for catastrophic claims.

(36) Trend – The change over time in claim costs per unit of exposure. This is comprised of both insurance and medical trend.

(37) Underwriting Status – The risk classification factors, excluding demographic, geographic and family composition factors, of an insured used to determine the applicable rate to be charged from the premium schedule.

(38) Underwriting Wearoff – The gradual increase from initial low expected claims that results from underwriting selection to higher expected claims for later durations.

Specific Authority 624.308, 627.410 FS. Law Implemented 624.307(1), 627.410, 627.411, 627.6699(6)(d) FS. History–New .

4-149.104 Rate Filing Procedures.

(1) A premium schedule shall be considered filed with the Department upon the Department's receipt of all material required by this rule. The date the Department receives the complete package of material becomes the starting date for the 30 or 45 day statutory period. A company may consider the filing to be deemed approved at the end of the statutory period if the Department has not approved or disapproved the filing before that date. The Department's approval of the filing shall rely upon the contents and accuracy of the company's actuarial memorandum and certification if the filing is not disapproved for failure to comply with this rule chapter.

(2) A complete health insurance rate filing shall include two copies of all of the following:

(a) A brief letter explaining the type and nature of the filing.

1. The letter shall indicate if the filing is for a new contract form, a revised premium schedule for an existing contract form, and whether it is a resubmission of a previously disapproved filing.

2. If the filing is a resubmission, the letter shall indicate when the previous filing was submitted, the Florida filing number, and the date of the disapproval or withdrawal.

(b)1. Completed Form DI4-561 (rev 7/91), Health Insurance Filing Requirements Summary, as adopted in rule 4-149.190;

2. Completed Form DI4-562A (rev 4/91), Standardized Data Letter/Florida Department of Insurance/Division of Insurer Services/Health Forms Filing, as adopted in rule 4-149.190; and

3. Form DI4-562B (rev 7/91), Standardized Data Letter/Florida Department of Insurance/Division of Insurer Services/Health Rates Filing, as adopted in rule 4-149.190, completed in accordance with the instructions contained in Form DI4-562 (rev 7/91), Standardized Data Letter/Health Insurance/Instruction Sheet, as adopted in rule 4-149.190.

(c) An actuarial memorandum, containing the specific information required by rule 4-149.110.

(d) Premium schedules that define all proposed rates, methodologies and rating factors for determining rates applicable in the state. For companies that have a complete rate manual on file with the Department, only the pages that are being changed need to be filed along with a detailed explanation of the changes on the rates, unless a complete manual is requested by the Department.

(3)(a) Filings shall be mailed to: Bureau of Life and Health Forms & Rates, Division of Insurer Services, Department of Insurance, Post Office Box 8040, Tallahassee, FL 32314-8040.

(b) Responses to letters requesting additional information sent to the Department by Federal Express or any other form of special delivery shall be delivered to: Department of Insurance, 1st Floor, Larson Building, 200 East Gaines Street, Tallahassee, FL 32399-0328. Responses may be faxed to the Department using the facsimile number indicated on the Department's letterhead. Faxed responses shall not exceed 10 pages.

(4)(a) The Department shall request additional information necessary to reach a determination on the filing. The information requested shall include data required by this rule chapter, clarification, explanation or justification of the content of a filing or omissions of information from the filing required by this rule chapter. The information requested shall be necessary to properly evaluate the calculations, methods or assumptions used by the company to adequately justify that the proposed rates, changes to the underlying rating manual and related forms are in compliance with the laws and regulations of Florida.

(b) Every company shall submit the required information by a date certain stated in the letter requesting additional information to allow the Department sufficient time to perform a proper review within the statutory time period. The Department shall attempt to provide at least 14-days for the company to respond to an initial letter requesting additional information.

(5) All incomplete or illegible filings will not be considered to be received and will be returned without processing.

Specific Authority 624.308, 627.410 FS. Law Implemented 624.307(1), 627.410, 627.411, 627.6699(6) FS. History–New .

4-149.105 Health Rate Filing Standards.

(1) Companies shall maintain records sufficient to provide the details of the information required by this Part, except as provided by rule 4-149.108(9)(a)5.(v)

(2) The required data shall be the most current data necessary to properly evaluate the rate request.

(3)(a) Limited pay contracts issued subsequent to six months following the effective date of this rule chapter must provide, that in the event of a rate increase by the company:

1. The contract shall provide for paid-up policy benefits in the event of policyholder termination within six months of the effective date of the rate increase to the insured.

2. The minimum required paid-up benefits shall be at least equal to the ratio of the number of years (and partial years) paid less one divided by the number of years in the premium paying period less one times the policy benefits at the time of policyholder termination.

(b) Notice shall be provided insureds at the time of a rate increase notifying them of their benefits under this provision of the contract if they terminate coverage.

(4) No portion of any rate increase shall be for the purpose of recapturing past incurred claims.

(5) A company may use external indicators, such as zip codes or counties, for determining the rate relationships contained in a premium schedule. When used, a company may not change the rate relationships or rate charged an insured upon a change of the external indicator, such as if zip codes are changed by the USPS, without first filing with the Department for approval. This does not include a rate change to an insured as a result of action or other change by the insured within the existing premium schedule in the absence of a change to the external indicator.

(6) Premium schedules shall be actuarially internally consistent recognizing any differences in anticipated claims costs, i.e., all other things being equal, a $1,000 deductible policy has a lower premium than a $250 deductible policy.

(7) Franchise Insurance shall be considered to be individual insurance under these Rules unless the franchise insurance is a health benefit plan under section 627.6699, Florida Statutes. In that event, the franchise insurance shall be considered to be group insurance.

(8) Medical trend for a future rating period shall be determined by any of the following:

(a) If the company has credible data based on rule 4-149.107, by considering the company's claims experience for at least the immediately preceding three years using generally accepted actuarial principles and complying with actuarial standards of practice;

(b) By an independent statistical publishing agency;

(c) By an independent actuarial consulting firm specializing in preparing trend projections;

(d) By a Department analysis of statewide experience for companies in the market; or

(e) For Medicare supplement contracts, using information published by the Health Care Financing Administration.

(9) Medical trend factors, to be applied to an approved premium schedule, are approved for a one year period only or until a subsequent rate filing, which is filed before the end of such period, is approved.

Specific Authority 624.308, 627.410 FS. Law Implemented 624.307(1), 627.410, 627.411, 627.6699(6) FS. History–New .

4-149.106 Pooling of Similar Health Contract Forms.

(1)(a) In order to provide for equitable risk sharing for all generations of policyholders, all individual contract forms providing for similar benefits shall be combined in a single rate filing.

(b) This includes contract forms being actively offered for sale and those which are no longer actively being offered for sale and contract forms originally issued by the company and those acquired from another company by assumption reinsurance or corporate consolidation.

(c)1. Except as provided in (e) below, contract forms shall be considered to have similar benefits if the benefit configuration under the contract form is of the same type, e.g., medical expense; hospital/surgical; disability; home health care; long term care.

2. Contract forms that provide benefits through a defined network of providers may be maintained in a separate rating pool from those without a defined network of providers. The company must demonstrate that the in-network incurred claims represent at least 70% of the contract form's total incurred claims during two of the last three years to maintain such separate rating pools. The company shall provide this demonstration at the time of the initial filing of a separate pool and upon request by the Department thereafter.

(d) Covered services, benefit triggers, benefit restriction and authorization procedures, negotiated provider arrangements, co-pay amounts, co-pay options, deductible sizes, daily limits, inside limits, and outside limits may vary by contract form and such forms shall still be required to be considered as having similar benefits.

(e)1. A company which proposes to maintain separate rating pools shall be required, when filing for a change to the premium schedule, to justify to the Department that the benefits of forms in the separate rating pools are not similar.

2. To justify that a form is not similar to other form(s) in a pool, the company must demonstrate that at least 60% of the benefits of the form are not similar to any other form in the pool. The demonstration is evaluated by using common morbidity assumptions of the existing pool, and must show that at least 60% of the benefits of the form are not included within the pool and cannot be reasonably determined from the claims cost experience of the pool. As an example, compare a new form providing only comprehensive mental health benefit to a pool of major medical forms that include only very limited mental health benefit as a component of the coverage. Compare the mental health benefits of the new form to the mental health benefits of the pool on a common morbidity basis. If more than 60% of the new benefits are attributed to coverage not included in the claim costs of the pool, the new form may be maintained in a separate rating pool.

3. A company requesting separate rating pools based on this subsection (e) shall file the demonstration of compliance with the Rule for review and approval at least 30 days prior to the rate filing. The 30-day review period in section 627.410(6), Florida Statute, does not apply to this demonstration.

(f) Once contract forms have been pooled, they remain so for all rating purposes, except as provided by rule 4-149.106(3)(c)3.

(2) Separate rating pools may be used for blanket insurance contract forms and group conversion contract forms.

(3)(a) When contract forms have been combined, a rate revision request shall not differentiate between the experience of the individual contract forms, so that there is a level percentage change to the premium schedules. Modifications from a level percentage change to the premium schedules within a pool shall be permitted if the company demonstrates that:

1. Its most popular actively marketed form during the prior year, would not be adequately rated based on applicable loss ratio standards due solely to the application of a level percentage change to the pool; or

2. The level percentage increase, together with increases in the prior two years, does not exceed a total of $15 per month; or

3. The use of common morbidity assumptions will materially misstate the frequency of claims because of differences in benefit triggers. For purposes of this demonstration, benefit trigger differences shall be due to:

a. Accident-only versus accident and sickness qualifications; or

b. Medically necessary versus ADL qualifications; or

c. Specified disease versus non-disease limited qualifications (e.g., major medical)

(b) Modifications from a level percentage change to the premium schedules within a pool shall be permitted to recognize differences in the following factors:

1. Industry/occupation factor;

2. Relative benefit differences based on common morbidity assumptions;

3. Medical expense savings attributed to specific provider contracts;

4. Geographic area factors.

5. A medical trend difference due to different policy features or benefits, such as if one form has pharmacy benefits and another does not.

(c)1. All Medicare supplement contract forms of the same type, as defined in 4-156.012(3)(c), shall be pooled.

2. A company may request a non-level percentage increase for Medicare supplement forms from that determined by a level percentage change within the pool. This shall be approved if the company can demonstrate that a refund would be required on one or more forms if the premium rates were increased at the level pool percentage rate. In providing this demonstration, the company may include the effect of no more than two years of additional experience, consistent with the projections contained in the ARC filing.

3. All forms that together have been required to pay a refund may be maintained in a separate rating pool.

(d) At the option of the company, a rate increase that produces a value that does not exceed $15 per month need not be applied. The company must demonstrate that such request will be applied in a consistent manner within the pool. Not implementing such increase will result in lost revenue. The company may reflect the impact of the lost revenue in one of two ways.

1. Reflect such lost revenue as earned premium in all future rate filings, or

2. Increase the loss ratio standards of the form pursuant to rule 4-149.108(9)(a).

(4) Limited pay contracts must maintain the experience in a separate rating pool for all rating purposes, except a company may request to use common morbidity assumptions with lifetime paying contracts. If common morbidity assumptions are used, they must be used for both rating pools.

(5) If a pool is comprised of forms with different loss ratio standards, the loss ratio standard for the pool shall be the weighted average, based on the present value of earned premiums (past and future), of the pool's component forms.

(6)(a) A paid-up contract shall be removed from the rating pool when it becomes paid-up.

(b) Upon removal from the pool, the company may establish, as a claim, the value of the reserve for the paid-up benefit. Such reserve shall be based on the most recent assumptions used in evaluating the premium paying pool. The claim established shall not exceed the total premiums paid for the paid-up contract, less any claims previously paid, since issue.

(7) Experience attributed to providing a benefit upon the death of the insured, except for coverage permitted by section 624.603 and 627.603, Florida Statute, shall not be included in the rating pool used to determine health benefit premiums or increases to a premium schedule.

Specific Authority 624.308, 627.410 FS. Law Implemented 624.307(1), 627.410, 627.411, 627.6699(6) FS. History–New .

4-149.107 Credibility of Incurred Health Claims Experience.

(1)(a) Claims experience that is not credible is insufficient to predict the future experience of a contract form. This occurs when the experience is too limited to be statistically reliable.

(b) Non-credible experience is subject to significant volatility and variability and is not necessarily predictive of future experience or future rate needs.

(c) In analyzing the contract's claims experience for the basis of determining projected incurred claims, only credible experience shall be used.

(d) Amounts paid by the company which are not incurred claims, such as punitive damages awarded, shall be removed from all experience analysis and not used in determining future rate increases. However, stop loss reinsurance costs shall be recognized in lieu of the claims reimbursed by the reinsurer.

(e) Experience is considered fully credible (100%) if it has 2,000 or more contracts inforce at the date of evaluation. If fewer than 500 contracts are inforce, the experience is considered to be non-credible (0%).

(f) Linear interpolation is used for inforce amounts between 500 and 2,000.

(g) In lieu of the 2,000 contract standard at the date of evaluation, the 2,000 contract standard may be met, at the option of the company, by 2,000 life-years over an exposure period of not to exceed the most recent three year period. In this event, all projections must be based upon the results over the entire exposure period as a single year and not using each year individually and with such experience being considered to be at the end-point of the exposure period. A contract’s contribution to life-years is determined from the beginning of the contract to it’s termination date, i.e., a contract inforce on January 1 that terminates on June 30 has .5 life-years.

(h) For group contracts, the numbers herein refer to the individual group certificates.

(i) If the Florida experience is comprised of fully credible data, only actual Florida experience shall be used.

(j) A blend of actual Florida and actual nationwide experience shall be used only if Florida-only experience is only partially credible. Where Florida experience has partial credibility, the actual nationwide experience used in the credibility weighting shall be net of actual Florida experience.

(k) If Florida experience is not fully credible and total nationwide experience is fully credible, the actual Florida experience will be combined with the actual nationwide experience weighted by the credibility factor of each. For example, if Florida experience has 875 contracts, the actual Florida loss ratios will be weighted by a factor of .25 ((875-500)/1,500) and the actual nationwide loss ratio by .75.

(l) If nationwide experience is not fully credible, the combined weights of the Florida and nationwide credibility factors will total the nationwide credibility factor that will be less than 1.0, *e.g.*, Florida experience has 875 contracts and nationwide has 1,625 contracts. The 500 initial number of policies, that are determined to be the non-credible threshold, shall be allocated equally to the Florida and nationwide experience, i.e., 250 each. The actual Florida loss ratio will be weighted by .42 ((875-250)/1500) and the actual nationwide loss ratio net of Florida experience by .33 ((1625-875-250)/1500). The total combined credibility will be the nationwide credibility factor of .75 ((1625-500)/1500). This is further combined with the expected loss ratio for the remaining .25.

(2) A company may request to use nationwide experience for a product where there are no geographical cost differences reflected in the premium schedule. The company may make this request in the original filing or the first filing after the effective date of this rule chapter. The company shall stipulate, in writing, that the Florida rates are not intended to vary from rates charged in other states, except for adjusting the premium schedule to meet compliance with the minimum loss ratio standards of this rule chapter. If the application of this provision to existing forms results in the need for a large rate increase, as defined by rule 4-149.108(15)(a) or (b), but without the determination of insurer conduct, the increase shall be phased in over a two-year period.

(3) For insurance that has a low expected frequency of claims, such as disability income insurance or long term care insurance, the 2,000-policy level above does not apply. 100% credibility shall be determined as 1,000 claims over the most recent five-year period. Fewer than 200 claims will be 0% credible, with the credibility percentage linearly determined between 200 and 1,000 claims. Partial credibility shall be determined consistent with rule 4-149.107(1).

(4)(a) A company may file for approval an alternative method of determining credibility if it determines that the above credibility standards are not appropriate. The company shall provide to the Department the reason and detailed justification why neither of the above standards will produce statistically credible predictive results. The company shall provide detailed statistical analysis to demonstrate that the proposed method produces results that have a statistically greater predictive value and reduced standard of error than the above standards. The company shall provide the results of the proposed method and the above standards including the predictive error of each.

(b) The method shall use actual Florida experience to the degree credible, then actual nationwide experience, and then other appropriate data.

(c) The alternate method shall use sound actuarial principles and comply with actuarial standards of practice.

(d) The request for approval for an alternate credibility standard and method shall be submitted for review and approval at least 30 days prior to a rate filing. The 30-day review period in section 627.410(6), Florida Statute, does not apply to this request.

Specific Authority 624.308, 627.410 FS. Law Implemented 624.307(1), 627.410, 627.411, 627.6699(6) FS. History–New _____.

4-149.108 Reasonableness of Health Benefits in Relation to Premiums.

(1) Sections 627.410 and 627.411, Florida Statutes, require contract benefits to be reasonable in relation to the premium charged. In order to satisfy this requirement, the premium schedule must satisfy the standards contained in this Rule.

(2)(a) The anticipated loss ratio developed in the initial filing using the original pricing actuarial memorandum will establish the initial lifetime standards for each contract form, coverage and benefit option.

(b) The initial lifetime loss ratio standard must equal or exceed the minimum loss ratio from the tables set forth in Rules 4-149.108(4) through (8).

(c) At initial filing, the modified lifetime loss ratio standard is equal to the initial lifetime loss ratio.

(d)1. The modified lifetime loss ratio shall be annually calculated and the modified lifetime loss ratio standard increased, if necessary, pursuant to rule 4-149.108(9)(a).

2. The modified lifetime loss ratio standard shall not be increased due to the provisions of rule 4-149.108(9)(a)3. or rule 4-149.108(9)(a)5.(iii) or (iv), to a level larger than the greater of 85% and the loss ratio that is fifteen percentage points over the initial filed lifetime loss ratio standard for the form. This does not prevent a company from filing a form with a higher loss ratio, in which case such higher loss ratio standard shall apply.

(3) For premium schedule revisions or certification of continued use of an existing premium schedule, the proposed premium schedule must satisfy the following criteria applied to inforce business:

(a) The anticipated loss ratio at the time of the filing must equal or exceed the modified lifetime loss ratio standard in rule 4-149.108(2)(d);

(b) The modified lifetime loss ratio calculated at the time of the filing must equal or exceed the modified lifetime loss ratio standard in rule 4-149.108(2)(d), except as provided for by rule 4-149.111(4)(b)5.

(c) Where the company is unable to produce necessary experience for a discontinued form to determine compliance with loss ratio standards, the company shall provide an explanation of the reasons why such experience is not available, and demonstrate that the inforce for such form is less than 10% of the pool. If the company provides such information, the form shall be removed from the pool and subject to a rate increase limited to the lesser of the pool's rate change and medical trend as determined by rule 4-149.105(8)(b), (c), (d) or (e).

(4) The minimum initial lifetime loss ratio for individual contracts and group certificate forms issued, delivered, or issued for delivery in this state prior to 6/1/94 that were approved by the Department prior to 2/1/94, shall be the loss ratio and loss ratio adjustment formula that was in effect at the time the form was approved. Such forms shall be subject to the filing requirements and standards of this rule chapter for ARC filings received after the effective date of this rule chapter.

(5) The minimum initial lifetime loss ratio for individual contract forms and group certificate forms not subject to subsection (4) above or forms that are continued available for sale after 6/1/94 must meet the standards set forth herein.

(a) Loss Ratio Table – Individual and Stop-Loss Contract Forms

Type of Renewal Clause	Group C Products Loss Ratio	Group B Products Loss Ratio
Non-Cancelable	55%	50%
Non-Renewable	60%	55%
Guaranteed Renewable	65%	60%
All other	70%	65%
Minimum Acceptable	55%	50%

(b) For new forms and rate revisions to existing forms with an average annual premium of $1,000 or less after the impact of an ARC filing, the minimum lifetime loss ratios in (a) above are adjusted in accordance with the formula:

R'=(A-25I)R/A

where: R = the loss ratio from the table;

A = the average annualized premium per individual insured;

I = (CPI-U, year N-1)/103.9

R' = the adjusted loss ratio;

Note: R' cannot be less than:

1. Ten percentage points less than R for forms with an average annual premium of $500 or less; or

2. Five percentage points less than R for forms with an average annual premium over $500 but not in excess of $1,000; and

3. The minimum acceptable lifetime loss ratio; except for accident only non-cancelable policies which shall not be less than 45%.

(6) For blanket insurance contract forms, as defined in section 627.659, Florida Statutes, the minimum lifetime loss ratio is 65%.

(7)(a) For group conversion contract forms issued on either a group or an individual basis, excluding long-term care and Medicare supplement contracts, the minimum lifetime loss ratio is 120%.

(b) The company may charge the excess experience of the group conversion loss ratio to the group experience.

(c) The premium schedule applicable to group conversion insurance subject to section 627.6675, Florida Statutes, shall not exceed the limits of section 627.6675(3)(a), Florida Statutes.

(8) Medicare supplement contract forms, and long-term care and limited benefit contract forms subject to section 627.9403, Florida Statutes, are not subject to the above minimum loss ratios in rule 4-149.108(4) or (5). With respect to such contract forms, the minimum initial lifetime loss ratios are found in rule chapters 4-156 and 4-157, respectively and subject to the filing requirements and standards of this rule chapter.

(9) Modified Lifetime Loss Ratio.

(a) Excluding non-cancelable contract forms, the modified lifetime loss ratio standard and durational loss ratios used to determine expected claims applicable to an ARC filing shall be determined annually as follows:

1. Unchanged Modified Lifetime Loss Ratio.

a. The modified lifetime loss ratio standard shall remain unchanged when the company makes a complying ARC filing that requests a rate change that results in a modified lifetime loss ratio, calculated after the effects of the rate change, that is equal to the modified lifetime loss ratio standard in rule 4-149.108(2)(d).

b. The modified lifetime loss ratio standard shall remain unchanged when the company makes a complying ARC filing, pursuant to rule 4-149.111(4)(b), that does not request a rate increase but demonstrates that the modified lifetime loss ratio calculated is equal to the modified lifetime loss ratio standard in rule 4-149.108(2)(d) or is otherwise acceptable under other provisions of this rule chapter.

c. The company shall provide the durational loss ratios in effect at the time of the ARC filing and, if changed, the revised durational loss ratios as modified by the ARC filing.

2. Increased Modified Lifetime Loss Ratio.

a. The modified lifetime loss ratio standard shall be changed for future filings when a company makes a complying ARC filing that certifies to a higher modified lifetime loss ratio than the modified lifetime loss ratio standard based on rule 4-149.108(2)(d) in the most recent ARC filing. The modified lifetime loss ratio standard in rule 4-149.108(2)(d) shall be increased to what is certified.

b. The company shall provide the durational loss ratios in effect at the time of the ARC filing and the revised durational loss ratios as modified by the ARC filing. The revised durational loss ratios shall reflect the increase in the modified lifetime loss ratio and shall support the projected values in the ARC filing.

c. If the Department approves a rate change that is different than that contained in the ARC filing, a revised ARC filing shall not be required and the modified lifetime loss ratio standard and the durational loss ratios to be used in later ARC filings will be those contained in the ARC filing which was certified by the actuary.

3. Interim Modified Lifetime Loss Ratio.

a. A company that is in violation of section 627.410(7), Florida Statutes, at the time of an ARC filing, shall determine an interim modified lifetime loss ratio standard to be used as the standard for the ARC filing. A violation occurs if the company has failed to file or has filed an ARC which is determined not to comply with the provisions of section 627.410(7), Florida Statutes pursuant to rule 4-149.111(6).

b. The interim modified lifetime loss ratio standard will be calculated as of the time 12-months prior to the date of the current ARC filing using the most recent approved ARC filing which contains all of the experience necessary in conjunction with the current filing, as follows.

(i) The lesser of the actual and expected claims, for the past experience reflected in the prior ARC filing;

(ii) Actual earned premiums for the period from inception through the end of the experience period in the Transition ARC filing;

(iii) The greater of the actual and expected claims (based on the durational loss ratios in the prior ARC filing) during the period from the last ARC filing to the date 12-months prior to the filing date;

(iv) For the last 12-month period, the projected incurred claims and earned premiums in the prior ARC filing;

(v) Projected values for the future from the prior ARC filing; and

(vi) The modified lifetime loss ratio standard in rule 4-149.108(2)(d) shall be increased to equal the interim modified lifetime loss ratio.

c. The current ARC filing will be evaluated using rule 4-149.108(9)(a)1. or 2. above.

4. Expected Claims. The revised durational loss ratios contained in the current ARC filing shall be used to determine additions to expected claims as required by rule 4-149.103(28)(a)1.a. in future ARC filings. The expected claim values for prior periods in the current ARC filing shall not be restated. They shall remain as the expected values that were previously determined from the durational loss ratios applicable at that time.

5. Transition. This provision shall apply to the first ARC filing (transition ARC filing) made after the effective date of this rule chapter and within twelve months of the effective date of this rule chapter.

a. A modified lifetime loss ratio for the form shall be calculated from the most recent approved ARC filing made by the company, which contains all of the experience necessary, or if none, the original filing shall be considered the prior ARC filing. The calculation shall use the prior ARC filing and additional experience as follows:

(i) The lesser of the actual and expected claims, for the past experience reflected in the prior ARC filing:

(ii) Actual earned premiums for the period ending with the filing date;

(iii) For the period since the prior ARC filing, the lesser of actual claims and expected claims using the durational loss ratios in the prior ARC filing; and

(iv) Projected values of the future anticipated experience with no rate change in the current year and a second projection with a rate increase that produces a result equal to the initial lifetime loss ratio. Where the prior ARC filing assumed a continuing medical trend applicable to both projected claims and earned premiums, medical trend, not exceeding that used in the prior ARC filing, may be used in all future years for both claims and premiums in the “no rate change” calculation.

b. If the rate increase used in (i)d. above is no more than the greater of fifteen percent and 150% of medical trend as determined by rule 4-149.105(8)(b), (c), (d), or (e), the company shall make an ARC filing in accordance with (9)(a)1. or 2. above. At its option, a company may file for a rate increase subject to subsection (iii) below.

c. If the rate increased used in (i)d. above is greater than fifteen percent, or if elected by the company, the maximum rate increase is limited to the greater of 15% and 150% of medical trend, as determined by rule 4-149.105(8)(b), (c), (d) or (e), for two years, or 10% for a Group B product. The

modified lifetime loss ratio standard in rule 4-149.108(2)(d) shall be increased to the modified lifetime loss ratio determined from the ARC filing made in the second year with the rate increase in such filing being limited by this provision.

d. If c. above applies, but the company is able to demonstrate that it has made ARC filings in compliance with section 627.410(7), Florida Statutes, in each of the preceding three years, the two-year period in c. above shall be extended to three years.

e. If a company does not the have durational loss ratios necessary to accurately develop expected claims for past periods, the company shall submit proposed durational loss ratios to the Department for approval. The durational loss ratios proposed are those which will be used to determine past expected claims and shall therefore reflect the original pricing expectations of the form. For forms that were no longer made available for sale after 6/1/94, in lieu of expected claims based on durational loss ratios, the company may use the lifetime loss ratio standard times earned premium as the value of expected claims for the period prior to the effective date of this rule.

f. A transition ARC filing made within three months of the effective date of this rule chapter shall be permitted to be made up to three months beyond the time period provided by section 627.410(7), Florida Statute.

(b)1. To recognize random fluctuations, the increase in loss ratio standard in rule 4-149.108(9)(a) above will not occur if the nationwide experience has less than 50% credibility, or

2. The actuary adequately justifies a rate increase on a Group B product of less than 10%, or if more than 10%, one where the largest increase on any policy/certificate does not exceed $15 per month, but requests approval by the Department to defer the rate increase. The actuary must certify that the rate change ultimately requested will not exceed the greater of 10% or $15 per month.

(c) A company filing for a rate increase which is less than that which is justified by this rule chapter, may request exemption from the provisions of rule 4-149.108(9)(a) for such filing. This request shall be granted if the company is able to demonstrate that there is a planned schedule of rate actions. The schedule shall be in the best interest of existing policyholders and for the purpose of mitigating the effect of an increase that is in compliance with this rule chapter. The schedule shall be for existing insureds only with new insureds being charged an approved rate justified by this rule chapter. The planned schedule shall converge to the new issue rate by the third year of approval. The company shall reflect the lost revenue as earned premium for past periods in future rate filings in order to avoid the modified lifetime loss ratio being increased.

(d) A company may request a modification to the provisions of rule 4-149.108(9)(a) when adverse experience is being realized on existing business and the actuary is able to justify that experience from new sales is expected to emerge differently from current assumptions. The revised durational loss ratio standards for the form shall be developed by projecting the existing inforce business and assumed new sales at expected levels for the next three years over the entire lifetime of the form. This provision may only be requested once, within a ten-year period, for each form category defined by rule 4-149.108(15)(a)6.

(10) The original premium schedule for forms sold after 6-1-94 or approved after 2-1-94 must incorporate, for the entire lifetime of the contract form, all projected effects of insurance trend. If all pricing assumptions are realized, the only future rate increases necessary to maintain the anticipated loss ratio would be to reflect the effect of medical trend.

(11) A premium schedule shall be considered to result in unfair discrimination and be grounds for disapproval if it contains or incorporates any of the following:

(a) Attained age premium schedules, for contract forms approved after 2/1/94 or sold after 6/1/94, that do not:

1. Limit the percentage increase in the premium by age to not exceed the percentage increase in the ultimate claim cost for the same change in age.

2. Level percentage rate changes to an approved premium schedule shall be deemed to be acceptable in maintaining this standard.

(b) The rates developed for a new contract form are less than the rates being charged for an existing contract form with similar benefits unless the company is able to provide adequate justification for such difference. Any such justification must provide sufficient information to provide a comparison of the two contract forms that shall include adjusting for benefit differences. This standard shall not apply to contract forms where the rates are not subject to future rate increases. The company may request additional consideration by the Department if the company offers all insureds under the existing contract form the option of transferring to the new, lower cost contract form at the predominantly issued rate without evidence of insurability;

(c) A premium schedule which:

1. Charge insureds of the same actuarially supportable class a different rate;

2. Charge the same rate to insureds of the same actuarially supportable class for different benefit levels;

3. Is intended to discourage sales to a certain portion of the population, whether by age, geographic location, or some other criteria;

4. Is intended to encourage sales to one portion of the population to the detriment of another.

(d) For forms approved subsequent to the effective date of this rule chapter, an issue age premium schedule which is not smooth. Smooth is defined as a premium schedule that complies with one of the two following conditions for periods of level benefits:

1. The second differences of the premium schedule do not change sign (i.e., from positive to negative or from negative to positive); or

2. At any time where the sign of the second differences of the premium schedule changes, the five first differences of the premium schedule around the sign change are all within 150% of the smallest non-zero value. In the case where the smallest non-zero value is the smallest first difference, other first differences shall not exceed 200%.

(12)(a) Pursuant to section 627.410(6)(d), rating structures that incorporate select and ultimate premium structures or use premium class definitions that classify the insured based on duration since issue, are prohibited.

(b) Prohibited rating practices include any premium schedules that have:

1. Premiums that vary based on the time elapsed since issuance of the contract, except where renewal rates are lower than new issue rates as specifically permitted or required in this rule chapter; or

2. For contracts issued subsequent to the effective date of this rule chapter, premium guarantees on guaranteed renewable policies, except for certificates under a group policy issued to an employer group.

(13) Pursuant to section 627.410(6)(d)3., Florida Statutes, attained age premium structures where more than 50% of the contracts/certificates are issued to persons age 65 or older are prohibited. Only issue age premium schedules are permitted.

(14) A company that is requesting a uniform rate increase, where the annual impact to all renewing insureds is less than 10%, may file a simplified actuarial memorandum consisting only of items: 1, 2, 4, 11, 12, 13, 15, 16, 18, 19, 20, 21 & 22 of rule 4-149.110(2). Any of the other items listed in rule 4-149.110(2) shall also be filed if they are being changed from the immediate prior filing.

(15) Companies filing rate increases after the effective date of this rule chapter shall be subject to this paragraph where insurer conduct is involved and where the rate increase request results in an increase in the renewal premiums that is not viable for the policyholder market as defined herein. This subsection is available to a company if it has not been previously applied within a ten-year period to such form category, pooled group of forms or any form with similar benefits. At the option of the company in lieu of a reduced approval level on all premiums, a rate increase will be permitted that results in two premium schedules; one premium schedule for new business and one for the existing business at the time of implementation of this provision. The new business schedule shall be at an approved rate level that will be greater than the premium schedule applicable to existing insureds. This deviation from a single premium schedule shall not be construed to be unfairly discriminatory and shall be approved, subject to the rate increase and the resulting anniversary impact to affected insureds, being limited as follows:

(a) For Group C products with an increase of 15% or more, the increase shall be permitted subject to the following:

1. The approved new issue premium schedule shall apply to all new policies sold subsequent to the effective date of Department rate approval. Future rate filings shall not permit any further increase in the deviation in new issue and renewal premium schedules. The new issue premium schedule, and groups renewing at such premium schedule, will be adjusted based on rate filings made in accordance with this Part and the provisions of this subsection.

2. At the implementation of the new issue premium schedule in excess of the current premium schedule, the current premium schedule shall be increased at a level not to exceed the greater of 10% or 135% of medical trend, as determined by rule 4-149.105(8)(b), (c), (d) or (e).

3. Future changes to the premium schedule for policies existing at the time of the implementation of the new issue premium schedule shall be limited to the greater of 10% of the new issue premium schedule, or 135% of the rate increase ultimately approved for the new issue premium schedule, until the two schedules converge.

4. The experience used to justify future rate filings shall reflect premiums for all business adjusted to the full new issue premium schedule. This reflects the lost revenue as earned premium in future rate filings.

5. All insureds subject to a renewal rate less than the new issue rate shall be provided a notice, approved by the Department in the rate filing, disclosing to the insured:

a. That the increase will be phased in over a period of time, and

b. What the rate would have been without the phase-in provision being applied.

6. For purposes of this section, form category means the market category and type of coverage. These are:

a. individual medical expense,

b. short term disability,

c. long term disability, and

d. Medicare supplement.

7. If medical trend, as determined by rule 4-149.105(8)(b), (c), (d), or (e) reduces by more than 20% of the trend at the time of application of rule 4-149.108(15), the company may file for a revised plan of scheduled rate actions to maintain convergence of the renewal premium schedule with the new issue premium schedule as anticipated by rule 4-149.108(15)(a)3. at the time of the implementation of this provision.

(b) For Group B products with an increase of 10% or more, except where the greatest increase to any policy/certificate does not exceed $10 per month, shall be phased in as follows:

1. The increase shall be phased in over a period not to exceed three years with no increase exceeding 10%.

2. If the three increases would exceed 10% in each year, the increase shall be a uniform dollar increase amount for each of the three years.

3. Additional rate increases during the phase in period may be filed for medical trend only.

4. The provisions of rule 4-149.108(15)(a)1., 4., and 5. shall apply.

(c) The rate increases shall only be implemented on a consistent annual date no more frequently than once in any twelve-month period.

(16)(a) If any of the following are met, any rate increase requested shall be denied as not viable for the policyholder market unless a long term plan of corrective rate and pricing action is submitted to and approved by the Department.

1. There has been more than one event of insurer conduct during a ten-year period within a form category, pooled group of forms, or forms with similar benefits; or

2. There has been the same event of insurer conduct, within the past ten-year period, for more than one form category.

(b) If a rate filing represents the second consecutive year of rate increases made after January 1, 1999, each exceeding both 150% of medical trend, as determined by rule 4-149.105(8)(b), (c), (d), or (e), and 15%, the company must include a detailed explanation of which assumptions in previous filings or ARCs have changed, the basis of the original assumptions, and the basis of the change. The explanation must discuss whether further increases in excess of these levels are expected and over what time period they are anticipated. If no change of assumption is made, the company must explain why this trend level is appropriate for the particular product, including a detailed explanation of benefit components and trend by component if the company has relied on such components in the prior development of the assumptions. If the company is unable to provide such information or demonstration, or the information indicates that the increase is the result of inappropriate rating practices, including but not limited to, violations of actuarial standards of practice, discriminatory pricing, or the use of invalid assumptions (which were not reasonable or good faith assumptions at the time they were developed or thereafter used in projections) the rate increase shall be denied as not viable for the policyholder market unless a long term plan of corrective rate and pricing action is submitted to and approved by the Department.

(c) In determining the application of rule 4-149.108(16), the Department shall consider at a minimum, the following:

1. Whether the ultimate premium after the increase is within the range of rates actually being charged by other companies for comparable coverage, excluding the highest and lowest rate in the market;

2. Whether there will be more than one premium increase to the affected insureds over a 12 month period; and

3. Whether the premium schedule increase is more than 150% of medical trend as determined by rule 4-149.105(8)(b), (c), (d) or (e).

(17)(a) In order to assure that premium escalations are viable for the policyholder market, forms that have been discontinued as to new sales and that are not in a rating pool with at least one form currently available for sale in Florida, or nationwide if nationwide experience is used for credibility purposes, shall be limited as contained herein. Rate increases in excess of medical trend, as determined by rule 4-149.105(8)(b), (c), (d) or (e), for Group C products shall be limited to a rate increase that is the average rate increase approved over the past six months for other similar forms of the company currently available for sale, if any. If the company has no other similar forms, the increase shall be limited to the average rate increase approved over the past six months on forms with similar benefits currently available for sale offered by other companies. For Group B products, if there have been less than six filings made with the Department in the last six months by other companies for forms with similar benefits, an annual rate increase shall not exceed 10%. For purposes of this paragraph, rate increases subject to rule 4-149.108(15) or (16) shall not be considered in determining the average.

(b) At the option of the company, for long term care insurance contract forms, the company may request an alternate rating plan from that indicated in subparagraph (a) above. The company shall demonstrate that the long term care risks have materially changed based on judicial interpretations, federal or state mandates, or a significant change in the service capacity in the statewide long term care market. An example of which would be a 50% change in a three-year period of the number of assisted living facility beds per 1,000 persons over 65 years of age. The plan shall provide an option, without any additional premium payment, of a paid-up contract for any policyholder that terminates coverage within 120 days of the next premium due date following notice of the rate increase. The paid-up contract shall be the shortened benefit period option provided by section 627.94072(3), Florida Statute.

(18)(a) A company may elect rule 4-149.108(18) for Group B contract forms. The election may be at the initial time of form approval or at any subsequent rate filing provided all of these standards had been met during the period prior to such election. Once elected, this standard may not be discontinued. A company electing to be subject to the standards of this Rule shall be exempt from the provisions of rule 4-149.108(9), (15), (16) and (17) above and any filing for a rate change shall be subject to a file and use standard. The Department shall disapprove the rate increase if it determines that the standards of this Rule have not been met.

(b) The initial premium charged an insured shall not increase during the initial four (4) years in which the policy is inforce.

(c) Except as provided in paragraph (d) below, any premium rate increases, after the initial four-year period, are subject to the following restrictions:

1. For insureds attained age eighty (80) and over, the premium charged may not increase more than 10% in the aggregate during the preceding five-year period.

2. For insureds attained age sixty-five (65) to age eighty (80), the premium charged may not increase more than 15% in the aggregate during the preceding five-year period.

3. For insureds under attained age sixty-five (65), the premium charged may not increase more than 25% in the aggregate during the preceding five-year period.

(d) A company may elect to file for a premium rate increase pursuant to the provisions of this Rule:

1. In the event of amendments to state or federal law which would materially affect the company's risk,

2. Judicial interpretations or rulings rendered regarding the coverages resulting in unforeseen claim liabilities.

(19)(a) Changes to initial pricing assumption factors listed below shall be permitted based on adequately justified data and subject to the limits in this subsection. Such limits shall not apply to changes to factors that are annually updated.

(b) An anniversary increase in excess of medical trend, as determined by rule 4-149.105(8)(b), (c), (d) or (e), due to all changes within the rate filing exceeding the limits in rule 4-149.108(15)(a) or (b), shall be required to be spread over a two-year period.

(c) An anniversary increase in excess of medical trend, as determined by rule 4-149.105(8)(b), (c), (d) or (e), due to all changes within the rate filing exceeding two times the limits in rule 4-149.108(15)(a) or (b), shall be required to be spread over a three-year period.

(d) The pricing assumption factors are:

1. A change in the relative relationship of the benefit option factors;

2. A change in the relative relationship of the area factors, excluding changes due to negotiated provider contracts;

3. A change in the relative relationship of the age/sex factors; or

4. A change to other pricing assumptions material to the rate determination, such as persistency and durational loss ratios, that are not annually updated through the projections used in determining the modified lifetime loss ratio.

(20) The Department shall annually determine and publish the medical trend of the five largest companies offering Group C coverage. Effective January 1, 2000, the Department shall annually revise the percentage at the beginning of rule 4-149.108(15)(a) to be determined as 150% of the arithmetic average of the five largest carriers and one independent publishing agency. The Florida average shall be determined by weighting each carrier's medical trend by their respective carriers annualized premium volume. The average shall be determined from 1/6 of the independent publishing agency's nationwide trend and 5/6 from the Florida carrier's average.

(21) The Department shall solicit comments to re-evaluate the provisions of rule 4-149.108(15) and 4-149.108(9) regarding viability and rate stability and to re-evaluate the percentage and dollar triggers in this rule chapter at least every three years.

(22) This provision applies to long term care contract forms approved after the effective date of this rule chapter and long term care contract forms issued subsequent to six months after the effective date of this rule chapter. Initial loss ratio compliance may be demonstrated, at the company's option, with or without the explicit recognition of active life reserves (ALR). When a company has elected to use ALR in the determination of loss ratio compliance; expected and incurred claims, anticipated, lifetime and modified lifetime loss ratios shall be determined using ALR in the same manner as was used in the original approved filing of the form. The provisions of this subsection (22), however, use incurred claims without the inclusion of ALR. A rate schedule shall be determined to be excessive unless the following standards are met.

(a) Where the ALR are explicitly recognized in the demonstration of compliance with the loss ratio standards:

1. The increase in ALR used by the company and added to incurred claims for demonstrating loss ratio compliance shall be demonstrated to be released to pay incurred claims.

2. Projected ALR used by the company, which is released in any duration, shall not exceed projected incurred claims at such duration.

3. The sum of the projected change in ALR used by the company, over the entire lifetime of the form, shall equal zero.

(b)1. Because ALR are used to prefund future claims and thereby reduce the need for future rate increases, the company shall demonstrate that at the time of any ARC filing for a rate increase the value of the ALR at least equal to the Natural Reserve (NR) is made available to pay future incurred claims.

2. The filing must demonstrate that the PVB reduced by the NR, all divided by the PVP, equals or exceeds the value Z, i.e., $(PVB-NR)/PVP \geq Z$.

a. PVB is the present value of future incurred claims without inclusion of ALR.

b. PVP is the present value of future gross premiums.

c. Z is determined, at inception of the form, as the level percentage of renewal premiums (RP) that together with first year expected claims (EC) all divided by PVP is equal to the LR%, i.e., $[Z*PV(RP) + EC]/PVP = LR\%$.

d. The NR is determined as Z times the cumulative renewal earned premiums reduced by the lessor of the cumulative actual claims and the cumulative expected claims excluding the appropriate first year claims, i.e.,

Z * (cumulative renewal premiums) – lessor (cumulative actual and expected claims) = NR.

e. LR% is the greater of the modified lifetime loss ratio standard for the form calculated without inclusion of ALR, and 60%.

(c) The company shall certify that the statutory reserves held in its financial statements are at least as great as the level reflected in the filing.

Specific Authority 624.308, 627.410 FS. Law Implemented 624.307(1), 627.410, 627.411, 627.6699(6) FS. History–New .

4-149.109 Grounds for Disapproval.

(1) A health rate filing shall be disapproved if:

(a) The benefits are unreasonable in relation to the premiums charged based on the standards in this rule chapter;

(b) A company does not respond to a letter requesting additional information by the date and time required in the letter, unless extended in writing by the Department;

(c) The filing contains inaccurate or inconsistent data;

(d) The filing does not combine the experience of all contract forms providing similar benefits, in accordance with rule 4-149.106; or

(e) The filing does not use credible data as defined in rule 4-149.107.

(2) The Department shall set forth in the disapproval letter the specific basis for the disapproval. The Department shall indicate, if not previously requested under rule 4-149.104(4)(a), what additional data or explanation would be required to better evaluate whether the company's request would be adequately justified.

(3) When a requested change to the premium schedule is unable to be approved due to the company failing to satisfy the standards or provisions of this rule chapter, but the Department has sufficient information to determine that a portion of such request is adequately justified, the Department shall indicate such portion; however, in no event shall any such indication convey rate-making authority to the Department.

Specific Authority 624.308, 627.410 FS. Law Implemented 624.307(1), 627.410, 627.411, 627.6699(6) FS. History–New .

4-149.110 Actuarial Memorandum for Health Rate Filings.

(1) The actuarial memorandum is a critical document used in the consideration of any filing.

(a) For an initial filing, this document establishes the standards that will be used in considering future rate changes. It is therefore critical that the company and the actuary ensure that the contents of the memorandum are accurate. For a premium schedule revision, the document shall adequately justify the proposed changes.

(b) Pricing assumptions shall reflect the actuary's best estimate of future anticipated experience.

(c) All assumptions shall be adequately justified by supporting data and available to the Department upon request, and

(d) If a company provides projections based on assumptions that differ from those historically experienced, those used in the original filing of the form, or those used for products with similar coverage, it must adequately justify such assumptions and provide an explanation of the reason for the differences.

(2) The actuarial memorandum shall contain each of the following numbered items, as defined in subsection (3), below.

(a) Item 1. Scope & Purpose of Filing

(b) Item 2. Description of Benefits

(c) Item 3. Renewability Clause

(d) Item 4. Applicability

(e) Item 5. Morbidity, Marketing, and Underwriting

(f) Item 6. Mortality and Interest

(g) Item 7. Voluntary Lapse

(h) Item 8. Expenses

(i) Item 9. Premium Classes

(j) Item 10. Issue Age Range

(k) Item 11. Area Factors

(l) Item 12. Average Annual Premium

(m) Item 13. Premium Modalization Rules

(n) Item 14. Active Life Reserves

(o) Item 15. Trend Assumption – Medical and Insurance

(p) Item 16. Minimum Required Loss Ratio

(q) Item 17. Distribution of Business

(r) Item 18. Experience – Past & Future

(s) Item 19. History of Rate Adjustments

(t) Item 20. Number of Policyholders

(u) Item 21. Proposed Effective Date

(v) Item 22. Actuarial Certification

(3) The terms listed in subsection (2) above are described as follows:

(a) Item 1. Scope and Purpose of Filing:

1. This section shall specify whether the filing is a new filing, a rate revision, or a justification of an existing rate.

2. For individual forms and long term care forms, the filing shall contain a summary comparing benefits and rates to existing forms currently available for sale providing similar benefits, as defined by rule 4-149.106.

3. For new individual forms, the company shall provide the date and reason for the discontinuance, within the past five years, of forms with similar benefits as described in rule 4-149.106. The company shall also indicate whether or not the approval of the new form will result in the discontinuance of the offering of any other individual form.

(b) Item 2. Description of Benefits: This section shall include a brief description of:

1. The benefits provided by the contract form, and if applicable,

2. The benefit amounts per unit of coverage, and

3. The available number of units.

(c) Item 3. Renewability Clause: This section shall identify the renewability classification of the form as defined in rule 4-149.103(33).

(d) Item 4. Applicability: This section shall specify whether the company anticipates new issues under the contract form or renewals only.

(e) Item 5. Morbidity, Marketing, and Underwriting:

1. This section shall describe the morbidity basis for the contract form including the source or sources utilized by the company, a brief description of the marketing and underwriting method used by the company, and the effect of the underwriting on claim costs, by duration and in total.

2. A sample claim cost table shall be provided.

3. The company shall separately state the effects of the different types of underwriting, *i.e.*, medical, financial and plan appropriateness. An example of an acceptable brief description is: "This policy form is subject to limited underwriting with (yes/no) questions. The expected impact is: Duration 1 = .15; duration 2 = .05; overall = .03 decrease in claim costs."

(f) Item 6. Mortality and Interest: – This section shall state the mortality basis and pricing interest assumptions utilized by the company. The interest assumption shall at least equal the valuation interest rate for the form.

(g) Item 7. Voluntary Lapse: – This section shall provide a sample lapse table used by the company.

(h) Item 8. Expenses: – This section shall include a brief description of all expense assumptions used by the company, including per policy and percentage of premium expense separately for acquisition, maintenance, and commissions, and any other assumption used. These must be listed for each policy year as well as the average levelized percentage of premium.

(i) Item 9. Premium Classes: This section shall state all the attributes upon which the premium rates vary.

(j) Item 10. Issue Age Range:

1. This section shall specify the issue age range of the form.

2. A statement shall be made as to whether the premiums are on an issue age, attained age, or other basis.

(k) Item 11. Area Factors:

1. This section shall include a brief description and justification for any area factors utilized by the company, and an explanation of any changes since the last filing.

2. The area factors and definitions must also be displayed.

3. Where the consistency of area factors is not readily able to be determined by the filing, a graphic depiction of the area table will be required to be provided, upon request of the Department, to illustrate the geographic boundaries and consistency of area factors.

(l) Item 12. Average Annualized Premium:

1. This section shall display the average annualized premium for both Florida and the nation.

2. If a rate adjustment is proposed, average annualized premiums reflecting the premium schedule both before and after the proposed adjustment shall be provided and the anniversary or annual impact to renewing insureds, i.e., the effect of prior increases, trend, etc.

3. The average annualized premium per policy for individual insurance or per certificate for group insurance shall be calculated based on the distribution of Florida business considering all factors, including modal loading, applicable to the premium schedule.

4. This distribution is:

a. The anticipated issue distribution, if the filing is a new policy form; and

b. The actual inforce distribution, if the filing is for a rate revision or rate justification.

5. Premiums for riders, endorsements and amendments, as well as all fees, must be added to the base plan premiums in proportion to the distribution to determine this average.

(m) Item 13. Premium Modalization Rules:

1. This section shall display the modalization factors and fees utilized by the company, as applicable.

2. For premium modes other than annual, the level of the fees and factors shall not exceed the following, unless adequately justified by the company as necessary to cover the actual additional expenses and loss of investment income on the annual premium for the modal billing:

a. .09 for monthly,

b. .265 for quarterly, and

c. .52 for semi-annual mode payments.

(n) Item 14. Active Life Reserves:

1. This section shall provide a description of the reserve method to be used for the contract.

2. The parameters of mortality, morbidity, lapse and interest shall be presented.

3. Sample calculations for selected ages and durations shall be displayed in new contract filings.

4. The reserve included in loss ratio calculations as provided by rule 4-149.108(22), may be less than the statutory reserve established in accordance with 1. through 3. above and must be separately shown and described.

5. Because these reserves do not represent claim payments, but provide for timing differences, and except as provided by rule 4-149.108(22), they shall not be included in any benefit and loss ratio calculations.

(o) Item 15. Trend Assumptions – Medical and Insurance:

1. This section must describe the trend assumptions utilized by the company in pricing the product and the relevance of the trend based on the features of the particular product.

2. All factors affecting the projection of future claims must be presented.

3. The trend assumptions shall be presented for both medical and insurance trend.

4. A table showing earned premium and loss ratios determined on a constant premium rate basis at the proposed premium schedule level for at least the prior three years.

(p) Item 16. Minimum Required Loss Ratio for the Form:

1. This section shall state the minimum required loss ratio for the form and, where applicable, show the calculation in determining the ratio pursuant to rule 4-149.108(5)(b).

2. This section shall include the initial filed lifetime loss ratio for the form.

3. For a rate change, this shall reflect the modified lifetime loss ratio standard as indicated in rule 4-149.108(2)(d), or as determined by rule 4-149.108(9)(a)3. where applicable.

4. The modified lifetime loss ratio determined by the filing.

(q) Item 17. Distribution of Business:

1. This section shall provide the anticipated issue distribution for new contract forms and for rate revisions, the actual inforce distribution and the originally expected pricing distribution.

2. All criteria having a rating difference shall be included, including but not limited to modal, age, area, benefit, and rider distribution.

(r) Item 18. Experience on the Form (Past and Future Anticipated):

1. This section shall provide a table of the contract form's actual past experience as well as a projection of that expected for the remaining entire lifetime, for the existing business assuming no new entrants, for:

a. Florida only experience; and

b. Nationwide experience, if Florida only experience is not fully credible or if the company elects rule 4-149.107(2). The Nationwide experience provided shall be the complete experience of the company inclusive of Florida experience.

c. When approved credibility method used is different than rule 4-149.107(1) or (3), a table of credibility determined values along with the detail and explanation of how they were derived.

2. For new contract forms, the projection of future anticipated experience may be assumed to be on an annual mode and shall be provided for the entire lifetime assuming an initial number of entrants displaying columns a, b, d, e, h, and i of subsection 5., below for:

a. The expected distribution of sales,

b. The base policy form only, and

c. Each rider or option separately. For riders or options which are not separable from the base coverage because they affect the benefits or assumptions of the base policy, separate projections shall be displayed for the base policy coverage and 100% assumed election of each rider or option separately.

3. For a rate change filing, a table of experience from inception of the form shall be displayed for each calendar year.

4. For a rate change filing, a series of tables shall be displayed for each policy year within each calendar year for the past three calendar years and for any calendar year where past expected claim values are changed from the prior ARC filing. The company shall provide an explanation of the reason for any changes in prior values. The company shall be prepared to justify prior expected claim values if requested by the Department. For the first ARC filing made subsequent to the effective date of this rule chapter, the company shall be prepared to document all prior expected claim values.

5. The experience information shall include the following in a columnar format for the proposed premium schedule change and with no rate change:

a. Year

b. Earned premium

c. Paid claims

d. Incurred claims (Identifying the claim reserve component and updating incurred claims as reserves run-off)

e. Incurred loss ratio (=d/b)

f. Expected claims

g. Expected loss ratio (=f/b)

h. Active Life Reserves and increase in active life reserves

i. Number of contracts (and life-years if used)

6. For future years in an ARC filing, a projection table consisting of columns a, b, d, e, and i of subsection 5 above. For long term care forms using ALR pursuant to section 4-149.108(22), “h” shall be included in the projection table.

7. The specific methodology or formulas and sample calculations used to generate the projected values shall be provided.

8. The table shall provide column totals and subtotals for the past experience period and future experience period. The table shall clearly show cumulative expected claims, cumulative incurred claims, the lifetime loss ratio, and the modified lifetime loss ratio.

9. The complete durational loss ratio table implicit in the determination of the expected claims for the current year as well as the durational loss ratio table in effect prior to the filing. This will be the basis of expected claims for future experience. If these are being revised from the loss ratios in effect prior to this filing, an explanation and justification of the revised table shall be provided.

10. For a rate change filing, the Department requests that the filing include the above data in an electronic spreadsheet format. The cell entries for the projected values shall provide for the formula development of the values rather than hard-coded entries of values. The spreadsheet file shall also establish the assumptions used in determining the projections, such as interest discount rate, percentage rate change, persistency, etc., in designated cells in advance of the table.

11. For new forms, a graphic depiction of the premium schedule by age and benefit shall be submitted to assist the Department in analyzing the internal consistency of the premium schedule. To the degree possible, as many curves as possible should be on the same graph. For attained age premium schedules, this should be on the same graph as the ultimate claim cost curve.

(s) Item 19. History of Rate Adjustments: This section shall list the approval dates and average percentage rate adjustments since inception for all Florida policy forms included in the filing, including trend increase approvals.

(t) Item 20. Number of Policyholders: This section shall report, on both a Florida-only and a nationwide basis:

1. The number of policyholders/certificateholders inforce,

2. The number of such policyholders who will be affected by the proposed rate revision, and

3. An explanation of any difference in the two numbers, i.e., some insureds may be on premium waiver, paid-up, etc.

(u) Item 21. Proposed Effective Date: This section shall state:

1. The proposed effective date, and

2. The method of the proposed rate revision implementation, i.e., on anniversary, next premium due date, etc.

(v) Item 22. Actuarial Certification: Certification by a qualified actuary that to the best of the actuary's knowledge and judgment:

1. The filing complies with the applicable laws of the State of Florida and with the Rules of the Department of Insurance,

2. The filing complies with all appropriate Actuarial Standards of Practice.

3. That the benefits provided under the filing are reasonable in relation to the proposed premiums, and

4. The modified lifetime loss ratio of [insert] and anticipated loss ratio of [insert] are derived from the projected experience using assumptions reasonably expected to develop.

Specific Authority 624.308, 627.410 FS. Law Implemented 624.307(1), 627.410, 627.411, 627.6699(6) FS. History–New .

4-149.111 Annual Rate Filing Procedures.

(1)(a) Every company writing health insurance shall file an ARC demonstrating the reasonableness of the benefits in relation to premium rates, for all such contract forms issued, delivered or issued for delivery in this state.

(b) Non-cancelable forms that were discontinued for sale prior to 6/1/94 and where the annual premium is less than $350 for over 90% of the policies inforce, shall be exempt from this filing requirement.

(2) An ARC filing must be received by the Department for each contract form or pooled block of contract forms no later than 12 months from the date of approval or acknowledgment of the previous filing for the contract form. Filings made and accepted for filing by the Department do not constitute approval or agreement with any pooling arrangements. See rule 4-149.106(1)(e).

(3) The filings required by this Part shall be on a company distinct basis.

(4) Filings shall be prepared in accordance with rule 4-149.104 including all forms referenced therein, and in accordance with either (a) or (b), below. For Medicare supplement forms, a filing pursuant to (a) is required.

(a) A rate filing shall be prepared, under the direction of an actuary, which contains documentation that the proposed benefits are reasonable in relation to the premium rates, pursuant to the applicable rating laws and this Part.

(b) If no rate change is proposed:

1. An actuary shall prepare a filing certifying that benefits are reasonable in relation to premiums currently charged in accordance with the applicable rating laws and this Part. This means that the rates are sustainable by the company with supporting projections based on a current zero percent rate change to the premium schedule for the next 12-month period and future rate changes not exceeding the medical trend assumptions, if applicable, applied to the claim cost projections.

2. The filing must contain:

a. The experience, past and future, on the form as detailed in rule 4-149.110(3)(r), and

b. The actuarial certification detailed in rule 4-149.110(3)(v).

c. Where the company is not changing premium rates or assumptions, the actuary shall so certify.

3. The modified lifetime loss ratio standard for the form in rule 4-149.108(2)(d) shall be increased as prescribed by rule 4-149.108(9)(a), excluding contract forms where premium schedules are not subject to future rate increases.

4. Pursuant to section 627.410(7)(c), Florida Statutes, if the company does not employ a qualified actuary, a rate certification shall be prepared by company personnel or consultants with a minimum of 5-years experience in insurance ratemaking. In such cases, the chief executive officer of the company shall review and sign the rate certification indicating his agreement with the conclusions.

5. A company shall be required to bring a form into compliance with rule 4-149.108(2)(d) if the lifetime loss ratio, calculated at the time of the ARC filing, is less than the modified lifetime loss ratio standard for the form, as defined in rule 4-149.108(2)(d), assuming a 15% increase in the actuary's best estimate of projected claim costs with no other change to the projection. The company shall file two experience exhibits, one with and one without the 15% claim cost margin. This provision shall not apply if the average policy duration on the form is less than 1.5 and the nationwide experience for durations three and later have less than fifty-percent credibility.

(5) For forms with less than 500 policies/certificates inforce nationwide, the Department will waive the requirement for a certification of reasonableness upon receipt of written request from the company provided the company's solvency is not adversely affected.

(6) An ARC filing which is not made in compliance with the standards of this rule chapter, is incomplete, or does not provide additional information requested by the Department to determine that the ARC filing is complete, accurate and in compliance with this rule chapter and actuarial standards of practice, shall be determined not to have complied with the provisions of section 627.410(7), Florida Statute.

Specific Authority 624.308, 627.410 FS. Law Implemented 624.307(1), 627.410, 627.6699(8) FS. History–New .

4-149.112 Loss Ratio Guarantee Filings.

(1) Applicability

(a) This Rule is applicable to individual accident and health insurance contract forms filed pursuant to the provisions of section 627.410(8), Florida Statutes.

(b) If a company elects the loss ratio guarantee option, then the provisions of section 627.410(8), Florida Statutes and this Part are mandatory.

(c) The following policies are not eligible to be filed pursuant to the loss ratio guarantee provisions of section 627.410(8), Florida Statutes:

1. Medicare Supplement policies as defined by section 627.672, Florida Statutes;

2. Long-term care policies as defined by section 627.9404, Florida Statutes;

3. Other policy forms under which more than 50% of the policies are issued to individuals age 65 or over; and

4. Any policy form with existing inforce business that was not subject to an approved loss ratio guarantee in the immediate preceding year.

5. Policy forms that are in violation of any provision of the insurance laws or regulations that would have an impact on the determination of the reasonableness of the benefits in relation to the premiums charged.

(2) Initial Filing Exercising the Loss Ratio Guarantee Option.

(a) In order for a company to exercise the rate filing option in section 627.410(8), Florida Statutes, the initial loss ratio guarantee filing for new products shall be made in compliance with Rules 4-149.101 through 4-149.110, and shall be accompanied by a specific written statement regarding the details of the loss ratio guarantee documenting the durational and lifetime loss ratios.

(b) The terms of the guarantee, and the durational and lifetime loss ratios, as filed with the initial request for approval of a loss ratio guarantee, are subject to Department approval.

(c) An officer of the company shall sign the guarantee.

(d) A copy of a disclosure to be provided to all insureds with the issuance of the contract and at the time of any rate revision summarizing that the coverage is subject to a loss ratio guarantee and not prior approval of the Department.

(3) Rate Renewals Pursuant to a Currently Approved Loss Ratio Guarantee. Rates shall be considered approved upon receipt by the Department of a filing which contains the rates and any modification factors, if applicable, and is accompanied by the most current approved loss ratio guarantee. The loss ratio guarantee shall:

(a) Be in writing;

(b) Be signed by an officer of the company;

(c)1. Contain a presentation of the anticipated lifetime and durational target loss ratios contained in the actuarial memorandum in the filing when the loss ratio guarantee was originally approved.

2. If statutory changes render any portion of the original actuarial memorandum obsolete, an amended memorandum shall be filed to reflect those changes and shall contain revised durational and lifetime target loss ratios which are subject to approval by the Department;

(d) Contain a guarantee that the applicable loss ratios for the experience period in which the revised rates will take effect, and for each one year experience period thereafter until further revised rates are filed, will meet the applicable durational and lifetime target loss ratios and rate increase limitations in rule 4-149.108(15), (16) & (17) to ensure that rate escalations are viable for the policyholder market;

(e)1. Contain a certification, signed by an actuary, that the currently expected lifetime loss ratio is not more than 5% less than the filed lifetime loss ratio.

2. The certification shall contain the currently expected lifetime loss ratio and its justification;

(f)1. Contain a guarantee that an independent auditor shall audit the applicable loss ratio results for the experience period at the company's expense.

2. An independent auditor shall be an actuary or an accountant that is:

a. Without bias with respect to the company, and

b. Free from any obligation to or interest in the company, its management, or its owners.

3. The independent auditor shall not have any relationship with the company or any conflict of interest that would impair his or her integrity or objectivity.

4.a. The audit shall be performed in the second calendar quarter of the year following the end of the experience period.

b. The results of the audit shall be reported to the Department no later than the end of that quarter.

5. The audit shall be performed in accordance with generally accepted actuarial and accounting principles and shall conform to the actuarial demonstration requirements in rule 4-149.110;

(g) Contain a guarantee that a refund will be made to policyholders of the amount necessary to bring the applicable experience period loss ratio up to the durational target loss ratios referred to in paragraph (c), above. Any such refund shall:

1. Be proportional, based on earned premium during the experience period;

2. Be made to all policyholders in this state that are insured under the applicable policy form as of the last day of the experience period;

3. Not be required for an individual if that refund would be less than $10. Refunds of less than $10 shall be aggregated and paid proportionally to the policyholders receiving refunds;

4. Include interest compounded monthly at the then current variable loan interest rate for life insurance policies pursuant to section 627.4585, F.S., from the end of the experience period until the date of payment;

5. Be paid during the third calendar quarter of the year following the experience period.

6. Not be made until 60 days after the filing of the audit report required by paragraph (f), above; and

7. Be calculated so that the refund is subtracted from earned premiums in the loss ratio calculation, provided however the premium refund shall not be considered a benefit payment, and shall contain a guarantee that if the applicable loss ratio exceeds the durational target loss ratio for that experience period by more than 20% of the durational target loss ratio, the company shall withdraw the policy form for purposes of issuing new policies, if so directed by the Department. This guarantee will apply only when there are at least 2,000 policyholders nationwide or 2,000 accumulated policyholder years.

(4)(a) Applicable loss ratio is defined as the Florida-only loss ratio.

(b) If Florida experience is not fully credible, the loss ratio shall be adjusted based on nationwide loss ratio experience in accordance with rule 4-149.107.

Specific Authority 624.308, 627.410 FS. Law Implemented 624.307(1), 627.410 FS. History–New _____.

Part VI Filing of Forms

4-149.120 Purpose and Scope.

(1) Every contract must be submitted to the Department for approval in accordance with the provisions of this Part.

(2) The purpose of Part VI of this rule chapter is to establish filing procedures to assist companies and the Department in preparing and processing life, annuity, accident, and health insurance form filings.

(3) This Part shall apply to all form filings of policies and applications for accident and health insurance, including outlines of coverage, as well as all form filings for life insurance and annuities.

(4) Funding agreements are not required to be filed with the Department for approval.

Specific Authority 627.308, 627.410 FS. Law Implemented 624.307(1), 627.410 FS. History–New _____.

4-149.121 Form Filing Procedures.

(1)(a)1. All form filings shall be made in accordance with paragraph (b) below.

2. All material submitted shall be legible.

3. A file which is illegible or which contains illegible material will be returned unprocessed.

4. A filing will not be considered to have been received and will not be processed until it is complete. A complete filing consists of the material described in paragraph (b) below.

(b) A complete form filing shall consist of the following items:

1.a. A brief transmittal letter, in triplicate, explaining the type and nature of the filing, including the subject, the purpose, and any unusual features relative to products being sold by other companies.

b. The letter shall also indicate whether the submission is a new filing or a resubmission. If the filing is a resubmission, the letter shall indicate when the previous filing was submitted and the date of the approval or disapproval, and the Florida filing numbers of the prior filing.

c. All group contract forms shall indicate the specific Florida statutory cites under which the group contract is qualified to be issued. The filing shall contain sufficient detail to justify the group's qualification under the particular statute section cited;

2.a. Form DI4-560 (rev 4/91), Standardized Data Letter/Florida Department of Insurance/Division of Insurer Services/Forms Filing (Life and Annuities), as adopted in rule 4-149.190, completely filled out, including the certification in Part VII; or

b. Form DI4-562A and B (rev 4/91), Standardized Data Letter/Florida Department of Insurance/Division of Insurer Services/Health Forms Filing and Health Rates Filing, as adopted in rule 4-149.190, completely filled out, including the rate certification completed in accordance with the instructions contained in Form DI4-562 (rev 7/91), Standardized Data Letter/Health Insurance/Instruction Sheet, as adopted in rule 4-149.190;

c.(i) When submitted, both Form DI4-560 and Forms DI4-562A and B shall contain the company's bar code label in the upper right hand corner of the form.

(ii) Additional bar code labels may be obtained from the Document Processing Section, 200 East Gaines Street, Tallahassee, Florida 32399-0311. The request shall be in writing and shall contain the company name, the federal employer identification number, and payment of $30 for each company.

3. Form DI4-561 (rev 7/91), Health Insurance Filing Requirements Summary, as adopted in rule 4-149.190, for all health form filings;

4. Any certifications of readability, rates, cost indices, or other items, if required by Rule or statute;

5. Three copies of the form(s) being filed. Each form shall:

a. Include the name of the company;

b. Have an identifying form number in the lower left hand corner of the first page of the form;

6. Each filing shall contain an actuarial memorandum, certified and signed by a qualified actuary. The actuarial memorandum for life and annuity product filings shall demonstrate compliance with the Standard Valuation Law. Filings for life insurance products other than annuities shall also demonstrate compliance with the Standard Nonforfeiture Law. The Department shall use the actuarial guidelines and other guidance included in the NAIC Examiners Handbook as adopted by Rule 4-138 in evaluating compliance with section 625.121, 627.476, and 627.807 as required by section 627.411(1)(a), Florida Statutes.

7. If the company wishes a copy of the form stamped with the Department's approval, the company shall include a self-addressed envelope, with sufficient postage affixed, as part of the form filing.

(2)(a) Each filing shall contain forms for only one type of coverage, e.g., ordinary life, variable life, medical expense.

(b) A filing may contain more than one form if the forms are for the same type of coverage.

(3) Each filing shall contain forms for only one company.

(4) A single form which contains both life and health coverage shall be submitted, with all appropriate forms and checklists, for both life and health coverage.

(5)(a) Complete filings shall be mailed to: Bureau of Life and Health Forms & Rates, Division of Insurer Services, Department of Insurance, Post Office Box 8040, Tallahassee, FL 32314-8040.

(b) All filings sent to the Department by special delivery shall be delivered to: Department of Insurance, 1st Floor, Larson Building, 200 East Gaines Street, Tallahassee, FL 32399-0328.

(6)(a) Only complete filings prepared in accordance with this Part will be processed.

(b) Any filing submitted without all of the required forms or information will be considered incomplete.

(c) All incomplete filings will be returned without processing.

(7) Definitions. As used in this Part:

(a) A new filing is one that is being submitted for the first time, and includes revisions of a previously approved form.

(b) A resubmission is one that is being submitted in response to a final disapproval from the Department. A resubmission does not include ongoing correspondence under the same filing number prior to an affirmative approval or disapproval by the Department.

(c) An illustration is a ledger or proposal used in the sale of a life or annuity insurance policy that shows non-guaranteed elements.

(d) Market Value Adjustment (MVA) – A formula in a contract that adjusts the surrender values of the contract to reflect the changes in current interest rate levels since the beginning of the interest guarantee period.

(e) Funding Agreements – A contract that does not include, directly or indirectly, the risk of any life contingencies and does not provide any insurance on a human life.

Specific Authority 624.308, 627.410 FS. Law Implemented 624.307(1), 624.307, 625.121, 627.410, 627.476, 627.807 FS. History–New _____.

4-149.122 Review.

(1)(a) Filings will be reviewed in accordance with the applicable statutes and Rules.

(b) Filings will be disapproved for inconsistencies or ambiguities that are misleading in violation of section 626.9541, Florida Statutes.

(2)(a) A group life or group annuity contract form may not reserve the right to change contractual provisions that will adversely affect any contract benefit, including annuitization benefits, attributable to contributions already made. A company may make such a change in the contract only with the prior written consent of the policyholder, or certificateholder for a group policy where contributions are made by the certificateholder.

(b) Contract terms providing for the nature and parameters of prospective changes clearly indicated and explained in the contract are permitted.

(3) A contract form that provides for guaranteed settlement options must clearly disclose the basis used to determine such options in the contract.

(4) Except for unallocated group annuity contract forms, all annuity contract forms with a fixed accumulation fund option must include a table of guaranteed values in the contract and associated certificate, if applicable.

(5) The company shall submit a description of distribution systems (e.g., direct marketing, marketing through agents, marketing through financial or other institutions, funeral homes), and the intended target population for all product filings.

(6) A contract form may provide for a MVA, which reflects the changes in current interest rate levels since the beginning of the interest rate guarantee period, upon partial or full surrender of the contract only if the market value formula provides for both upward and downward adjustments. The actuarial memorandum must indicate the basis for the MVA

adjustment and demonstrate that the formula provides for reasonable equity to both the contract holder and the company. Typical formulas provide for a constant that requires that the reference interest rate must decline at least that amount before the contractholder receives any increase in surrender values as a result of the MVA formula. This constant may not exceed .0025. A one way MVA is permitted for employer/pension group contracts where the one way adjustment is limited to the group level and not administered at the individual level.

(7) A sample policy or contract summary required by section 626.99, Florida Statutes, prepared on a "John Doe" basis utilizing the assumptions contained in the "John Doe" sample contract specified in the filing must be included for informational purposes with all applicable policy form filings. The form will be disapproved if the summary does not comply with section 626.99, Florida Statute.

(8) If a sales illustration is to be used with the form, a copy of a sales illustration, based on the John Doe sample specification page in the filing, must be included for informational purposes with the policy form filing. The form will be disapproved if the illustration isn't consistent with the form or is misleading pursuant to section 626.9541, Florida Statute.

(9) All contract forms must be sufficiently clear and contain sufficient language and contract provisions that the contract benefits can be clearly determined from the contract filed for approval.

(10) Contract forms may designate certain quantitative values as variable within the contract for filing purposes provided that:

(a) The variable value is completed and not variable when issued to a purchaser;

(b) Where the designated variable is an option selected by the contract purchaser, it must be indicated on the contract application;

(c) All potential values for the variable option are indicated in the filing including a clear statement that all options are available to all applicants or, if not, the target market of each option and why discrimination would not occur;

(d) Statutory minimum standards are met at all times for all values permitted within the variable range; and.

(e) A summary of how often and what parameters will affect the company's determination of the value.

(11) For life and annuity products, a contract form may provide for certain factors to be subject to change at the option of the company, such as a current expense charge or current credited interest rate or current bonus rate. All contract forms with factors subject to change at the option of the company over the term of the contract form must contain a maximum or minimum value in the contract that creates a guaranteed minimum contract benefit. Examples include such contract terms as maximum cost of insurance rates, minimum credited interest rates and maximum expense charges.

(12) An annuity contract with a maturity date exceeding age 70 must contain a provision permitting the owner to elect an earlier maturity date.

Specific Authority 624.308, 627.410, 627.805, 626.9611 FS. Law Implemented 624.307(1), 627.474, 627.410, 627.411, 626.9541, 626.9641, 626.99, 624.307, 625.121, 627.476 FS. History–New _____.

4-149.123 Prohibited Policies.

(1) Definitions. For purposes of this rule section, the following terms are defined as follows:

(a) Tontine policy or contract – a financial arrangement in which a group of participants share the benefits of a contract where upon the default or death of any participant, the benefits are distributed among the remaining participants and where the policy has no value to any of the participants until the end of a specified period or term.

(b) Contingent endowment policy or contract – a tontine type policy which provides a cash payment or other benefit convertible to cash, payable to the last surviving insured contingent upon the prior death of all other insureds who have been grouped together.

(c) Coupon policy or contract or annual endowment policy or contract – a specialty-type of life insurance with coupons or annual endowments attached to the policy.

1. Each coupon or endowment is redeemable in cash at the end of the policy year.

2. Generally premiums on these types of policies are higher than on standard life insurance policies in order to pay for the coupons.

3. This definition does not include traditional annuity or life insurance contracts that pay benefits annually.

(2) No company shall issue, deliver, or issue for delivery any contract defined or described in subsection (1) above.

(3) This rule shall not be construed to limit the prohibitions specified in section 627.479(1), Florida Statutes.

Specific Authority 624.308, 627.410, 627.479(2) FS. Law Implemented 624.307(1), 627.479 FS. History–New _____.

DEPARTMENT OF REVENUE

NOTICE OF CABINET AGENDA ON APRIL 11, 2000

The Governor and Cabinet, on April 11, 2000, sitting as head of the Department of Revenue, will consider approval of amendments to Rules 12E-1.005, 12E-1.012, 12E-1.022 and 12E-1.023, FAC., for adoption. The proposed amendments to Rule 12E-1.005, FAC., are necessary to implement new statutory provisions which require the remittance of payments to the Florida State Disbursement Unit. The proposed amendments to Rule 12E-1.012, FAC., are needed to clarify the procedures for responding to a request from a consumer reporting agency for information about overdue support owed

by an obligor, to incorporate the procedures for periodic reporting of overdue support to consumer reporting agencies and the procedures for requesting consumer reports from consumer reporting agencies. The proposed amendments to Rule 12E-1.022, FAC., are necessary to revise the Department's procedures for establishing repayment to the Department when a payment disbursement error occurs. The proposed amendments to Rule 12E-1.023, FAC., are needed to conform with the statutory provisions authorizing the Department to seek the suspension of an obligor's driver license and motor vehicle registration based upon delinquent child support payments or failure of the obligor to comply with a subpoena or similar order to appear relating to paternity or child support proceedings. The proposed rules were originally noticed in the Florida Administrative Weekly of February 11, 2000, Vol. 26, No. 6, pp. 575-582. A public hearing on the proposed rules was held on March 6, 2000. No comments were received at the public hearing.

DEPARTMENT OF TRANSPORTATION

RULE CHAPTER NO.:	RULE CHAPTER TITLE:
14-66	Relocation Assistance Regulations
RULE NOS.:	RULE TITLES:
14-66.001	Purpose
14-66.002	Scope
14-66.003	Definitions
14-66.004	Public Information
14-66.005	Advisory Services
14-66.006	Written Notices
14-66.007	Relocation Assistance Program
14-66.008	Moving and Related Expenses
14-66.009	Replacement Housing Payments
14-66.010	Mobile Homes
14-66.011	Claim Filing and Documentation
14-66.012	Appeal Rights

NOTICE OF WITHDRAWAL

Notice is hereby given that the above rule chapter amendment, notice of which was published in Florida Administrative Weekly, Vol. 25, No. 29, dated July 23, 1999, is hereby withdrawn. Change notices were published in Florida Administrative Weekly, Vol. 25, No. 40, October 8, 1999 and Vol. 26, No. 5, dated February 4, 2000.

DEPARTMENT OF HEALTH

Division of Family Health Services

RULE NO.:	RULE TITLE:
64F-17.005	Penalties

NOTICE OF WITHDRAWAL

Notice is hereby given that the above rule, as noticed in Vol. 25, No. 10, March 25, 1999, Florida Administrative Weekly, has been withdrawn.

P.O. X07195

Section IV
Emergency Rules

DEPARTMENT OF THE LOTTERY

RULE TITLE:	RULE NO.:
Reduction in Workforce	53ER00-10

SUMMARY OF THE RULE: The emergency rule sets forth provisions regarding procedures to be followed in a reduction in workforce.

THE PERSON TO BE CONTACTED REGARDING THE EMERGENCY RULE IS: Diane D. Schmidt, Legal Analyst, Department of the Lottery, Capitol Complex, Tallahassee, Florida 32399-4011

THE FULL TEXT OF THE EMERGENCY RULE IS:

53ER00-10 Reduction in Workforce.

(1) When the Department of the Lottery implements a reduction in workforce, the reduction will be conducted by seniority, determined by the total length of continuous service with the Lottery beginning with the original date of hire. For purposes of this rule, seniority will be applied within each District and at Headquarters, within each adversely affected job classification. In the event of identical seniority dates among employees within an adversely affected job classification, the employee(s) to be included in the reduction in workforce will be selected by lot, except as follows. The tie breaker procedure described in the previous sentence will not be applied in the event that one or more of the incumbents of adversely affected position(s) possess unique qualifications that fulfill an essential business purpose of the Lottery. An example of such qualifications is bilingual capability where such capability is essential to the performance of the employee's job.

(2) An employee whose position is abolished due to a reduction in workforce shall be placed on administrative leave with full pay and benefits for a period of two weeks following the effective date of the reduction in force, except as provided in subsection (3).

(3) An employee whose position is abolished due to a reduction in workforce and whose vesting date in the Florida Retirement System (FRS) is on or before September 30, 2000, shall be placed on administrative leave according to the following provisions:

(a) The employee will first be required to exhaust all accrued and subsequently earned annual, holiday, and compensatory leave balances.

(b) Once the employee exhausts all leave balances, he or she will be granted administrative leave with full pay and benefits for a period sufficient to reach the vestment date. The use of annual, holiday, or compensatory leave shall not be approved after the effective date of the reduction in workforce, except as provided in this subsection.