Section I
Notices of Development of Proposed Rules and Negotiated Rulemaking

DEPARTMENT OF INSURANCE

RULE TITLES:	RULE NOS.:
Purpose	4-144.001
Approval Procedures	4-144.002
Credit for Reinsurance Allowed a Domestic Ceding Insurer	4-144.005
Accounting Requirements; Life and Health Reinsurance Agreements	4-144.010

PURPOSE AND EFFECT: The proposed rule will be to amend the rule to incorporate the 2000 legislative changes to section 624.610, F.S.

SUBJECT AREA TO BE ADDRESSED: To incorporate the 2000 legislative changes in section 624.610, F.S.

SPECIFIC AUTHORITY: 624.308 FS.

LAW IMPLEMENTED: 624.307(1), 624.316, 624.317, 624.318, 624.321, 624.324, 624.34, 624.401, 624.404, 624.407, 624.413, 624.424, 624.501(20)(c), 624.5091, 624.610, 628.051, 628.801, 629.081 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW:

TIME AND DATE: 9:00 a.m., September 19, 2000.

PLACE: Room 116, Larson Building, 200 E. Gaines Street, Tallahassee, FL

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Bob Norris, Financial Administrator, Insurer Services, Department of Insurance, phone (850)413-5054

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this program, please advise the Department at least 5 calendar days before the program by contacting: Yvonne White, (850)922-3110, Ext. 4214.

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS AVAILABLE AT NO CHARGE FROM THE CONTACT PERSON LISTED ABOVE.

DEPARTMENT OF INSURANCE

RULE TITLES:	RULE NOS.:
Purpose	4-157.001
Applicability and Scope	4-157.002
Definitions	4-157.003
Out-of-State Group Long-Term Care Insurance	4-157.004
Pre-existing Conditions	4-157.006
Conditions of Eligibility	4-157.007
Minimum Coverage	4-157.009
Requirements for Replacement	4-157.016
Prior Institutionalization	4-157.017
Right to Return Policy – Free Look	4-157.018
Long-Term Care Policies – Statements Required	4-157.019
Outline of Coverage	4-157.020
Nonforfeiture Protection Provision	4-157.023
Required Disclosure Provisions	4-157.024
Prohibition Against Post – Claims Underwriting	4-157.025
Discontinuance and Replacement	4-157.026
Appropriateness of Recommended Purchase	4-157.027
Requirements for Application Forms and Replacement Coverage	4-157.028
Prohibition Against Preexisting Conditions & Probationary Periods in Replacement Policies or Certificates	4-157.029
Reporting Requirements	4-157.030
Requirement to Deliver Shopper's Guide	4-157.031

PURPOSE AND EFFECT: To adopt NAIC standards applicable to Long Term Care and Certain Limited Benefit Insurance policies.

SUBJECT TO BE ADDRESSED: Adoption of NAIC standards regarding the content, rates, and sales of Long Term Care and Limited Benefit insurance policies.

SPECIFIC AUTHORITY: 624.308, 627.9407 FS.

LAW IMPLEMENTED: 624.307(1), 624.3161, 626.9541, 627.9403, 627.9405, 627.9406, 627.9407, 627.94072, 626.9641 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW:

TIME AND DATE: 2:00 p.m., September 19, 2000

PLACE: Room 116, Larson Building, 200 East Gaines Street, Tallahassee, Florida

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Frank Dino, Department of Insurance, 200 East Gaines Street, Tallahassee, FL 32399-0329, (850)413-5014

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this program, please advise the Department at least 5 calendar days before the program by contacting: Yvonne White, (850)413-4214.

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

LONG-TERM CARE <u>& CERTAIN</u>
<u>LIMITED BENEFIT</u> INSURANCE

4-157.001 Purpose.

Specific Authority 624.308(1), 627.9407(1) FS. Law Implemented 624.307(1), 629.9402, 627.9407(1) FS. History–New 5-17-89, Formerly 4-81.001, <u>Repealed _____</u>.

4-157.002 Applicability and Scope.

(1) No change.

(2) The provisions of Chapter 4-157 shall apply to such long-term care policies issued or renewed on or after the effective date of Chapter 4-157; however, the provisions of Chapter 4-157 do not apply to any policy that is not subject to the provisions of sections 627.6401-627.9408, F.S.~~, as presently existing or as hereafter amended.~~

(3) Pursuant to s. 627.9403, F.S., the provisions of this rule shall also apply to limited benefit policies that limit coverage to care in a nursing home only or to one or more lower levels of care required or authorized to be provided that are issued on or after October 1, 1996.

Specific Authority 624.308(1), 627.9407(1) FS. Law Implemented 624.307(1), 627.9403, 627.9406, 627.9407(1) FS. History–New 5-17-89, Formerly 4-81.002, Amended _____.

4-157.003 Definitions.

As used in these rules and as used in long-term care policies, the following terms shall have meanings no more restrictive than the following:

(1) through (3) No change.

(4) "Nursing home" means a facility or distinctly separate part of a hospital or other institution which is licensed by the appropriate licensing agency to engage primarily in providing nursing care and related services to inpatients and provides 24-hour a day nursing service, and has a nurse on duty or on call at all times and maintains clinical records for all patients and as defined and licensed pursuant to the provisions of Chapter 400, Florida Statutes.

(5) through (7) No change.

(8) "Home Health Care" as defined in Chapter 400, Florida Statutes.

(9) "Assisted Living Facility" as defined in Chapter 400, Florida Statutes.

(10) "Adult Day Care Center" as defined in Chapter 400, Florida Statutes.

(11) "Nurse Registry" as defined in Chapter 400. Florida Statutes.

Specific Authority 624.308(1), 627.9407(1) FS. Law Implemented 624.307(1), 627.9407 FS. History–New 5-17-89, Formerly 4-81.003, Amended _____.

4-157.004 Out-of-State Group Long-Term Care Insurance.

(1) No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in s~~ection~~ 627.9405(1)(c) or (d), F.S. unless this state or such other state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met. Evidence to this effect shall be filed by the insurer with the department pursuant to the procedures specified in s~~ection~~ 627.410, F.S. Such evidence shall consist of:

(a) Filing of policy and certificate forms, including rates and rate development information, as though the policy/certificate were issued in this state, which demonstrate that the requirements of s~~ections~~ 627.9401-627.9408, F~~lorida~~ S~~tatutes~~, and these rules have been met, except s~~ection~~ 627.9405(2), F.S.; or

(2) In order for a state to be deemed to have statutory and regulatory long-term care insurance requirements substantially similar to those adopted in Florida, that ~~such~~ state shall ~~must~~ require that long-term care policies meet at least all of the following requirements:

(a) A minimum period of coverage of at least 24 consecutive months for coverage in a nursing home for each covered person. In addition to coverage for care in a nursing home all long-term care policies shall provide coverage for at least one type of lower level of care for each covered person. In furtherance of this requirement, benefits for all lower levels of care, shall provide a level of benefits equivalent to 50 percent of the benefits provided for nursing home coverage. i.e., if the nursing home benefit amount is $100 per day then the required lower level of care benefit amount shall be $50 per day or if more than one lower level of care is provided than each lower level of care shall provide a benefit amount of $50 per day;

(b) A 60% minimum lifetime loss ratio meeting the standards of 4-157.022 ~~at levels at which benefits are reasonable in relation to premiums and calculated in a manner which provides for adequate reserving of the long-term care insurance risk~~;

(c) A 30-day "free look" period, or longer, within which individual certificateholders ~~policyholders~~ have the right to return the certificate ~~policy~~ after its delivery and to have the premium refunded for any reason;

(d) through (i) No change.

(j) A minimum 30-day grace period for nonpayment of premium with notice and protection requirements as provided by s. 627.94072, F.S.

(k) Pursuant to s. 627.94072, F.S., a mandatory offer to the potential insured policyholder or certificateholder, as applicable, of a nonforfeiture provision meeting the standards of 4-157.023; and

(l) A conversion or continuation privilege at least as favorable as 4-157.010.

(m) A prohibition or limitation on an elimination in excess of 180 days as required by 4-157.013.

(3) No change.

(4)(a) All changes to rates, together with an actuarial memorandum developing and justifying the rate change, shall be filed with the Department pursuant to the procedures specified in s. 627.410, F.S.

(b) For those policies which have been determined to be regulated by a state with substantially similar long term care insurance requirements, pursuant to paragraph (1)(b) above, form and rate changes shall be filed informationally prior to

use. ~~To the extent that Section 627.9406, Florida Statutes, and this rule require that an out-of-state group policy form or rate be filed with the department for approval, such form or rate may not be amended or changed prior to approval by the Department pursuant to the procedures specified in Section 627.410, Florida Statutes.~~

Specific Authority 624.308(1), 627.9407(1) FS. Law Implemented 624.307(1), 627.9403, 627.9406 FS. History–New 5-17-89, Formerly 4-81.004, Amended _____.

4-157.006 Pre-existing Conditions.

Specific Authority 624.308(1), 627.9407(1) FS. Law Implemented 624.307(1), 627.9407(1),(4) FS. History–New 5-17-89, Formerly 4-81.006, Repealed _____.

4-157.007 Conditions of Eligibility.

(1) No change.

(2) Subsection 627.9405(2), F.S., does not require the sponsoring policyholder to contribute premiums. However no insurer may establish rules for eligibility, including continued eligibility if the sponsoring policyholder contributes any portion of the premium. ~~No group long-term care policy may be issued or issued for delivery in this state unless all members of the group, or all of any class or classes thereof, are declared eligible and acceptable to the insurer at the time of issuance of the policy, subject to any exception to this requirement expressly authorized by Section 627.9405, Florida Statutes, as presently existing or as hereafter amended.~~

Specific Authority 624.308(1), 627.9407(1) FS. Law Implemented 624.307(1), 627.9407(1), 627.9405(2) FS. History–New 5-17-89, Formerly 4-81.007, Amended _____.

4-157.009 Minimum Coverage.

(1) through (2) No change.

(3) No long-term care policy may provide significantly more coverage for care in a nursing home than coverage for lower levels of care. In furtherance of this requirement, benefits for all lower levels of care~~, in the aggregate,~~ shall provide a level of benefits equivalent to 50 percent of the benefits provided for nursing home coverage~~,~~ i.e., if the nursing home benefit amount is $100 per day then the required lower level of care benefit amount shall be $50 per day or if more than one lower level of care is provided then each lower level of care shall provide a benefit amount of $50 per day. For the purposes of applying this 50 percent equivalency requirement to a policy benefit period, the lower level of care shall be, in the aggregate, 50 percent of the benefit period provided for nursing home coverage. If a long-term care policy provides nursing home coverage for an unlimited duration, the nursing home benefit shall be considered to be payable for ten years and the lower level of care shall be payable for 5 years, in the aggregate. A long-term care policy may use an overall lifetime benefit maximum which may be exhausted by any combination of benefits

(4) For the purposes of this rule, "lower level(s) of care" means the following:

(a) No change.

(b) Assisted Living Facility. ~~Adult congregate living facility;~~

(c) through (h) No change.

Specific Authority 624.308(1), 627.9407(1) FS. Law Implemented 624.307(1), 627.9407(1),(3) FS. History–New 5-17-89, Formerly 4-81.009, Amended _____.

4-157.016 Requirements for Replacement.

Specific Authority 624.308(1), 626.9611, 627.9407 FS. Law Implemented 624.307(1), 626.9541, 626.9641, 627.9407(1) FS. History–New 5-17-89, Formerly 4-81.016, Repealed _____.

4-157.017 Prior Institutionalization.

Specific Authority 624.308(1), 627.9407(1) FS. Law Implemented 624.307(1), 627.9407(5) FS. History–New 5-17-89, Formerly 4-81.017, Repealed _____.

4-157.018 Right to Return Policy – Free Look.

Specific Authority 624.308(1), 627.9407(1) FS. Law Implemented 624.307(1), 627.9407(1),(7) FS. History–New 5-17-89, Formerly 4-81.018, Repealed _____.

4-157.019 Long-Term Care Policies – Statements Required.

Specific Authority 624.308(1), 627.9407(1) FS. Law Implemented 624.307(1), 627.9407(1),(8) FS. History–New 5-17-89, Formerly 4-81.019, Repealed _____.

4-157.020 Outline of Coverage.

An outline of coverage shall be delivered to an applicant for an individual long-term care insurance policy or certificateholder at the time of application ~~for an individual policy~~. In the case of direct response solicitations, the insurer shall deliver the outline of coverage upon the applicant's request, but regardless of request, shall make such delivery no later than at the time of policy delivery. The content and format of the outline of coverage shall be ~~Such outline of coverage shall include~~:

(1) The outline of coverage shall be free-standing document, using no smaller than ten point type.

(2) The outline of coverage shall contain no material of an advertising nature.

(3) Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.

(4) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

(5) Format for outline of coverage:

[COMPANY NAME]
[ADDRESS – CITY & STATE]
[TELEPHONE NUMBER]
LONG-TERM CARE INSURANCE
OUTLINE OF COVERAGE
[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any question is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

(a) This policy is [an individual policy of insurance] ([a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).

(b) PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights an obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

(c) TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

1. [Provide a brief description of the right to return – "free look" provision of the policy.]

2. [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

(d) THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

1. [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.

2. [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

(e) LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting period] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

(f) BENEFITS PROVIDED BY THIS POLICY.

1. [Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.]

2. [Institutional benefits, by skill level.]

3. [Non-institutional benefits, by skill level.]

[Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.]

(g) LIMITATIONS AND EXCLUSIONS.

[Describe:

1. Preexisting conditions;

2. Non-eligible facilities/provider;

3. Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by family member, etc.);

4. Exclusions/exceptions;

5. Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits descried in (f) above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

(h) RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicated the following:

1. That the benefit level will not increase over time;

2. Any automatic benefit adjustment provisions;

3. Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

4. And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

(i) ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

(j) PREMIUM.

[1. State the total annual premium for the policy;

2. If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

(k) ADDITIONAL FEATURES.

[1. Indicate if medical underwriting is used;

2. Describe other important features and other mandatory offers.]

~~(1) The name and principal address of the insurer or service association;~~

~~(2) A statement of identification of the policy or contract;~~

~~(3) A policy form number;~~

~~(4) A description of the principal benefits and coverage provided in the policy;~~

~~(5) A statement of the principal exclusions, reductions, and limitations contained in the policy;~~

~~(6) If the policy is not expected to cover 100 percent of the cost of services for which coverage is provided, as statement clearly describing any such limitations;~~

~~(7) A statement of the renewal provisions, including any reservation in the policy of a right to change premiums;~~

~~(8) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions; and~~

~~(9) A statement that the policy has been approved as a long-term care insurance policy meeting the requirements of Florida Law.~~

Specific Authority 624.308(1), 627.9407(1) FS. Law Implemented 624.307(1), 627.9407(1),(9) FS. History–New 5-17-89, Formerly 4-81.020, Amended _____.

4-157.023 Nonforfeiture Protection Provision.

(1)(a) All insurers offering long term care insurance policies or certificates in this state shall offer a nonforfeiture protection provision at the time of issue as required by s. 627.94072, F.S.

(b) If the insurer offers an option other than the shortened benefit period option, the nonforfeiture protection option offered shall be determined such that the benefits provided are determined at time of issue to be at least actuarially equivalent to those provided by the shortened benefit period option.

(2) Other nonforfeiture protection provisions shall not be offered for sale in this state unless they meet the provisions of this rule.

Specific Authority 624.308(1), 627.9407 FS. Law Implemented 624.307(1), 627.9407, 627.94072 FS. History–New _____.

4-157.024 Required Disclosure Provisions.

(1) Renewability. Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned and shall appear on the first page of the policy.

(2) Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

(3) Payment of Benefits. A long-term care insurance policy which provides for the payment of benefits based on standards described as "mutual and customary," "reasonable and customary" or words of similar import shall include a definition of such terms and the formula or criteria used by the insurer in determining the amount to be paid and an explanation of such terms in its accompanying outline of coverage.

(4) Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."

Specific Authority 624.308(1), 627.9407 FS. Law Implemented 624.307(1), 627.9407 FS. History–New _____.

4-157.025 Prohibition Against Post – Claims Underwriting.

(1) All applications for long-term care insurance policies or certificates except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(2)(a) If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

(b) If any information disclosed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

(3) Except for policies or certificates which are guaranteed issue:

(a) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate: "Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy."

(b) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery: "Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of our [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]"

(c) Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the insurer shall obtain one of the following:

1. A report of a physical examination;

2. An assessment of functional capacity;

3. An attending physician's statement; or

4. Copies of medical records.

(4) A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

(5) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated and shall annually furnish this information to the Department in the format prescribed by the National Association of Insurance Commissioners in Appendix A, which is hereby adopted and incorporated by reference.

Specific Authority 624.308(1), 627.9407 FS. Law Implemented 624.307(1), 627.9407 FS. History–New _____.

4-157.026 Discontinuance and Replacement.

If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

(1) Shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

(2) Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services;

Specific Authority 624.308(1), 627.9407 FS. Law Implemented 627.307(1), 627.9407 FS. History–New _____.

4-157.027 Appropriateness of Recommended Purchase.

In recommending the purchase or replacement of any long-term care insurance policy or certificate any agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

Specific Authority 624.308(1), 627.9407 FS. Law Implemented 624.307(1), 627.9407 FS. History–New _____.

4-157.028 Requirements for Application Forms and Replacement Coverage.

(1) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing such questions may be used.

(a) Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

(b) Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months?

1. If so, with which company?

2. If that policy lapsed, when did it lapse?

(c) Are you covered by Medicaid?

(d) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

(2) Agents shall list any other health insurance policies they have sold to the applicant.

(a) List policies sold which are still in force.

(b) List policies sold in the past five (5) years which are no longer in force.

(3) Solicitations Other than Direct Response. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its agent; shall furnish the applicant, prior to issuance or delivery to the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]:

(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention.

(a) Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(b) State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(c) If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(d) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all question on the application concerning your medical health history. Failure to include all material medical information on the application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

_____

(Signature of Agent, Broker or Other Representative)

[Typed Name and Address of Agent or Broker]

The above "Notice to Applicant" was delivered to me on:

_____ (Date)

_____ (Applicant's Signature)

(4) Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] Insurance Company.

Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

(a) Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or

delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(b) State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

(c) If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the propose replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(d) [To be included only if the application is attached to the policy] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

_____ (Company Name)

(5) Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the propose replacement. The existing policy shall be identified by the insurer, name of the insured and policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Such notice shall be made within five (5) working days from the data the application is received by the insurer or the date the policy is issued, whichever is sooner.

Specific Authority 624.308(1), 627.9407 FS. Law Implemented 624.307(1), 627.9407 FS. History–New _____.

4-157.029 Prohibition Against Preexisting Conditions & Probationary Periods in Replacement Polices or Certificates.

If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

Specific Authority 624.308(1), 627.9407 FS. Law Implemented 624.307(1), 627.9407 FS. History–New _____.

4-157.030 Reporting Requirements.

(1) Every insurer shall maintain records for each agent of the agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

(2) Every insurer shall report annually by June 30 the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by (1) above.

(3) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

(4) Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

(5) Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total number of policies in force as of the preceding calendar year.

(6) Every insurer shall report annually by June 30 for qualified long-term care insurance contracts the number of claims denied for each class of business, expressed as a percentage of claims denied, other than claims denied for failure to meet the waiting period or because of any applicable preexisting condition.

(7) For purposes of this section, “policy” shall mean only long-term care insurance and “report” means on a statewide basis.

(8) Reports shall be filed with the Bureau of Life & Health Solvency and Market Conduct, Division of Insurer Services.

Specific Authority 624.308(1), 627.9407 FS. Law Implemented 624.307(1), 624.3161, 627.9407 FS. History–New _____.

4-157.031 Requirement to Deliver Shopper's Guide.

(1) A long term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the Department, shall be provided to all prospective applicants for a long-term care insurance policy or certificate.

(a) In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

(b) In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

(2) Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under s. 626.99, F.S.

(3) At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

(a) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions for death benefits;

(b) An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;

(c) Any exclusions, reductions and limitations on benefits of long-term care; and

(d) If applicable to the policy type, the summary shall also include:

1. A disclosure of the effects of exercising other rights under the policy;

2. A disclosure of guarantees related to long-term care costs of insurance charges, and

3. Current and projected maximum lifetime benefits.

(4) Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. Such report shall include:

(a) Any long-term care benefits paid out during the month;

(b) An explanation of any changes in the policy, e.g. death benefits or cash values, due to long-term care benefits being paid out; and

(c) The amount of long-term care benefits existing or remaining.

Specific Authority 624.308(1), 627.9407 FS. Law Implemented 624.307(1), 627.9407 FS. History–New _____.

PUBLIC SERVICE COMMISSION

UNDOCKETED

RULE TITLE: RULE NO.:
Meter Accuracy at Installation 25-7.063

PURPOSE AND EFFECT: The purpose of the change is to improve meter accuracy at installation and to eliminate the requirement to conduct random tests of accuracy of new meters and only require testing if the meter shipment arrives with apparent damage.

SUBJECT AREA TO BE ADDRESSED: Gas meter accuracy and testing requirements.

SPECIFIC AUTHORITY: 366.05(1) FS.

LAW IMPLEMENTED: 366.05(1) FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW:

TIME AND DATE: 9:30 a.m., October 4, 2000

PLACE: Room 309, Gunter Building, 2540 Shumard Oak Blvd., Tallahassee, Florida

Submit workshop request within 14 days to: Christiana T. Moore, Division of Appeals, 2540 Shumard Oak Boulevard, Tallahassee, FL 32399-0850.

Any person requiring some accommodation at this workshop because of a physical impairment should call the Division of Records and Reporting at (850)413-6770 at least 48 hours prior to the hearing. Any person who is hearing or speech impaired should contact the Florida Public Service Commission by using the Florida Relay Service, which can be reached at 1(800)955-8771 (TDD).

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Edward Mills, Division of Safety and Electric Reliability, Florida Public Service Commission, 2540 Shumard Oak Blvd., Tallahassee, FL 32399-0862, (850)413-6650

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS AVAILABLE AT NO CHARGE FROM THE CONTACT PERSON LISTED ABOVE.

DEPARTMENT OF CORRECTIONS

RULE TITLE: RULE NO.:
Qualified Representatives 33-102.202

PURPOSE AND EFFECT: The purpose of the proposed rule is to ensure that inmate participation in administrative proceedings is in accordance with the intent of the administrative procedures act, and to ensure proper utilization of department resources in providing for such participation. The effect of the proposed rule is to restrict inmates from acting as qualified representatives in administrative proceedings.

SUBJECT AREA TO BE ADDRESSED: Administrative proceedings.

SPECIFIC AUTHORITY: 944.09 FS.

LAW IMPLEMENTED: 120.81, 944.09 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Perri King Dale, 2601 Blair Stone Road, Tallahassee, Florida 32399-2500

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

33-102.202 Qualified Representatives.

Inmates shall not act as qualified representatives in administrative proceedings.

Specific Authority 944.09 FS. Law Implemented 120.81, 944.09 FS. History–New .

AGENCY FOR HEALTH CARE ADMINISTRATION

Cost Management and Control

RULE TITLES:	RULE NOS.:
Submission of Ambulatory Patient Data	59B-9.011
Definitions	59B-9.013
Reporting Instructions	59B-9.015
Certification and Audit Procedures	59B-9.017
Ambulatory Patient Data Format – Data Elements and Codes	59B-9.018
Ambulatory Patient Data Tape/Diskette Format – Record Layout	59B-9.019
Data Standards	59B-9.020
Manual Submission of Data	59B-9.021

PURPOSE AND EFFECT: The proposed rule amendments require that providers report separately for each separate location. Multi-facility tapes will no longer be accepted. The proposed rule amendments clarify that patient visits in which the patient is transferred to inpatient care shall not be reported as an ambulatory visit unless the patient is transferred to another facility.

The proposed rule amendments eliminate report requirements for small ambulatory centers with fewer than 300 patient visits per quarter, and the manual report option is eliminated for ambulatory centers having fewer than 300 patient visits per quarter.

The proposed rule amendments limit desk and field audits of data to 24 months from the initial submission of data, and require that ambulatory centers correct any errors and certify the data, or verify the correctness of the data previously submitted and certified within 60 days of receipt of notice of audit findings.

The proposed rule amendments will add the categories, Children's Medical Services and Healthy Kids to the data field, principal payer, and change the definition of the payer categories, Medicaid and Medicaid HMO to include MediKids and MediKids HMO starting with ambulatory visits occurring on or after January 1, 2001. The proposed rule amendments will add an unknown category to data field, patient sex. The proposed rule amendments change the data element, patient status, from an optional to a required data element and add two hospice categories starting with ambulatory visits occurring on or after January 1, 2001. The proposed rule amendments define other race and unknown race categories. The proposed rule amendments change the name of the data elements, referring or ordering physician ID # and referring or ordering physician UPIN # to attending physician ID # and attending physician UPIN #. The proposed rule amendments change the zip code designation for homeless patients from 22222 to HHHHH and change the designation for foreign patients from 00009 to FFFFF.

The proposed rule amendments eliminate the edit standard for unknown social security number and unknown or invalid zip codes. Out-of-state and unknown attending physicians are not permitted.

Other proposed rule amendments will add data elements and expand data fields starting in 2002.

SUBJECT AREA TO BE ADDRESSED: The agency is developing amendments to rule 59B-9.011 that will require providers to submit a separate report for each separate location. The agency is proposing amendments to rule 59B-9.017 that will limit a desk or field audit of a patient data report to 24 months from initial submission of the report. The agency is developing amendments to rules 59B-9.013, 59B-9.015 and rules 59B-9.018 through rules 59B-9.020 that will change definitions, change the data element, patient status, from an optional to a required data element, add data element categories, modify definitions of data elements and data elements categories, and modify data standards. Rule 59B-9.021 is repealed.

The agency is developing amendments to rules 59B-9.011 through rules 59B-9.021 that will add data elements and expand data fields starting in 2002.

SPECIFIC AUTHORITY: 408.15(8) FS.

LAW IMPLEMENTED: 408.061, 408.062, 408.063, 408.15(11) FS.

A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW:

TIME AND DATE: 1:30 p.m., September 26, 2000

PLACE: Florida Hospital Celebration Health, Education Center, 400 Celebration Place, Orlando, Florida 34747

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Jerry Mayer, Director, Information Technology, Building 3, 2727 Mahan Drive, Tallahassee, Florida 32308

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

59B-9.011 Submission of Ambulatory Patient Data.

(1) through (2) No change.

(3) Each facility ~~and provider~~ in (1)(a) above shall submit a separate report for each location per 59A-3.203, F.A.C. Each facility in (1)(b) above shall submit a separate report for each location per 59A-5.003, F.A.C. Each facility or provider in (1)(c), (1)(d) or (1)(e) above shall submit a separate report for each separate location ~~separately, as set forth in Rules 59B-9.018 and 59B-9.019, F.A.C., except that a group practice or entity may submit one report~~. ~~Multi-facility tapes may be~~

~~submitted provided all records are identifiable to an entity and there is a listing attached that identifies entities, their AHCA number and a contact person.~~

(4) No change.

(5) Any ambulatory center which has a total of 300 ~~200~~ or more patient visits per Rule 59B-9.014, F.A.C., for the reporting period is required to report data as set forth in Rules 59B-9.018 and 59B-9.019, F.A.C.

(6) through (7) No change.

Specific Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063, 408.07, 408.08 FS. History–New 9-6-93, Formerly 59B-7.011, Amended 6-29-95, 12-28-98, _____.

59B-9.013 Definitions.

(1) through (3) No change.

(4) "Inpatient" means a patient who has an admission order given by a licensed physician or other individual who has been granted admitting privileges by the hospital. Inpatient shall include obstetric patients who experience a length of stay of twenty-four hours or less. Observation patients are excluded unless they are admitted. ~~"Premises" means those buildings, beds and equipment located at the address of the licensed facility and all other buildings, beds, and equipment for the provision of hospital or ambulatory surgical care located in such reasonable proximity to the address of the licensed facility as to appear to the public to be under the dominion and control of the licensee.~~

(5) through (6) No change.

(7) "Attending ~~Referring or Ordering~~ Physician" means a licensed physician ~~who would be expected to certify and re-certify the medical necessity of the services rendered or~~ who has ~~is the~~ primary responsibility ~~care giver~~ for the patient's medical care and treatment or who certifies as to the medical necessity of the services rendered. ~~The attending physician may be the referring physician.~~

(8) "Operating or Performing Physician" means a licensed physician who has primary responsibility for the surgery or who scheduled the surgery ~~physically performs the out-patient procedure or who supervises the other medical professionals performing such procedures~~.

(9) No change.

Specific Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063, 395.002 FS. History–New 9-6-93, Formerly 59B-7.013, Amended 6-29-95, 12-28-98, _____.

59B-9.015 Reporting Instructions.

(1) through (2) No change.

(3) Ambulatory centers shall report one record for each patient per visit, excluding records of any patient visit in which the patient was transferred to inpatient care and admitted unless the patient was transferred to another facility. If more than one visit for the same patient occurs on the same date, report one record which includes all required data for all visits of that patient to the ambulatory center occurring on that date. If more than one visit occurs on different dates by the same patient, report one record for each date of visit, unless the dates of visits are directly associated to the service. See 59B-9.013(5), F.A.C.

(4) through (6) No change.

Specific Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063 FS. History–New 9-6-93, Formerly 59B-7.015, Amended 6-29-95, 12-28-98, 1-4-00, _____.

59B-9.017 Certification and Audit Procedures.

(1) through (3) No change.

(4) The agency shall conduct a desk audit or a field audit of an ambulatory data report no later than twenty-four (24) months following the initial submission of data. The agency will notify each ambulatory center of any possible errors discovered by audit and request that the ambulatory center either correct the data or verify that the data is complete and correct. The notice shall indicate that the ambulatory center must return corrected data if there are errors and certify the data within sixty (60) days of receipt of the notice, or the ambulatory center Chief Executive Officer must verify by signature that the previously submitted and certified data is complete and correct within sixty (60) days of receipt of the notice. The notice shall clearly indicate that the ambulatory center may be subject to penalties pursuant to Rule 59B-9.022.

Specific Authority 408.15(8) FS. Law Implemented ~~408.006(5),~~ 408.061, 408.08(1), 408.08(5), 408.15(11) FS. History–New 9-6-93, Formerly 59B-7.017, Amended 6-29-95, _____.

59B-9.018 Ambulatory Patient Data ~~Tape/Diskette~~ Format – Data Elements and Codes.

(1) No change.

(2) (a) through (c) No change.

(d) Patient Racial Background A one ~~1~~ digit code as follows:

1 – American Indian/Eskimo/Aleut

2 – Asian or Pacific Islander

3 – Black

4 – White

5 – White Hispanic

6 – Black Hispanic

7 – Other (Use if patient is not described by above categories)

8 – No Response (Use if patient refuses to disclose)

(e) No change.

(f) Patient Sex A one ~~1~~ digit code as follows:

1 – Male

2 – Female

3 – Unknown (Use if unknown due to medical condition.)

(g) Patient Zip Code A five character ~~5 digit~~ zip code of the patient's permanent address: XXXXX

(h) No change.

(i) Principal Payer Code A one ~~1~~ character field as follows:

A – Medicare

B – Medicare HMO

C – Medicaid and MediKids

D – Medicaid HMO and MediKids HMO

E – Commercial Insurance

F – Commercial HMO

G – Commercial PPO

H – Workers' Compensation

I – CHAMPUS ~~Champus~~

J – VA

K – Other State/Local Govt

L – Self Pay (No third party coverage)

M – Other

N – Charity

O – Children's Medical Services (Required for ambulatory visits occurring on or after January 1, 2001.)

P – Healthy Kids (Required for ambulatory visits occurring on or after January 1, 2001.)

(j) through (ggg) No change.

(hhh) Attending ~~Referring or Ordering~~ Physician ID # Enter the Florida license number of the referring/ordering physician, beginning with "FL". An eleven character alpha-numeric field (e.g. FLME1234567). ~~If out-of-state physician, fill with the physician's state two letter abbreviation and 9's (e.g. NY999999999 for a physician from New York). For non-U.S. physicians (a physician licensed and practicing in another country and not licensed in the U.S.), fill with "XX" and 9's (e.g. XX999999999).~~

(iii) Attending ~~Referring or Ordering~~ Physician UPIN # (Optional) Enter the UPIN number of the attending ~~referring/ordering~~ physician. A six character alpha-numeric field.

(jjj) through (zzz) No change.

(aaaa) Patient Status ~~(Optional)~~ Required for ambulatory visits occurring on or after January 1, 2001. A two digit code indicating patient disposition as follows:

01 Home

02 To a short-term general hospital

03 To a skilled nursing facility

04 To an intermediate care facility

05 To another institution

06 Home under care of home health care organization

07 Left this facility against medical advice (AMA)

08 Home on IV medications

20 Expired

50 Hospice – home

51 Hospice – medical facility

(bbbb) through (cccc) No change.

(3) No change.

Specific Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063 FS. History–New 9-6-93, Formerly 59B-7.018, Amended 6-29-95, 12-28-98, _____.

59B-9.019 Ambulatory Patient Data Tape/Diskette Format – Record Layout.

"Type" means (A)lpha or (N)umeric or combination field. "Justification" is either (R)ight or (L)eft. The data elements for each ambulatory patient data record must have a logical record length of 400 characters with the following record layout:

(1) No change.

(2)(a) through (f) No change.

(g) PATIENT ZIP CODE A/N ~~N~~ L ~~R~~ 5 40-44

(h) through (ggg) No change.

(hhh) ATTENDING PHYSICIAN ~~REFERRING OR ORDERING PHYS.~~ ID # A/N L 11 214-224

(iii) ATTENDING PHYSICIAN ~~REFERRING OR ORDERING PHYS.~~ UPIN # A/N L 6 225-230

(jjj) through (3) No change.

Specific Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063 FS. History–New 9-6-93, Formerly 59B-7.019, Amended 6-29-95, 12-28-98, _____.

59B-9.020 Data Standards.

(1) through (2) No change.

(3) The Social Security Number (SSN) is a 9 digit required field required for all patients ~~who~~ having ~~have had~~ SSNs ~~assigned~~. ~~(E.g., those not having SSNs may include newborns up to 2 years of age or very old patients who may not have ever had one assigned.)~~ Social Security Number 000000000 is acceptable for newborns and infants up to 2 years of age who do ~~have~~ not have ~~had~~ a social security number ~~assigned~~. For patients not from the U.S., use 555555555. For those patients where all efforts ~~have been made~~ to obtain the social security number have been unsuccessful or where one is unavailable, and ~~but~~ the patient is two (2) years of age or older ~~over the age of 2~~ and a resident of the U.S. use 777777777. ~~Unknown SSN (777777777) must not exceed 5 percent of the total records per report period.~~

(4) Race is a single digit entry showing: 1 – American Indian/Eskimo/Aleut, 2 – Asian/Pacific Islander, 3 – Black, 4 – White, 5 – White Hispanic, 6 – Black Hispanic, 7 – Other (Use if patient is not described by above categories), 8 – No Response (Use if patient refuses to disclose). It is a required field for all patients who self-report race as requested by the center.

(5) No change.

(6) Sex designation is required. Must be 1-Male, or 2-Female, or 3-Unknown.

(7) A valid patient zip code is required and must be 5 characters ~~digits~~. Use FFFFF ~~00009~~ for foreign zip codes. Use HHHHH ~~22222~~ for at large (homeless) zip codes. ~~If the zip~~

~~code is missing or in the wrong format the record is an error. Unknown (00000) or invalid zip codes must equal 1.0% or less of records per report period.~~ No blank fields are permitted.

(8) No change.

(9) Principal Payer is required and must be an alpha character A through P ~~N~~.

(10) through (15) No change.

(16) The Attending ~~Referring or Ordering~~ Physician ID is a required entry showing the identification number of the attending ~~referring or ordering~~ physician. An eleven character alpha-numeric field using the State of Florida physician license number, preceded by the prefix FL. Florida physicians shall have four alphas preceding seven digits (e.g. FLME1234567). ~~For out-of-state physicians, fill with the physician's home state two letter abbreviation and 9's (e.g. NY999999999 for a physician from New York) and fill in the unique physician's identification number (UPIN) number in the next field. For non-U.S. physicians (a physician licensed and practicing in another country and not licensed in the U.S.), fill with "XX" and 9's (e.g. XX999999999). For those patients where all efforts have been made to obtain the referring or ordering physician's ID or where one is unavailable, but the physician is practicing in the U.S. use ZZ999999999. Unknown physician ID (ZZ999999999) must not exceed 5 percent of the total records per report period.~~

(17) The Attending ~~Referring or Ordering~~ Physician UPIN Number is an optional entry showing the identification number of the attending ~~referring or ordering~~ physician.

(18) through (34) No change.

(35) Patient Status is a required ~~an optional~~ entry from 01-08, 20, or 50-51 ~~blank fill~~.

(36) No change.

Specific Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063 FS. History–New 9-6-93, Formerly 59B-7.020, Amended 6-29-95, 12-28-98, _____.

59B-9.021 Manual Submission of Data.

~~Facilities having more than 199 reportable visits and fewer than 300 reportable visits in a quarter shall submit ambulatory patient data using either form AHCA-2000-MIS-13, or according to the requirements in Rule 59B-9.015.~~

~~(1) Form AHCA-2000-MIS-13, may be obtained from the Agency for Health Care Administration, Ambulatory Patient Data Section, 2727 Mahan Drive, Fort Knox Building #3, Tallahassee, Florida 32308-5403.~~

~~(2) Form AHCA-2000-MIS-13 is titled "Ambulatory Patient Detail Reporting Form". The effective date of the form is July 1, 1995. Form AHCA-2000-MIS-13 is incorporated by reference.~~

Specific Authority 408.15(8) FS. Law Implemented 408.061 FS. History–New 9-6-93, Formerly 59B-7.021, Amended 6-29-95, 1-4-00, Repealed _____.

AGENCY FOR HEALTH CARE ADMINISTRATION

Health Care Cost Containment Board

RULE TITLES:	RULE NOS.:
Definitions	59E-7.011
Reporting and Audit Procedures	59E-7.012
Data Elements and Formatting Requirements	59E-7.014
General Provisions	59E-7.016

PURPOSE AND EFFECT: The proposed rule amendments limit desk and field audits of data to 24 months from the initial submission of data, and require that hospitals correct any errors and certify the data, or verify the correctness of the data previously submitted and certified within 60 days of receipt of notice of audit findings.

The proposed rule amendments change the age standards for the data fields, social security number and infant linkage identifier from age one to age two starting January 1, 2001. The proposed rule amendments add the categories, Children's Medical Services and Healthy Kids to the data field, principal payer, and change the definition of the payer categories, Medicaid and Medicaid HMO to include MediKids and MediKids HMO starting with discharges occurring on or after January 1, 2001. The proposed rule amendments add two hospice categories, hospice-home and hospice-medical facility, to the data field, inpatient discharge status starting with discharges occurring on or after January 1, 2001. The proposed rule amendments change the definitions of other race and unknown race categories.

The proposed rule amendments change the zip code designation for homeless patients from 22222 to HHHHH and change the designation for foreign patients from 00009 to FFFFF.

The proposed rule amendments eliminate the edit standard for unknown social security number.

The proposed rule amendments eliminate the requirement that hospitals install and use data processing edits supplied by the agency.

Other proposed rule amendments will add data elements and expand data fields starting in 2002.

SUBJECT AREA TO BE ADDRESSED: The agency is proposing amendments to rule 59E-7.012 that will limit a desk or field audit of a patient data report to 24 months from initial submission of the report. The agency is proposing amendments to rules 59E-7.011 and 59E-7.014 that will add data element categories, modify definitions of data elements and data elements categories, and modify data standards. The agency is proposing an amendment to rule 59E-7.016 that eliminates the requirement that each hospital install and use data processing edits supplied by the agency.

The agency is developing amendments to rules 59E-7.011 through rules 59E-7.016 that will add data elements and expand data fields starting in 2002.

SPECIFIC AUTHORITY: 408.15(8) FS.
LAW IMPLEMENTED: 408.061, 408.15(11) FS.
A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW:
TIME AND DATE: 10:00 a.m., September 26, 2000
PLACE: Florida Hospital Celebration Health, Education Center, 400 Celebration Place, Orlando, Florida 34747
THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Jerry Mayer, Director, Information Technology, Building 3, 2727 Mahan Drive, Tallahassee, Florida 32308

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

59E-7.011 Definitions.

As used in Rules 59E-7.011 through 59E-7.016, F.A.C.:

(1) through (3) No change.

(4) "Inpatient" means a patient who has an admission order given by a licensed physician or other individual who has been granted admitting privileges by the hospital. Inpatient ~~This~~ shall include obstetric patients who experience a length of stay of twenty-four hours or less. Observation ~~Short stay and observation~~ patients are excluded unless they are admitted.

~~(5) "Groups 1 through 7 — General, Short-term Acute Care" means any establishment that offers services more intensive than those required for room, board, personal services, and general nursing care, and offers facilities and beds for use beyond 24 hours by individuals requiring diagnosis, treatments, or care for illness, injury, deformity, infirmity, abnormality, disease, or pregnancy; diagnostic radiology services; clinical laboratory; and treatment facilities for surgery or obstetrical care, or other definitive medical treatment of similar extent (s. 395.002(12)(a) & (b), F.S.).~~

~~(6) "Group 8 – Teaching Hospital" means any hospital formally affiliated with an accredited medical school that exhibits activity in the area of medical education as reflected by at least seven different resident physician specialties and the presence of 100 or more resident physicians.~~

~~(7) "Group 9 – Family Practice Teaching Hospital" means a freestanding, community-based hospital licensed under this chapter that offers a 3-year family practice residency program accredited through the Residency Review Committee of the Accreditation Council of Graduate Medical Education or the Postdoctoral training of the American Osteopathic Association.~~

~~(8) "Group 12 – Specialty Rehabilitation Hospital" means a hospital in grouping 12 of the Agency's hospital peer grouping and a hospital certified by Medicare as a long-term care hospital.~~

~~(9) "Group 13 – Long-term Psychiatric" means a facility which provides acute or subacute psychiatric care with an average length of stay (ALOS) exceeding 60 days.~~

~~(10) "Group 14 – Specialty Hospital" means any facility which meets the provisions of 59E-7.011(5), and which regularly makes available either the range of services offered by a general hospital, but restricted to a defined age or gender group of the population; or a restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illnesses or disorders (s. 395.002(14)(a),(b), F.S.).~~

~~(11) "Groups 15 through 17 – Short-term Psychiatric Hospital" means a facility which provides acute or subacute psychiatric care with an average length of stay (ALOS) not exceeding 60 days.~~

(5)~~(12)~~ "Newborn" means a newborn baby born within the facility or the initial admission of an infant to any acute facility within 24 hours of birth.

~~(13) "Premises" means those buildings, beds and equipment located at the address of the licensed facility and all other buildings, beds, and equipment for the provision of hospital care located in such reasonable proximity to the address of the licensed facility as to appear to the public to be under the dominion and control of the license.~~

(6)~~(14)~~ "UPIN" means Unique Physician Identifier Number.

Specific Authority 408.061(1)(e), 408.15(8) FS. Law Implemented 408.061 FS. History–New 12-15-96, Amended _____.

59E-7.012 Reporting and Audit Procedures.

(1) All acute care hospitals and all short term psychiatric hospitals (hereinafter referred to as "hospital/hospitals"), in operation for all or any of the reporting periods described in Rule 59E-7.012(2) below, shall submit hospital inpatient discharge data in a format consistent with requirements of Rules 59E-7.011 through 59E-7.016 to the Agency following the provisions of this Rule~~, commencing with discharges for the 1st quarter 1997 (01/01/97 — 03/31/97)~~.

(2) For purposes of submission of hospital inpatient discharge data, hospital shall be any hospital licensed under Chapter 395, Florida Statutes except state-operated hospitals, long-term psychiatric hospitals with an average length of stay exceeding 60 days and comprehensive rehabilitation hospitals as defined in 59A-3.201, F.A.C. ~~in the following groups as set out in the Florida Hospital Uniform Reporting System Manual: Groups 1 through 9, 12 through 17, and any new hospital assigned to these groups as defined in 59E-7.012.~~ Additionally, long-term psychiatric hospitals~~, Group 13 in the Florida Hospital Uniform Reporting Manual,~~ are required to submit aggregated data following the format and context as presented in the Psychiatric Reporting Format AHCA PSY III dated 9/12/88 and herein incorporated by reference.

(3) Each hospital ~~premises~~ shall submit a separate report for each location per 59A-3.203, F.A.C. ~~report separately, as set forth in Rules 59E-7.012 and 59E-7.014, F.A.C.~~

(4) through (7) No change.

(8)(a) No change

(b)1. through 2. No change.

3. The data in the text file shall contain the same data elements and codes, the same record layout and meet the same data standards required for tapes or diskettes mailed to the agency as described ~~comply with the formatting requirements specified~~ in Rules 59E-7.014 and 59E-7.016.

(c) through (d) No change.

(9) through (11) No change.

(12) The agency shall conduct a desk audit or a field audit of a report no later than twenty-four (24) months following the initial submission of data. The agency will notify each hospital of any possible errors discovered by audit and request that the hospital either correct the data or verify that the data is complete and correct. The notice shall indicate that the hospital must return corrected data if there are errors and certify the data within sixty (60) days of receipt of the notice, or the hospital Chief Executive Officer must verify by signature that the previously submitted and certified data is complete and correct within sixty (60) days of receipt of the notice. The notice shall clearly indicate that the hospital may be subject to penalties pursuant to Rule 59E-7.013.

Specific Authority 408.061(1)(e), 408.15(8) FS. Law Implemented 408.061, 408.08(1), 408.08(2), 408.15(11) FS. History–New 12-15-96, Amended 1-4-2000, _____.

59E-7.014 Data Elements and Formatting Requirements.

(1)(a) No change.

(b)1. through 6. No change.

7. Inpatient Social Security Number. The social security number (SSN) of the inpatient receiving treatment/services during this hospital stay. A nine digit numeric field to facilitate retrieval of individual case records, to be used to track inpatient readmissions, and for epidemiological or demographic research use. A SSN is required for each inpatient record if the patient is two years of age or ~~indicating an inpatient of the age of 1 year and~~ older except in cases of very old persons never issued a SSN, foreign visitors (including illegal aliens), and migrant workers (non-citizens). One SSN; one inpatient. DO NOT share SSNs in this field. (See also provisions in 59E-7.014(3)(b)7.)

8. Inpatient Race. A one digit code as follows:

1 – American Indian/Eskimo/Aleut

2 – Asian or Pacific Islander

3 – Black

4 – White

5 – Hispanic – White

6 – Hispanic – Black

7 – Other (Use if patient is not described by above categories ~~If none of the above~~)

8 – No Response (Use if patient refuses to disclose ~~Valid only if data is not available~~)

9. No change.

10. Inpatient Sex. A one digit code as follows:

1 – Male

2 – Female

3 – Unknown (Use if unknown due to medical condition.)

11. through 15. No change.

16. Inpatient Discharge Status. A two digit code as follows:

01 – Discharged Home

02 – Discharged to a short-term general hospital

03 – Discharged to a skilled nursing facility

04 – Discharged to an intermediate care facility

05 – Discharged to another type of institution

06 – Discharged to home under care of home health care organization

07 – Left this hospital against medical advice (AMA)

08 – Discharged home on IV medications

20 – Expired

50 – Discharged to hospice – home (Required for discharges occurring on or after January 1, 2001.)

51 – Discharged to hospice – medical facility (Required for discharges occurring on or after January 1, 2001.)

17. Principal Payer Code. A one character alpha field as follows:

A – Medicare

B – Medicare HMO

C – Medicaid and MediKids

D – Medicaid HMO and MediKids HMO

E – Commercial Insurance

F – Commercial HMO

G – Commercial PPO

H – Workers' Compensation

I – CHAMPUS ~~Champus~~

J – VA

K – Other State/Local Government

L – Self Pay/Under-insured (no third party coverage or less than 30% estimated insurance coverage)

M – Other

N – Charity

O – Children's Medical Services (Required for discharges occurring on or after January 1, 2001.)

P – Healthy Kids (Required for discharges occurring on or after January 1, 2001.)

18. through 67. No change.

68. Infant ~~First Year~~ Linkage Identifier. A required field for patients less than two (2) years of age ~~newborn birth and infant identification with the baby's mother up to the first year of life~~. A nine digit numeric field. Use the mother's (preferred) or father's (acceptable) SSN. CAUTION: If the patient ~~not reporting a birth or infant~~ is two (2) years ~~over one (1) year~~ of age or older, this field is zero filled. To be used only for

research purposes to link infants with their respective mother. (Linkage identifiers are required for infants less than two years of age starting January 1, 2001.)

69. No change.

(c) No change.

(2)(a) No change.

(b)1. through 10. No change.

11. INPATIENT ZIP CODE A/N ~~N~~ L ~~R~~ 5 55-59

12. through 67. No change.

68. INFANT ~~FIRST YEAR~~ LINKAGE IDENTIFIER N R 9 410-418.

69. No change.

(c) No change.

(3)(a) No change.

(b)1. through 6. No change.

7. The Social Security Number (SSN) is a nine (9) digit required field for all ~~in~~patients having social security numbers. ~~Since all United States citizens one (1) year of age and older are required to have SSNs for tax exemption purposes,~~ SSNs should be submitted for all ~~in~~patients two (2) years ~~one (1) year~~ of age or older. Patients ~~Inpatients~~ not having SSNs should be in one of the following groups: newborns and infants ~~(i.e.,~~ less than 2 years ~~1 year~~ of age~~)~~, very old ~~in~~patients never issued a SSN, foreign visitors (including aliens), and migrant workers (i.e., non-citizens). An entry of ~~SSN~~ 000-00-0000 is acceptable for patients less than two (2) years ~~newborns up to one (1) year~~ of age who do not have an SSN. For patients not from the U.S., use 555-55-5555, if a SSN ~~one~~ is not assigned. For those patients where ~~all~~ efforts ~~have been made~~ to obtain the SSN have been unsuccessful or where one is unavailable, and ~~but~~ the patient is two (2) years or older ~~over the age of one (1) year~~ and a resident of the U.S., use 777-77-7777. ~~Unknown SSN (777-77-7777) must not exceed five (5) percent of the total records per report period.~~ DO NOT share SSNs in this field; one SSN – one inpatient. ~~The use of "Other" for SSNs will trigger an edit of data, and will result in a partially rejected record if the total meets or exceeds 5% of discharges.~~

8. Inpatient Race is a single digit entry showing: 1 P American Indian/Eskimo/Aleut, 2 – Asian or Pacific Islander, 3 – Black, 4 – White, 5 – Hispanic-White, 6 – Hispanic-Black, 7 – Other (Use if patient is not described by above categories ~~to be used only if none is known~~), 8 – No Response (Use if patient refuses to disclose ~~if the inpatient refuses the information~~). For use by AHCA as demographic and epidemiological information, and health planning. Not an optional field.

9. through 10. No change.

11. A valid ~~Inpatient~~ Zip Code is required; must be five digits. Use FFFFF ~~Zip Code 00009~~ for patients ~~inpatients~~ of foreign origin. Use HHHHH ~~the Zip Code 22222~~ for homeless patients, or those having no permanent Zip Code. Use ~~Zip Code~~ 00000 for unknown zip codes. ~~The Zip Code field will be edited and if the total of Zip Code 00000 to 22222 equals or exceeds 1% of total discharges for either of these entries, the hospital file will be error flagged for rejection if not corrected or validated.~~ Spaces are not acceptable.

12. through 15. No change.

16. Inpatient Discharge Status is a required field; must be two digits using the codes 01 – 08, ~~or~~ 20, or 50 – 51 (59E-7.014(1)(b)16.).

17. Principal Payer Code is a required field; must be a single alpha character (UPPERCASE), A – P ~~M~~. Describes the primary source of expected reimbursement to the hospital for services.

18. through 67. No change.

68. Infant ~~Newborn~~ Linkage Identifier is a required field~~,~~ of nine numeric digits. Enter the mother's Social Security Number or if the mother's Social Security Number is not available, enter the father's Social Security Number in the Infant Linkage Identifier field for patients less than two (2) years of age ~~any birth which occurs in the hospital~~. ~~Use the mother's SSN only in this field, and if the patient is a newborn Type of Admission 4 (birth) or an infant up to one (1) year of life.~~ Use 999-99-9999 in the Infant Linkage Identifier field for unknown or unreportable mother's and father's SSN (i.e., adoptions). If the patient ~~is not a newborn (Type of Admission 4) or age~~ is two (2) years of age or older ~~greater than one (1) year~~, the field is zero filled.

69. No change.

(c) No change.

Specific Authority 408.061(1)(e), 408.15(8) FS. Law Implemented 408.061 FS. History–New 12-15-96, Amended _____.

59E-7.016 General Provisions.

(1) through (2) No change.

~~(3) Hospitals are required to enter the full set of the AHCA programming edits on their data processing systems to be used as an integral part of the processing cycle prior to submitting their quarterly data to the AHCA. Edits will be provided to hospitals or vendors/corporate offices in hard copy printouts for installation into data processing systems. If hospitals utilize an outside service for data processing or have their data prepared by a corporate office, they are responsible for notifying their service of the requirement to install the edits, and to provide the service office with a copy of the AHCA edits. Failure to install and utilize the edits will result in the initiation of legal action.~~

(3)~~(4)~~ No change.

Specific Authority 408.061(1)(e), 408.15(8) FS. Law Implemented 408.061 FS. History–New 12-15-96, Amended _____.

AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid

RULE TITLE: RULE NO.:

Hearing Services 59G-4.110

PURPOSE AND EFFECT: The purpose of this rule amendment is to incorporate by reference the Florida Medicaid Hearing Services Coverage and Limitations Handbook**,** July 2000. The effect will be to incorporate by reference in the rule the current Florida Medicaid Hearing Services Coverage and Limitations Handbook.

SUBJECT AREA TO BE ADDRESSED: Hearing Services.

SPECIFIC AUTHORITY: 409.919 FS.

LAW IMPLEMENTED: 409.906, 409.908 FS.

IF REQUESTED IN WRITING BY AN AFFECTED PERSON AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW.

TIME AND DATE: 9:00 a.m. – 12:00 p.m., September 13, 2000

PLACE: Agency for Health Care Administration, 2728 Mahan Drive, Building #3, Conference Room E, Tallahassee, Florida

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT IS: Helen Sancho, Medicaid Program Development, P. O. Box 12600, Tallahassee, Florida 32317-2600, (850)922-7322

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

59G-4.110 Hearing Services.

(1) No change.

(2) All physicians, audiologists and hearing aid specialists enrolled in the Medicaid program must be in compliance with the provisions of the Florida Medicaid Hearing Services Coverage and Limitations Handbook**,** July 2000 ~~January 2000~~ which is incorporated by reference, and the Florida Medicaid Provider Reimbursement Handbook, HCFA-1500 and Child Health Check-Up 221, which is incorporated by reference in 59G-5.020. Both handbooks are available from the Medicaid fiscal agent.

Specific Authority 409.919 FS. Law Implemented 409.906, 409.908 FS. History–New 8-3-80, Amended 7-21-83, Formerly 10C-7.522, Amended 4-13-93, Formerly 10C-7.0522, Amended 12-21-97, 10-13-98, 5-7-00, _____.

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

Building Code Administrators and Inspectors Board

RULE TITLE:	RULE NO.:
Continuing Education	61G19-9

PURPOSE AND EFFECT: The Board proposes to review the rules in this chapter to determine if amendments are necessary.

SUBJECT AREA TO BE ADDRESSED: Continuing education for biennial renewal; Continuing education course sponsors; Registration of course sponsors; Approval of courses; Approval of proctored telecourses; Qualifications of course instructors; Course syllabus; Records required to be maintained by course sponsors; Audit of certificates of completion; Advertising of continuing education courses; Continuing education courses required by disciplinary action; Continuing education course sponsor fees.

SPECIFIC AUTHORITY: 455.2124, 468.606, 468.627 FS.

LAW IMPLEMENTED: 455.214, 468.627 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE SCHEDULED AND ANNOUNCED IN THE NEXT AVAILABLE ISSUE OF THE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Anthony Spivey, Executive Director, Building Code Administrators and Inspectors Board, Northwood Centre, 1940 N. Monroe Street, Tallahassee, Florida 32399-0750

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS NOT AVAILABLE.

DEPARTMENT OF HEALTH

Board of Acupuncture

RULE TITLES:	RULE NOS.:
Herbal Therapies	64B1-4.004
Oriental Massage	64B1-4.005
Qi Gong	64B1-4.006
Electroacupuncture	64B1-4.007
Adjunctive Therapies	64B1-4.008
Dietary Guidelines	64B1-4.009
Traditional Chinese Medical Concepts, Modern Oriental Medical Techniques	64B1-4.010
Acupuncture Diagnostic Techniques, Western Diagnostic Terminology	64B1-4.011
Acupoint Injection Therapies	64B1-4.012

PURPOSE AND EFFECT: The proposed rules will define and explain the various therapies and techniques which are part of and may be practiced by a licensed acupuncturist.

SUBJECT AREA TO BE ADDRESSED: Herbal Therapies; Oriental Massage; Qi Gong; Electroacupuncture; Adjunctive Therapies; Dietary Guidelines; Traditional Chinese Medical Concepts, Modern Oriental Medical Techniques; Acupuncture Diagnostic Techniques, Western Diagnostic Terminology; Acupoint Injection Therapies.

SPECIFIC AUTHORITY: 457.104 FS., Section 62, Chapter 2000-318, Laws of Florida.

LAW IMPLEMENTED: Section 62, Chapter 2000-318, Laws of Florida.

A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW:

TIME AND DATE: 9:00 a.m. or soon thereafter, September 13, 2000

PLACE: The Hilton Miami Airport, 5101 Blue Lagoon Drive, Miami, Florida 33126

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: William Buckhalt, Executive Director, Board of Acupuncture, 4052 Bald Cypress Way, Bin #C06, Tallahassee, Florida 32399-3256

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT 64B1-4.004-.011 IS NOT AVAILABLE.

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

64B1-4.012 Acupoint Injection Therapies.

Adjunctive therapies shall include Acupoint Injection Therapy which means the injection of herbs, homeopathies, and other nutritional supplements into acupuncture points by means of hypodermic needles. Acupoint Injection Therapy shall not include intravenous therapy.

Specific Authority 457.104 FS., Section 62, Chapter 2000-318, Laws of Florida. Law Implemented Section 62, Chapter 2000-318, Laws of Florida. History–New _____.

DEPARTMENT OF HEALTH

Board of Chiropractic Medicine

RULE TITLE: RULE NO.:

Licensure and Certification Reexamination Fees 64B2-12.003

PURPOSE AND EFFECT: The purpose is to update the rule text by increasing the reexamination fee for the licensure examination.

SUBJECT AREA TO BE ADDRESSED: Reexamination fee.

SPECIFIC AUTHORITY: 455.574(2), 460.405, 460.406(1) FS.

LAW IMPLEMENTED: 455.474(2), 460.406 FS.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT IS: Joe Baker, Jr., Executive Director, Board of Chiropractic Medicine/MQA, 4052 Bald Cypress Way, Bin #C07, Tallahassee, Florida 32399-3257

THE PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

64B2-12.003 Licensure and Certification Reexamination Fees.

The reexamination fee for the licensure examination shall be five hundred dollars ($500.00) ~~four hundred fifty dollars ($450.00)~~. The reexamination fee for the Acupuncture Certification Examination shall be seventy five dollars ($75.00).

Specific Authority 455.574(2), 460.405, 460.406(1) FS. Law Implemented 455.574(2), 460.406 FS. History–New 1-10-80, Formerly 21D-12.03, Amended 2-24-86, 5-10-87, 4-19-89, 10-9-90, 10-15-92, Formerly 21D-12.003, 61F2-12.003, 59N-12.003, Amended 1-18-98, _____.

Section II
Proposed Rules

DEPARTMENT OF BANKING AND FINANCE

Board of Funeral and Cemetery Services

RULE TITLE: RULE NO.:

Preneed Funeral Contract Consumer Protection Trust Fund 3F-10.001

PURPOSE AND EFFECT: This rule is being amended to delete the option of a remittance credit when a cancelled contract is rewritten, as this option is no longer available.

SUMMARY: This rule sets forth the criteria for how, when, and the amounts of remittances by a certificateholder to the Preneed Funeral Contract Consumer Protection Trust Fund, pursuant to the provisions of section 497.413, F.S.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: No Statement of Estimated Regulatory Cost was prepared.

Any person who wishes to provide information regarding the statement of estimated costs, or to provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days of this notice.

SPECIFIC AUTHORITY: 497.103, 497.413 FS.

LAW IMPLEMENTED: 497.413 FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Diana M. Evans, Executive Director, Board of Funeral and Cemetery Services, 101 East Gaines Street, Tallahassee, Florida 32399-0350

THE FULL TEXT OF THE PROPOSED RULE IS:

3F-10.001 Preneed Funeral Contract Consumer Protection Trust Fund.

The amounts required to be remitted by a Certificateholder to the Preneed Funeral Contract Consumer Protection Trust Fund, pursuant to the provisions of Section 497.413, Florida Statutes, shall be determined in accordance with the following criteria:

(1) through (5) No change.

(6) If a contract is cancelled after thirty days of execution, the Certificateholder shall not be entitled to credit the remittance for that contract against future remittances ~~unless such contract is immediately rewritten~~.