~~2. The model's skin was not cut/pinched by clippers or other tools during the haircut.~~

~~3. Candidate used freehand technique when doing the haircut.~~

(4) Failure of the examinee to complete the services required in a particular category tested in the practical examination, e.g., shampoo, haircut, or shave, shall result in the examinee losing the possible points assigned to that area.

(5) The score necessary to achieve a passing grade on the written portion of the restricted licensure examination shall be no less than seventy-five (75) percent out of one hundred (100) percent of the total possible points on the written examination. The score necessary to achieve a passing grade on the practical portion of the restricted licensure examination shall be no less than seventy-five (75) percent (based on the average of the examiners' scores) out of one hundred (100) percent of the total possible points on the practical examination. All examiner's scores will be averaged before any percentages are rounded according to the formula stated below. In rounding percentages, any percentage which is point five (.5) or above shall be rounded up to the next whole number. Percentages less than point five (.5) shall be rounded down to the next whole number.

Specific Authority 455.217, 476.064(4), 476.134, 476.144 FS., Chapter 98-323, Laws of Florida. Law Implemented 455.217, 476.134, 476.144 FS., Chapter 98-323, Laws of Florida. History–New 11-12-87, Amended 3-22-92, 1-26-93, Formerly 21C-16.007, Amended 9-15-94, 12-9-98, _____.

DEPARTMENT OF HEALTH

Council of Licensed Midwifery

RULE TITLE: RULE NO.:

Meetings; Notice of Meetings, Agenda and Quorum 64B24-1.004

PURPOSE AND EFFECT: The Department of Health proposes to review the existing language in this rule to determine if amendments are necessary.

SUBJECT AREA TO BE ADDRESSED: Meetings, notice of meetings, agenda and quorum.

SPECIFIC AUTHORITY: 456.004(5) FS.

LAW IMPLEMENTED: 456.011(3), 467.004 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 CONTACED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Pamela King, Executive Director, 4052 Bald Cypress Way, Tallahassee, Florida 32399-3256.

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

Section II
Proposed Rules

DEPARTMENT OF INSURANCE

RULE TITLES:	RULE NOS.:
Foreign and Alien Insurers Filing for a Certificate of Authority	4-136.002
Surplus Lines	4-136.004
Domestic Insurers Filing for an Application for Permit	4-136.006
Domestic Insurers Filing for a Certificate of Authority	4-136.011
Procedure to Amend Existing Certificate of Authority to Add a New Line of Business	4-136.015
Registration as a Purchasing Group	4-136.031

PURPOSE, EFFECT AND SUMMARY: The amendments adopt updated forms for use by companies seeking to do business in Florida.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: None.

Any person who wishes to provide information regarding the statement of estimated regulatory 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: 624.308 FS.

LAW IMPLEMENTED: 624.09, 624.307(1), 624.34, 624.401, 624.404, 624.407, 624.408, 624.411, 624.413, 624.414(1), 624.416(4), 624.422, 624.466, 624.501, 625.306, 625.502, 626.7451(11), 626.913, 626.918, 627.6488(1), 628.041, 628.051, 628.061, 628.071, 628.081, 628.091, 628.121, 628.161, 628.171, 628.221, 628.231, 628.251, 628.261, 624.451, 628.46, 628.4615, 628.471, 628.907, 629.071, 629.081, 629.101, 629.122, 629.131, 629.181 FS.

IF REQUESTED IN WRITING WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW (IF NOT REQUESTED, THIS HEARING WILL NOT BE HELD):

TIME AND DATE: 9:00 a.m., October 9, 2002

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

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 the person listed below.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Gwen Chick, Division of Insurer Services, Department of Insurance, 200 East Gaines Street, Tallahassee, Florida 32399-0326, (850)413-2570

THE FULL TEXT OF THE PROPOSED RULES IS:

4-136.002 Foreign and Alien Insurers Filing for a Certificate of Authority.

All foreign entities seeking a certificate of authority shall comply with the requirements of Sections 624.404, 624.413 and related Florida Statutes, and shall submit the following forms:

(1) through (15) No change.

(16) An investigative report in accordance with the instructions on Form DI4-905, "Instructions for Furnishing Background Investigative Reports," rev. 02/01 ~~6/99~~;

(17) through (18) No change.

Specific Authority 624.308 FS. Law Implemented 624.307(1), 624.34, 624.401, 624.404, 624.407, 624.413, 624.422, 624.501, 626.7451(11), 628.161, 628.907 FS. History–New 2-26-92, Amended 9-19-00, _____.

4-136.004 Surplus Lines.

Applications submitted as an Insurer under Florida's Surplus Lines Law, pursuant to Section 626.913, Florida Statutes, shall contain all of the following forms:

(1) through (8) No change.

(9) An investigative report in accordance with the instructions on Form DI4-905, "Instructions for Furnishing Background Investigative Reports," rev. 02/01 ~~6/99~~;

(10) No change.

(11)~~(12)~~ Form DI4-1298, "Management Information Form," rev. 4/97.

Specific Authority 624.308 FS. Law Implemented 624.307(1), 624.34, 624.422, 624.501, 626.913, 626.918 FS. History–New 2-26-92, Amended 9-19-00, _____.

4-136.006 Domestic Insurers Filing for an Application for Permit.

All domestic insurers filing an Application for Permit, pursuant to Chapter 628, Florida Statutes, for the following: Domestic Property and Casualty Insurers, Title Insurers, and Life and Health Insurers, pursuant to Section 628.051, Florida Statutes; Domestic Assessable Mutual Insurers, pursuant to Section 628.051, Florida Statutes; and Domestic Captive Insurers, pursuant to Chapter 628, Part III, shall submit the following common forms:

(1) through (4) No change.

(5) An investigative report in accordance with the instructions on Form DI4-905, "Instructions For Furnishing Background Investigative Reports," rev. 02/01 ~~6/99~~;

(6) through (14) No change.

Specific Authority 624.308 FS. Law Implemented 624.307(1), 624.34, 624.401, 624.404, 624.407, 624.413, 624.422, 624.501, 626.7451(11), 628.051 FS. History–New 2-26-92, Amended 9-19-00, _____.

4-136.011 Domestic Insurers Filing for a Certificate of Authority.

(1) All domestic entities seeking a certificate of authority, pursuant to Sections 624.466, 628.6011, or 628.051, or to Chapter 628, Part I, or to Chapter 629, Florida Statutes, shall submit the following forms:

(a) through (f) No change.

(g) An investigative report in accordance with the instructions on Form DI4-905, "Instructions For Furnishing Background Investigative Reports", rev. 02/01 ~~6/99~~;

(h) through (r) No change.

(2) Applications submitted for Certificate of Authority as a Commercial Self-Insurance Fund shall contain all of the following forms pursuant to Section 624.462, Florida Statutes:

(a) through (l) No change.

(m) An investigative report in accordance with the instructions on Form DI4-905, "Instructions for Furnishing Background Investigative Reports," rev. 02/01 ~~6/99~~; and

(n) No change.

(3) Applications submitted for a Certificate of Authority of Domestic Reciprocal Insurers, pursuant to Chapter 629, Florida Statutes, shall submit the following forms:

(a) through (q) No change.

(r) Form DI4-905, "Instructions for Furnishing Background Investigative Reports," rev. 02/01 ~~6/99~~.

Specific Authority 624.308 FS. Law Implemented 624.307(1), 624.34, 624.401, 624.404, 624.407, 624.411, 624.413, 624.414(1), 624.422, 624.466, 624.501, 624.6488(1), 625.306, 625.502, 628.041, 628.6011, 628.051, 628.061, 628.071, 628.081, 628.091, 628.121, 628.051, 628.161, 628.171, 628.221, 628.231, 628.251, 628.261, 628.451, 628.461, 628.4615, 628.471, 629.071, 629.081, 629.091, 629.101, 629.121, 629.131, 629.181 FS. History–New 2-26-92, Amended 9-19-00, _____.

4-136.015 Procedure to Amend an Existing Certificate of Authority to Add a New Line of Business.

(1) through (2) No change.

(3) Any insurer seeking to add a new line of insurance to an existing certificate of authority shall submit all of the following applicable forms:

(a) through (f) No change.

(g) Form DI4-1093, "State of Florida Form for Small Employer Carrier's Application to Become a Risk Assuming Carrier or a Reinsuring Carrier," rev. 05/02 ~~9/95~~.

(4) through (5) No change.

Specific Authority 624.308(1) FS. Law Implemented 624.09, 624.307(1), 624.404, 624.408, 624.413, 624.414, 624.416(4), 624.501(20), 627.6488(1) FS. History–New 3-30-92, Amended 9-2-96, 9-19-00, _____.

4-136.031 Registration as a Purchasing Group.

(1) All entities seeking registration as a purchasing group shall comply with the requirements of Section 627.948, Florida Statutes, and shall submit:

(a) through (b) No change.

(c) All purchasing groups shall comply with the information contained in Form DI4-515, "Purchasing Group – Notice and Registration," rev. 10/07/99 and submit the following forms where applicable:

1. through 3. No change.

4. Form DI4-905, "Instructions for Furnishing Background Investigative Reports," rev. 02/01 ~~6/99~~; and

5. No change.

(2) through (4) change.

Specific Authority 624.308, 627.954 FS. Law Implemented 624.307(1),(3), 624.318, 624.321, 626.611(14), 627.948 FS. History–New 1-30-91, Formerly 4-107.002, Amended 9-19-94, 9-19-00, _____.

NAME OF PERSON ORIGINATING PROPOSED RULE: Gwen Chick, Division of Insurer Services, Department of Insurance

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: MIchelle Newell, Director, Division of Insurer Services, Department of Insurance

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: July 23, 2002

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: August 2, 2002

DEPARTMENT OF INSURANCE

RULE TITLES:	RULE NOS.:
PART I LONG TERM CARE STANDARDS FOR POLICIES ISSUED PRIOR TO MARCH 1, 2003	
Purpose	4-157.001
Applicability and Scope	4-157.002
Out-of-State Group Long-Term Care Insurance	4-157.004
Conversion or Continuation Privilege	4-157.010
Reporting	4-157.023
PART II LONG TERM CARE STANDARDS FOR POLICIES ISSUED ON OR AFTER MARCH 1, 2003	
Purpose	4-157.101
Applicability and Scope	4-157.102
Definitions	4-157.103
Policy Practices and Provisions	4-157.104
Refund of Premium	4-157.105
Required Disclosure Provisions	4-157.106
Required Disclosure of Rating Practices to Consumers	4-157.107
Initial Filing Requirements	4-157.108
Prohibition Against Post-Claims Underwriting	4-157.109
Requirements for Application Forms and Replacement Coverage	4-157.110
Reporting Requirements	4-157.111
Reserve Standards	4-157.112
Premium Rate Schedule Increases	4-157.113
Filing Requirements – Out-of-State Groups	4-157.114
Filing Requirements for Advertising	4-157.115
Suitability	4-157.116
Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates	4-157.117
Nonforfeiture Benefit Requirements	4-157.118
Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts	4-157.119
Standard Format Outline of Coverage	4-157.120
Requirement to Deliver Shopper's Guide	4-157.121
Penalties	4-157.122

PURPOSE, EFFECT AND SUMMARY: To adopt National Association of Insurance Commissioners' standards regarding the content, rates, and sales of long term care and limited benefit insurance policies.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: None.

Any person who wishes to provide information regarding the statement of estimated regulatory 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: 624.308, 627.9407 FS.

LAW IMPLEMENTED: 624.307(1), 624.3161, 626.9541, 267.9403, 627.9405, 627.9406, 627.9407, 627.94072, 626.9641 FS.

IF REQUESTED IN WRITING WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW (IF NOT REQUESTED, THIS HEARING WILL NOT BE HELD):

TIME AND DATE: 9:00 a.m., October 1, 2002

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

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Frank Dino, Bureau of Life and Health Forms and Rates, Division of Insurer Services, Department of Insurance, 200 East Gaines Street, Tallahassee, Florida 32399-0328, (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 the person listed above.

THE FULL TEXT OF THE PROPOSED RULES IS:

PART I LONG TERM CARE STANDARDS FOR POLICIES ISSUED PRIOR TO MARCH 1, 2003

4-157.001 Purpose.

The purpose of these rules is :

(1) T~~t~~o implement Part XVIII ~~Chapter 88-57, Laws of Florida, creating new Part XIX~~ of Chapter 627, F.S., pertaining to requirements of long-term care insurance policies,

(2) T~~t~~o promote the public interest,

(3) Tto promote the availability of long-term care insurance policies,

(4) Tto protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices,

(5) Tto establish standards for long-term care insurance,

(6) Tto facilitate public understanding and comparison of long-term care insurance policies, and

(7) Tto facilitate flexibility and innovation in the development of long-term care insurance coverage.

Specific Authority 624.308(1), 627.9407(1) FS. Law Implemented 624.307(1), 627.9402, 627.9407(1) FS. History–New 5-17-89, Formerly 4-81.001, Amended _____.

4-157.002 Applicability and Scope.

(1) through (2) No change.

(3) The provisions of Part I shall apply to all long-term care policies and certificates issued in this state which are not included in the scope of Part II.

(4) All appendices incorporated by reference are available from the Bureau of Life and Health Forms and Rates, Larson Building, 200 East Gaines Street, Tallahassee, Florida 32399-0328.

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 _____.

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

(1) No change.

(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, such state must require that long-term care policies meet at least all of the following requirements:

(a) through (b) No change.

(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;

(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 Section 627.410, F.S. and Rule Chapter 4-149, F.A.C. as though the policy had been issued in Florida.

(b) For those policies which have been determined to be regulated by a state with substantially similar long term care insurance requirements, pursuant to Rule 4-157.004(1)(b), F.A.C., form and rate changes shall be filed for informational purposes at least 30 days 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 _____.

4-157.010 Conversion or Continuation Privilege.

(1) through (5) No change.

(6)(a) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age and risk class at inception of coverage under the group policy from which conversion is made.

(b) Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age and risk class used in determining the coverage issued at inception of coverage under the group policy replaced.

(7) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

(a) Termination of group coverage resulted from a certificateholder's ~~an individual's~~ failure to make any required payment of premium or contribution when due. This does not include such situations as the individual's authorizing and making payment that is not ultimately paid to the insurer due to bank, employer, or policyholder error, or

(b) No change.

(8) through (10) No change.

Specific Authority 624.308(1), 627.9407(1) FS. Law Implemented 624.307(1), 627.646, 627.6675, 627.9407(1) FS. History--New 5-17-89, Formerly 4-81.010, Amended _____.

4-157.023 Reporting.

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

(2) Every insurer shall report annually by June 30 the 10 percent of its agents with the greatest percentages of lapses and replacements as measured by Rule 4-157.023(1), F.A.C., in the format prescribed by Appendix J, which is incorporated herein by reference.

(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 in this state.

(4) Every insurer shall report annually by June 30 the number of lapsed policies as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the end of the preceding calendar year in this state in the format prescribed in Appendix J.

(5) Every insurer shall report annually by June 30 the number of replacement policies sold as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the preceding calendar year in this state in the format as prescribed in Appendix J.

(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 in this state, in the in Appendix E, which is incorporated herein by reference.

(7) For purposes of this section:

(a) "Policy" means only long-term care insurance;

(b) "Claim" means, subject to paragraph 4-157.023(8)(c), F.A.C., a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

(c) "Denied" means the insurer refuses to pay a claim for any reason other than claims not paid for failure to meet the elimination period or because of an applicable preexisting condition; and

(d) "Report" means on a statewide basis.

(8) 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 that the insured voluntarily effectuated, and shall annually furnish this information to the Department by March 1 of each year in the format prescribed in Appendix A, which is incorporated herein by reference.

(9) Reports required under this Rule 4-157.023, F.A.C. shall be filed with the Bureau of Market Conduct, Division of Insurer Services.

Specific Authority 624.308(1), 627.9407(1), 627.9408 FS. Law Implemented 624.307(1), 627.9402, 627.9407(1), 627.410(7) FS. History–New _____.

PART II LONG TERM CARE STANDARDS FOR POLICIES ISSUED ON OR AFTER MARCH 1, 2003

4-157.101 Purpose.

The purpose of the provisions of this rule chapter is to implement Part XVIII of Chapter 627, to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance.

Specific Authority 624.308(1),627.9407(1), 627.9407(2), 627.9407(6), 627.9408 FS. Law Implemented 624.307(1), 627.9402, 627.9407(1) FS. History–New _____.

4-157.102 Applicability and Scope.

(1) Except as otherwise specifically provided, the provisions of this rule chapter shall apply to long-term care insurance policies delivered or issued for delivery in this state, and to policies delivered or issued for delivery outside this state to the extent provided in Section 627.9406, F.S., and Rule 4-157.114, F.A.C., by an insurer, a fraternal benefit society as defined in Section 632.601, F.S., a health care services plan as defined in Section 641.01, F.S., a prepaid health clinic as defined in Section 641.402, F.S., or a multiple-employer welfare arrangement as defined in Section 624.437, F.S.

(2) Pursuant to Section 627.9403, F.S., the provisions of this rule chapter 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. For limited benefit policies, the term and reference to Long Term Care as used within this rule chapter, shall be considered to be, and replaced by, the term Limited Benefit.

(3) The provisions of this rule chapter apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if:

(a) The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;

(b) The disability income policy is advertised, marketed or offered as insurance for long-term care services; or

(c) Benefits under the policy may commence after the policyholder has reached Social Security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

(4) The provisions of this rule chapter shall apply to all long-term care policies or certificates issued on or after March 1, 2003. Notwithstanding the above, for certificates issued under a group long-term care insurance policy as defined in Section 627.9405(1)(a), F.S., which policy was in force at the time this amended rule chapter became effective, the provisions of this rule chapter shall apply to certificates issued on or after the policy anniversary following September 1, 2003.

(5)(a) The provisions of Rule Chapter 4-149, F.A.C., shall apply to long-term care insurance coverage filings. In the event of conflict between Rule Chapter 4-149, F.A.C., and this Part II, the provisions of this Part II shall prevail.

(b) In filing the required annual rate certification filings pursuant to Section 627.410(7)(b), F.S., and Rule 4-149.007, F.A.C., the annual rate certification filing shall include the certification required by paragraph 4-157.108(1)(c), F.A.C.

Specific Authority 624.308(1),627.9407(1), 627.9408 FS. Law Implemented 624.307(1), 627.9403, 627.9406 FS. History–New _____.

4-157.103 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) "Adult day care center" means a program for 6 or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

(2) "Assisted living facility" means a residential arrangement that provides individualized personal care and health services for persons who require assistance with activities of daily living.

(3)(a) "Exceptional increase" means only those increases filed by an insurer as exceptional for which the Department determines the need for the premium rate increase is justified:

1. Due to changes in laws or regulations applicable to long-term care coverage in this state; or

2. Due to increased and unexpected utilization that affects the majority of insurers of similar products.

(b) Except as provided in Rule 4-157.113, F.A.C., exceptional increases are subject to the same requirements as other premium rate schedule increases.

(c) Upon request of the Department, a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase at the expense of the company making the filing shall be made.

(d) The Department, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

(4) "Hands-on assistance" or "services" means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.

(5) "Home health services" means medical and non-medical services provided to ill, disabled, or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living, and respite care services.

(6) "Hospital" means a hospital as defined and licensed pursuant to the provisions of Chapter 395, F.S., or pursuant to substantially similar provisions of another state's licensing laws.

(7) "Incidental," as used in subsection 4-157.113(9), F.A.C., means that the value of the long-term care benefits provided is less than 10 percent of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

(8) "Institutionalization" means that confinement to a hospital, facility, or center licensed pursuant to any parts of Chapters 400 or 395, F.S., or pursuant to substantially similar provisions of another state's licensing laws.

(9) "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

(10) "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

(11) "Nursing home facility" or "nursing home" as defined in Section 400.021(11), F.S.

(12) "Nurse registry" as defined in Section 400.462(15), F.S.

(13) "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

(14) "Personal information" means any individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health or any other personal characteristics. "Personal information" includes an individual's name and address and "medical record information" but does not include "privileged information".

(15) "Privileged information" means any individually identifiable information that:

(a) Relates to a claim for insurance benefits or a civil or criminal proceeding involving an individual; and

(b) Is collected in connection with or in reasonable anticipation of a claim for insurance benefits or civil or criminal proceeding involving an individual.

(16) "Qualified actuary" means a member in good standing of the American Academy of Actuaries.

(17) "Similar policy forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered.

(a) Certificates of groups that meet the definition in Section 627.9405(1)(a), F.S., are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications.

(b) For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

(18) "Waiting period" or "probationary period" as used in a long-term care policy means that period of time which follows the date a person is initially insured under the policy before the coverage or coverages of the policy shall become effective as to that person.

Specific Authority 624.308(1), 626.9611, 627.9407(1), 627.9408 FS. Law Implemented 624.307(1), 627.9407(1), 626.9541 FS. History–New _____.

4-157.104 Policy Practices and Provisions.

(1) Renewability. The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Rule 4-157.106, F.A.C.

(a) A policy issued to an individual shall not contain renewal provisions other than "guaranteed renewable" or "noncancellable."

(b) The term "guaranteed renewable" shall be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(c) The term "noncancellable" shall be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

(d) The term "level premium" shall only be used when the insurer does not have the right to change the premium.

(e) In addition to the other requirements of this subsection 4-157.104(1), F.A.C., a qualified long-term care insurance contract shall be guaranteed renewable within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

(2) Limitations and Exclusions. A policy may not be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:

(a) Preexisting conditions or diseases pursuant to Sections 627.9407(4)(a) and (b), F.S.;

(b) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;

(c) Alcoholism and drug addiction;

(d) Illness, treatment, or medical condition arising out of:

1. War or act of war (whether declared or undeclared);

2. Participation in a felony, riot, or insurrection;

3. Service in the armed forces or units auxiliary thereto;

4. Suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or

5. Aviation (this exclusion applies only to non-fare-paying passengers).

(e) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance;

(f) Expenses for services or items available or paid under another long-term care insurance or health insurance policy;

(g) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.

(h) This subsection is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

(3) Conditions of Eligibility. The provision of 627.9405(2), F.S., does not require the sponsoring policyholder of a group policy to contribute premiums; however, if the sponsoring policyholder does contribute any premium, all members of the group, or all of any class or classes thereof, shall be declared eligible and acceptable to the insurer at the time of issuance of the policy.

(4) Minimum Coverage.

(a) All long-term care policies shall provide coverage for at least 24 consecutive months for each covered person for care in a nursing home.

(b) All long-term care policies shall provide coverage for at least one type of lower level of care, in addition to coverage for care in a nursing home.

(c)1.a. No long-term care policy shall 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 shall provide a level of benefits equivalent to at least 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 at least $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 at least $50 per day.

b. 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, at least 50 percent of the benefit period provided for nursing home coverage.

c. If a long-term care policy provides nursing home coverage for an unlimited duration, the lower level of care shall be payable for at least 3 years in the aggregate.

2. A long-term care policy may use an overall lifetime benefit maximum, in lieu of the specific coverage identified by paragraph (c), above, which may be exhausted by any combination of benefits provided the overall lifetime benefit maximum is at least 150 percent of the minimum coverage required by paragraph 4-157.104(4)(a), F.A.C. times the amount of daily nursing home benefit purchased.

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

1. Nursing service;

2. Assisted living facility;

3. Home health services;

4. Adult day care center;

5. Adult foster home;

6. Community care for the elderly;

7. Personal care and social services;

8. Such other lower levels of care as approved by the Department.

(5) Group Coverage Certificate. A certificate issued pursuant to a group long-term care insurance policy, which policy is delivered or issued for delivery in this state, shall include:

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

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

(c) Unless the policy is provided to the certificateholder, a statement that the description of principal benefits is a summary of the policy and that the group master policy should be consulted to determine governing contractual provisions;

(d) Person insured;

(e) Person to whom benefits are payable;

(f) Group contract number;

(g) Certificate number;

(h) Effective date; and

(i) Time certificate is effective.

(6) Death Benefits. An individual long term care policy shall not include a policy benefit that is incurred upon the death of an insured in excess of $1,000 pursuant to Section 627.603, F.S. Such benefits may be provided as an option that the insured may purchase or not purchase for a separate premium from the base policy coverage.

(7) Extension of Benefits.

(a) Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination.

(b) The extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits, and may be subject to any policy waiting period and all other applicable provisions of the policy.

(8) Continuation or Conversion.

(a) Group long-term care insurance issued in this state shall provide covered individuals with a basis for continuation or conversion of coverage.

(b) For the purposes of this rule, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due.

(c) For the purposes of this rule, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least 6 months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy the individual is covered, without evidence of insurability.

(d)1. For the purposes of this rule, "converted policy" means an individual policy of long-term care insurance providing benefits identical to, or benefits determined by the Department to be substantially equivalent to or in excess of, those provided under the group policy from which conversion is made.

2. The policy and rate schedule for the converted policy shall be a policy that is available, at the time of conversion, for general sales by the insurer.

3. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the Department, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including provider system arrangements, service availability, benefit levels and administrative complexity.

(e) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than 31 days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

(f)1. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age and risk class at inception of coverage under the group policy from which conversion is made.

2. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age and risk class used in determining the coverage issued at inception of coverage under the group policy replaced.

(g) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

1. Termination of group coverage resulted from a certificateholder's failure to make any required payment of premium or contribution when due. This does not include such situations as the individual's authorizing and making payment which is not ultimately paid to the insurer due to bank, employer, or policyholder error; or

2. The terminating coverage is replaced not later than 31 days after termination by group coverage effective on the day following the termination of coverage:

a. Providing benefits identical to or benefits determined by the Department to be substantially equivalent to or in excess of those provided by the terminating coverage; and

b. The premium for which is calculated in a manner consistent with the requirements of paragraph 4-157.104(8)(f), F.A.C.

(h)1. Notwithstanding any other provision of this subsection 4-157.104(8), F.A.C., a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses.

2. The provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund that reflects the reduction in benefits payable.

(i) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

(j) Notwithstanding any other provision of this subsection 4-157.104(8), F.A.C., an insured individual whose eligibility for group long-term care coverage is based upon the individual's relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship.

(k) For the purposes of this section a "managed-care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management, or use of specific provider networks.

(9) 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:

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

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

(10) Premium Restrictions.

(a) Except for premium rate increases pursuant to Rule 4-157.113, F.A.C., or due to benefit changes elected by the insured, the premium rate schedule shall be designed to be level based on the issue age of the insured. Any discount provided at issue may not be removed once issued.

(b)1. The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under Rule 4-157.118, F.A.C., the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

2. A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under Rule 4-157.118, F.A.C., the initial annual premium shall be based on the reduced benefits.

(11) Electronic Enrollment for Group Policies.

(a) In the case of a group defined in Section 627.9405(1)(a), F.S., any requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:

1. The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

2. The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention, and prompt retrieval of records; and

3. The insurer is responsible that the telephonic or electronic enrollment process provides necessary and reasonable safeguards to assure that the confidentiality of personal and privileged information is maintained.

(b) The insurer shall make available, upon request of the Department, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

Specific Authority 624.308(1), 627.9407(1), 627.9407(6), 627.9408 FS. Law Implemented 624.307(1), 627.410(6), 627.9402, 627.9407, 627.9405(2), 627.646, 627.603 FS. History–New _____.

4-157.105 Refund of Premium.

In the event of cancellation, the insurer shall return the unearned portion of any premium paid.

Specific Authority 624.308(1), 627.9407(1), 627.9407(6), 627.9408 FS. Law Implemented 624.307(1), 627.6043, 627.6645, 627.9407 FS. History–New _____.

4-157.106 Required Disclosure Provisions.

(1) Renewability. Individual long-term care insurance policies shall contain a renewability provision.

(a) The provision:

1. Shall be appropriately captioned;

2. Shall appear on the first page of the policy;

3. Shall clearly state that the coverage is guaranteed renewable or noncancellable; and

4. Shall not apply to policies that do not contain a renewability provision, and under which the right to non-renew is reserved solely to the policyholder.

(b) A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change, as defined in paragraph 4-157.104(1)(b), F.A.C.

(2) Riders and Endorsements.

(a) 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 that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured.

(b) After the date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing and signed by the insured, except if increased benefits or coverage are required by law.

(c) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider, or endorsement.

(3) Payment of Benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of these terms and an explanation of the terms in the policy and its accompanying outline of coverage in compliance with Section 627.6044, F.S.

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

(5) Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in Section 627.9407(5), F.S., shall set forth a description of the limitations or conditions, including any required number of days of confinement in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

(6) Disclosure of Tax Consequences.

(a) With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor.

(b) The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.

(c) This disclosure requirement shall not apply to qualified long-term care insurance contracts.

(7) Benefit Triggers.

(a) Activities of daily living and cognitive impairment shall be used to measure an insured's need for long term care, shall be described in the policy or certificate in a separate paragraph, and shall be labeled "Eligibility for the Payment of Benefits."

(b) Any additional benefit triggers shall also be explained in this section.

(c) If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description.

(d) 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 shall be specified.

(8) A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as required by Section 627.9407(12), F.S., that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

(9) A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as required by Section 627.9407(12), F.S., that the policy is not intended to be a qualified long-term care insurance contract.

Specific Authority 624.308(1), 627.9407(1), 627.9408 FS. Law Implemented 624.307(1), 627.9402, 627.9407, 627.6044, 627.94074 FS. History–New _____.

4-157.107 Required Disclosure of Rating Practices to Consumers.

(1) Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this rule to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such case, an insurer shall provide all of the information listed in this rule to the applicant no later than at the time of delivery of the policy or certificate.

(a) A statement that the policy may be subject to rate increases in the future;

(b) An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision;

(c) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(d) A general explanation for applying premium rate or rate schedule adjustments that shall include:

1. A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and

2. The right to a revised premium rate or rate schedule as provided in paragraph 4-157.107(1)(b), F.A.C., if the premium rate or rate schedule is changed;

(e)1. Information regarding each premium rate increase on this policy form or similar policy forms over the past 10 years for this state or any other state that, at a minimum, identifies:

a. The policy forms for which premium rates have been increased;

b. The calendar years when the form was available for purchase; and

c. The amount or percentage of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

2. The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

3. An insurer shall have the right to exclude from the disclosure premium rate increases that apply only to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

4.a. If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this Part II or the end of a 24 month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure.

b. The nonaffiliated selling insurer shall include the disclosure of that rate increase in accordance with subparagraph 4-157.107(1)(e)1, F.A.C.

5. If the acquiring insurer in subparagraph 4-157.107(1)(e)4., F.A.C., files for a subsequent rate increase, even within the 24 month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in subparagraph 4-157.107(1)(e)4., F.A.C., the acquiring insurer shall make all disclosures required by paragraph 4-157.107(1)(e), F.A.C., including disclosure of the earlier rate increase referenced in subparagraph 4-157.107(1)(e)4., F.A.C.

(2) An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under paragraphs 4-157.107(1)(a) and (e), F.A.C. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

(3) An insurer shall use the content and format of Appendices B and F, which are incorporated herein by reference, to comply with the requirements of subsection 4-157.107(1), F.A.C.

(4)(a) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer.

(b) The notice shall include the information required by subsection 4-157.107(1), F.A.C., when the rate increase is implemented.

Specific Authority 624.308(1), 627.9407(1), 627.9408, 626.9611 FS. Law Implemented 624.307(1), 627.9402, 627.9407(1), 626.9541 FS. History–New _____.

4-157.108 Initial Filing Requirements.

(1) An insurer shall provide the information listed in this subsection for approval pursuant to Section 627.410, F.S. prior to making a long-term care insurance form available for sale.

(a) A filing made pursuant to Rule Chapter 4-149, F.A.C., with the actuarial material identified below in lieu of the actuarial memorandum required by subparagraph 4-149.003(2)(b)4., F.A.C.

(b) A copy of the disclosure documents required in Rule 4-157.107, F.A.C.; and

(c) An actuarial certification consisting of at least the following:

1. A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

2. A statement that the policy design and coverage provided have been reviewed and taken into consideration;

3. A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

4. A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

a. Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

b. A statement that the assumptions used for reserves contains reasonable margins for adverse experience;

c. A statement that the net valuation premium for renewal years does not increase; and

d. A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur;

(I) An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;

(II) If the gross premiums for certain age groups appear to be inconsistent with this requirement, upon request of the Department, a demonstration under subsection 4-157.108(2), F.A.C., based on a standard age distribution shall be made; and

5.a. A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

b. A comparison of the premium schedules and benefits for similar policy forms that are currently available from the insurer with an explanation of the relative value of the benefit differences; and

6.a. The date and explanation of the reason for the discontinuance of all forms discontinued within the past 5 years;

b. Whether any currently available form will be discontinued upon approval of the proposed form; and

c. A summary of the significant differences between the forms.

(2) Upon request of the Department, an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

Specific Authority 624.308(1), 627.9407(1), 627.9408 FS. Law Implemented 624.307(1), 627.9402, 627.9407, 627.410(6) FS. History–New _____.

4-157.109 Prohibition Against Post-Claims Underwriting.

(1) All applications for long-term care insurance policies or certificates except those that 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 that 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 the medications listed in the 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 that 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] may have 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 your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company may have 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 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.

Specific Authority 624.308(1), 626.9611, 627.9407(1), 627.9408 FS. Law Implemented 624.307(1), 627.9402, 626.5941, 627.9407(1) FS. History–New _____.

4-157.110 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 containing the questions may be used. With regard to a replacement policy issued to a group defined by Section 627.9405(1)(a), F.S., the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement.

(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 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 that are still in force.

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

(3) Solicitations Other than Direct Response.

(a) 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 of the individual long-term care insurance policy a notice regarding replacement of accident and sickness or long-term care coverage.

(b) One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer.

(c) The notice shall be provided in the format prescribed in Appendix G, which is incorporated herein by reference.

(4) Direct Response Solicitations.

(a) Whenever a sale will involve replacement, an insurer 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.

(b) The notice shall be provided in the format prescribed in Appendix H, which is incorporated herein by reference.

(5) Where replacement is intended, the replacing insurer shall notify in writing the existing insurer of the proposed replacement.

(a) The existing policy shall be identified by the insurer, name of the insured, and policy number or address including zip code.

(b) Notice shall be made within 5 working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

Specific Authority 624.308(1), 627.9407(1), 627.9408, 626.9611 FS. Law Implemented 624.307(1), 627.9402, 627.9407(1), 626.9541 FS. History–New _____.

4-157.111 Reporting Requirements.

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

(2) Every insurer shall report annually by June 30 the 10 percent of its agents with the greatest percentages of lapses and replacements as measured by subsection 4-157.111(1), F.A.C. in the format as prescribed in Appendix J.

(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 in this state.

(4) Every insurer shall report annually by June 30 the number of lapsed policies as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the end of the preceding calendar year in this state in the format as prescribed in Appendix J.

(5) Every insurer shall report annually by June 30 the number of replacement policies sold as a percentage of its total annual sales and as a percentage of its total number of policies in force as of the preceding calendar year in this state in the format as prescribed in Appendix J.

(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 in this state in the format as prescribed in Appendix E.

(7) For purposes of this section:

(a) "Policy" means only long-term care insurance;

(b) "Claim" means, subject to paragraph 4-157.111(7)(c), F.A.C., a request for payment of benefits under an in force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

(c) "Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

(d) "Report" means on a statewide basis.

(8) Every insurer shall report annually by June 30 the information required by subsection 4-157.116(8), F.A.C.

(9) Based on the provisions of Rule 4-157.109, F.A.C., 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 that the insured voluntarily effectuated and shall annually furnish this information, by March 1 of each year, in the format as prescribed in Appendix A.

(10) Reports required under this Rule 4-157.111, F.A.C., shall be filed with the Bureau of Market Conduct, Division of Insurer Services.

Specific Authority 624.308(1), 627.9407(1), 627.9408 FS. Law Implemented 624.307(1), 627.9402, 627.9407(1), 627.410(7) FS. History–New _____.

4-157.112 Reserve Standards.

(1)(a) When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies which meet the conditions of subsection 4-157.113(9), F.A.C., policy reserves for the benefits shall be determined in accordance with Section 625.121, F.S. Claim reserves shall also be established in the case when the policy or rider is in claim status.

(b)1. Reserves for policies and riders shall be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates.

2. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial.

3. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits.

4. In no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

(c) In the development and calculation of reserves for policies and riders, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures, and all other considerations which have an impact on projected claim costs, including the following:

1. Definition of insured events;

2. Covered long-term care facilities;

3. Existence of home convalescence care coverage;

4. Definition of facilities;

5. Existence or absence of barriers to eligibility;

6. Premium waiver provision;

7. Renewability;

8. Ability to raise premiums;

9. Marketing method;

10. Underwriting procedures;

11. Claims adjustment procedures;

12. Waiting period;

13. Maximum benefit;

14. Availability of eligible facilities;

15. Margins in claim costs;

16. Optional nature of benefit;

17. Delay in eligibility for benefit;

18. Inflation protection provisions; and

19. Guaranteed insurability option.

(d) Any applicable valuation morbidity table shall be certified by a member of the American Academy of Actuaries as appropriate as a statutory valuation table.

(2) When long-term care benefits are provided other than as in subsection 4-157.112(1), F.A.C., reserves shall be determined in accordance with Part III of Chapter 4-154, F.A.C.

Specific Authority 624.308(1), 627.9407(1), 627.9408 FS. Law Implemented 624.307(1), 627.9402, 627.9407(1), 625.121 FS. History–New _____.

4-157.113 Premium Rate Schedule Increases.

(1) An insurer shall file with the Department for approval any premium rate schedule increase, including an exceptional increase, pursuant to Section 627.410, F.S. The filing shall include:

(a) A filing made pursuant to Rule Chapter 4-149, F.A.C., with the actuarial information identified below in lieu of the actuarial memorandum required by subparagraph 4-149.003(2)(b)4., F.A.C.

(b) Information required by Rule 4-157.107, F.A.C.;

(c) Certification by a qualified actuary that:

1. No further premium rate schedule increases are anticipated If the requested premium rate schedule increase is implemented and the underlying assumptions are realized;

2. The premium rate filing is in compliance with the provisions of Rule 4-157.113, F.A.C.;

(d) An actuarial memorandum justifying the rate schedule change request that includes:

1. Lifetime projections of earned premiums and incurred claims based on both the current rate schedule and the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including a summary and the reason for any assumptions that deviate from those used for pricing other forms currently available for sale;

a. Calendar year values for the complete history of the combined experience of the form with all other similar policy forms, and projections of the remaining future lifetime of the forms. For pooling purposes, coverages providing non-institutional benefits may establish different experience pools based upon similar benefits consistent with Rule Chapter 4-149, F.A.C.

b. The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

c. The projections shall demonstrate compliance with subsection 4-157.113(2), F.A.C.; and

d. For exceptional increases,

(I) The projected experience shall be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(II) In the event the Department determines as provided in paragraph 4-157.103(4)(d), F.A.C., that offsets may exist, the insurer shall use appropriate net projected experience;

2. Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

3. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the insurer have been relied on by the actuary;

4. A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

5. In the event that it is necessary to maintain consistent premium rates for new certificates and certificates issued under a group long-term care insurance policy as defined in Section 627.9405(1)(a), F.S., receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates;

(e) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits; and,

(f) Sufficient information for review and approval of the premium rate schedule increase by the Department.

(2) All premium rate schedule increases shall be determined in accordance with the following requirements:

(a) Exceptional increases shall provide that 70 percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(b) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

1. The accumulated value of the initial earned premium times 58 percent;

2. 85 percent of the accumulated value of prior premium rate schedule increases on an earned basis;

3. The present value of future projected initial earned premiums times 58 percent; and

4. 85 percent of the present value of future projected premiums not in subparagraph 4-157.113(2)(b)3., F.A.C., on an earned basis;

(c) In the event that a policy form has both exceptional and other increases, the values in subparagraphs 4-157.113(2)(b)2. and 4., F.A.C., will also include 70 percent for exceptional rate increase amounts; and

(d) All present and accumulated values used to determine rate increases shall use a discount rate no less than the maximum valuation interest rate for contract reserves as specified in the subparagraph 4-154.204(2)l., F.A.C. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

(3)(a) For each rate increase that is implemented, the insurer shall include within each annual rate certification filing made pursuant to Rule 4-149.007, F.A.C, updated projections, as defined in paragraph 4-157.113(1)(d), F.A.C., annually for the next 3 years and include a comparison of actual results to projected values.

(b) The Department shall extend the period to greater than 3 years if actual results are not consistent with projected values from prior projections.

(c) For group insurance policies that meet the conditions in subsection 4-157.113(10), F.A.C., the projections required by this rule shall be provided to the policyholder in lieu of filing with the Department.

(4)(a) If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in paragraph 4-157.113(1)(d), F.A.C., shall be included in each annual rate certification filing made pursuant to Rule 4-149.007, F.A.C., every 5 years following the end of the required period in subsection 4-157.113(3), F.A.C.

(b) For group insurance policies that meet the conditions in subsection 4-157.113(10), F.A.C., the projections required by this subsection shall be provided to the policyholder in lieu of filing with the Department.

(5)(a) If the Department has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection 4-157.113(2), F.A.C., the Department shall require the insurer to implement any of the following:

1. Premium rate schedule adjustments; or

2. Other measures to reduce the difference between the projected and actual experience.

(b) In determining whether the actual experience adequately matches the projected experience, consideration shall be given to subparagraph 4-157.113(1)(d)5., F.A.C., if applicable.

(6) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(a) A plan, subject to Department approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the Department may impose the condition in subsection 4-157.113(7), F.A.C.; and

(b) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection 4-157.113(2), F.A.C., had

the greater of the original anticipated lifetime loss ratio or 58 percent been used in the calculations described in subparagraphs 4-157.113(2)(b)1. and 3., F.A.C.

(7)(a) For a rate increase filing that meets the following criteria, the Department shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

1. The rate increase is not the first rate increase requested for the specific policy form or forms;

2. The rate increase is not an exceptional increase; and

3. The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse

(b)1. In the event significant adverse lapsation has occurred, is anticipated in the filing, or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the Department shall determine that a rate spiral exists.

2. Following the determination that a rate spiral exists, the Department shall require the insurer to offer, without underwriting and at the underwriting class that is most comparable to the original underwriting class of each insured, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates. The offer shall:

a. Be subject to the approval of the Department;

b. Be based on actuarially sound principles, but not be based on attained age; and

c. Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

2. The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

a. The maximum rate increase determined based on the combined experience; and

b. The maximum rate increase determined based only on the experience of the insureds originally issued the form plus 10 percent.

(8) If the Department determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the Department shall, in addition to the provisions of subsection 4-157.113(7), F.A.C., prohibit the insurer from either:

(a) Filing and marketing comparable coverage for a period of up to 5 years; or

(b) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

(9) Subsections 4-157.113(1) through (8), F.A.C., shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in subsection 4-157.103(8), F.A.C., if the policy complies with all of the following provisions:

(a) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(b) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of Section 627.476, F.S. or Chapter 4-164, as applicable; and

(c) An actuarial memorandum is filed with the Department that includes:

1. A description of the basis on which the long-term care rates were determined;

2. A description of the basis for the reserves;

3. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

4. A description and a table of each actuarial assumption used. For expenses, an insurer must include percentage of premium dollars per policy and dollars per unit of benefits, if any;

5. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

6. The estimated average annual premium per policy and the average issue age;

7. A statement as to whether underwriting is performed at the time of application.

a. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting.

b. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

8. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

(10) Subsections 4-157.113(5) and (7), F.A.C., shall not apply to group insurance policies as defined in Section 627.9405(1)(a), F.S., where:

(a) The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

(b) The policyholder, and not the certificateholders, pay a material portion of the premium, which shall not be less than 20 percent of the total premium for the group in the calendar year prior to the year a rate increase is filed.

(11)(a) A insurer may choose to continue to make a current policy form available for sale after the effective date in subsection 4-157.102(4), F.A.C.

(b) All policyholders of any form sold after the effective date of subsection 4-157.102(4), F.A.C., shall be provided equal treatment and protection of the provisions of Rules 4-157.113 and .118, F.A.C.

(c) If the insurer elects to continue using a currently approved form, the insurer shall notify the Department of the election no later than January 1, 2003.

Specific Authority 624.308(1), 627.9407(1), 626.9611, 627.9408 FS. Law Implemented 624.307(1), 627.9402, 627.9407, 626.9541, 627.410(6) FS. History–New _____.

4-157.114 Filing Requirement – Out-of-State Groups.

(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 Section 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 the requirements have been met. Evidence to this effect shall be filed by the insurer with the Department pursuant to the procedures specified in Section 627.410, F.S. The 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 Sections 627.9401-627.9408, F.S., and these rules have been met; or

(b)1. Filing of a truthful certification by an officer of the insurer that another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in Florida has made a determination that such requirements have been met; and

2. Filing of the policy and certificate forms to be issued and delivered, including rates and rate development information, which demonstrate that the requirements of another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in Florida have been met.

(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 state shall 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 and an additional coverage of 50 percent for lower levels of care as provided in subsection 4-157.104(4), F.A.C.

(b) The standards of Rules 4-157.108 and .113, F.A.C.;

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

(d) A prohibition or limitation on pre-existing condition exclusions at least as favorable to a policyholder as that specified in Section 627.9407(4), F.S.;

(e) A prohibition against a policy or certificate excluding or using waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described pre-existing diseases or physical conditions beyond any pre-existing condition waiting period;

(f) A prohibition or limitation on prior institutionalization provisions at least as favorable to a certificateholder as that specified in Section 627.9407(5), F.S., including the mandatory offer provisions of paragraph (5)(c) of that section;

(g) A prohibition or limitation on certificate cancellations or nonrenewals at least as favorable to a certificateholder as that specified in Section 627.9407(3)(a), F.S.;

(h) A requirement that a policy and certificate prominently disclose that the policy and certificate may not cover all of the costs associated with long-term care which may be incurred by the buyer during the period of coverage and that the buyer is advised to periodically review the certificate in relation to the changes in the cost of long-term care;

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

(j) Pursuant to Section 627.94072, F.S., a mandatory offer to the potential insured policyholder or certificateholder, as applicable, of a nonforfeiture provision meeting the standards of Rule 4-157.118, F.A.C.;

(k) Pursuant to Section 627.94072, F.S., a mandatory offer to the potential insured policyholder or certificateholder, as applicable, of an inflation protection provision:

(l) Contain a contingent benefit upon lapse provision at least as favorable to the insured as that in Rule 4-157.118, F.A.C.;

(m) Disclosure of rating practices to consumers as outlined in Rule 4-157.107, F.A.C.;

(n) A conversion or continuation privilege at least as favorable as subsection 4-157.104(8), F.A.C.; and

(o) A prohibition or limitation on an elimination period in excess of 180 days;

(3) Unless a group policy issued in another state has been filed for approval in Florida, no such policy or certificate issued thereunder shall contain a statement that the policy has been approved as a long-term care policy meeting the requirements of Florida law or words of similar meaning.

(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 Section 627.410, F.S., and this rule chapter as though the policy had been issued in Florida.

(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 4-157.114(1)(b), F.A.C., form and rate changes shall be filed for informational purposes at least 30 days prior to use.

Specific Authority 624.308(1), 627.9407(1), 627.9408 FS. Law Implemented 624.307(1), 627.9402, 627.9406 FS. History–New _____.

4-157.115 Filing Requirements for Advertising.

Every insurer, health care service plan or other entity providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement and marketing material intended for use in this state whether through written, radio, television, electronic or other medium for review or approval by the Department as provided by Rule Chapter 4-150, F.A.C.

Specific Authority 624.308(1), 627.9407(2), 627.9408 FS. Law Implemented 624.307(1), 627.9402, 627.9407(2) FS. History–New _____.

4-157.116 Suitability.

(1) This Rule shall not apply to life insurance policies that accelerate benefits for long-term care.

(2) Every insurer, health care service plan, or other entity marketing long-term care insurance (the "insurer") shall:

(a) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

(b) Train its agents in the use of its suitability standards; and

(c) Maintain a copy of its suitability standards and make them available for inspection upon request by the Department.

(3)(a) To determine whether the applicant meets the standards developed by the insurer, the agent and insurer shall develop procedures that take the following into consideration:

1. The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

2. The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

3. The values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

(b)1. The insurer and the agent shall make reasonable efforts to obtain the information set out in paragraph 4-157.116(3)(a), F.A.C. The efforts shall include presentation to the applicant, at or prior to application, the Long-Term Care Personal Worksheet. The personal worksheet used by the insurer shall contain, at a minimum, the information in the format contained in Appendix B, which is incorporated herein by reference, in not less than 12 point type. The issuer may request the applicant to provide additional information to comply with its suitability standards.

2. A copy of the issuer's personal worksheet shall be filed with the Department.

(c) A completed personal worksheet shall be returned to the insurer prior to the insurer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

(d) The sale or dissemination outside the insurer or agency by the insurer or agent of information obtained through the personal worksheet is prohibited.

(4) The insurer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

(5) Agents shall use the suitability standards developed by the insurer in marketing long-term care insurance.

(6) At the same time the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format as prescribed in Appendix C, which is incorporated herein by reference, in not less than 12 point type.

(7)(a) If the insurer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the insurer may reject the application.

(b) In the alternative, the insurer shall send the applicant a letter similar to Appendix D, which is incorporated herein by reference.

(c) If the applicant has declined to provide financial information, the insurer may use some other method to verify the applicant's intent.

(d) Either the applicant's returned letter or a record of the alternative method of verification shall be made a part of the applicant's file.

(8) The insurer shall report annually to the Department:

(a) The total number of applications received from residents of this state;

(b) The number of those who declined to provide information on the personal worksheet;

(c) The number of applicants who did not meet the suitability standards; and

(d) The number of those who chose to confirm after receiving a suitability letter.

Specific Authority 624.308(1), 627.9407(1), 627.9408, 626.9611 FS. Law Implemented 624.307(1), 627.9402, 627.9407(1), 626.9541 FS. History–New _____.

4-157.117 Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies 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(1), 626.9611, 627.9408 FS. Law Implemented 624.307(1), 627.9402, 627.9407(1), 626.9541 FS. History–New _____.

4-157.118 Nonforfeiture Benefit Requirement.

(1) This rule does not apply to life insurance policies or riders meeting the conditions of subsection 4-157.113(9), F.A.C., containing accelerated long-term care benefits.

(2)(a) All insurers offering long term care insurance in this state shall offer a nonforfeiture protection provision at the time of issue as required by Section 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 actuarially equivalent to those provided by the shortened benefit period option.

(3)(a) If the offer for nonforfeiture benefits required to be made under Section 627.94072, F.S., is rejected, for individual and group policies without nonforfeiture benefits the insurer shall include in the policy, or as a rider or endorsement to the policy, the contingent benefit upon lapse described in this rule.

(b) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(c) The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least 45 days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

(d) On or before the effective date of a substantial premium increase as defined in paragraph 4-157.118(3)(c), F.A.C., the insurer shall:

1. Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

2.a. Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of the shortened benefit period nonforfeiture benefit contained in Section 627.94072, F.S.

b. This option may be elected at any time during the 120 day period referenced in paragraph 4-157.118(3)(c), F.A.C., and shall be available from the end of the grace period and is not restricted to being available only on or after the third policy anniversary; and

3. Notify the policyholder or certificateholder that a default or lapse at any time during the 120 day period referenced in paragraph 4-157.118(3)(c), F.A.C., shall be deemed to be the election of the offer to convert in subparagraph 4-157.118(3)(d)2., F.A.C.,

(4) To determine whether contingent nonforfeiture upon lapse provisions are triggered under paragraph 4-157.118(3)(c), F.A.C., a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

(5)(a) When the premium payment period is less than the term of eligibility for benefits under the policy, the insurer shall upon lapse provide a contingent benefit that in the event of any rate increase by the insurer:

1. The insurer shall provide for paid-up policy benefits in the event of policyholder termination within 120 days of the due date of the premium so increased if the ratio in subparagraph 2. below is at least 40 percent.

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

3. In addition, the insurer shall provide the contingent benefit upon lapse required by subsection 4-157.118(3), F.A.C.

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

Specific Authority 624.308(1), 627.9407(1), 627.9408 FS. Law Implemented 624.307(1), 627.9402, 627.9407, 627.94072, 627.410(6) FS. History–New _____.

4-157.119 Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts.

(1) A qualified long term care insurance contract shall pay only for qualified long term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(2)(a)1. A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's being chronically ill as defined in Section 627.9404(4), F.S.

2. Certifications regarding activities of daily living and cognitive impairment shall be performed by a licensed health care practitioner as defined by Section 627.9404(6), F.S.

(b) When a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and the insured is in claim status, the certification shall not be rescinded and additional certifications shall not be performed until after the expiration of the 90 day period.

(3) Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

Specific Authority 624.308(1), 627.9407(1), 627.9408 FS. Law Implemented 624.307(1), 627.9402, 627.9407(1), 627.94074 FS. History–New _____.

4-157.120 Standard Format Outline of Coverage.

This rule implements, interprets, and makes specific, the provisions of Section 627.9407(10), F.S., in prescribing a standard format and the content of an outline of coverage.

(1) The outline of coverage shall be a freestanding document, using no smaller than 10-point type.

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

(3) Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the 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 shall be as contained in Appendix I, which is incorporated herein by reference.

Specific Authority 624.308(1), 627.9407(1), 627.9408 FS. Law Implemented 624.307(1), 627.9402, 627.9407 FS. History–New _____.

4-157.121 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 of a long-term care insurance policy or certificate.

(a) An agent shall 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 shall be presented in conjunction with any application or enrollment form.

(2) Life insurance policies or riders meeting the conditions of subsection 4-157.113(9), F.A.C., containing accelerated long-term care benefits are not required to furnish the above referenced guide, but shall furnish the policy summary required under Section 626.99, F.S.

Specific Authority 624.308(1), 627.9407(1), 626.9611, 627.9408 FS. Law Implemented 624.307(1), 627.9402, 626.9541, 627.9407(1) FS. History–New _____.

4-157.122 Penalties.

In addition to any other penalties provided by the laws of this state, any insurer and any agent found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to 3 times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

Specific Authority 624.308(1), 627.9407(1), 627.9408, 626.9611 FS. Law Implemented 624.307(1), 627.9402, 626.9521 FS. History–New _____.

NAME OF PERSON ORIGINATING PROPOSED RULE: Frank Dino, Bureau of Life and Health Forms and Rates, Division of Insurer Services, Department of Insurance

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Rich Robleto, Bureau Chief, Bureau of Life and Health Forms and Rates, Division of Insurer Services, Department of Insurance

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: June 6, 2002

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: June 21, 2002

DEPARTMENT OF CITRUS

RULE CHAPTER TITLE:	RULE CHAPTER NO.:
Market Classification, Maturity Standards and Processing or Packing Restrictions for Hybrids	20-13
RULE TITLES:	**RULE NOS.:**
Robinson Tangerines; Classification and Standards	20-13.007
K-Early Citrus Fruit; Classification and Standards	20-13.008

PURPOSE AND EFFECT: Repeal of Classification Standards set for Robinson Tangerines and K-Early Citrus Fruit to insure fruit is shipped interstate and intrastate on the same schedule and classification as the Citrus Administrative Committee.

SUMMARY: Repeals classification standards on Robinson Tangerines and K-Early Citrus Fruit.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: No Statement of Regulatory Cost has been prepared.

Any person who wishes to provide information regarding the statement of estimated regulatory 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: 601.10(1),(7), 601.11, 601.9910(3) FS.

LAW IMPLEMENTED: 601.11, 601.21, 601.9910(3) FS.

A HEARING WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW:

TIME AND DATE: 10:30 a.m., October 30, 2002

PLACE: Department of Citrus Building, 1115 East Memorial Boulevard, Lakeland, Florida

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULES IS: Alice P. Wiggins, Administrative Assistant, Legal Department, Florida Department of Citrus, P. O. Box 148, Lakeland, Florida 33802-0148

THE FULL TEXT OF THE PROPOSED RULES IS:

20-13.007 Robinson Tangerines; Classification and Standards.

Specific Authority 601.10(1),(7), 601.11, 601.9910(3) FS. Law Implemented 601.11, 601.21, 601.9910(3) FS. History–Formerly 105-1.43(6), Revised 1-1-75, Formerly 20-13.07, Repealed _____.

20-13.008 K-Early Citrus Fruit; Classification and Standards.

Specific Authority 601.10(1),(7), 601.11, 601.9910(3) FS. Law Implemented 601.11, 601.9910 FS. History–Formerly 105-1.34(7), Revised 1-1-75, Formerly 20-13.08, Amended 10-13-96, Repealed _____.

NAME OF PERSON ORIGINATING PROPOSED RULE: Ken Keck, General Counsel

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Ken Keck, General Counsel

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: July 17, 2002

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: August 2, 2002

DEPARTMENT OF CITRUS

RULE CHAPTER TITLE:	RULE CHAPTER NO.:
Loading Manifest to be Furnished to the Inspector--Fresh Citrus Fruit	20-40
RULE TITLE:	**RULE NO.:**
Requirements of Manifest	20-40.001

PURPOSE AND EFFECT: Repealing Classification Standards for Dancy tangerines to insure fruit is shipped interstate and intrastate on the same schedule and classifications as the Citrus Administrative Committee.

SUMMARY: Repeal of classification standards for Dancy tangerines.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: None.

Any person who wishes to provide information regarding the statement of estimated regulatory 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: 601.10(1), 601.11 FS.

LAW IMPLEMENTED: 601.091, 601.11, 601.46, 601.52, 601.99 FS.

A HEARING WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW:

TIME AND DATE: 10:30 a.m., October 30, 2002

PLACE: Department of Citrus Building, 1115 East Memorial Boulevard, Lakeland, Florida

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Alice P. Wiggins, Administrative Assistant, Legal Department, Florida Department of Citrus, P. O. Box 148, Lakeland, Florida 33802-0148

THE FULL TEXT OF THE PROPOSED RULE IS:

20-40.001 Requirements of Manifest.

Each shipper shall deliver to the inspector a copy of the loading manifest on each shipment of citrus fruit, which manifest shall indicate, in addition to other information prescribed by the Department of Agriculture, the following:

(1) Name and registration number of shipper.

(2) Date of shipment.

(3) Grade of fruit.

(4) Brand or trademark, if applicable.

(5) Railroad car number; truck or trailer license number.

(6) Variety of fruit:

(a) Oranges shall be classified as early, midseason, or late.

(b) Grapefruit shall be classified with a notation as to whether it is a seeded or seedless variety and a notation as to whether it is a white or colored variety.

~~(c) Tangerines (Dancy).~~

(c)~~(d)~~ All other varieties shall be classified in conformity with Department of Citrus Rule Chapter 20-13.

(7) Size or weight of fruit and type of container:

(a) Itemized list of fruit sizes or range of sizes for each grade, variety of fruit and type of container.

(b) When container content is shown in terms of weight, itemized list showing weight, variety of fruit and type of container.

(c) For bulk fruit, fruit sizes shall be estimated by the inspector and shipper together.

(8) "Color Added," if appropriate.

(9) If fruit was packed in a different production area in this state from that in which it was grown, the production area shall be indicated as defined in Section 601.091, Florida Statutes.

(10) Destination of shipments:

(a) City and State in U.S.A. and city and province in Canada or Mexico.

(b) Shipments to points in Florida shall show whether destination is east or west of Suwanee River.

(c) Offshore Export shall show Country.

(11) Signature of person authorized to sign for shipper.

Specific Authority 601.10(1), 601.11 FS. Law Implemented 601.091, 601.11, 601.46, 601.52, 601.99 FS. History–Formerly 105-1.09(1), Revised 1-1-75, Amended 8-7-77, Formerly 20-40.01, Amended 3-28-90, 12-21-93, 8-30-95, _____.

NAME OF PERSON ORIGINATING PROPOSED RULE: Ken Keck, General Counsel

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Ken Keck, General Counsel

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: July 17, 2002

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: August 2, 2002

DEPARTMENT OF HEALTH

Board of Opticianry

RULE TITLE: RULE NO.:

Application for Examination and Licensure 64B12-9.0015

PURPOSE AND EFFECT: The Board proposes to promulgate language in this rule to set forth and clarify the licensure requirements for applicants.

SUMMARY: New language incorporated with existing language elucidates certification of applicants for licensure and updates the application form.

SPECIFIC AUTHORITY: 456.013, 456.017, 456.072, 484.005, 484.007, 484.014(2) FS.

LAW IMPLEMENTED: 456.013, 456.017, 456.072, 484.007, 484.014(2) FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE SCHEDULED AND ANNOUNCED IN THE FAW.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Sue Foster, Executive Director, Board of Opticianry, 4052 Bald Cypress Way, Bin #C08, Tallahassee, Florida 32399-3258

THE FULL TEXT OF THE PROPOSED RULE IS:

64B12-9.0015 Application for Examination and Licensure.

(1) Any person seeking licensure as an optician shall submit to the Board a completed application to take the examination on form DH-MQA 1065, 3/02 ~~DPR-DO-002~~ provided by the Department. The application shall be accompanied with the application fee specified in Rule 64B12-11.002, F.A.C., which is non-refundable, and the examination fee specified in Rule 64B12-11.003, F.A.C., which shall be refunded if the applicant is denied examination or does not timely complete application.

(2) through (3) No change.

(4) Any application which does not provide all information required by the application forms shall ~~be~~ not be considered by the Board until it has been completed. Any applicant who fails to complete the application within 12 ~~6~~ months of its receipt in the Board office shall be required to apply as an initial applicant.

(5) Upon certifying applicants for the licensure examination, the Board shall also certify applicants for licensure, contingent and effective upon the following: ~~successful completion of required examinations and no discovery of disqualifying factors prior to licensure. Successful examination candidates must pay the initial licensure fee and obtain licensure within one year of notification of successful passage of the examination.~~

(a) Successful completion of required examinations,

(b) Successful completion of a two-hour laws and rules course by a Board approved laws and rules course provider, to be effective March 1, 2003,

(c) Successful completion of a two-hour continuing education course relating to the prevention of medical errors. The course must be approved by the Board and shall include a study of root-cause analysis, error reduction and prevention, and patient safety,

(d) No discovery of disqualifying factors prior to licensure, and

(e) Payment of the initial licensure fee within one (1) year of notification of successful passage of the examination.

(6) through (7) No change.

Specific Authority 456.013, 456.017, 456.072~~(2),(5),~~ 484.005, 484.007, 484.014(2) FS. Law Implemented 456.013, 456.017, ~~455.213(1),~~ 456.072~~(2), (5),~~ 484.007, 484.014(2) FS. History–New 3-30-89, Amended 3-29-92, 2-18-93, Formerly 21P-9.0015, Amended 5-2-94, Formerly 61G13-9.0015, 59U-9.0015, Amended 1-4-98, _____.

NAME OF PERSON ORIGINATING PROPOSED RULE: Board of Opticianry

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

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: May 8, 2002

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: August 2, 2002

DEPARTMENT OF HEALTH

Board of Opticianry

RULE TITLE: RULE NO.:

Duplicate Licensee Fee 64B12-11.017

PURPOSE AND EFFECT: This proposed amendment sets forth the fee requirements for wall certificates and duplicate wall certificates.

SUMMARY: Licensed opticians who were licensed prior to July 1, 1998 may obtain a wall certificate, or duplicate wall certificate, for $25.00.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: None.

Any person who wishes to provide information regarding the statement of estimated regulatory 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: 456.025(7), 484.005 FS.

LAW IMPLEMENTED: 456.025(7) FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE SCHEDULED AND ANNOUNCED IN THE FAW.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Sue Foster, Executive Director, Board of Opticianry, 4052 Bald Cypress Way, Bin #C08, Tallahassee, Florida 32399-3258

THE FULL TEXT OF THE PROPOSED RULE IS:

64B12-11.017 Duplicate License Fee.

(1) If a duplicate license is requested by a licensee, the fee is $25 for the duplicate license.

(2) Licensees licensed prior to July 1, 1998 may obtain a wall certificate by submitting a written request to the Board along with a $25.00 fee.

(3) If a duplicate wall certificate is requested by a licensee, the fee is $25.00 for the duplicate wall certificate.

Specific Authority 456.025(7), 484.005 FS. Law Implemented 456.025(7) FS. History–New 2-23-93, Formerly 21P-11.017, 61G13-11.017, 59U-11.017, Amended _____.

NAME OF PERSON ORIGINATING PROPOSED RULE: Board of Opticianry

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

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: May 8, 2002

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: August 16, 2002

DEPARTMENT OF HEALTH

Board of Opticianry

RULE TITLE: RULE NO.:

Standards for Continuing Professional Education 64B12-15.003

PURPOSE AND EFFECT: This proposed rule amendment is intended to update the continuing education requirements for all licensed opticians.

SUMMARY: The Board proposes to update the existing continuing education requirements by adding courses relating to contact lens and the prevention of medical errors.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: None.

Any person who wishes to provide information regarding the statement of estimated regulatory 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: 456.013(7), 484.005, 484.008(3) FS.

LAW IMPLEMENTED: 456.013(7), 484.008(3) FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE SCHEDULED AND ANNOUNCED IN THE FAW.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Sue Foster, Executive Director, Board of Opticianry, 4052 Bald Cypress Way, Bin #C08, Tallahassee, Florida 32399-3258

THE FULL TEXT OF THE PROPOSED RULE IS:

64B12-15.003 Standards for Continuing Professional Education.

(1) through (3)(c) No change.

(d) One (1) hour must be in contact lens theory and practice;

(e) Effective August 1, 2002, a two (2) hour continuing education course relating to the prevention of medical errors. The course must be approved by the Board and shall include a study of root-cause analysis, error reduction and prevention, and patient safety; and

(f)~~(d)~~ Two (2) ~~Four (4)~~ hours shall be electives consisting of courses in one or more of the subjects of categories (a) through (c) above or subjects relating to management of a practice from a business perspective including sales and marketing, business and finance, personnel management, stress management, risk management, fire prevention or disaster planning.

(4) through (7) No change.

Specific Authority 456.013(7), 484.005, 484.008(3) FS. Law Implemented 456.013(7), 484.008(3) FS. History–New 10-12-80, Formerly 21P-15.03, Amended 3-5-87, 8-10-87, 10-29-87, 1-6-88, 6-11-92, Formerly 21P-15.003, Amended 4-17-94, Formerly 61G13-15.003, Amended 3-14-95, Formerly 59U-15.003, Amended 4-20-99, 12-31-00, _____.

NAME OF PERSON ORIGINATING PROPOSED RULE: Board of Opticianry

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

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: August 21, 2002

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: August 16, 2002

DEPARTMENT OF HEALTH

Board of Orthotists and Prosthetists

RULE TITLE:	RULE NO.:
Licensure Without Examination Fees	64B14-2.001

PURPOSE AND EFFECT: The Board proposes to repeal this rule as it is no longer necessary.

SUMMARY: This rule is being repealed as 468.805, F.S., licensure no longer applies to the Board of Orthotists and Prosthetists.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: None.

Any person who wishes to provide information regarding the statement of estimated regulatory 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: 456.025, 468.802, 468.805 FS.

LAW IMPLEMENTED: 456.025, 468.805 FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE SCHEDULED AND ANNOUNCED IN THE FAW.

THE PERSON TO BE CONTACED REGARDING THE PROPOSED RULE IS: Joe Baker, Jr., Executive Director, Board of Orthotists and Prosthetists, 4052 Bald Cypress Way, Bin #C07, Tallahassee, Florida 32399-3257

THE FULL TEXT OF THE PROPOSED RULE IS:

64B14-2.001 Licensure Without Examination Fees.

Specific Authority 456.025, 468.802, 468.805 FS. Law Implemented 456.025, 468.805 FS. History–New 2-25-99, Repealed _____.

NAME OF PERSON ORIGINATING PROPOSED RULE: Board of Orthotists and Prosthetists

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Board of Orthotists and Prosthetists

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: July 1, 2002

DEPARTMENT OF HEALTH

Board of Physical Therapy Practice

RULE TITLE:	RULE NO.:
Licensure as a Physical Therapist by Examination	64B17-3.001

PURPOSE AND EFFECT: The Board proposes to update the existing rule text.

SUMMARY: This rule eliminates information redundant of statute. This rule establishes Federation standards and a Federation report as the basis for establishing equivalency and also requires English language proficiency.

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

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

SPECIFIC AUTHORITY: 486.025(1), 486.031(3) FS.
LAW IMPLEMENTED: 456.017, 486.031, 486.051 FS.
IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE SCHEDULED AND ANNOUNCED IN THE FAW.
THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Kaye Howerton, Board Executive Director, Board of Physical Therapy Practice, 4052 Bald Cypress Way, Bin #C05, Tallahassee, Florida 32399-3255

THE FULL TEXT OF THE PROPOSED RULE IS:

64B17-3.001 Licensure as a Physical Therapist by Examination.

Every applicant for examination for licensure as a physical therapist shall demonstrate to the Board that the applicant ~~he~~ satisfies the following qualifications:

~~(1) That he is eighteen years old.~~

~~(2) That he possesses a good moral character.~~

(1)~~(3)~~ That the applicant ~~he~~ has received a ~~bachelor's~~ degree~~, or its equivalent,~~ in physical therapy, which course of study has been approved for the training of physical therapists by the Commission on Accreditation for Physical Therapy Education (CAPTE). ~~American Physical Therapy Association, the appropriate accrediting agency recognized by the Commission on Recognition of Postsecondary Accreditation,~~ at the time of ~~his~~ graduation.

(2) For foreign graduates a~~; and, if a foreign graduate,~~ determination that the ~~his~~ credentials are ~~as being deemed~~ equivalent to education required for licensure as a physical therapist ~~a bachelor's degree in physical therapy~~ in the United States ~~is required~~. Educational credentials ~~deemed~~ equivalent to those required for the education and preparation of physical therapists in this country shall be determined by ~~utilizing the National Council on Evaluation of Foreign Educational Credentials' materials published by the American Association of College Registrars and Admissions Officers and the guidelines of~~ the Federation of State Boards of Physical Therapy (FSBPT). ~~When the Federation of State Boards of Physical Therapy guidelines are utilized, a minimum of 25 general education credits shall be required.~~

(3)~~(4)~~ The Board will require ~~In order to permit the Board to determine whether the foreign graduate actually received an equivalent education in physical therapy, each applicant must demonstrate equivalency to the Board's Education Committee and shall submit~~ the following:

(a) Successful passage of a Board approved English proficiency examination if English was not the language of instruction.

~~(a) A certified or notarized photocopy of the original diploma evidencing the degree in physical therapy. A certified translation is required for any diploma which is not in English.~~

~~(b) An original sealed transcript or a certified or notarized photocopy of the original transcript and seal for all education evidencing equivalency of a United States bachelor's of science degree in physical therapy. A certified translation is required for each transcript which is not in English.~~

(b)~~(c)~~ A report from the ~~an appropriate~~ credentialing agency, in which the educational expert or physical therapist evaluator is not affiliated with the institutions or individuals under review, interpreting the foreign credentials in terms of the approximately comparable level of educational achievement in the United States. Upon submission of the report, the agency will also present documentation to the committee evidencing that the individual or team conducting the evaluation and offering comments contained in the report is competent to conduct foreign credentials evaluations. ~~This competency shall be demonstrated upon showing that the individual or team conducting the evaluation consist of:~~

~~1. A physical therapist with a license in good standing in any state or territory of the United States who has at least 2 years experience with accredited United States physical therapy education and curriculum design; and~~

~~2. An evaluator with at least 5 years experience in evaluating education and curriculum design and foreign academic credentials for the purpose of determining academic equivalency to a United States education.~~

(c)~~(d)~~ At a minimum, the report shall contain the following information:

1. A clear and definitive statement as to whether the education is equivalent to a CAPTE-accredited physical therapy educational program.

1. through 5. renumbered 2. through 6. No change.

7. Proof of oral and written English proficiency by successful passage of a Board approved English examination if English was not the language of instruction.

~~(e) The Committee shall recommend to the Board that it decline to consider any report which fails to meet the above criteria.~~

Specific Authority 486.025(1), 486.031(3) FS. Law Implemented 456.017, 486.031, 486.051 FS. History–New 8-6-84, Amended 6-2-85, Formerly 21M-7.20, Amended 5-18-86, Formerly 21M-7.020, 21MM-3.001, Amended 3-1-94, Formerly 61F11-3.001, Amended 12-22-94, 4-10-96, Formerly 59Y-3.001, Amended 12-30-98, _____.

NAME OF PERSON ORIGINATING PROPOSED RULE: Board of Physical Therapy Practice
NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Board of Physical Therapy Practice
DATE PROPOSED RULE APPROVED BY AGENCY HEAD: August 2, 2002
DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: May 24, 2002

DEPARTMENT OF HEALTH

Board of Physical Therapy Practice

RULE TITLE: RULE NO.:

Licensure as a Physical Therapist Assistant by Examination 64B17-4.001

PURPOSE AND EFFECT: The Board proposes to update the existing rule text.

SUMMARY: This rule eliminates information redundant of statute. This rule establishes Federation standards and a Federation report as the basis for establishing equivalency and also requires English language proficiency.

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

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

SPECIFIC AUTHORITY: 486.025, 486.102 FS.

LAW IMPLEMENTED: 456.017, 486.102(3), 486.104 FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD AT A TIME, DATE AND PLACE TO BE NOTICED IN THE NEXT AVAILABLE FLORIDA ADMINISTRATIVE WEEKLY.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Kaye Howerton, Board Executive Director, Board of Physical Therapy Practice, 4052 Bald Cypress Way, Bin #C05, Tallahassee, Florida 32399-3255

THE FULL TEXT OF THE PROPOSED RULE IS:

64B17-4.001 Licensure as a Physical Therapist Assistant by Examination.

Every applicant for examination for licensure as a physical therapist assistant shall demonstrate to the Board that the applicant ~~he~~ satisfies the following qualifications:

~~(1) That he is eighteen years old.~~

~~(2) That he possess a good moral character.~~

(1)~~(3)~~ That the applicant ~~he~~ has received a ~~an associate's~~ degree as a physical therapist assistant, ~~or its equivalent, for physical therapist assistants,~~ which course of study has been approved for the training of physical therapist assistants by the Commission on Accreditation for Physical Therapy Education (CAPTE), ~~American Physical Therapy Association, the appropriate accrediting agency recognized by the Commission on Recognition of Postsecondary Accreditation,~~ at the time of ~~his~~ graduation.

(2) For foreign graduates, ~~a; and, if a foreign graduate,~~ determination that the ~~his~~ credentials are ~~as being deemed~~ equivalent to education required for licensure ~~an associate's degree~~ for physical therapist assistants in the United States is required.

(3) The Board will require ~~(4) In order to permit the Board to determine whether the foreign graduate actually received an equivalent education as a physical therapist assistant, each applicant must demonstrate equivalency to the Board's Education Committee and shall submit~~ the following:

(a) Successful passage of a Board approved English proficiency examination if English was not the language of instruction.

~~(a) A certified or notarized photocopy of the original diploma evidencing the associate degree as a physical therapist assistant. A certified translation is required for any diploma which is not in English.~~

~~(b) An original sealed transcript or a certified or notarized photocopy of the original transcript and seal for all education evidencing equivalency of a United States associate of science degree as a physical therapist assistant. A certified translation is required for each transcript which is not in English.~~

(b)~~(c)~~ A report which shall contain the following information: ~~an appropriate credentialing agency, in which the educational expert or physical therapist evaluator is not affiliated with the institutions or individuals under review, interpreting the foreign credentials in terms of the approximately comparable level of educational achievement in the United States. Upon submission of the report, the agency will also present documentation to the committee evidencing that the individual or team conducting the evaluation and offering comments contained in the report is competent to conduct foreign credentials evaluation. This competency shall be demonstrated upon showing that the individual or team conducting the evaluation consist of:~~

~~1. A physical therapist with a license in good standing in any state or territory of the United States who has at least 2 years experience with accredited United States physical therapy education and curriculum design; and~~

~~2. An evaluator with at least 5 years experience in evaluating education and curriculum design and foreign academic credentials for the purpose of determining academic equivalency to a United States education.~~

~~(d) At a minimum, the report shall contain the following information:~~

1. A clear and definitive statement as to whether the education is equivalent to a CAPTE-accredited physical therapist assistant educational program.

1. through 5. renumbered 2. through 6. No change.

7. Proof of oral and written English proficiency by successful passage of a Board approved English examination if English was not the language of instruction.

~~(e) The Committee shall recommend to the Board that it decline to consider any report which fails to meet the above criteria.~~

Specific Authority 486.025, 486.102 FS. Law Implemented 456.017, 486.102(3), 486.104 FS. History–New 8-6-84, Amended 6-2-85, Formerly 21M-10.20, Amended 5-18-86, Formerly 21M-10.020, 21MM-4.001, Amended 3-1-94, Formerly 61F11-4.001, Amended 12-22-94, 4-10-96, Formerly 59Y-4.001, Amended _____.

NAME OF PERSON ORIGINATING PROPOSED RULE: Board of Physical Therapy Practice

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Board of Physical Therapy Practice

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: August 2, 2002

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: May 24, 2002

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Economic Self-Sufficiency Program Office

RULE TITLE: RULE NO.:

Food Stamp Program Case Processing 65A-1.602

PURPOSE AND EFFECT: The federal Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 allows states the option to require child support enforcement (CSE) cooperation as a condition of eligibility for the receipt of food stamps. The 1997 Florida Legislature enacted this option in s. 414.32, F.S., but allowed the department to delay implementation of optional PRWORA components under s. 414.55, F.S., in order to implement other mandatory components. The 2000 Florida Legislature repealed s. 414.55, F.S., requiring implementation of s. 414.32, F.S.

SUMMARY: The proposed rule provides for CSE cooperation as a condition of food stamp eligibility in accordance with the requirements of 7 CFR subpart 273.11(o) and (p). It also provides for the impact of CSE cooperation on the expedited food stamp process; the impact of failure to cooperate on the assistance group; attesting to court ordered child support payments; and, the definition of the term "current with child support payments." Additionally, it clarifies the determination of cooperation and good cause; and, incorporates forms by reference to reflect statutory changes and federal regulatory requirements.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COST: None.

Any person who wishes to provide information regarding the statement of estimated regulatory 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: 414.45 FS.

LAW IMPLEMENTED: 414.32 FS.

IF REQUESTED WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD AT THE TIME, DATE AND PLACE SHOWN BELOW. (IF NOT REQUESTED, THIS HEARING WILL NOT BE HELD):

TIME AND DATE: 9:00 a.m., September 23, 2002

PLACE: 1317 Winewood Boulevard, Building 3, Room 100, Tallahassee, Florida

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Audrey Mitchell, Program Administrator, Economic Self-Sufficiency, Program Support Unit, 1317 Winewood Boulevard, Building 3, Room 421, Tallahassee, Florida 32399-0700, (850)488-3090

THE FULL TEXT OF THE PROPOSED RULE IS:

65A-1.602 Food Stamp Program Case Processing.

(1) through (2) No change.

(3) Certification Periods for AGs Entitled to Expedited Services. When an AG is certified on an expedited service basis and has postponed verification, the AG will be assigned either a certification period which is limited by the postponed verification, i.e., either one or two months in length, or the certification period warranted by AG circumstances. Food stamp case approval must not be delayed for verification of child support enforcement (CSE) cooperation for an AG meeting expedited food stamp criteria.

(4) Child Support Enforcement Cooperation. CSE cooperation is a condition of eligibility for the receipt of food stamps in accordance with 7 CFR subpart 273.11(o) and (p). The Economic Self-Sufficiency Specialist (ESS) will use CF-ES 2640, Temporary Cash Assistance (TCA)/Medicaid/Food Stamp Program Child Support Cooperation Notice, July 02, incorporated by reference, to explain the CSE cooperation requirements to food stamp applicants and recipients.

(5) Custodial Parents. The ESS will refer custodial parents subject to CSE requirements to the CSE agency for the determination of cooperation. Information on cooperation and good cause criteria will be provided using CF-ES 2640 and CF-ES 2641, Claim Notice Good Cause for Refusal to Cooperate, July 02, incorporated by reference.

(6) Non-Custodial Parents. A non-custodial parent or an alleged parent of a child under the age of 18 must cooperate in good faith with CSE requirements to establish paternity or to enforce a support order for the child in accordance with 7 CFR subpart 273.11(p). Information on cooperation and good cause criteria will be provided using CF-ES 2640 and CF-ES 3107, Statement Attesting to Court Ordered Child Support Payments, July 02, incorporated by reference,

(7) Attesting to Court Ordered Child Support Payments. The department will use a self-declaration form, CF-ES 3107, to determine individuals who are court ordered to make child support payments. A non-custodial parent who is required to make court ordered child support payments must sign CF-ES 3107 or be considered non-cooperative and excluded from the AG. The individual's statement is to be accepted unless questionable. Although the individual's statement is acceptable for determining technical eligibility for food stamps,

verification of the amount of the court ordered child support payment is required to receive a child support deduction in the food stamp budget.

(8) Current with Child Support Payment. "Current with child support payment" means that the non-custodial parent is not delinquent in any payment (within the last 30 days) due under a court order, including a court approved delay in payment or a court ordered payment plan or a CSE approved payment plan, or it means the non-custodial parent meets criteria for an inability to cooperate in accordance with 7 CFR subpart 273(p)(2), such as:

(a) The individual receives temporary cash assistance or Supplemental Security Income or claims a medical incapacity that is substantiated through a statement from a licensed physician that the individual is unable to work and the individual attests or states in writing that there is no other source of income; or

(b) Reunification with the family or physical custody of the child(ren) changed from the custodial parent to the non-custodial parent and action has been initiated for a change in the physical custody (not to exceed 90 days). Court ordered visitation does not constitute a change in custody.

(9) Impact of Failure to Cooperate. Upon a determination by the Department of Children and Family Services that failure to meet child support requirements was without good cause, action will be taken to deny approval or to impose a food stamp penalty for the non-cooperative individual only and a notice of adverse action will be generated to the participant. The non-cooperative individual is to be treated as a Prorated Adult in the food stamp filing unit and the individual's income will be prorated and their assets will be counted in full in determining eligibility for the remaining AG members. The remainder of the AG may be approved, but the non-cooperative individual will be excluded until verification of CSE cooperation is provided.

(10) Re-Qualifying Upon Cooperation. Upon verification that the individual is in compliance with CSE requirements, and that all other requirements of eligibility have been met, the department will take action to add the individual to the AG or to remove the food stamp sanction and reinstate benefits.

(11) Copies of CF-ES 3106, CF-ES 2640, and CF-ES 2641 may be obtained from the Department of Children and Family Services, Economic Self-Sufficiency, 1317 Winewood Boulevard, Building 3, Room 421, Tallahassee, Florida 32399-0700.

Specific Authority 414.45 FS. Law Implemented 414.32 FS. History–New 1-31-94, Formerly 10C-1.602, Amended 7-29-01, _____.

NAME OF PERSON ORGINATING PROPOSED RULE: Lonna Cichon, Government Operations Consultant II

NAME OF SUPERVISOR OR PERSON WHO APPROVED THE PROPOSED RULE: Audrey Mitchell, Program Administrator, Economic Self-Sufficiency Policy, Program Support Unit

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: August 22, 2002

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: November 10, 2000

Section III
Notices of Changes, Corrections and Withdrawals

FLORIDA PAROLE COMMISSION

RULE NOS.:	RULE TITLES:
23-25.001	General
23-25.002	Definitions
23-25.003	Addiction Recovery Supervision Evaluation Procedure
23-25.004	Addiction Recovery Supervision
23-25.005	Revocation of Addiction Recovery Supervision

NOTICE OF CHANGE

Notice is hereby given that the following changes have been made to the proposed rules in accordance with subparagraph 120.54(3)(d)1., F.S., published in Vol. 28, No. 31, August 2, 2002, issue of the Florida Administrative Weekly.

THE FULL TEXT OF THE PROPOSED RULE IS:

23-25.001 General.

The Parole Commission is charged with establishing the term and conditions of supervision for offenders released from incarceration who are subject to the addiction-recovery supervision as provided under section 944.4731, F.S. The Parole Commission has the authority to issue warrants and revoke such supervision upon a finding of a violation of a condition of addiction-recovery supervision.

Specific Authority 944.4731(8) FS. Law Implemented 944.4731, 947.141 FS. History–New _____.

23-25.002 Definitions.

(1) Chair – means the Chair of the Parole Commission.

(2) Addiction Recovery Supervisor – means the person assigned to provide supervision for the Releasee.

(3) Commission – means the Parole Commission.

(4) Controlled Substance – means a "controlled substance" as defined in section 893.02, F.S.

(5) Conviction – means a "conviction" as defined in section 921.0021, F.S.

(6) Department – means the Department of Corrections

(7) Eligible Offender – means any offender who meets the criteria of section 944.4731(2)(a), F.S.

(8) History of substance abuse or addiction – means: (1) a score of 4 or more on the Department of Corrections Drug Simple Screening Instrument; or (2) two or more prior