Florida Office of Insurance Regulation

2013 Accident and Health Premium and Enrollment Annual Data Filing Requirements

If you have any questions during your submission process, please contact

Market Data Collection and Statistical Reporting Unit

Via email: AnnualA&HReporting_1094-1386@floir.com

Required Filers and General Reporting Definitions

Section 624.316, F.S., authorizes the Office of Insurance Regulation (the "Office") to examine all insurers regarding "affairs, transactions, accounts, records, and assets." Section 627.9175, F.S., reads, in part, "Each health insurer, prepaid limited health services organization, and health maintenance organization shall submit, no later than April 1 of each year, to the office information concerning health and accident insurance coverage and medical plans being marketed and currently in force in this state." The Form OIR-B2-1094 has been modified from last year's appearance to accommodate some of the changes required under the new Federal Healthcare laws. Additionally, Form OIR-B2-1094 now satisfies certain Long Term Care reporting requirements previously gathered under a separate data call under Section 627.9407, F.S. Form OIR-B2-1386 and the 1386 Supplemental Form both remain the same as the CY2012 data collection. Additionally, no changes have been made to the definition of filers required to file in this annual data call.

The required filers include the following Florida Certification of Authority Categories:

(1) FRATERNAL BENEFIT SOCIETY
(2) PROPERTY AND CASUALTY INSURER
(3) HEALTH MAINTENANCE ORGANIZATION (HMO)
(4) PRE-PAID LIMITED HEALTH SERVICE ORGANIZATION
(5) LIFE AND HEALTH INSURER

having one or more of the following Florida Lines of Business active during the calendar reporting year:

a. FRATERNAL HEALTH
b. ACCIDENT AND HEALTH
c. DENTAL SERVICE PLAN CORPORATION (PREPAID DENTAL)
d. AMBULANCE SERVICE
e. OPTOMETRIC SERVICES
f. PHARMACEUTICAL SERVICES
g. HEALTH MAINTENANCE ORGANIZATIONS
h. PREPAID LIMITED HEALTH SERVICE ORGANIZATION
i. MENTAL HEALTH SERVICES
j. SUBSTANCE ABUSE SERVICES
k. CHIROPRACTIC SERVICES
l. PODIATRIC CARE SERVICES
m. MISC. – PLHSO

The electronic filing via the Industry Portal (https://iportal.fldfs.com) of this information is required pursuant to Section 627.316, F.S., and Rules 69O-137.004 and 69O-154.112(3), Florida Administrative Code.

Specific instructions on the use of the Industry Portal’s Data Reporting module are available upon request from AnnualA&HReporting_1094-1386@floir.com

“NO DATA FILING” is to be used if the reporting entity had

● no direct Florida premiums (written or earned) during the calendar reporting year

AND

● no direct Florida losses incurred during the calendar reporting year

AND

● no enrolled Florida resident groups or primary insureds as of December 31st of the calendar reporting year.
“DATA FILING” is to be used by all other reporting entities. The data template contained in this category includes:

1. Report of Gross Annual Premiums and Enrollment Data for Health Benefit Plans Issued to Florida Residents, OIR-B2-1094

The accident and health coverage types (as defined by the National Association of Insurance Commissioners Uniform Product Coding Matrix for Life, Accident/Health, Annuity, Credit Products unless otherwise specified) are included in the ROW and COLUMN instructions that follow.
### Row Definitions:

| TYPE OF INSURANCE DESCRIPTION | TOI or Sub-TOI Code per NAIC
|-------------------------------|---------------------------------|
| **Major Medical** - A hospital/surgical/medical expense contract that provides comprehensive benefits as defined in the state in which the contract will be delivered. In Florida this means insurance that is designed to cover expenses of serious illness, chronic care (excluding long-term care) and/or hospitalization. The term does NOT include accident-only, specified disease, individual hospital indemnity, credit, dental-only, vision-only, prepaid products, Medicare supplement, long-term care, or disability income insurance; similar supplemental plans provided under a separate policy, certificate, or contract of insurance, which do not duplicate coverage under an underlying health plan and are specifically designed to fill gaps in the underlying health plan, coinsurance, or deductibles; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance. | H16G
| **Hospital/Surgical/Medical Expense** - An insurance contract that provides coverage to or reimburses the covered person for hospital, surgical, and/or medical expense incurred as a result of injury, sickness, and/or medical condition. | H16I
| **Conversion** - Guarantees an insured whose coverage is ending for specified reasons a right to purchase a policy without presenting evidence of insurability. | H15G
| **Accident Only** - An insurance contract that provides coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accident. | H15I
| **Accidental Death & Dismemberment** - An insurance contract that pays a stated benefit in the event of death and/or dismemberment caused by accident or specified kinds of accidents. | H06
| **Blanket Accident/Sickness** -- A health insurance contract that covers all of a class of persons not individually identified in the contract. | H02G
| **Dental** - Insurance that provides benefits for routine dental examinations, preventive dental work and dental procedures needed to treat tooth decay and diseases of the teeth and jaw. | H02I
| **Disability Income** (includes Business Overhead Expense; Short Term; Long Term; and Combined Short Term and Long Term) - A policy designed to compensate insureds for a portion of the income they lose because of a disabiliy injury or illness. | H03G
| **Administrative Services Only (ASO)** - ASO describes the contractual arrangement utilized by a self-funded employer, whereby a separate company processes claims and other administrative needs pertinent to the employer's health care plans. (Please report fees in "Total Direct Premiums Earned" and "Direct Premiums Earned for New Business Only" and "Covered Lives") | H03I
| **Other Prepaid Health Services not listed below**: Pursuant to Section 636.003(5), F.S., "Limited health service" also includes ambulance services, mental health services, substance abuse services, chiropractic services, podiatric care services, and pharmaceutical services. "Limited health service" does not include inpatient, hospital surgical services, or emergency services except as such services are provided incident to the limited health services. | H04

These definitions include the following subcategories:

- **Guarantee Issue (HIPAA, FS 627.6487(3))**
- **Individually Underwritten**
- **Self-Employed or Sole Proprietor (FS 627.6699)**

- **2 - 50 Member Groups (FS 627.6699)**
- **51 - 100 Member Groups (FS 627.6699)**
- **101+ Member Groups (FS 627.652)**

**Conversion** - Guarantees an insured whose coverage is ending for specified reasons a right to purchase a policy without presenting evidence of insurability.

**Accident Only** - An insurance contract that provides coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by or necessitated as a result of accident or specified kinds of accident.

**Accidental Death & Dismemberment** - An insurance contract that pays a stated benefit in the event of death and/or dismemberment caused by accident or specified kinds of accidents.

**Blanket Accident/Sickness** -- A health insurance contract that covers all of a class of persons not individually identified in the contract.

**Dental** - Insurance that provides benefits for routine dental examinations, preventive dental work and dental procedures needed to treat tooth decay and diseases of the teeth and jaw.

**Disability Income** (includes Business Overhead Expense; Short Term; Long Term; and Combined Short Term and Long Term) - A policy designed to compensate insureds for a portion of the income they lose because of a disabiliy injury or illness.
<table>
<thead>
<tr>
<th>TYPE OF INSURANCE DESCRIPTION</th>
<th>TOI or Sub-TOI Code per NAIC Uniform Coding Matrix (Revised 1/1/05)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Excess/Stop Loss</strong> (includes Accident &amp; Sickness; Managed Care; Provider; and Self-Funded Health Plan) - This type of insurance may be extended to either a health plan or a self-insured employer plan. Its purpose is to insure against the risk that any one claim will exceed a specific dollar amount or that an entire plan's losses will exceed a specific amount. As defined in Section 627.6482 (14), F.S., “Stop-loss coverage” means an arrangement whereby an insurer insures against the risk that any one claim will exceed a specific dollar amount or that an entire self-insurance plan's losses will exceed a specific amount.</td>
<td>H12</td>
</tr>
<tr>
<td><strong>Hospital Indemnity</strong> - An insurance contract that pays a fixed dollar amount without regard to the actual expense incurred for each day the covered person is confined to the hospital as a result of injury, sickness, and/or medical condition.</td>
<td>H14G H14I</td>
</tr>
<tr>
<td><strong>Limited Benefit</strong> (includes Specified Disease; Critical Illness; Dread Disease; Dread Disease – Cancer Only; HIV Indemnity; Intensive Care; and Organ &amp; Tissue Transplant)-&lt;br&gt;(a) Pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Benefits can be paid as expense incurred, per diem, or a principle sum.&lt;br&gt;(b) Provides a daily benefit for confinement in a qualified intensive care unit of a certified hospital. Benefits are specific to services delivered by the staff of a hospital intensive care unit. Benefits not to exceed a stated dollar amount per day.&lt;br&gt;(c) Provides benefits for services incurred as a result of human and/or non-human organ transplant. Benefits are specific to the delivery of care associated with the covered organ or tissue transplant. Benefits not to exceed a stated dollar amount per day.</td>
<td>H07G H07I H08G H08I H09G H09I</td>
</tr>
<tr>
<td><strong>Long Term Care-Comprehensive</strong> -- Coverage that provides both facility (nursing home) and non-facility (home health care) benefits. This includes products that offer one type of benefit through a base form and the second type through a rider. All extension of benefit riders providing comprehensive coverage are included.</td>
<td>LTC05G LTC05I</td>
</tr>
<tr>
<td><strong>Long Term Care-Facility Only</strong> -- Coverage that provides only facility (nursing home) benefits. All extension of benefit riders providing facility only coverage are included.</td>
<td>LTC04G LTC04I</td>
</tr>
<tr>
<td><strong>Long Term Care-Non-Facility Only</strong> -- Coverage that provides only non-facility (home health care) benefits. All extension of benefit riders providing non-facility only coverage are included.</td>
<td>LTC02G LTC02I</td>
</tr>
<tr>
<td><strong>Long Term Care-Accelerated Benefit Rider</strong> -- Coverage that provides any type of long term care benefit paid from either a life or annuity product.</td>
<td>FLLTC06</td>
</tr>
<tr>
<td><strong>Short Term Care</strong> (includes Home Health Care; Nursing Home; and Adult Day Care) - Coverage that provides medical and other services to insured's who need constant care in their own home or in a nursing facility for periods of less than one year.</td>
<td>H13G H13I</td>
</tr>
<tr>
<td><strong>Medicare Supplement</strong> - Insurance coverage sold on an individual or group basis to help fill the &quot;gaps&quot; in the protections granted by the federal Medicare program. This is strictly supplemental coverage and cannot duplicate any benefits provided by Medicare. It is structured to pay part or all of Medicare's deductibles and co-payments. It may also cover some services and expenses not covered by Medicare. Also known as &quot;Medigap&quot; insurance.</td>
<td>MS02G MS02I MS03G MS03I MS04G MS04I MS05G MS05I MS06</td>
</tr>
<tr>
<td><strong>Champus/Tricare Supplement</strong> - Civilian Health and Medical Program of the Uniformed Services (Champus). A private health plan that provides beneficiaries eligible for Champus with supplemental health care coverage.</td>
<td>H05</td>
</tr>
<tr>
<td><strong>Prescription Drug</strong> - Prescription drug plan that covers the cost of drugs (except those dispensed in a hospital or in an extended care facility) that are required by either state or federal law to be dispensed by prescription. Drugs for which prescriptions are not required by law may be covered.</td>
<td>H17G H17I</td>
</tr>
<tr>
<td>TYPE OF INSURANCE DESCRIPTION</td>
<td>TOI or Sub-TOI Code per NAIC Uniform Coding Matrix (Revised 1/1/05)</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Sickness - Limited benefit expense policies. Provides benefits for sickness only. Benefits not to exceed a stated dollar amount per day.</td>
<td>H18G  H18I</td>
</tr>
<tr>
<td>Student - A health insurance contract that covers a class of students not individually identified in the contract.</td>
<td>H04.001</td>
</tr>
<tr>
<td>Travel - Limited benefit expense policies. Provides benefits for loss incurred while travelling generally outside a 100-mile radius of the US borders. *May extend to domestic as well as foreign travel. May provide both sickness and injury benefits. May include loss of baggage benefits. May include air transportation services for emergencies. Benefits not to exceed a stated dollar amount per day, per month or trip duration. (*Subject to applicable state limitations.)</td>
<td>H19G  H19I</td>
</tr>
<tr>
<td>Vision - Limited benefit expense policies. Provides benefits for eye care and eye care accessories. Generally provides a stated dollar amount per annual eye examination. Benefits often include a stated dollar amount for glasses and contacts. May include surgical benefits for injury or sickness associated with the eye.</td>
<td>H20G  H20I</td>
</tr>
<tr>
<td>Other - NOT to include the following: Medicare (All Titles), Medicare + Choice, HCPP, Medicaid (All Titles), SCHIP, FEHBP, Florida Healthy Kids, Florida Health Flex Plans, self-insured business, credit (group and individual), or credit A&amp;H (group and individual)</td>
<td>H21 Other</td>
</tr>
</tbody>
</table>

**Accident and Health Insurance Premiums and Losses** - The Total Direct Premiums Earned and the Total Direct Losses Incurred from the company’s Annual Statement are entered and compared to the premium and loss sums from lines 1 through 37. These amounts should equal or an explanatory letter will be required.

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Please note that as defined in Section 627.6482(12), premium means the entire cost of an insurance plan, including the administrative fee, the risk assumption charge, and, in the instance of a minimum premium plan or stop-loss coverage, the incurred claims whether or not such claims are paid directly by the insurer.

Beginning January 1, 2013, the Office no longer requires that Discount Medical Plan Organization premium, loss, or enrollment information be reported on the 1094 template. When using Line 37 ("Other") be sure to upload an explanation of the products you are including in that line. When applicable, the Office will contact you and instruct that the products be included on a detail line.
For each of the health coverage types listed above, the following information is required:

**Column Definitions:**

<table>
<thead>
<tr>
<th>Column Definition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL DIRECT PREMIUMS EARNED</td>
<td>Requested data is your company's direct premium earned from January 01 through December 31, inclusive, for the calendar reporting year. Provide only earned premium specific to covered Florida residents. This cell should contain a whole number or zero.</td>
</tr>
<tr>
<td>DIRECT LOSSES INCURRED</td>
<td>Requested data is your company's direct losses incurred from January 01 through December 31, inclusive, for the calendar reporting year. Provide only losses specific to covered Florida residents. This cell should contain a whole number or zero.</td>
</tr>
<tr>
<td>RATIO OF DIRECT LOSSES INCURRED TO DIRECT PREMIUMS EARNED</td>
<td>This is an auto-calculation field. It divides [DIRECT LOSSES INCURRED] by [TOTAL DIRECT PREMIUMS EARNED].</td>
</tr>
<tr>
<td>WAS THIS COVERAGE ACTIVELY TRANSACTED DURING THE REPORTING PERIOD?</td>
<td>This cell is used to indicate whether or not your company sold any policies of the associated coverage in each row during the calendar reporting year. A policy is considered to be sold if it meets the definition of an insurance transaction per Section 624.10, F.S. Responding &quot;YES&quot; means sales did occur during the calendar reporting year. Responding &quot;NO&quot; means sales did not occur during the calendar reporting year.</td>
</tr>
<tr>
<td>DIRECT PREMIUMS EARNED FOR NEW BUSINESS ONLY</td>
<td>Requested data is your company's direct premium earned for new business only from January 01 through December 31, inclusive, for the calendar reporting year. Provide earned premium specific to covered Florida residents. The data contained in this cell should be included in the total reported for &quot;TOTAL DIRECT PREMIUMS EARNED.&quot; This cell should contain a whole number or zero. If the coverage associated with this cell was sold during the calendar reporting year, this cell should be entered as a whole number or zero. Otherwise, please enter zero.</td>
</tr>
<tr>
<td>PERCENTAGE OF NEW BUSINESS PREMIUMS TO TOTAL PREMIUMS</td>
<td>This is an auto-calculation field. It divides [DIRECT PREMIUMS EARNED FOR NEW BUSINESS ONLY] by [TOTAL DIRECT PREMIUMS EARNED] then multiplies the result by 100 to convert it to a percentage.</td>
</tr>
<tr>
<td>EMPLOYEES/GROUPS, IF GROUP COVERAGE, AT END OF REPORTING CY</td>
<td>For all group categories, provide the number of employers who covered Florida resident employees, as of December 31 for the calendar reporting year. This cell should contain a positive, whole number or zero.</td>
</tr>
<tr>
<td>PRIMARY ENROLLEES AT END OF REPORTING CY</td>
<td>Provide the total number of resident individual policyholders or resident group employee/member certificateholders, as of December 31 for the calendar reporting year. This cell should contain a positive, whole number or zero.</td>
</tr>
</tbody>
</table>
Additional Filing Requirements for All Insurers Marketing Guaranteed Issue Health Insurance to Eligible Individuals as defined by Section 627.6487(3), F.S.

Please note that "insurer" means any entity that provides health insurance in this state. This includes an insurance company with a valid certificate in accordance with chapter 624, a health maintenance organization with a valid certificate of authority in accordance with part I or part III of chapter 641, a prepaid health clinic authorized to transact business in this state pursuant to part II of chapter 641, multiple employer welfare arrangements authorized to transact business in this state pursuant to ss. 624.436-624.45, or a fraternal benefit society providing health benefits to its members as authorized pursuant to chapter 632.

Florida law defines “individual health insurance” as health insurance offered to an individual. This definition includes certificates of coverage offered to individuals in Florida as part of a group policy issued to an association outside this state. "Health insurance" means any hospital or medical expense incurred policy, health maintenance organization subscriber contract pursuant to chapter 627 or chapter 641, or any other health care plan or arrangement that pays for or furnishes medical or health care services, whether by insurance or otherwise. The term does not include short term, accident, dental-only, vision-only, fixed indemnity, limited benefit, or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self insurance.

The companies defined above are required to complete and submit the reporting form OIR-B2-1386, Individual Health Coverage Policy Forms Issued/Renewed in Florida portion of the data template. Associated additional documentation to be submitted includes the following information:

1. Listing of plan name, corresponding form number(s) and a brief description of benefits for each individual major medical and/or hospital, surgical, medical expense policy issued and/or enforce with the company.
2. The two ACTIVELY TRANSACTED individual major medical and/or hospital, medical and surgical expense policy forms which generate the largest and next to largest direct premium earned volume for the company. If either of these forms is made available with co-payment options, riders, endorsements, etc., the company is to specify the most popular option combination based on direct premiums earned volume. Please note: the top two forms identified may consist of any combination of basic policy form and/or policy form combination based on direct premium earned volume.
3. For the two policy forms identified above:
   a. The date this Office approved each form, if applicable, is to be provided.
   b. The Office’s file log number under which each form was approved, if applicable, is to be provided.
   c. A description of the benefits provided is to be included.
   d. A copy of each form (and any options, riders, endorsements, etc.) is to be uploaded.
   e. All marketing materials provided to eligible individuals (HIPAA-eligible) are to be uploaded.
   f. An explanation of how these eligible individuals are to be informed of the availability of the company’s applicable individual coverages is to be uploaded.

Data Submission Validation Process

Computerized Validations:
There are two stages of data validation performed on your data template before it can be received by the Office.

The first of these are built into the data template itself. As you navigate the template, you will be given various “Validation Assistance” alerts. For example, if a type of coverage is defined as GROUP coverage, you will receive an alert as you begin to enter data in the [EMPLOYERS/GROUPS, IF GROUP COVERAGE, AT END OF REPORTING CY] cell that reads: “If the number of Employers/Groups reported is zero, then the number of Primary Enrollees and the number of Covered Enrollee Dependents must also be zero.” If you enter zero in the cell, the data template will not allow you to enter anything but zero in the [PRIMARY ENROLLEES AT END OF REPORTING CY] and [COVERED ENROLLEE DEPENDENTS AND JOINT PRIMARY INSUREDS AT END OF REPORTING CY] cells.

The second stage of computerized validations is performed at the time you submit your data template. These validations are performed “behind the scenes” by the Office’s computer system. These checks notify you by email if you have missed a required cell or made a similar type of data entry error on the data template. At the time your email notification is sent, your data template is returned to your Industry Portal workbench area so that corrections can be made. If you feel you need assistance with the corrections, please contact the Office via email at: AnnualA&HReporting_1094-1386@floir.com

Reviewer Validations:
Once your data submission reaches the Office, a staff member rechecks your data for reasonability. This can include comparing your submitted data to other sources and previous data submission received from your company.

If the reviewer has a question or needs clarification, he/she will contact you by email or phone. This clarification letter will reference the “file log number” assigned to your data submission by the Office. This tracking number will be used on all communication from the Office about your data.

Once the reviewer is satisfied with your data submission, you will receive a final disposition letter by email which closes your data submission filing. Final disposition you will see in these letters include:

1. **FILING NOT REQUIRED**: This means your company is not required to report this data. No further action will be needed on your part.

2. **SUBMISSION ERROR**: This means your submission does not meet the filings standards for this specific reporting requirement. Depending on the type of error your submission contained, you may or may not need to resubmit your data under another Office tracking number.

3. **EXEMPT**: This final disposition means your submission of “NO DATA” meets the reporting requirement for this reporting period. No further action will be needed on your part for the reporting period covered by your data submission. Please note: Receiving an exemption letter does not preclude the necessity of filing additional data or no data filings in the future. In most cases, your company will need to continue to file each reporting period.

4. **WITHDRAWN**: This means your company requested your submission under the assigned file log number be closed by the Office. In most cases, this is done so that you can “start from scratch” and re-file your data under a new file log number.

5. **ACCEPTED**: A final disposition letter of acceptance means that the reviewer has completed his/her reasonability checks and feels your data submission is valid. No further action is required at this time.

6. **REFERRED**: This type of letter means that based on the data submitted and any additional information provided, your data submission will be referred to the Office’s Market Investigation Unit for additional follow up.