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

September 29, 2015

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

Contact: **Karen Kees**
(850-413-2474)

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

ITEM	SUBJECT	RECOMMENDATION

1. Minutes of the Financial Services Commission for August 5, 2015.

(ATTACHMENT 1) **FOR APPROVAL**

2. Approval of the Office of Insurance Regulation to Contract with the Proposed Consultant to Conduct the Workers' Compensation Peer Review

   Section 627.285, Florida Statutes, requires that the Financial Services Commission contract, at least once every other year, for an independent actuarial peer review and analysis of the ratemaking processes of any licensed rating organization that makes rate filings for workers' compensation insurance in Florida.

   The National Council on Compensation Insurance (NCCI) is responsible for collecting statistical information and making workers' compensation rate filings on behalf of Florida's insurers. By law, the contract requires the submission of a final report to the Commission, the President of the Senate, and the Speaker of the House of Representatives by February 1, 2016.

   The Office has conducted the formal solicitation process by way of Request for Quote (RFQ). In order to meet this statutory requirement, it is recommended that the Office, on behalf of the Financial Services Commission, enter into the attached agreement with Oliver Wyman Actuarial Consulting, Inc. to perform the required peer review.

(ATTACHMENT 2) **FOR APPROVAL**

3. Request for Approval for Publication of Rule 69O-154.202,.203,.204 Long Term Morbidity Tables

Over time mortality and morbidity tables no longer reflect anticipated future projected benefits. The NAIC has adopted updated morbidity tables applicable to Long Term Disability policies. This rule is being amended to adopt the updated NAIC long term disability morbidity tables.

(ATTACHMENT 3) **APPROVAL FOR PUBLICATION**

4. Request for Approval for Final Adoption of Proposed Repeal of Rule 69O-157.302,.303,.304; Long Term Care-Rates

These rules are being repealed and the Long-Term Care Facility Only Rates, Home Health Care Only Rates, and Comprehensive Only Rates from the body of the rules will be published to the OIR website to facilitate a more rapid updating of the most recently published new business rates. The new business rates are determined by a statutorily prescribed formula and accordingly are not required to be adopted by rule.

(ATTACHMENT 4) **APPROVAL FOR FINAL ADOPTION**

5. Request for Approval for Final Adoption of Proposed Amendment to Rule 69O-166.031; Mediation of Property Insurance Claims

The rule governs the administrative requirements of section 627.7015, F.S. regarding the mediation of residential and commercial property insurance claims. The Department of Financial Services administers the program and has adopted rule 69J-166.031, F.A.C. This rule comprehensively addresses all aspects of the mediation program. OIR rule 69O-166.031, F.A.C. at one point was identical to the DFS rule. Over time, the DFS rule has been amended and is not identical to the OIR rule. Much of the OIR rule is redundant and is not necessary. The revised rule is being amended to merely cross reference the DFS rule and maintain the penalty for an insurer’s failure to appear at the mediation conference.

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

STATE OF FLORIDA
OFFICE OF INSURANCE REGULATION
AND

THIS CONTRACT (Contract) is entered into by and between the State of Florida, Office of Insurance Regulation (Office), 200 East Gaines Street, Tallahassee, Florida 32399 or its successor, and

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(Contractor), effective as of the last date signed below.

WHEREAS, the Office has determined that it is in need of actuarial services for an independent peer review and analysis of the ratemaking processes of NCCI as further described herein; and

WHEREAS, the Contractor, as a provider of actuarial consulting services, has the expertise and ability to faithfully perform such services,

NOW THEREFORE, in consideration of the services to be performed and payments to be made, together with the mutual covenants and conditions set forth hereinafter, the parties agree as follows:

1. Contract

a) Entire Contract: Order of Precedence. This Contract, including any Attachments referred to herein and attached hereto each of which is incorporated herein for all purposes, constitutes the entire agreement between the parties with respect to the subject matter hereof and supersedes all prior agreements, whether written or oral, with respect to such subject matter. If there are conflicting provisions between the documents that make up the Contract, the order of precedence for the documents is as follows:

- The Contract document;
- The documents and materials attached to or incorporated by reference in the Contract including the approved final version of the Statement of Work;
- The solicitation (OIR RFQ for Actuarial Consulting Services for Peer Review of the NCCI, July 21, 2015)(hereinafter the "RFQ")

2. Services, Deliverables and Delivery Schedule.

The Contractor agrees to render the services or other units of deliverables as set forth in the Office's RFQ, to include the Office's statement of work and the accepted pricing. The Contractor's performance shall be subject to all the terms, conditions, and understandings set forth in the solicitation which is incorporated by reference, copies of which are attached hereto.

The services or other units of deliverables specified in the Solicitation and accompanying documents including the Statement of Work shall be delivered in accordance with the schedule in the Contractor's accepted proposal and consistent with the solicitation.

3. Term of Contract.

Contractor will be paid in accordance with the terms and conditions as stated in the RFQ. The term of the Contract begins upon the execution of the contract by all parties and ends the close of business on February 28,

2016. This contract is a fixed price contract and is not subject to renewal. No travel expenses shall be paid. Invoices are to be submitted to:

Richard Fox
State of Florida – Office of Insurance Regulation
200 East Gaines Street, Larson Building, Room 121
Tallahassee, FL 32399

The Office shall have the right to unilaterally terminate or suspend the Contract, by providing the Contractor thirty (30) calendar day's written notice.

4. Performance Standards and Acceptance.

a) All of the Contractor's Deliverables related to these commodities or services shall be submitted to the Office's contract manager for review and approval. The Office's approval and inspection of Contractor's services shall require no longer than five (5) business days from date of delivery of services, and fifteen (15) business days for delivery of documentary deliverables such as reports and procedures. The Office reserves the right to reject deliverables as outlined in the Statement of Work as incomplete, inadequate or unacceptable due in whole or in part to the Contractor's lack of satisfactory performance under the terms of this Contract. The Office, at its option, may allow additional time within which the Contractor may remedy the objections noted by the Office and the Office may, after having given the Contractor a reasonable opportunity to complete, make adequate or acceptable said deliverables, including but not limited to reports, declare this Contract to be in default. All status reports must be submitted timely showing tasks or activities worked on, attesting to the level of services provided, hours spent on each task/activity, and upcoming major tasks or activities.

b) Performance Standards. The Contractor warrants that: (1) the Services will be performed by qualified personnel, (2) that the services will be of the kind and quality described in the Statement of Work, (3) the services will be performed in a professional and workmanlike manner in accordance with industry standards and practices, (4) the services shall not and do not infringe upon the intellectual property rights, or any other proprietary rights, of any third party, and (5) that its employees shall comply with any security requirements and processes as provided by the Office, or provided by the Office's customer, for work done at the Office or other locations. The Office reserves the right to investigate or inspect at any time whether the services or qualifications offered by the Contractor meet the Contract requirements. If the Office determines that the qualifications or financial standing are not satisfactory, or that performance is untimely, the Office may terminate the Contract.

5. Payment.

a) Subject to the terms and conditions established by this Contract and the billing procedures established by the Office, the Office agrees to pay the Contractor for services rendered.

b) Vendor Rights. Contractors providing goods and services to an agency should be aware of the following time frames. Upon receipt, an agency has five (5) business days to inspect and approve the goods and services, unless the Proposal specifications, purchase orders or Contract specifies otherwise. An agency has 20 calendar days to deliver a request for payment (voucher) to the Office. The 20 calendar days are measured from the date the invoice is received after the goods or services are received, inspected and approved. The Office is to approve the invoice in the state financial system within 20 calendar days.

If a payment is not available within 40 calendar days, a separate interest penalty, computed at the rate determined by the State of Florida Chief Financial Officer pursuant to section 215.422, F. S., will be due and payable, in addition to the invoice amount, to the Contractor. To obtain the applicable interest rate, please refer to http://www.myfloridacfo.com/aadir/interest.htm . Invoices returned to a Contractor due to preparation errors will result in a payment delay. Invoice payment requirements do not start until a properly completed invoice is provided to the State agency with the proper tax payer identification information documentation to be submitted before the prompt payment standards are to be applied. Interest penalties of less than one (1) dollar will not be enforced unless the Contractor requests payment.

A Vendor Ombudsman has been established with the Department of Financial Services. The duties of this individual include acting as an advocate for Contractors who may be experiencing problems in obtaining timely payment(s) from a state agency. The Vendor Ombudsman may be reached at (850) 413-5516.

c) Taxes. The Office is exempted from payment of Florida state sales and use taxes and Federal Excise Tax. The Contractor, however, shall not be exempted from paying Florida state sales and use taxes to the appropriate governmental agencies or for payment by the Contractor to suppliers for taxes on materials used to fulfill its contractual obligations with the Office. The Contractor shall not use the Office's exemption number in securing such materials. The Contractor shall be responsible and liable for the payment of all its FICA/Social Security and other taxes resulting from this Contract. The Contractor shall provide the Office its taxpayer identification number upon request.

d) Expenses. The Contract is a fixed price contract with invoicing after approval of the final deliverable, and no separate expenses or travel will be paid.

e) Payment Processing. All charges for services rendered or for reimbursement of expenses authorized by the Office in accordance with Paragraphs 3 and 4 shall be submitted to the Office in sufficient detail for a proper pre-audit and post-audit to be performed. All payments for professional services will be paid to the Contractor only upon the timely and satisfactory completion of all services and other units of deliverable such as reports, findings and drafts, which are required by Paragraphs 1 and 2 above and upon the written acceptance of said services and units of deliverables such as reports, findings and drafts by the Office's designated contract manager.

f) Contingency. If the terms of this Contract extend beyond the current fiscal year, the State of Florida's performance and obligation to pay under this Contract is contingent upon an annual appropriation by the Legislature.

6. Data Security and Confidentiality.

a) The Contractor, its employees, subcontractors and agents shall comply with all security procedures of the Office in performance of this Contract. The Contractor shall provide immediate notice to the Office Information Security Office (ISO) in the event it becomes aware of any security breach and any unauthorized transmission of state data or of any allegation or suspected violation of security procedures of the Office. Except as required by law or legal process and after notice to the Office, the Contractor shall not divulge to third parties any confidential information obtained by the Contractor or its agents, distributors, resellers, subcontractors, officers or employees in the course of performing Contract work, including, but not limited to, Rule Chapter 71A-1, Florida Administrative Code (F.A.C.), security procedures, business operations information, or commercial proprietary information in the possession of the state or the Office. The Contractor shall not be required to keep confidential information that is

publicly available through no fault of the Contractor, material that the Contractor developed independently without relying on the state's confidential information or information that is otherwise obtainable under state law as a public record.

b) Loss of Data. In the event of loss of any State data or record where such loss is due to the negligence of the Contractor or any of its subcontractors or agents, the Contractor shall be responsible for recreating such lost data in the manner and on the schedule set by the Office at the Contractor's sole expense, in addition to any other damages the Office may be entitled to by law or the Contract. In the event lost or damaged data is suspected, the Contractor will perform due diligence and report findings to the Office and perform efforts to recover the data. If is unrecoverable, Contractor will pay all the related costs associated with the remediation and correction of the problems engendered by any given specific loss. Further, failure to maintain security that results in certain data release will subject the Contractor to the administrative sanctions for failure to comply with section 817.5681, F.S., together with any costs to the Office of such a breach of security caused by the Contractor.

c) Data Protection. No Office data (State Data) or information will be transmitted to, stored in, processed in, or shipped to off-shore locations or out of the United States of America regardless of method, except as required by law. Examples of these methods include (but are not limited to): FTP transfer, DVD, tape, or drive shipping; regardless of level of encryption employed. Access to State Data shall only be available to approved and authorized staff, including remote/offshore personnel, that have a legitimate business need. Requests for remote access shall be submitted to the Office's Help Desk. With approval, third parties may be granted time-limited terminal service access to IT resources as necessary for fulfillment of related responsibilities. Third parties shall not be granted remote access via VPN, private line, or firewall holes. Requests for exceptions to this provision may be submitted to the Office for approval. All remote connections are subject to detailed monitoring via two-way log reviews and the use of other tools, as deemed appropriate. When remote access needs change, the ISO shall be promptly notified and access shall be removed promptly. The Contractor shall encrypt all data transmissions containing confidential or confidential and exempt information. Remote data access must be provided via a trusted method such as SSL, TLS, SSH, VPN, IPSec or a comparable protocol approved by the Office. Confidential information must be encrypted using an approved encryption technology when transmitted outside of the network or over a medium not entirely owned for managed by the Office.

The Contractor agrees to protect, indemnify, defend and hold harmless the Office from and against any and all costs, claims, demands, damages, losses and liabilities arising from or in any way related to the Contractor's breach of data security or the negligent acts or omissions of the Contractor related to this subsection.

7. **Public Records.**

The Consultant shall, to the extent required by section 119.0701, Florida Statutes:

i. maintain public records that would ordinarily and necessarily be required by the Office in order to perform the service;
ii. provide access on the same conditions and at a cost not exceeding that provided in chapter 119.07, Florida Statutes; and
iii. ensure exempt or confidential documents are not disclosed
iv. Meet all requirements for retaining public records and transfer, at no cost, to the Office all public records in the Contractor's possession upon termination of the contract and destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements.

The Consultant shall immediately notify the Office upon receipt of a public records request for records pertaining to this Agreement. The Office may unilaterally cancel this contract if the Consultant refuses to allow public access to all documents, papers, letters, or other material made or received by the Contractor in conjunction with this Agreement, unless the records are exempt from section 24(a) of Article I of the Florida Constitution and section 119.07(1), Florida Statutes.

Work papers and other information obtained during the course of an examination or investigation are confidential and exempt from Florida's Public Records Law while the examination or investigation is active as described in section 624.319, Florida Statutes. Notwithstanding the foregoing, all records, work papers, emails, or other information related to the performance of service shall be maintained by the Consultant in the same manner as would be required by the Office.

The Consultant shall not be required to disclose any proprietary, trade secret, or information protected by law pursuant to section 119.07, Florida Statutes. If the Consultant receives a public records request or a subpoena for confidential or trade secret information, the Consultant shall furnish copies of the request and of any records in its possession that are responsive to the request to the Office. The Office will either defend the request or produce any public records or subpoenaed records to the requesting party.

In the event that a judge in a court of competent jurisdiction orders the Consultant to produce records in its possession directly to a court or other party, the Consultant shall comply with the order and shall furnish a copy of any records produced to the Office.

The Consultant is required to become familiar with Florida Public Records Act with regard to records associated with this Agreement.

8. Insurance.

During the Contract term, the Contractor at its sole expense shall provide commercial insurance of such a type and with such terms and limits as may be reasonably associated with the Contract. At a minimum, this includes the following types of insurance for anyone directly or indirectly employed by the Contractor and the amount of such Insurance shall be the minimum limits as follows, unless otherwise approved by the Contract Manager:

a) Commercial general liability coverage, bodily injury, property damage: $1,000,000 per occurrence/$2,000,000 aggregate.
b) Automobile liability coverage, bodily injury, property damage: $1,000,000 Combined Single Limits. Insuring clause for both bodily injury and property damage shall be amended to provide coverage on an occurrence basis.
c) Workers' compensation and employer's liability insurance covering all employees engaged in any Contract work, in accordance with Chapter 440, F.S.

Such coverage may be reduced with the consent of the Contract Manager since certain subcontractors have potentially less exposure in liability than other subcontractors. Except as agreed in a separate writing, no self-insurance coverage shall be acceptable unless Contractor is licensed or authorized to self-insure for a particular coverage listed above in the State of Florida, or is an in insured member of a self-insurance group that is licensed to self-insure in the State of Florida. Upon request, the Contractor shall provide its certificate of insurance. The limits of coverage under each policy maintained by the Contractor shall not be interpreted as limiting the Contractor's liability and obligations under the Contract. All insurance policies shall be through insurers authorized or eligible to write policies in Florida.

c) The commitment of any material breach of this Contract by the Contractor, failure to timely deliver a material deliverable, discontinuance of the performance of the work, failure to resume work that has been discontinued within a reasonable time after notice to do so, or abandonment of the Contract;

d) Employment of an unauthorized alien in the performance of the work;

e) One or more of the following circumstances, uncorrected for more than thirty (30) calendar days unless within the specified thirty (30) day period, the Contractor (including its receiver or trustee in bankruptcy) provides to the Office adequate assurances, reasonably acceptable to the Office, of its continuing ability and willingness to fulfill its obligations under the Contract:

(1) Entry of an order for relief under Title 11 of the United States Code;
(2) The making by the Contractor of a general assignment for the benefit of creditors;
(3) The appointment of a general receiver or trustee in bankruptcy of the Contractor's business or property;
(4) An action by the Contractor under any state insolvency or similar law for the purpose of its bankruptcy, reorganization, or liquidation;
(5) Entry of an order revoking the certificate of authority granted to the Contractor by the State or other licensing authority;

f) The Contractor makes or has made an intentional material misrepresentation or omission in any materials provided to the Office or fails to maintain the required insurance.

g) If the Office determines that the services to be furnished do not meet the specified requirements, or that the qualifications, financial standing, or facilities are not satisfactory, or that performance is untimely, the Office may terminate the Contract.

11. Liability and Indemnification.

a) No provision in this Contract shall require the Office to hold harmless or indemnify the Contractor, insure or assume liability for the Contractor's negligence, waive the Office's sovereign immunity under the laws of Florida, or otherwise impose liability on the Office for which it would not otherwise be responsible. Except as otherwise provided by law, the parties agree to be responsible for their own attorney fees incurred in connection with disputes arising under the terms of this Contract.

b) The Office's maximum liability for any damages, regardless of form of action, shall in no event exceed the *actual* contract cost to the Contractor for the relevant products or services giving rise to the liability, from the date of performance of the applicable services.

12. Remedies.

a) **Damages for Non-Performance.**
To the extent that financial consequences are not further specified in the Statement of Work, the following apply. Nothing in this section shall be construed to make the Contractor liable for delays that are beyond its reasonable control. Nothing in this section shall limit the Office's right to pursue its remedies for other types of damages:

(1) Liquidated Damages. Contractor acknowledges that its failure to meet [an agreed upon deadline] [or other key service deliverable] for delivery of services will damage the Office but that by their

nature such damages are impossible to ascertain presently and will be difficult to ascertain in the future. Accordingly, the parties agree upon a reasonable amount of liquidated damages which are not intended to be a penalty and are solely intended to compensate for unknown and unascertainable damages. Accordingly liquidated damages shall be assessed on the Contractor according to the Statement of Work.

(2) Actual or other Damages. In lieu of liquidated damages, other damages may be assessed on the Contractor as specified in the remedies for nonperformance identified in the Statement of Work. Failure to use the appropriate technical requirements as identified in the Statement of Work will result in automatic task rejection and may not be invoiced or paid until correction of the task. Failure to complete the required duties as outlined in the Statement of Work may result in the rejection of the invoice. Notwithstanding any provisions to the contrary, written acceptance of a particular deliverable does not foreclose the Office's remedies in the event those performance standards that cannot be readily measured at the time of delivery are not met.

b) Step-in Rights

(1) For noncompliance by the Contractor with tasks related to public records, the Office at its option may enforce these provisions by exercising "Step-In" rights as described below:

(2) If the Office exercises its Step-In rights, the Contractor must cooperate fully with the Office (including its personnel and any third parties acting on behalf of the Office) and shall provide, at no additional charge to the Office, all assistance reasonably required by the Office as soon as possible, including:

a. providing access to all relevant equipment, premises and software under the Contractor's control as required by the Office (or its nominee); and

b. ensuring that the Contractor personnel normally engaged in the provision of the Public Records Tasks are available to the Office to provide assistance which the Office may reasonably request.

(3) The Office's Step-In rights will end, and the Office will hand back the responsibility to the Contractor, when the Contractor demonstrates to the Office's reasonable satisfaction that the Contractor is capable of resuming provision of the affected Public Records Tasks in accordance with the requirements of the Contract solicitation and that the circumstances giving rise to the Step-In right cease to exist and will not recur.

(4) The Contractor must reimburse the Office for all reasonable costs incurred by the Office (including reasonable payments made to third parties) in connection with the Office's exercise of Step-In rights and provision of the affected Public Records Tasks (Step-In Costs).

(5) The Office will continue to pay the Contractor the charges [or] Contractor will continue to retain its fee (including that portion which relates to the affected Public Records Tasks) due for the products or services, provided that the Contractor reimburses the Office for the Step-In Costs. If the Contractor fails to reimburse the Office within 30 days of receipt of the Office's demand for payment of Step-In Costs, the Office is entitled to set off such Step-In Costs against a subsequent invoice [or] pursue other remedies to receive reimbursement for Step-In Costs.

13. State property.

Title to all property furnished by the Office under this Contract shall remain in the Office, and Contractor shall surrender to the Office all property of the Office prior to settlement upon completion, termination, or cancellation. The parties shall settle any transfers of property which may have been required to be furnished to the Office or which otherwise belongs to the Office; and the Contractor shall provide written certification to the Office that the Contractor has surrendered to the Office all said property.

All deliverables delivered to the Office and all of the data collected or created for or provided by the Office (State data) shall become and remain the Office's property upon receipt and acceptance. Upon termination the Contractor shall return State-owned materials being utilized by the Contractor and all State data in a standard format designated by the Office. All work materials developed or provided by the Contractor under this Contract and any prior agreement between the parties shall be deemed to be work made for hire and owned exclusively by the State of Florida, Office of Financial Services.

14. Contract Modification.

This Contract may be amended only by a written agreement between both parties subject to the provisions of Chapter 287, F.S.

15. Nonexclusive Contract.

This procurement will not result in an exclusive license to provide the services described in the solicitation or the resulting Contract. The Office may, without limitation and without recourse by the Contractor, contract with other vendors to provide the same or similar services.

16. Statutory Notices.

The Office shall consider the employment by any contractor of unauthorized aliens a violation of section 274A(e) of the Immigration and Nationality Act. Such violation shall be cause for unilateral cancellation of this Contract. An entity or affiliate who has been placed on the public entity crimes list or the discriminatory vendor list may not submit a proposal on a contract to provide any goods or services to a public entity, may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity, and may not transact business with any public entity pursuant to limitations under Chapter 287, F.S.

17. Compliance with Federal, State and Local Laws.

The Contractor and all its agents shall comply with all federal, state and local regulations, including, but not limited to, nondiscrimination, wages, social security, worker's compensation, licenses and registration requirements. The Contractor shall retain records relating to the Contract and its performance for the longer of five (5) years after the expiration of the Contract or the period required by the General Records Schedules maintained by the Florida Department of State (available at: http://dlis.dos.state.fl.us/recordsmgmt/gen_records_schedules.cfm). If applicable, section 508 compliance information on the supplies and services in this Contract are available on a website indicated by the Contractor. The Electronic and Information Technology standard can be found at: http://www.section508.gov/.

18. Miscellaneous.

a) This Contract, and any referenced or attached addendum embodies the entire agreement of the parties. There are no other provisions, terms, conditions, or obligations. This Contract supersedes all previous oral or written communications, representations or agreements on this subject. In any conflict between this Contract and any referenced or attached addendum, the terms and conditions of this Contract shall take precedence and govern. Acceptance of service or processing of documentation on forms furnished by the Contractor for approval or payment shall not constitute acceptance of any proposed modification to terms and conditions.

b) Any dispute concerning performance of the Contract shall be decided by the Office's designated Contract Manager, who shall reduce the decision to writing and send a copy to the Contractor at a

previously provided address. In the event a party is dissatisfied with the dispute resolution decision, jurisdiction for any dispute arising under the terms of the Contract will be in the courts of the State of Florida, and venue will be in the Second Judicial Circuit, in and for Leon County. Except as otherwise provided by law, the parties agree to be responsible for their own attorney fees incurred in connection with disputes arising under the terms of this Contract.

c) The laws of the State of Florida and the Office's rules govern this Contract.

d) The Contractor agrees that no funds received by it under this Contract will be expended for the purpose of lobbying the Legislature or a state agency pursuant to section 216.347, F. S., except that pursuant to the requirements of section 287.058(6), F. S., during the term of any executed contract between the Contractor and the state, the Contractor may lobby the executive or legislative branch concerning the scope of services, performance, term, or compensation regarding that contract.

e) The Contractor is an independent contractor, and is not an employee or agent of the Office.

f) All services contracted for are to be performed solely by the Contractor and may not be subcontracted or assigned without the prior written consent of the Office. The Office may refuse access to or require replacement of any Contractor employee, subcontractor or agent for cause, including but not limited to technical or training qualifications, quality of work, change in security status, or non-compliance with an Office policy or other requirement. Such action shall not relieve the Contractor of its obligation to perform all work in compliance with the Contract. The Office may reject and bar from any Office facility for cause any of the Contractor's employees, subcontractors or agents.

g) Guarantee of Parent Corporation. In the event the Contractor is a subsidiary of another corporation or other business entity, the Contractor asserts that its parent corporation will guarantee all of the obligations of the Contractor for purposes of fulfilling the obligations of the Contract. In the event the Contractor is sold during the period the Contract is in effect, the Contractor agrees that it will be a requirement of sale that the new parent company guarantee all of the obligations of the Contractor.

h) The respective obligations of the parties, which by their nature would continue beyond the termination or expiration of this Contract, including without limitation, the obligations regarding confidentiality, proprietary interests, and limitations of liability, shall survive termination, cancellation or expiration of this Contract.

i) The Contractor hereby agrees to protect, indemnify, defend and hold harmless the Office from and against any and all costs, claims, demands, damages, losses and liabilities arising from or in any way related to the Contractor's breach of this contract or the negligent acts or omissions of the Contractor.

j) The Office shall not be deemed to assume any liability for the acts, omissions to act or negligence of the Contractor, its agents, servants, and employees, nor shall the Contractor disclaim its own negligence to the Office or any third party.

k) If a court of competent jurisdiction deems any term or condition herein void or unenforceable, the other provisions are severable to that void provision, and shall remain in full force and effect.

l) During the term of this Contract, the Contractor shall not knowingly employ, subcontract with or sub-grant to any person (including any non-governmental entity in which such person has any employment or other material interest as defined in section 112.312 (15), F. S., who is employed by the state or who

has participated in the performance or procurement of this Contract except as provided in section 112.3185, F. S.

19. Execution in Counterparts and Authority to Sign.

This Contract may be executed in counterparts, each of which shall be an original and all of which shall constitute the same instrument. Each person signing this Contract warrants that he or she is duly authorized to do so and to bind the respective party to the Contract.

20. Contract Administration.

a) The Office's Contract Manager is Cindi Cooper. Any questions regarding the day to day administration of this contract shall be directed to:

Cyndi Cooper
Florida Office of Insurance Regulation
200 East Gaines Street
Tallahassee, Florida 32399
(850) 413-5368
Cindi.Cooper@floir.com

b) The Contractor's Contract Manager is: _____

c) All written and verbal approvals referenced in this Contract must be obtained from the parties' Contract Managers designated in this section or their designees in writing. Notices required to be in writing must be delivered or sent to the intended recipient by hand delivery, certified mail or receipted courier and shall be deemed received on the date received or the date of the certification of receipt.

IN WITNESS WHEREOF, the parties by their duly authorized representatives have signed this Contract.

_____

Contractor Representative

Title: _____

Date: _____

Florida Office of Insurance Regulation

_____

Belinda M. Miller
Chief of Staff

Date: _____

M E M O R A N D U M

DATE: August 14, 2015

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

THROUGH: Anoush Brangaccio, General Counsel

FROM: Virginia Christy
Stephen Fredrickson

SUBJECT: Cabinet Agenda for September 29, 2015
Request for Approval to Publish Amendments to
Rule 69O-154.202,.203,.204
Long Term Disability Morbidity Tables
Assignment # 170568-15

The Office of Insurance Regulation requests that these proposed rule amendments be presented to the Cabinet aides on or before September 23, 2015 and to the Financial Services Commission on September 29, 2015, with a request to approve for publication the proposed rules.

Over time mortality and morbidity tables no longer reflect anticipated future projected benefits. The NAIC has adopted updated morbidity tables applicable to Long Term Disability policies.

Sections 624.308(1), 625.121(14), 625.081, 624.307(1),625.121,F.S., provide rulemaking authority and laws implemented for these rules.

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

Approved for signature:

Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

Kevin M. McCarty, Commissioner
Office of Insurance Regulation

69O-154.202 Definitions.

As used in this rule chapter, the following terms have the following meaning:

(1) thru (9) No Change

(10) Group Long-Term Disability Income. The term group long-term disability income includes group contracts providing group disability income coverage with a maximum benefit duration longer than two years. Group long-term disability income contracts are based on a group pricing structure. The term "group long-term disability" does not include group short-term disability (coverage with benefit periods of two years or less in maximum duration). It also does not include voluntary group disability income coverage that is priced on an individual risk structure and generally sold in the workplace.

(Renumber Subsequent Sections)

Rulemaking ~~Specific~~ Authority 624.308(1), 625.121(14), 625.081 FS. Law Implemented 624.307(1), 625.081, 625.121 FS. History–New 4-14-99, Formerly 4-154.202, Amended 3-1-04.

69O-154.203 Categories of Reserves.

Adequacy of an insurer's health insurance reserves shall be determined on the basis of all three categories combined. However, these standards emphasize the importance of determining appropriate reserves for each of the three categories separately.

(1)(a) No Change

(b) Minimum Standards for Claim Reserves.

1. Disability Income.

a. Interest. The maximum interest rate for claim reserves is specified in subsection 69O-154.204(2), F.A.C.

b. Morbidity. Minimum standards for morbidity are those specified in subsection

69O-154.204(1), F.A.C., except that, at the option of the insurer:

(I) For claims incurred on or before December 31, 2006, with a duration from date of disablement of less than two years, reserves may at the option of the insurer be based on the insurer's experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

Each insurer may elect which of the following to use as the minimum morbidity standard for claim reserves:

(A) The minimum morbidity standard in effect for claim reserves as of the date the claim was incurred, or

(B) The standards as defined in (II) applied to all open claims. Once an insurer elects to calculate reserves for all open claims on the standard defined in (II), all future valuations must be on that basis.

(II) For individual disability income claims incurred on or after January 1, 2007, the minimum standards with respect to morbidity are those specified in 69O-154.204, except that, at the option of the insurer, assumptions regarding claim termination rates for the period less than two years from the date of disablement may, at the option of the insurer, be based on the insurer's experience, if such experience is considered credible, or upon other assumptions designed to place a sound value on the liabilities.

(III) No Change

(IV) For group disability income claims incurred on or after January 1, 2007 and on or before September 30, 2014.

(A) No Change

(B) Assumptions regarding claim termination rates for the period two or more years but less than five years from the date of disablement may, with the approval of the

Office, be based on the insurer's experience, if such experience is considered credible, and for which the insurer maintains underwriting and claim administration control. The request for such approval of a plan of modification to the reserve basis must include:

(i) An analysis of the credibility of the experience;

(ii) A description of how all of the insurer's experience is proposed to be used in setting reserves;

(iii) A description and quantification of the margins to be included;

(iv) A summary of the financial impact that the proposed plan of modification would have had on the insurer's last filed annual

statement;

(v) A copy of the approval of the proposed plan of modification by the commissioner of the state of domicile; and

(vi) Any other information deemed necessary by the office.

(C) Each insurer may elect which of the following to use as the minimum morbidity standard for group long-term disability income claim reserves:

(i) The minimum morbidity standard in effect for claim reserves as of the date the claim was incurred, or

(ii) The standards as defined in Paragraph (1)(b)(iii), applied to all open claims.

(iii) Once an insurer elects to calculate reserves for all open claims on a more recent standard then all future valuations must be on that basis.

(V) No Change

(VI) For group long-term disability income claims incurred on or after October 1, 2014, and on or before December 31, 2016, the minimum standards with respect to morbidity may be based on the 2012 GLTD termination table

(http://www.naic.org/documents/01_naic_2012_group_long-term_disability_valuation_table.xls) or subsequent table with considerations of:

(A) The insurer's own experience computed in accordance with Actuarial Guideline XLVII as included in the NAIC Accounting Practices and Procedures Manual, adopted by rule 69O-137.001(4), and

(B) An adjustment to include an own experience measurement margin derived in accordance with Actuarial Guideline XLVII, as included in the NAIC Accounting Practices and Procedures Manual, and

(C) A credibility factor derived in accordance with Actuarial Guideline XLVII

(D) Subject to the conditions in this paragraph, the 2012 GLTD or subsequent table with considerations outlined in paragraph(B) shall be used in determining minimum standards with respect to morbidity for group long term disability claims incurred on or after January 1, 2017.

(VII) Subject to the conditions in this Section, the 2012 GLTD or subsequent table with considerations outlined in Paragraph (b)1 shall be used in determining minimum standards with respect to morbidity for group long term disability claims incurred on or after January 1, 2017.

(A) and (B) No Change

(1)(b)1.c. thru (1)(b)2. No Change

(2) and (3) No Change

Rulemaking ~~Specific~~ Authority 624.308(1), 625.121(14), 625.081 FS. Law Implemented 624.307(1), 625.081, 625.121 FS. History–New 4-14-99, Formerly 4-154.203, Amended 3-1-04, 4-7-05, 11-2-06.

69O-154.204 Specific Minimum Standards for Morbidity, Mortality and Interest.

Specific minimum standards for morbidity, mortality and interest which apply to claim reserves according to year of incurral and to contract reserves according to year of issue:

(1) Morbidity.

(a) No Change

(b) Minimum morbidity standards for valuation of specified group contract health insurance benefits shall be as follows:

1. Disability Income Benefits Due to Accident or Sickness , where rules 69O-154.201 - 69O-154.210 reference 69O-154.204; otherwise Actuarial Guideline XLVII, as included in the most current version of the NAIC *Accounting Practices and Procedures Manual* adopted by rule 69O-137.001(4).

1. a. and b. No Change

(c) No Change

(2) and (3) No Change

Rulemaking ~~Specific~~ Authority 624.308(1), 625.121(14), 625.081 FS. Law Implemented 624.307(1), 625.081, 625.121 FS. History–New 4-14-99, Formerly 4-154.204, Amended 3-1-04, 4-7-05, 11-2-06.

690-154.202,.203,.204
Rulemaking authority

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.

625.121 Standard Valuation Law; life insurance.—
(1) SHORT TITLE.—This section shall be known as the "Standard Valuation Law."
(2) ANNUAL VALUATION.—The office shall annually value, or cause to be valued, the reserves for all outstanding life insurance policies and annuity and pure endowment contracts of each life insurer doing business in this state. In the case of an alien insurer, such valuation is limited to its insurance transactions in the United States. In calculating reserves, the office may use group methods and approximate averages for fractions of a year or otherwise, and may accept the insurer's calculation of such reserves. In lieu of the valuation of the reserves required of a foreign or alien insurer, the office may accept any valuation made or caused to be made by the insurance supervisory official of any state or other jurisdiction if the valuation complies with the minimum standard provided under this section. If a valuation is made by the office, the office may use its actuary or employ an actuary for that purpose; and the reasonable compensation of the actuary, at a rate approved by the office, plus reimbursement of travel expenses pursuant to s. 624.320, supported by an itemized statement of such compensation and expenses, shall be paid by the insurer upon demand of the office. If a domestic insurer furnishes the office with a valuation of its outstanding policies as computed by its own actuary or by an actuary deemed satisfactory for that purpose by the office, the valuation shall be verified by the actuary of the office without cost to the insurer. This section applies to the calculation of reserves for policies and contracts not subject to s. 625.1212.
(3) ACTUARIAL OPINION OF RESERVES.—
(a) Each life insurer doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commission by rule are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The commission by rule shall define the specifics of this opinion and add any other items determined necessary to its scope.
1. The opinion shall be submitted with the annual statement and must reflect the valuation of such reserve liabilities for each year ending on or before December 31 of the year before the operative date of the valuation manual as defined in s. 625.1212(2), and in accordance with s. 625.1212(4) for each year thereafter.
2. The opinion applies to all business in force, including individual and group health insurance plans, in the form and substance acceptable to the office as specified by rule of the commission.
3. The commission may adopt rules providing the standards of the actuarial opinion consistent with standards adopted by the Actuarial Standards Board on December 31, 2013, and subsequent revisions thereto if the standards remain substantially consistent.
4. The office may accept an opinion filed by a foreign or alien insurer with the insurance supervisory official of another state if the office determines that the opinion reasonably meets the requirements applicable to an insurer domiciled in this state.
5. As used in this subsection, the term "qualified actuary" means a member in good standing of the American Academy of Actuaries who also meets the requirements specified by rule of the commission.
6. Disciplinary action by the office against the insurer or the qualified actuary shall be in accordance with the insurance code and related rules adopted by the commission.
7. A memorandum in the form and substance specified by rule shall be prepared to support each actuarial opinion.

8. If the insurer fails to provide a supporting memorandum at the request of the office within a period specified by rule of the commission, or if the office determines that the supporting memorandum provided by the insurer fails to meet the standards prescribed by rule of the commission, the office may engage a qualified actuary at the expense of the insurer to review the opinion and the basis for the opinion and prepare such supporting memorandum as required by the office.
9. Except as otherwise provided in this subparagraph, any memorandum or other material in support of the opinion is confidential and exempt from s. 119.07(1) and is not subject to subpoena or discovery directly from the office; however, the memorandum or other material may be released by the office with the written consent of the insurer, or to the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the office for preserving the confidentiality of the memorandum or other material. If any portion of the confidential memorandum is cited by the insurer in its marketing, is cited before any governmental agency other than a state insurance department, or is released by the insurer to the news media, no portion of the memorandum is confidential. Neither the office nor any person who receives documents, materials, or other information while acting under the authority of the office or with whom such information is shared pursuant to this paragraph may testify in a private civil action concerning the confidential documents, materials, or information. However, the department or office may use the confidential and exempt information in the furtherance of any regulatory or legal action brought against an insurer as a part of the official duties of the department or office. A waiver of an applicable privilege or claim of confidentiality in the documents, materials, or information may not occur as a result of disclosure to the office under this section or any other section of the insurance code, or as a result of sharing as authorized under s. 624.4212.
(b) In addition to the opinion required by paragraph (a), the office may, pursuant to commission rule, require an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commission by rule, when considered in light of the assets held by the insurer with respect to the reserves and related actuarial items, including, but not limited to, the investment earnings on the assets and considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the insurer's obligations under the policies and contracts, including, but not limited to, the benefits under, and expenses associated with, the policies and contracts.
(c) The commission may provide by rule for a transition period for establishing any higher reserves which the qualified actuary may deem necessary in order to render the opinion required by this subsection.
(4) MINIMUM STANDARD FOR VALUATION OF POLICIES AND CONTRACTS ISSUED BEFORE OPERATIVE DATE OF STANDARD NONFORFEITURE LAW.—The minimum standard for the valuation of all such policies and contracts issued prior to the operative date of s. 627.476 (Standard Nonforfeiture Law) shall be any basis satisfactory to the office. Any basis satisfactory to the former Department of Insurance on the effective date of this code shall be deemed to meet such minimum standards.
(5) MINIMUM STANDARD FOR VALUATION OF POLICIES AND CONTRACTS ISSUED ON OR AFTER OPERATIVE DATE OF THE STANDARD NONFORFEITURE LAW.—Except as otherwise provided in paragraph (h) and subsections (6), (13), and (14), the minimum standard for the valuation of all such policies and contracts issued on or after the operative date of s. 627.476 shall be the commissioners' reserve valuation method defined in subsections (7), (11), and (14); 5 percent interest for group annuity and pure endowment contracts and 3.5 percent interest for all other such policies and contracts, or in the case of life insurance policies and contracts, other than annuity and pure endowment contracts, issued on or after July 1, 1973, 4 percent interest for such policies issued prior to October 1, 1979, and 4.5

percent interest for such policies issued on or after October 1, 1979; and the following tables:
(a) For all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in such policies:
1. For policies issued before the operative date of s. 627.476(9), the 1958 Commissioners Standard Ordinary (CSO) Mortality Table; except that, for any category of such policies issued on female risks, modified net premiums and present values, referred to in subsection (7), may be calculated according to an age up to 6 years younger than the actual age of the insured.
2. For policies issued on or after the operative date of s. 627.476(9), the 1980 Commissioners Standard Ordinary Mortality Table or, at the election of the insurer for any one or more specified plans of life insurance, the 1980 Commissioners Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors.
3. For policies issued on or after July 1, 2004, ordinary mortality tables, adopted after 1980 by the NAIC, adopted by rule by the commission for use in determining the minimum standard of valuation for such policies.
(b) For all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in such policies:
1. For policies issued before the first date, the 1961 Commissioners Standard Industrial Mortality Table is applicable according to s. 627.476, the 1941 Standard Industrial Mortality Table;
2. For policies issued on or after that date, the 1961 Commissioners Standard Industrial Mortality Table; and
3. For policies issued on or after October 1, 2014, a Commissioners Standard Industrial Mortality Table adopted by the NAIC after 1980 which is adopted by rule of the commission for use in determining the minimum standard of valuation for such policies.
(c) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the 1937 Standard Annuity Mortality Table or, at the option of the insurer, the Annuity Mortality Table for 1949, Ultimate, or any modification of these tables approved by the office.
(d) For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the Group Annuity Mortality Table for 1951; any modification of such table approved by the office; or, at the option of the insurer, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts.
(e) For total and permanent disability benefits in or supplementary to ordinary policies or contracts:
1. For policies or contracts issued on or after January 1, 1966, the tables of period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 disability study of the Society of Actuaries, with due regard to the type of benefit;
2. For policies or contracts issued on or after January 1, 1961, and before January 1, 1966, either of the tables specified in subparagraph 1. or, at the option of the insurer, the class three disability table (1926);
3. For policies issued before January 1, 1961, the class three disability table (1926); and
4. For policies or contracts issued on or after July 1, 2004, tables of disablement rates and termination rates adopted after 1980 by the NAIC, adopted by rule by the commission for use in determining the minimum standard of valuation for those policies or contracts.

Any such table for active lives shall be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(f) For accidental death benefits in or supplementary to policies:

1. For policies issued on or after January 1, 1966, the 1959 Accidental Death Benefits Table;
2. For policies issued on or after January 1, 1961, and before January 1, 1966, the 1959 Accidental Death Benefits Table or, at the option of the insurer, the Intercompany Double Indemnity Mortality Table;
3. For policies issued before January 1, 1961, the Intercompany Double Indemnity Mortality Table; and
4. For policies issued on or after July 1, 2004, tables of accidental death benefits adopted after 1980 by the NAIC, adopted by rule by the commission for use in determining the minimum standard of valuation for those policies.

Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(g) For group life insurance, life insurance issued on the substandard basis, and other special benefits, such tables as may be approved by the office as being sufficient with relation to the benefits provided by such policies.
(h) Except as provided in subsection (6), the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the operative date of this paragraph and for all annuities and pure endowments purchased on or after such operative date under group annuity and pure endowment contracts shall be the commissioners' reserve valuation method defined in subsection (7) and the following tables and interest rates:
1. For individual annuity and pure endowment contracts issued before October 1, 1979, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the office, and 6 percent interest for single-premium immediate annuity contracts and 4 percent interest for all other individual annuity and pure endowment contracts.
2. For individual single-premium immediate annuity contracts issued on or after October 1, 1979, and before October 1, 1986, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the office, and 7.5 percent interest. For such contracts issued on or after October 1, 1986, the 1983 Individual Annual Mortality Table, or any modification of such table approved by the office, and the applicable calendar year statutory valuation interest rate as described in subsection (6).
3. For individual annuity and pure endowment contracts issued on or after October 1, 1979, and before October 1, 1986, other than single-premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the office, and 5.5 percent interest for single-premium deferred annuity and pure endowment contracts and 4.5 percent interest for all other such individual annuity and pure endowment contracts. For such contracts issued on or after October 1, 1986, the 1983 Individual Annual Mortality Table, or any modification of such table approved by the office, and the applicable calendar year statutory valuation interest rate as described in subsection (6).
4. For all annuities and pure endowments purchased before October 1, 1979, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 Group Annuity Mortality Table, or any modification of this table approved by the office, and 6 percent interest.
5. For all annuities and pure endowments purchased on or after October 1, 1979, and before October 1, 1986, under group annuity and pure endowment contracts, excluding disability and accidental death benefits purchased under such contracts, the 1971 Group Annuity Mortality Table, or any modification of this table approved by the office, and 7.5 percent interest. For such contracts purchased on or after October 1, 1986, the 1983 Group

Annuity Mortality Table, or any modification of such table approved by the office, and the applicable calendar year statutory valuation interest rate as described in subsection (6).

After July 1, 1973, an insurer may have filed with the former Department of Insurance a written notice of its election to comply with this paragraph after a specified date before January 1, 1979, which shall be the operative date of this paragraph for such insurer. However, an insurer may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If an insurer does not make such election, the operative date of this paragraph for such insurer is January 1, 1979.

(i) In lieu of the mortality tables specified in this subsection, and subject to rules previously adopted by the former Department of Insurance, the insurance company may, at its option:
1. Substitute the applicable 1958 CSO or CET Smoker and Nonsmoker Mortality Tables, in lieu of the 1980 CSO or CET mortality table standard, for policies issued on or after the operative date of s. 627.476(9) and before January 1, 1989.
2. Substitute the applicable 1980 CSO or CET Smoker and Nonsmoker Mortality Tables in lieu of the 1980 CSO or CET mortality table standard.
3. Use the Annuity 2000 Mortality Table for determining the minimum standard of valuation for individual annuity and pure endowment contracts issued on or after January 1, 1998, and before July 1, 1998.
4. Use the 1994 GAR Table for determining the minimum standard of valuation for annuities and pure endowments purchased on or after January 1, 1998, and before July 1, 1998, under group annuity and pure endowment contracts.
(j) The commission may adopt by rule the model regulation for valuation of life insurance policies as approved by the NAIC in March 1999, including tables of select mortality factors, and may make the regulation effective for policies issued on or after January 1, 2000.
(k) For individual annuity and pure endowment contracts issued on or after July 1, 2004, excluding disability and accidental death benefits purchased under those contracts, individual annuity mortality tables adopted after 1980 by the NAIC, adopted by rule by the commission for use in determining the minimum standard of valuation for those contracts.
(l) For all annuities and pure endowments purchased on or after July 1, 2004, under group annuity and pure endowment contracts, excluding disability and accidental death benefits purchased under those contracts, group annuity mortality tables adopted after 1980 by the NAIC, adopted by rule by the commission for use in determining the minimum standard of valuation for those contracts.
(6) MINIMUM STANDARD OF VALUATION.—
(a) The interest rates used in determining the minimum standard for the valuation of:
1. All life insurance policies issued in a particular calendar year on or after the operative date of s. 627.476(9);
2. All individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1982;
3. All annuities and pure endowments purchased in a particular calendar year on or after January 1, 1982, under group annuity and pure endowment contracts; and
4. The net increase, if any, in a particular calendar year after January 1, 1982, in amounts held under guaranteed interest contracts,

shall be the calendar year statutory valuation interest rates for the year-of-issue purchase or increase as defined in this subsection.

(b) The calendar year statutory valuation interest rates I shall be determined as follows, and the results rounded to the nearest 0.25 percent:
1. For life insurance:

I = 0.03 + W(R1-0.03) + (W/2)(R2-0.09).

For purposes of this subparagraph, "R1" is the lesser of R and .09; "R2" is the greater of R and .09; "R" is the reference interest rate defined in this subsection; and "W" is the weighting factor defined in this subsection.

2. For single-premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options:

I = 0.03 + W(R-0.03).

For purposes of this subparagraph, "R" is the reference interest rate defined in this subsection, and "W" is the weighting factor defined in this subsection.

3. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue-year basis, except as stated in subparagraph 2., the formula for life insurance stated in subparagraph 1. shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of 10 years, and the formula for single-premium immediate annuities stated in subparagraph 2. shall apply to annuities and guaranteed interest contracts with guarantee durations of 10 years or less.
4. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single-premium immediate annuities stated in subparagraph 2. shall apply.
5. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change-in-fund basis, the formula for single-premium immediate annuities stated in subparagraph 2. shall apply.

However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than 0.5 percent, the calendar year statutory valuation interest rate for such life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980, the reference interest rate defined for 1979 being used, and shall be determined for each subsequent calendar year regardless of when s. 627.476(9) becomes operative.

(c) The weighting factors referred to in the formulas stated in paragraph (b) are given in the following tables:
1. Weighting factors for life insurance:

Guarantee Duration Weighting

(Years) Factors

10 or less:.....0.50

More than 10, but not more than 20:.....0.45

More than 20:.....0.35

For life insurance, the "guarantee duration" is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed in the original policy.

2. Weighting factor for single-premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options: 0.80.
3. Weighting factors for other annuities and for guaranteed interest contracts, except as stated in subparagraph 2., shall be as specified in sub-subparagraphs a., b., and c., according to the rules and definitions in sub-subparagraphs d., e., and f. and in paragraph (f):
a. For annuities and guaranteed interest contracts valued on an issue-year basis:

Guarantee Duration Weighting Factor

(Years) for Plan Type

5 or less:.....A–0.80

B–0.60

C–0.50

More than 5, but not more than 10:.....A–0.75

B–0.60

C–0.50

More than 10, but not more than 20:.....A–0.65

B–0.50

C–0.45

More than 20:.....A–0.45

B–0.35

C–0.35

b. For annuities and guaranteed interest contracts valued on a change-in-fund basis, the factors shown in sub-subparagraph a. increased by: 0.15 for Plan Type A; 0.25 for Plan Type B; 0.05 for Plan Type C.
c. For annuities and guaranteed interest contracts valued on an issue-year basis, other than those with no cash settlement options, which do not guarantee interest on considerations received more than 1 year after issue or purchase and for annuities and guaranteed interest contracts valued on a change-in-fund basis which do not guarantee interest rates on considerations received more than 12 months beyond the valuation date,

the factors shown in sub-subparagraph a. or derived in sub-subparagraph b. increased by: 0.05 for Plan Type A; 0.05 for Plan Type B; 0.05 for Plan Type C.
d. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the "guarantee duration" is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of 20 years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.
e. "Plan type," as used in the tables above, is defined as follows:
(I) Plan Type A: At any time, the policyholder may withdraw funds only with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer; the policyholder may withdraw funds only without such adjustment but in installments over 5 years or more; the policyholder may withdraw funds only as an immediate life annuity; or no withdrawal is permitted.
(II) Plan Type B: Before expiration of the interest rate guarantee, the policyholder may withdraw funds only with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer; the policyholder may withdraw funds only without such adjustment but in installments over 5 years or more; or no withdrawal is permitted. At the end of interest rate guarantee, funds may be withdrawn without such adjustment in a single sum or installments over less than 5 years.
(III) Plan Type C: The policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than 5 years either without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer or subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.
f. An insurer may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue-year basis or on a change-in-fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue-year basis.
(d) The "reference interest rate" referred to in paragraph (b) is defined as follows:
1. For all life insurance, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year next preceding the year of issue, of the interest rate index.
2. For single-premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or year of purchase, of the interest rate index.
3. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year-of-issue basis, except as stated in subparagraph 2., with guarantee duration in excess of 10 years, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the interest rate index.
4. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year-of-issue basis, except as stated in subparagraph 2., with guarantee duration of 10 years or less, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the interest rate index.
5. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the interest rate index.
6. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change-in-fund basis, except as stated in

subparagraph 2., the average over a period of 12 months, ending on June 30 of the calendar year of the change in the fund, of the interest rate index.
(e) The interest rate index shall be the Moody's Corporate Bond Yield Average-Monthly Average Corporates as published by Moody's Investors Service, Inc., if the index is calculated by using substantially the same methodology used by Moody's on January 1, 1981. If Moody's corporate bond yield average ceases to be calculated in substantially the same manner, the interest rate index shall be the index specified in the valuation manual, as applicable, as provided under s. 625.1212, or an index adopted by the NAIC and approved by rule adopted by the commission. The methodology used in determining the index approved by rule must be substantially the same as the methodology employed on January 1, 1981, for determining Moody's Corporate Bond Yield Average-Monthly Average Corporates as published by Moody's Investors Service, Inc.
(f) As used in this subsection, an "issue-year basis" of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of purchase of the annuity or guaranteed interest contract; and the "change-in-fund" basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.
(7) COMMISSIONERS' RESERVE VALUATION METHOD.—
(a)1. Except as otherwise provided in this subsection and subsections (11) and (14), reserves according to the commissioners' reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such policies, over the then-present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the policy, of all such modified net premiums shall be equal to the sum of the then-present value of such benefits provided for by the policy and the excess of sub-subparagraph a. over sub-subparagraph b. as follows:
a. A net-level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of such policy on which a premium falls due; provided, however, that such net-level annual premium shall not exceed the net-level annual premium on the 19-year premium whole life plan for insurance of the same amount at an age 1 year higher than the age at issue of such policy.
b. A net-1-year-term premium for such benefits provided for in the first policy year.
2. For any life insurance policy which is issued on or after January 1, 1985, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess, and which provides an endowment benefit, a cash surrender value, or a combination thereof in an amount greater than such excess premium, the reserve according to the commissioners' reserve valuation method as of any policy anniversary occurring on or before the assumed ending date, defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium, shall, except as otherwise provided in subsection (11), be the greater of the reserve as of such policy anniversary calculated as described in subparagraph 1. and the reserve as of such policy anniversary calculated as described in subparagraph 1. but with:
a. The value defined in subparagraph 1. being reduced by 15 percent of the amount of such excess first year premium;

b. All present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date;
c. The policy being assumed to mature on such date as an endowment; and
d. The cash surrender value provided on such date being considered as an endowment benefit.

In making the above comparison, the mortality and interest bases stated in subsections (5) and (6) shall be used.

(b) Reserves according to the commissioners' reserve valuation method for:
1. Life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums;
2. Group annuity and pure endowment contracts, purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under s. 408 of the Internal Revenue Code, as now or hereafter amended;
3. Disability and accidental death benefits in all policies and contracts; and
4. All other benefits, except life insurance and endowment benefits in life insurance policies, and benefits provided by all other annuity and pure endowment contracts,

shall be calculated by a method which is consistent with and yields results consistent with the principles of paragraph (a).

(c) This subsection shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under s. 408 of the Internal Revenue Code, as now or hereafter amended. Reserves according to the commissioners' annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in such contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by such contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of such contract, that become payable prior to the end of such respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate or rates specified in such contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values.
(8) MINIMUM AGGREGATE RESERVES.—
(a) In no event shall an insurer's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, issued on or after the operative date of s. 627.476, be less than the aggregate reserves calculated in accordance with the methods set forth in subsections (7), (11), and (12) and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for such policies.
(b) In no event may the aggregate reserves for all policies, contracts, and benefits be less than the aggregate reserves determined by the qualified actuary to be necessary to render the opinion required by subsection (3).
(9) OPTIONAL RESERVE BASIS.—

(a) Reserves for all policies and contracts issued prior to the operative date of s. 627.476 may be calculated, at the option of the insurer, according to any standards which produce greater aggregate reserves for all such policies and contracts than the minimum reserves required by the laws in effect immediately prior to such date.
(b) For any category of policies, contracts, or benefits specified in subsections (5) and (6), issued on or after the operative date of s. 627.476 (the Standard Nonforfeiture Law for Life Insurance), reserves may be calculated, at the option of the insurer, according to any standard or standards which produce greater aggregate reserves for such category than those calculated according to the minimum standard herein provided; but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be higher than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided for therein.
(10) LOWER VALUATIONS.—An insurer that adopted a standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard provided under this section shall, with the approval of the office, adopt a lower standard of valuation, but not lower than the minimum herein provided; however, for the purposes of this subsection, the holding of additional reserves previously determined by an appointed actuary, as defined in s. 625.1212(2), to be necessary to render the opinion required by subsection (3) may not be deemed to be the adoption of a higher standard of valuation.
(11) ADDITIONAL PREMIUM.—If in any contract year the gross premium charged by a life insurer on a policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, the minimum premium reserve required for the policy or contract shall be the greater of the reserve calculated according to the actual mortality table, rate of interest, and method used for the policy or contract, or the actual method used for the policy or contract but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest are those standards defined by subsections (4), (5), and (6). For any life insurance policy that is issued on or after January 1, 1985, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess, and which provides an endowment benefit, a cash surrender value, or a combination thereof in an amount greater than such excess premium, the foregoing provisions of this subsection shall be applied as if the method actually used in calculating the reserve for such policy were the method described in subsection (7), the provisions of subparagraph (7)(a)2. being ignored. The minimum premium reserve amount, if any, at each policy anniversary of such a policy is the excess, if any, of the amount determined by the foregoing provisions of this subsection plus the reserve calculated by the method described in subsection (7), the provisions of subparagraph (7)(a)2. being ignored, over the reserve actually calculated by the method described in subsection (7), the provisions of subparagraph (7)(a)2. being taken into account.
(12) RESERVE CALCULATION FOR INDETERMINATE PREMIUM PLANS.—In the case of a plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurer based on then estimates of future experience, or in the case of a plan of life insurance or annuity for which the minimum reserves cannot be determined by the methods described in subsections (7) and (11), the reserves that are held under such plan must:
(a) Be appropriate in relation to the benefits and the pattern of premiums for that plan; and
(b) Be computed by a method that is consistent with the principles of this section, as determined by rules adopted by the commission.

69O-154.202,.203,.204
Rulemaking authority

(13) CREDIT LIFE AND DISABILITY POLICIES.—
(a) For policies issued prior to January 1, 2004:
1. The minimum reserve for single-premium credit disability insurance, monthly premium credit life insurance, and monthly premium credit disability insurance shall be the unearned gross premium.
2. As to single-premium credit life insurance policies, the insurer shall establish and maintain reserves that are not less than the value, at the valuation date, of the risk for the unexpired portion of the period for which the premium has been paid as computed on the basis of the commissioners' 1980 Standard Ordinary Mortality Table and 3.5 percent interest. At the discretion of the office, the insurer may make a reasonable assumption as to the ages at which net premiums are to be determined. In lieu of the foregoing basis, reserves based upon unearned gross premiums may be used at the option of the insurer.
(b) For policies issued on or after January 1, 2004:
1. The minimum reserve for single-premium credit disability insurance shall be either:
a. The unearned gross premium, or
b. Based upon a morbidity table that is adopted by the National Association of Insurance Commissioners and is specified in a rule the commission adopts pursuant to subsection (14).
2. The minimum reserve for monthly premium credit disability insurance shall be the unearned gross premium.
3. The minimum reserve for monthly premium credit life insurance shall be the unearned gross premium.
4. As to single-premium credit life insurance policies, the insurer shall establish and maintain reserves that are not less than the value, at the valuation date, of the risk for the unexpired portion of the period for which the premium has been paid as computed on the basis of the commissioners' 1980 Standard Ordinary Mortality Table or any ordinary mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by rule adopted by the commission for use in determining the minimum standard of valuation for such policies; and an interest rate determined in accordance with subsection (6). At the discretion of the office, the insurer may make a reasonable assumption as to the ages at which net premiums are to be determined. In lieu of the foregoing basis, reserves based upon unearned gross premiums may be used at the option of the insurer.
(14) MINIMUM STANDARDS FOR HEALTH PLANS.—The commission shall adopt a rule containing the minimum standards applicable to the valuation of health plans in accordance with sound actuarial principles.

625.081 Reserve for health insurance.—For all health insurance policies, the insurer shall maintain an active life reserve which places a sound value on the insurer's liabilities under such policies; is not less than the reserve according to appropriate standards set forth in rules issued by the commission; and, with the exception of credit disability insurance, in no event, is less in the aggregate than the pro rata gross unearned premiums for such policies.

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

690-154.202,.203,.204
Rulemaking authority

M E M O R A N D U M

DATE: September 14, 2015

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

THROUGH: Anoush Brangaccio, General Counsel

FROM: Virginia Christy
Stephen Fredrickson

SUBJECT: Cabinet Agenda for September 29, 2015
Request for Final Approval to Adopt Repeal of
Rules 69O-157.302,.303,.304
Assignment # 164593-14

The Office of Insurance Regulation requests that this proposed rule repeal be presented to the Cabinet aides on or before September 23, 2015 and to the Financial Services Commission on September 29, 2015, with a request for Final Approval to Adopt the proposed rules. A notice of the Final Rule Hearing was published in the *Florida Administrative Register* on September 3, 2015.

The notice of proposed rules was published on July 20, 2015 in Volume 41, No. 139, of the *Register*. The hearing was not requested, therefore, the hearing was not held. No changes have been made.

These rules are being repealed from the body of the rules and the Long-Term Care Facility Only Rates, Home Health Care Only Rates, and Comprehensive Only Rates will be published to the OIR website to facilitate a more rapid updating of the most recently published new business rates. The new business rates are determined by a statutorily prescribed formula and accordingly are not required to be adopted by rule.

Sections 627.9408(1) and 627.9407(7) , F.S., provide rulemaking authority and laws implemented for these rules.

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

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

Approved for signature:

Anoush Brangaccio

Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

Kevin M. McCarty, Commissioner
Office of Insurance Regulation

690-157.302 Facility Only Rates

Rulemaking Authority 627.9408(1) FS. Law Implemented 627.9407(7) FS. History—New 11-1-07, Amended 5-31-09, 7-19-10 Repealed _____.

69O-157.303 Home Health Care Only Rates.

Rulemaking Authority 627.9408(1) FS. Law Implemented 627.9407(7) FS. History–New 11-1-07, Amended 5-31-09, 7-19-10 Repealed _____.

69O-157.304 Comprehensive Only Rates.

Rulemaking Authority 627.9408(1) FS. Law Implemented 627.9407(7) FS. History–New 11-1-07, Amended 5-31-09, 7-19-10 Repealed _____.

69O-157.302,.303,.304
Rulemaking Authority

627.9408 Rules.—
(1) The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to administer this part.
627.9407 Disclosure, advertising, and performance standards for long-term care insurance.—

(7) RATE STRUCTURE.—

(a) A long-term care insurance policy may not be issued if the premiums to be charged are calculated to increase based solely on the age of the insured.
(b) Any long-term care insurance policy or certificate issued or renewed, at the option of the policyholder or certificateholder, shall make available to the insured the contingent benefit upon lapse as provided in the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners in the second quarter of the year 2000.
(c) Any premium increase for existing insureds shall not result in a premium charged to the insureds that would exceed the premium charged on a newly issued insurance policy, except to reflect benefit differences. If the insurer is not currently issuing new coverage, the new business rate shall be as published by the office at the rate representing the new business rate of insurers representing 80 percent of the carriers currently issuing policies with similar coverage as determined by the prior calendar year earned premium.
(d) Compliance with the pooling provisions of s. 627.410(6)(e)3. shall be determined by pooling the experience of all affiliated insurers.

M E M O R A N D U M

DATE: September 2, 2015

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

THROUGH: Anoush Brangaccio, General Counsel

FROM: Virginia Christy
Stephen Fredrickson

SUBJECT: Cabinet Agenda for September 29, 2015
Request for Final Approval to Adopt Amendments to
Rule 69O-166.031
Assignment # 166860-15

The Office of Insurance Regulation requests that this proposed rule amendment be presented to the Cabinet aides on or before September 23, 2015 and to the Financial Services Commission on September 29, 2015, with a request for Final Approval to Adopt the proposed rules. A notice of the Final Rule Hearing will be published in the *Florida Administrative Register* on September 3, 2015.

The notice of proposed rules was published on July 14, 2015 in Volume 41, No. 135, of the *Register.* The hearing was not requested, therefore, the hearing was not held.

The rule governs the administrative requirements of section 627.7015, F.S. regarding the mediation of residential and commercial property insurance claims. The Department of Financial Services administers the program and has adopted rule 69J-166.031, F.A.C. This rule comprehensively addresses all aspects of the mediation program. OIR rule 69O-166.031, F.A.C. at one point was identical to the DFS rule. Over time, the DFS rule has been amended and is not identical to the OIR rule. Much of the OIR rule is redundant and is not necessary. The revised rule is being amended to merely cross reference the DFS rule and maintain the penalty for an insurer's failure to appear at the mediation conference.

Sections 624.308(1), 627.7015(4) 624.307(1), 624.418(2)(a), 624.421(1)(a), 624.4211(1)-(3), 626.9541(1)(i), 626.9581(1), 627.7015, F.S., provide rulemaking authority and laws implemented for this rule.

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

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

Approved for signature:

Anoush Brangaccio

Anoush Brangaccio, General Counsel

Approved for submission to Financial Services Commission:

Kevin M. McCarty, Commissioner
Office of Insurance Regulation

69O-166.031 Mediation of Property Insurance Claims.

(1) All insurers subject to Section 627.7015 F.S. shall comply with rule 69J-166.031, F.A.C. administered by the Department of Financial Services. A violation of rule 69J-166.031 is a violation of this rule and accordingly a violation of a rule of the Commission. ~~Purpose and Scope. This rule implements Section 627.7015, F.S. The program established under this rule is available to all first-party claimants and insurers prior to commencing the appraisal process set forth in their policies or commencing litigation. The program is also available to litigants referred to the Office from Circuit or County court. For claims which have not already been mediated under Rule 69O-166.030, F.A.C., the mediation procedures described in this rule are available to claims which arise from damage occurring in Dade or Monroe Counties as a result of Hurricane Andrew, as well as the unnamed March 13, 1993, storm wherever the property is located in the State of Florida. This program applies to personal lines claims but not to commercial coverages, or to private passenger motor vehicle insurance coverages, or to disputes relating to liability coverages in property insurance policies. This program does not apply to policies issued under the National Flood Insurance Program established under the National Flood Insurance Act of 1968. Before resorting to these procedures, insureds and insurers are encouraged to resolve claims as quickly and fairly as possible.~~

~~(2) Definitions. The following definitions shall apply for purposes of this rule:~~

~~(a) "Approved", as used in this rule with regard to approval of a mediator, means to designate based upon successfully meeting of the criteria set forth in Section 44.106, F.S., and the Florida Rules of Certified and Court Appointed Mediators which is incorporated by reference in paragraph (6)(a) of this rule, or Section 627.745(3)(b), F.S. Only approved mediators may mediate disputes under this rule.~~

~~(b) "Claim".~~

~~1. "Claim" refers to any dispute between the insurer and insured relating to a material issue of fact other than:~~

~~a. A dispute as to which the insurer has a reasonable basis to suspect fraud, or~~

~~b. A dispute where, based upon agreed facts as to the cause of loss, there is no coverage under the policy.~~

~~2. Unless the parties agree to mediate a claim involving a lesser amount, a "claim" involves the insured requesting $500 or more to settle the dispute, or the difference between the positions of the parties is $500 or more, either of which is notwithstanding of any applicable deductible.~~

~~3. A policy must have been in effect at the time of the loss to qualify as a "claim."~~

~~(c) "Complainant" refers to the party requesting mediation.~~

~~(d) "Office" means the Office of Insurance Regulation.~~

~~(e) "Respondent" refers to the party not first requesting mediation.~~

~~(f) "Service office" means a designated office of the Bureau of Consumer Outreach and Education, Division of Insurance Consumer Services, Department of Financial Services.~~

~~(3) Computation of Time. In computing any period of time described by this rule, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a legal holiday. All time periods specified in this rule refer to the number of calendar days, not business days, unless otherwise specified in this rule.~~

~~(4) Service Offices. For disposition of mediation conferences, the State of Florida shall be divided among the following designated service offices:~~

~~(a) Daytona Beach Service Office shall be composed of the following counties: Flagler, Marion, Putnam, and Volusia.~~

~~(b) Fort Lauderdale Service Office shall be composed of Broward county.~~

~~(c) Fort Myers Service Office shall be composed of the following counties: Charlotte, Collier, DeSoto, Glades, Hendry, Highlands, and Lee.~~

~~(d) Jacksonville Service Office shall be composed of the following counties: Alachua, Baker, Bradford, Clay, Columbia, Dixie, Duval, Gilchrist, Hamilton, Lafayette, Levy, Nassau, St. Johns, Suwannee, and Union.~~

~~(e) Miami Service Office shall be composed of Dade and Monroe counties.~~

~~(f) Orlando Service Office shall be composed of the following counties: Brevard, Citrus, Lake, Orange, Osceola, Seminole, and Sumter.~~

~~(g) Pensacola Service Office shall be composed of the following counties: Bay, Calhoun, Escambia, Gulf, Holmes, Jackson, Okaloosa, Santa Rosa, Walton, and Washington.~~

~~(h) Largo Service Office shall be composed of the following counties: Manatee, Pinellas, and Sarasota.~~

~~(i) Tallahassee Bureau of Consumer Assistance Service Office shall be composed of the following counties: Gadsden, Franklin, Jefferson, Leon, Liberty, Madison, Taylor, and Wakulla.~~

~~(j) Tampa Service Office shall be composed of the following counties: Hardee, Hernando, Hillsborough, Pasco, and Polk.~~

~~(k) West Palm Beach Service Office shall be composed of the following counties: Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie.~~

~~(5) Claim Settlement.~~

~~(a) At the time an insured files a first-party "claim" which falls within the scope of this rule, the insurer shall notify the insured of their right to participate in this program. Notification shall be in writing and shall be legible, conspicuous, and printed in typeface no smaller than any other text~~

~~contained in the notice. The notice shall include detailed instructions on how the insured is to request mediation and indicate that the parties have 21 days from the date of the notice within which to otherwise resolve the dispute. The notice shall include the insurer's address and phone number for requesting mediation. The notice shall describe the mediator selection process and shall state that if either of the parties so desires the Department of Financial Services will select the mediator. The notice shall refer to the parties' right to disqualify a mediator for good cause and paraphrase the definition of good cause as set forth in paragraph (7)(e) of this rule. The notice shall also indicate that the insured is to notify the insurer before the mediation conference if the insured will bring counsel to the conference, unless the insurer waives the right to the notice of counsel. After the 21 days, a request for mediation by the insured may be made either in writing to the insurer or by telephone call to the insurer. The date of request shall be documented in the insurer's claim file. Every 6 months the insurer shall request from the Department of Financial Services a list of mediators qualified to mediate disputes under this program. For a copy of the current list, the Department of Financial Services may be contacted at its Mediation Section, Bureau of Insurance Consumer Assistance, 200 East Gaines Street, Tallahassee, Florida 32399-0322 or at telephone number (850) 922-3132.~~

~~(b) Upon receiving a request for mediation, the insurer shall randomly select from the Department of Financial Services's list a mediator to conduct the mediation conference. The insurer shall immediately notify the mediator in writing of his or her selection and indicate the names and addresses of the parties and their known representatives, their phone numbers (if known), the date of the request for mediation, and that the mediation is to occur within 45 days of the request. If a mediator is disqualified, then the insurer shall randomly select another mediator. Failure of an insurer to abide by this procedure and to notify the insured as required above shall subject the~~

~~insurer to revocation, suspension, or fine as set forth in sub-subparagraph (9)(a)2.b. of this rule.~~

~~(6) Rejection of Mediation. An insurer may elect to reject mediation in situations where the dispute does not meet the definition of a "claim." If the insurer desires to reject mediation, the insurer shall reference this mediation process and specify in writing to the insured the reason(s) for the rejection. The insurer shall also notify the insured of the insured's right to contest the rejection. To contest the rejection, the insured or the insured's representative must write to the Department of Financial Services at its Mediation Section, Bureau of Insurance Consumer Assistance, 200 East Gaines Street, Tallahassee, Florida 32399-0322, within 60 days of the date of the insurer's rejection notification. In the insured's letter contesting the rejection, the insured must specifically state the reasons why the rejection is asserted to be improper. The insurer shall also indicate that the insured should include a copy of the insurer's rejection letter with the insured's letter to the Department of Financial Services. The Department of Financial Services shall determine whether the claim shall be mediated. The parties may elect to voluntarily mediate any dispute regardless of whether the cause of loss or policy status may be in question. In the event that a "claim" falls within the scope of this rule, the insurer shall follow the process set forth in paragraph (5)(b) above.~~

~~(7) Mediators.~~

~~(a) Mediator Approval. The Bureau of Agent and Agency Licensing, Department of Financial Services, shall approve as mediators those persons who meet the qualifications set forth in Section 627.745(3)(b), F.S. Persons wishing to be approved as mediators shall submit their qualifications to the Bureau of Agent and Agency Licensing, Department of Financial Services, 200 East Gaines Street, Tallahassee, FL 32399-0319, on Form OIR-591, "Application for Appointment as a Mediator", which is adopted and incorporated by reference in subsection 69B-211.002(30), F.A.C.~~

~~(b) List of Approved Mediators. The Bureau of Agent & Agency Licensing, Department of~~

~~Financial Services, shall maintain a list of all approved mediators, which list shall include the mediator's name, address, telephone number, social security number, a listing of counties in which each mediator is willing to mediate, and date of entry to the list.~~

~~(c) Grouping of Assignments. Requests for mediation will, if feasible, be grouped together and assigned to a single mediator. A mediator will be assigned a maximum of four mediation conferences under a single assignment.~~

~~(d) Procedure and Conduct. All mediation conferences shall be conducted in accordance with this rule, the Florida Rules for Certified and Court-Appointed Mediators as set forth in Rules 10.020-10.290, Florida Rules of Civil Procedure, as incorporated above, and other consistent rules of conduct as promulgated by the Supreme Court of Florida. Mediators shall have the same responsibilities to the Department of Financial Services as they have to the courts under the Florida Rules for Certified and Court-Appointed Mediators. The Florida Rules for Certified and Court-Appointed Mediators shall be read in a manner consistent with this rule and any conflict between this rule and the Florida Rules for Certified and Court-Appointed Mediators shall be resolved in favor of this rule. The mediator may meet with the parties separately, encourage meaningful communications and negotiations, and otherwise assist the parties to arrive at a settlement. For purposes of this mediation program, mediators shall have the immunity from suit provided to mediators in Section 44.107, F.S. All communications with the mediator shall be confidential. All statements made and documents produced at a settlement conference constitute settlement negotiations in anticipation of litigation. The mediation proceedings are confidential and inadmissible in any subsequent adversarial proceeding.~~

~~(e) Complaints; Discipline. At any time a party may move to disqualify a mediator for good cause. Good cause consists of conflict of interest between a party and the mediator, that the mediator is~~

~~unable to handle the conference competently, or other reasons which would reasonably be expected to impair the conference. Complaints concerning a mediator shall be written and submitted to the Bureau of Consumer Assistance, Office of Insurance Regulation, 200 East Gaines Street, Tallahassee, Florida 32399-0322. The Department shall review the following grounds for discipline:~~

~~1. Alleged instances of dishonest, incompetent, fraudulent, or unethical behavior on the part of a mediator;~~

~~2. Instances in which the mediator allegedly failed to promptly and completely respond to requests from the Department of Financial Services and instances in which the actions or failure to act on the part of the mediator violate this rule including the standards set forth in this sub-section or are counter to the intent and purpose of this mediation program or this rule;~~

~~3. Administrative action by any other agency or body against the mediator, regardless of whether the agency or body's regulation relates to mediation;~~

~~4. The mediator has been found guilty of or pled guilty or nolo contendere to a felony or a crime punishable by imprisonment of 1 year or more under the law of the United States of America or of any state thereof or under the law of any other country, without regard to whether a judgment of conviction has been entered by the court having jurisdiction of such cases.~~

~~If the Department of Financial Services determines that any of the above grounds exist, the Department of Financial Services shall institute proceedings in accordance with Chapter 120, F.S., to rescind the approval of the mediator to handle any mediation or arbitration program sponsored by the Department of Financial Services.~~

~~(8) Mediation Conference.~~

~~(a) Location.~~

~~1. The mediation conference shall be held at a reasonable location specified by the mediator~~

~~within a reasonable proximity of the insured property, unless all parties agree otherwise.~~

~~2. The Department of Financial Services will make available conference rooms at its various service offices throughout the state for possible use.~~

~~3. Before scheduling a mediation conference the mediator may contact the service office administrator to determine the availability of service office facilities to accommodate the mediation conference.~~

~~4. If no facilities are available at the service office for the particular mediation conference then the service office administrator will designate an alternative location, if available, for the mediation conference.~~

~~5. If the parties determine that the assigned conference location is inconvenient or impractical, the parties and mediator may agree to conduct the mediation conference at an alternative location.~~

~~6. The mediator will notify the parties in writing of the exact time, date, and location of the conference.~~

~~(b) Timing and Continuances. The mediation conference shall be held as scheduled by the mediator. Upon application by any party to the mediator for a continuance, the mediator shall, for good cause shown or if neither party objects, grant a continuance and shall notify all parties of the date and place of the rescheduled conference. Good cause includes severe illness, injury, or other emergency which could not be controlled by the party and could not reasonably be remedied by the party prior to the conference by providing a replacement representative or otherwise. Also, good cause includes the necessity of obtaining additional information, securing the attendance of a necessary professional, or the avoidance of significant financial hardship. If the insured demonstrates to the mediator the need for an expedited mediation conference due to an undue hardship, the conference shall be conducted at the earliest date convenient to all of the parties and~~

~~the mediator. Undue hardship will be demonstrated when holding the conference on a non-expedited basis would interfere with or contradict the treatment of a severe illness or injury, substantially impair a party's ability to assert their position at the conference, result in significant financial hardship, or other reasonably justified grounds.~~

~~(c) Attendance.~~

~~1. The complainant and respondent shall attend the mediation conference and be fully authorized to make an agreement to completely resolve the claim. All corporate parties who are complainants or respondents shall attend the conference in the person of a corporate representative who has full knowledge of the facts of the dispute and is fully authorized to make an agreement to completely resolve the dispute. An insurer will be deemed to have failed to appear if the insurer's representative lacks authority to settle the full value of the claim. The authority to settle the claim includes the ability to disburse the full settlement amount within 7 days of the conclusion of the conference. The insurer will produce at the conference a copy of the policy. The insurer will bring the entire claims file to the conference.~~

~~2. The mediation conference also may be attended by persons who may assist a party in presenting his claim or defense in the conference, such as contractors, adjusters, engineers, and interpreters. The parties may not have separate counsel in the mediation conference unless requested by the insured or the parties agree otherwise. If the insured elects to have an attorney participate in the conference, the insured shall notify the insurer of such participation before the conference, unless the parties agree otherwise. A party will be determined to have not negotiated in good faith if they or a person participating on their behalf continuously disrupts or otherwise inhibits the negotiations as determined by the mediator.~~

~~(d) Good Faith Negotiation. The participants are to negotiate in good faith to attempt to resolve~~

~~the dispute, however there is no requirement that the dispute must be resolved in mediation.~~

~~(e) Disposition. Mediators or insurance companies shall report to the Department of Financial Services on the status of property insurance (other than commercial) mediation conferences by submitting Form DFS-H0-1159, "Disposition of Property Insurance Mediation Conference and Company Remittance Form" (rev. 8/94), which is hereby adopted herein and incorporated by reference.~~

~~(9) Disbursement of Costs.~~

~~(a) The insurer shall pay the mediator's fee which shall not exceed $225. The Office reserves the right to reduce fees based on consumer surveys and cost analysis.~~

~~1. Completed Mediation Conference. If the mediation conference is held, the mediator shall receive the mediator's fee. Upon conclusion of the conference, the insurer shall remit $25 to the Department of Financial Services, Mediation Section, Bureau of Insurance Consumer Assistance, Tallahassee, Florida 32314-6100, along with reference to the claim number, identification of the parties, date of the mediation, and name of the mediator. These funds will be deposited in the Director's Regulatory Trust Fund to defer Department of Financial Services costs.~~

~~2. Cancellation Due To Absence. Failure of a party to arrive at the mediation conference within 30 minutes of the conference's starting time shall be considered an absence. Payment shall be as follows:~~

~~a. If the insured fails to appear at the conference, the conference shall be rescheduled upon the insured's payment of the mediator's fee for the conference scheduled to take the place of the conference at which the insured failed to appear.~~

(2) ~~b~~. If the insurer fails to appear at the conference without good cause the insurer shall pay the insured's actual cash expenses incurred in attending the conference and shall pay the mediator's

fee for the rescheduled conference. Good cause here includes severe illness, injury, or other emergency which could not be controlled by the insurer and could not reasonably be remedied by the insurer prior to the conference by providing a replacement representative or otherwise. If an insurer fails to appear at conferences with such frequency as to evidence a general business practice of failure to appear, the insurer shall be subject to penalty, including revocation, suspension, or fine, for violation of Section 626.9541(1)(i), F.S. Such suspension of an insurer's certificate of authority shall be for a period of 2 years. An administrative fine shall be in the amount of $2,500 per violation in cases of non-willful violation, and $20,000 per violation in cases of a knowing and willful violation. The office will mitigate these penalties based upon the following factors: Solvency of the insurer, best interests of or potential harm to insureds, and willfulness of the violation.

~~(b) Any disputes regarding the amount of disbursement of funds shall be resolved by the Department of Financial Services.~~

~~(c) Except as provided in subparagraph (8)(a)3., any expenses associated with the mediation conference, such as travel, telephone, postage, meals, lodging, facilities, and other related expenses, shall be borne by the party, mediator or other person incurring the expense.~~

~~(10) Post-Mediation.~~

~~(a) At the conclusion of the mediation conference, the mediator will file with the Department of Financial Services a mediator's status report indicating whether or not the parties reached a settlement. If the parties reached any settlement, then the mediator shall include a copy of the settlement agreement with the status report. In the event a settlement is reached, the insured shall have 3 business days from the date of the written settlement within which he or she may rescind the settlement provided that the insured has not cashed or deposited any check or draft disbursed to~~

~~him or her for the disputed matters as a result of the conference. If a settlement agreement is reached and not rescinded, it shall act as a release of specific issues that were presented at the conference.~~

~~(b) Any additional claims under the policy shall be presented as separate claims. However, the release shall not constitute a final waiver of rights of the insured with respect to claims for damages or expenses if circumstances that are reasonably unforeseen arise resulting in additional costs which would have been covered under the policy but for the release.~~

~~(c) If the insured decides not to participate in this program or if the parties are unsuccessful at resolving the claim, the insured may choose to proceed under the appraisal process set forth in the insured's insurance policy, or by litigation, or by any other dispute resolution procedure available under Florida law.~~

Rulemaking Authority 624.308(1), 627.7015(4) FS. Law Implemented 624.307(1), 624.418(2)(a), 624.421(1)(a), 624.4211(1)-(3), 626.9541(1)(i), 626.9581(1), 627.7015 FS. History–New 8-18-94, Amended 5-1-96, 4-6-00, Formerly 4-166.031, Amended _____.

69O-166.031
Rulemaking Authority

624.308 Rules.—
(1) The department and the commission may each adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of law conferring duties upon the department or the commission, respectively.

627.7015 Alternative procedure for resolution of disputed property insurance claims.—
(1) This section sets forth a nonadversarial alternative dispute resolution procedure for a mediated claim resolution conference prompted by the need for effective, fair, and timely handling of property insurance claims. There is a particular need for an informal, nonthreatening forum for helping parties who elect this procedure to resolve their claims disputes because most homeowner and commercial residential insurance policies obligate policyholders to participate in a potentially expensive and time-consuming adversarial appraisal process before litigation. The procedure set forth in this section is designed to bring the parties together for a mediated claims settlement conference without any of the trappings or drawbacks of an adversarial process. Before resorting to these procedures, policyholders and insurers are encouraged to resolve claims as quickly and fairly as possible. This section is available with respect to claims under personal lines and commercial residential policies before commencing the appraisal process, or before commencing litigation. Mediation may be requested only by the policyholder, as a first-party claimant, or the insurer. If requested by the policyholder, participation by legal counsel is permitted. Mediation under this section is also available to litigants referred to the department by a county court or circuit court. This section does not apply to commercial coverages, to private passenger motor vehicle insurance coverages, or to disputes relating to liability coverages in policies of property insurance.
(2) At the time a first-party claim within the scope of this section is filed by the policyholder, the insurer shall notify the policyholder of its right to participate in the mediation program under this section. The department shall prepare a consumer information pamphlet for distribution to persons participating in mediation.
(3) The costs of mediation shall be reasonable, and the insurer shall bear all of the cost of conducting mediation conferences, except as otherwise provided in this section. If an insured fails to appear at the conference, the conference shall be rescheduled upon the insured's payment of the costs of a rescheduled conference. If the insurer fails to appear at the conference, the insurer shall pay the insured's actual cash expenses incurred in attending the conference if the insurer's failure to attend was not due to a good cause acceptable to the department. An insurer will be deemed to have failed to appear if the insurer's representative lacks authority to settle the full value of the claim. The insurer shall incur an additional fee for a rescheduled conference necessitated by the insurer's failure to appear at a scheduled conference. The fees assessed by the administrator shall include a charge necessary to defray the expenses of the department related to its duties under this section and shall be deposited in the Insurance Regulatory Trust Fund.
(4) The department shall adopt by rule a property insurance mediation program to be administered by the department or its designee. The department may also adopt special rules which are applicable in cases of an emergency within the state. The rules shall be modeled after practices and procedures set forth in mediation rules of procedure adopted by the Supreme Court. The rules shall provide for:
(a) Reasonable requirement for processing and scheduling of requests for mediation.
(b) Qualifications, denial of application, suspension, revocation of approval, and other penalties for mediators as provided in s. 627.745 and the Florida Rules for Certified and Court-Appointed Mediators.
(c) Provisions governing who may attend mediation conferences.
(d) Selection of mediators.
(e) Criteria for the conduct of mediation conferences.
(f) Right to legal counsel.

(5) All statements made and documents produced at a mediation conference shall be deemed to be settlement negotiations in anticipation of litigation within the scope of s. 90.408. All parties to the mediation must negotiate in good faith and must have the authority to immediately settle the claim. Mediators are deemed to be agents of the department and shall have the immunity from suit provided in s. 44.107.
(6) Mediation is nonbinding; however, if a written settlement is reached, the insured has 3 business days within which the insured may rescind the settlement unless the insured has cashed or deposited any check or draft disbursed to the insured for the disputed matters as a result of the conference. If a settlement agreement is reached and is not rescinded, it shall be binding and act as a release of all specific claims that were presented in that mediation conference.
(7) If the insurer fails to comply with subsection (2) by failing to notify a policyholder of its right to participate in the mediation program under this section or if the insurer requests the mediation, and the mediation results are rejected by either party, the policyholder is not required to submit to or participate in any contractual loss appraisal process of the property loss damage as a precondition to legal action for breach of contract against the insurer for its failure to pay the policyholder's claims covered by the policy.
(8) The department may designate an entity or person to serve as administrator to carry out any of the provisions of this section and may take this action by means of a written contract or agreement.
(9) For purposes of this section, the term "claim" refers to any dispute between an insurer and a policyholder relating to a material issue of fact other than a dispute:
(a) With respect to which the insurer has a reasonable basis to suspect fraud;
(b) Where, based on agreed-upon facts as to the cause of loss, there is no coverage under the policy;
(c) With respect to which the insurer has a reasonable basis to believe that the policyholder has intentionally made a material misrepresentation of fact which is relevant to the claim, and the entire request for payment of a loss has been denied on the basis of the material misrepresentation;
(d) With respect to which the amount in controversy is less than $500, unless the parties agree to mediate a dispute involving a lesser amount; or
(e) With respect to a windstorm or hurricane loss that does not comply with s. 627.70132.

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

624.418 Suspension, revocation of certificate of authority for violations and special grounds.—

(2) The office may, in its discretion, suspend or revoke the certificate of authority of an insurer if it finds that the insurer:
(a) Has violated any lawful order or rule of the office or commission or any provision of this code.

624.421 Duration of suspension; insurer's obligations during suspension period; reinstatement.—
(1) Suspension of an insurer's certificate of authority shall be for:
(a) A fixed period of time not to exceed 2 years; or
624.4211 Administrative fine in lieu of suspension or revocation.—

(1) If the office finds that one or more grounds exist for the discretionary revocation or suspension of a certificate of authority issued under this chapter, the office may, in lieu of such revocation or suspension, impose a fine upon the insurer.
(2) With respect to any nonwillful violation, such fine may not exceed $5,000 per violation. In no event shall such fine exceed an aggregate amount of $20,000 for all nonwillful violations arising out of the same action. If an insurer discovers a nonwillful violation, the insurer shall correct the violation and, if restitution is due, make restitution to all affected persons. Such restitution shall include interest at 12 percent per year from either the date of the violation or the date of inception of the affected person's policy, at the insurer's option. The restitution may be a credit against future premiums due provided that interest accumulates until the premiums are due. If the amount of restitution due to any person is $50 or more and the insurer wishes to credit it against future premiums, it shall notify such person that she or he may receive a check instead of a credit. If the credit is on a policy that is not renewed, the insurer shall pay the restitution to the person to whom it is due.
(3) With respect to any knowing and willful violation of a lawful order or rule of the office or commission or a provision of this code, the office may impose a fine upon the insurer in an amount not to exceed $40,000 for each such violation. In no event shall such fine exceed an aggregate amount of $200,000 for all knowing and willful violations arising out of the same action. In addition to such fines, the insurer shall make restitution when due in accordance with subsection (2).

626.9541 Unfair methods of competition and unfair or deceptive acts or practices defined.—
(1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS.—The following are defined as unfair methods of competition and unfair or deceptive acts or practices:
(i) Unfair claim settlement practices.—
1. Attempting to settle claims on the basis of an application, when serving as a binder or intended to become a part of the policy, or any other material document which was altered without notice to, or knowledge or consent of, the insured;
2. A material misrepresentation made to an insured or any other person having an interest in the proceeds payable under such contract or policy, for the purpose and with the intent of effecting settlement of such claims, loss, or damage under such contract or policy on less favorable terms than those provided in, and contemplated by, such contract or policy; or
3. Committing or performing with such frequency as to indicate a general business practice any of the following:
a. Failing to adopt and implement standards for the proper investigation of claims;
b. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;
c. Failing to acknowledge and act promptly upon communications with respect to claims;
d. Denying claims without conducting reasonable investigations based upon available information;
e. Failing to affirm or deny full or partial coverage of claims, and, as to partial coverage, the dollar amount or extent of coverage, or failing to provide a written statement that the claim is being investigated, upon the written request of the insured within 30 days after proof-of-loss statements have been completed;
f. Failing to promptly provide a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a claim or for the offer of a compromise settlement;
g. Failing to promptly notify the insured of any additional information necessary for the processing of a claim; or
h. Failing to clearly explain the nature of the requested information and the reasons why such information is necessary.

i. Failing to pay personal injury protection insurance claims within the time periods required by s. 627.736(4)(b). The office may order the insurer to pay restitution to a policyholder, medical provider, or other claimant, including interest at a rate consistent with the amount set forth in s. 55.03(1), for the time period within which an insurer fails to pay claims as required by law. Restitution is in addition to any other penalties allowed by law, including, but not limited to, the suspension of the insurer's certificate of authority.
4. Failing to pay undisputed amounts of partial or full benefits owed under first-party property insurance policies within 90 days after an insurer receives notice of a residential property insurance claim, determines the amounts of partial or full benefits, and agrees to coverage, unless payment of the undisputed benefits is prevented by an act of God, prevented by the impossibility of performance, or due to actions by the insured or claimant that constitute fraud, lack of cooperation, or intentional misrepresentation regarding the claim for which benefits are owed.

626.9581 Cease and desist and penalty orders.—After the hearing provided in s. 626.9571, the department or office shall enter a final order in accordance with s. 120.569. If it is determined that the person charged has engaged in an unfair or deceptive act or practice or the unlawful transaction of insurance, the department or office shall also issue an order requiring the violator to cease and desist from engaging in such method of competition, act, or practice or the unlawful transaction of insurance. Further, if the act or practice is a violation of s. 626.9541 or s. 626.9551, the department or office may, at its discretion, order any one or more of the following:
(1) Suspension or revocation of the person's certificate of authority, license, or eligibility for any certificate of authority or license, if he or she knew, or reasonably should have known, he or she was in violation of this act.