NOTICES OF PROPOSED RULEMAKING

Unless exempted by A.R.S. § 41-1005, each agency shall begin the rulemaking process by first submitting to the Secretary of State's Office a Notice of Rulemaking Docket Opening followed by a Notice of Proposed Rulemaking that contains the preamble and the full text of the rules. The Secretary of State's Office publishes each Notice in the next available issue of the *Register* according to the schedule of deadlines for *Register* publication. Under the Administrative Procedure Act (A.R.S. § 41-1001 et seq.), an agency must allow at least 30 days to elapse after the publication of the Notice of Proposed Rulemaking in the *Register* before beginning any proceedings for making, amending, or repealing any rule. (A.R.S. §§ 41-1013 and 41-1022)

NOTICE OF PROPOSED RULEMAKING

TITLE 3. AGRICULTURE

CHAPTER 4. DEPARTMENT OF AGRICULTURE
PLANT SERVICES DIVISION

PREAMBLE

1. Sections Affected — **Rulemaking Action**
R3-4-228 — Amend

2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. § 3-107(A)(1)

Implementing statutes: A.R.S. §§ 3-201.01 and 3-202

3. A list of all previous notices appearing in the Register addressing the proposed rule:

Notice of Rulemaking Docket Opening: 10 A.A.R. 367, January 30, 2004

4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Sherry D. Blatner, Rules Analyst

Address: Arizona Department of Agriculture
1688 West Adams, Room 235
Phoenix, AZ 85007

Telephone: (602) 542-0962

Fax: (602) 542-5420

E-mail: sherry.blatner@agric.state.az.us

5. An explanation of the rule, including the agency's reasons for initiating the rule:

Subsection (A) provides definitions of terms used in the Section. Previously, a reference was made to the definitions in Article 1.

Subsection (B) modifies the list of areas under quarantine in the following states:

1. Florida, 10 counties are added;
2. Louisiana, the quarantine on the entire state is reduced to 13 parishes;
3. New Mexico, seven counties are added; and
4. Texas, seven counties are added.

Subsection (C) lists the regulated commodities, and moves exemptions to a new subsection (E).

Subsection (D) is a rewrite of restrictions on imports from an area under quarantine and requires an attestation from a plant regulatory official of the state of origin that a regulated commodity was treated as prescribed in subsection (F).

Subsection (E), "Exemption," is a new subsection created to clearly state information formerly provided with the discussion of regulated commodities. It provides detail on obtaining an exemption from treatment, as required in subsection (F).

Subsection (F) specifies one approved treatment, methyl bromide (Q label) and allows the Director to approve other treatments.

Subsection (G) restates disposition of a regulated commodity found not to be in compliance with this Section by reference back to the applicable statutes.

The Department committed to update these rules in the 1998 and 2003 five-year review reports presented by the Plant Services Division to the Governor's Regulatory Review Council.

6. A reference to any study relevant to the rule that the agency reviewed and either proposes to rely on or not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, any analysis of each study and other supporting material:

None

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

8. The preliminary summary of the economic, small business, and consumer impact:

A. *The Arizona Department of Agriculture*.

The Department will incur modest expenses related to training staff and educating the regulated community on the amendments.

B. *Political Subdivision.*

Other than the Department, no political subdivision is affected by this rulemaking.

C. *Businesses Directly Affected By the Rulemaking.*

Out-of-state growers and shippers of corn or sorghum who ship a regulated commodity into Arizona will need to become familiar with the revised listing of areas under quarantine and the prescribed restrictions, exemptions, and treatments available to ship into the state of Arizona.

Arizona receivers of regulated commodity will need to become familiar with restrictions on commodity import from the amended list of areas under quarantine.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name:	Sherry D. Blatner, Rules Analyst
Address:	Arizona Department of Agriculture 1688 West Adams, Room 235 Phoenix, AZ 85007
Telephone:	(602) 542-0962
Fax:	(602) 542-5420
E-mail:	sherry.blatner@agric.state.az.us

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

An oral proceeding is not scheduled for the proposed rule. To request an oral proceeding or to submit comments, please contact the rules analyst listed in item #4 between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday, except legal holidays. If a request for an oral proceeding is not made, the public record in this rulemaking will close at 5:00 p.m. on April 26, 2004.

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

None

12. Incorporations by reference and their location in the rule:

None

13. The full text of the rule follows:

TITLE 3. AGRICULTURE

CHAPTER 4. DEPARTMENT OF AGRICULTURE
PLANT SERVICES DIVISION

ARTICLE 2. QUARANTINE

Section
R3-4-228. European ~~corn borer, Ostrinia nubilalis (Hubn.)~~ Corn Borer

ARTICLE 2. QUARANTINE

R3-4-228. European ~~corn borer, Ostrinia nubilalis (Hubn.)~~ Corn Borer

~~**A.** Areas under quarantine:~~
~~1. New Mexico counties: Quay and Union.~~
~~2. Texas counties: Carson, Dallam, Deaf Smith, Gray, Hansford, Hartley, Hutchinson, Lipscomb, Moore, Ochiltree, Oldham, Potter, Randall, Robert and Sherman.~~
~~3. All other states and districts of the United States with these exceptions:~~
~~a. Alaska,~~
~~b. California,~~
~~c. Florida,~~
~~d. Hawaii,~~
~~e. Idaho,~~
~~f. Nevada,~~
~~g. New Mexico counties not included in (A)(1),~~
~~h. Oregon,~~
~~i. Texas counties not listed in (A)(2),~~
~~j. Utah,~~
~~k. Washington.~~

~~**B.** Commodities covered:~~
~~1. Corn -- Plants and all parts thereof including shelled corn, stalks, ears, cobs, fragments, or debris of the plant. "Shelled corn" -- means corn kernels separated from all other plant parts.~~
~~2. Sorghum -- Plants and all parts thereof including stalks, heads, fragments, or debris of the plant, EXCEPT combined grain and plant material which has passed through a grain combine.~~
~~3. Those parts of corn and sorghum plants or fragments which are capable of harboring larva or European corn borers are any portion of a host plant of any shape or size which cannot be passed through a 1/2 inch square aperture, and any completely whole, round, unerushed section, portion or piece of cob, stalk, or stem of 1 inch or more in length and 3/16 inch or more in diameter.~~

~~**C.** Restrictions:~~
~~1. Certification required on all corn and sorghum from area under quarantine: Except as provided in subsection (C)(2), each lot or shipment of corn and sorghums grown in or shipped from the area under quarantine described in subsection (A), imported or brought into this state must be accompanied by an official certificate evidencing compliance with one of the following conditions:~~
~~a. Certificates on shelled corn grown in or shipped from the quarantined area described in (A) above must either affirm that said grain has been passed through a 1/2 inch mesh screen or less or otherwise processed prior to loading and is believed to be free from stalks, cobs, stems, or portions of plants or fragments capable of harboring larva of the European corn borer, and, further, that the railroad car or truck was free from stalks, cobs, stems, or such portions of plants or fragments at time of loading, or affirm that said grain has been fumigated by a method and in a manner described by the State Entomologist, and setting forth the date of fumigation, dosage schedule and kind of fumigant used.~~
~~b. All shipments of combined harvested sorghum grain from the area under quarantine must be visually inspected by an inspector or agent of the State Entomologist to determine if the sorghum grain has been properly processed through a combine harvester or the shipment is covered by a U.S. Grade Certificate of No. 3 or better. Any shipment that does not comply with the requirements of this rule shall be placed under quarantine and forwarded to destination subject to conditions prescribed by the inspector or agent.~~
~~c. Any lot or shipment of shelled corn arriving in this state which is not accompanied by an official certificate as hereinbefore required, or which is certified on the basis of freedom from contamination with portions of plants or fragments capable of harboring larva of European corn borer as defined above, and which is found to be so contaminated, shall be deemed to be in violation of this rule and subject to disposal as provided in A.R.S. § 3-210.~~
~~d. All certificates issued in compliance with subsection (C)(1)(a) must also set forth the kind and quantity of the commodity constituting the lot or shipment covered thereby, the initials and number of the railway car or license number in the case of truck, and the names and addresses of the shipper and consignee.~~
~~2. Certain grain products conditionally exempt from certification: Certification requirements of subsection (C)(1) above are hereby waived on shelled popcorn, seed for planting, and on individual shipments or lots of 100 pounds or less of other clean shelled corn, or comprised of packages of less than 10 pounds, subject to inspection and freedom from portions of plants or fragments capable of harboring European corn borer.~~

3. Stalks, ears, cobs, or other parts, fragments, or debris of corn and sorghums admitted under disinfection or treatment certificate: Stalks, ears, cobs, or other parts, fragments, or debris of corn and sorghums, grown in or shipped from the area under quarantine imported as such or as packing or otherwise, will be admitted into the state of Arizona only provided each lot or shipment is accompanied by an official certificate of the state from which shipped, affirming that all stalks, ears, cobs, or other parts, fragments, or debris of such plants accompanied thereby have been treated as listed under subsection (E) of this quarantine and setting forth the date and full particulars of treatment applied.
4. Manufactured or processed products exempt from restriction: No restrictions are placed by this proclamation upon the movement of the restricted products herein defined which are processed or manufactured in such a manner as to eliminate all danger of carrying the pest herein quarantined against.

D. Disposition of violations: Any shipment or lot of quarantined articles as herein defined arriving in Arizona in violation of this quarantine shall be immediately sent out of the state or destroyed at the option and expense of the owner or owners, his or their responsible agents, and under the direction of the State Entomologist or his inspectors.

E. Treatments: European corn borer approved treatments:

1. Ear corn (dry):
   a. Ears of corn to be heated in a chamber at an air temperature of not less than 168° F for a period of not less than two hours. Ears of corn to be spread out on slat or wire shelves, not more than one layer deep. Air temperatures shall be taken at three points in the chamber and the time of sterilization shall begin when all thermometers reach 168° F after corn has been placed in the chamber.
   b. Atmospheric fumigation in a gastight chamber using a dosage schedule of 2 lbs. of methyl bromide per 1,000 cu. ft. for a period of six hours at temperature of 70° F or above.
   (CAUTION: Dosage schedules, temperatures, and time or exposure herein indicated should not be exceeded if corn is to be planted.)
2. Ear corn (green):
   a. Atmospheric fumigation in a gastight chamber using methyl bromide at the following rates for the period specified to be determined by the temperature of the product and interior of the fumigation chamber:

Temperature	**Lbs. per 1,000 cu. ft.**	**Exposure (hrs.)**
73° F & above	2	2.5
67-72° F	2.5	2.5
62-66° F	2.5	3
58-61° F	2.5	3.5
54-57° F	2.5	4
50-53° F	3	4
46-49° F	3	4.5
42-45° F	3.5	4.5
38-41° F	3.5	5

3. Freight car fumigation:
   (CAUTION: All freight cars must be properly tested for leaks and made gastight for the duration of exposure.)
   a. Bulk car corn: Atmospheric fumigation for a period of 16 hours using methyl bromide at the following rates to be determined by the temperature of the product and interior of the car during the period of exposure.

Temperature	**Lbs. per 1,000 cu. ft.**
60° F & above	3
50-59° F	3.5
40-49° F	4
30-39° F	4.5 (Hot gas method of application must be used at temperatures below 40° F.)
20-29° F	5

   b. Fumigation procedure for treating bulk shelled corn in loaded railway cars or van-type trucks as a basis for certification from European corn borer. Forced circulation required: The following described method shall be employed as a basis for issuing fumigation certificates on bulk shelled corn treated in railway cars and trucks to meet the requirements of the European corn borer quarantine.

i. All metal cars and vans: Only all metal freight cars or all metal trucking vans shall be used as fumigation chambers. The doors must be single doors and not over seven feet in width. Doors and other apertures must be sealed in a manner to make them gastight.

ii. Air circulation system:

(1) Each loaded railway car or trucking van shall be prepared so that air can be withdrawn from beneath grain and returned to the space above the load. This shall be provided by a system of probes inserted in the grain and connected by flexible tubing to a portable blower outside of the car which will return the air to the space above the load.

(2) The probe system (see diagram) shall consist of 10 probes 6 feet in length inserted equidistant in a line down the center of the car so that the perforated tips are near the floor level.

(3) The probes are to be connected by flexible tubing proportioned so that there is equal suction on each probe.

(4) One doorway shall be sealed with gastight laminated paper. The ducts shall lead through this paper seal to the portable blower.

(5) The blower shall have a capacity of not less than 625 c.f.m. against 5 inch static pressure and shall be of a design that can be made gastight. The gas can be introduced as a spray or through a volatizer into the exhaust duct at any point between the blower and the car or van, or introduced directly into the space above the load.

iii. Details of duct system:

(1) The intake side of the blower unit is connected to the inside duct system by a 15-foot length of 6-inch neoprene coated flexible tubing. Another 15 foot length of 8 inch tubing is attached to the exhaust side of the blower and the other end inserted into a metal collar inserted into the paper grain door above the load.

(2) The inside probe and duct system is constructed to neoprene coated flexible tubing. Two similar systems extend from the center to each end of the car or van and are connected by a Y section to a 5-foot section of 6-inch tubing which extends toward the door. The end of this section is fitted with a 6-inch diameter sheet metal tubing that extends through the paper grain door for connection to the intake side of the blower. (See diagram.)

(3) A set of 10 probes 6 foot in length are required. Probes are made from 1-1/4-inch I.D. Hard-drawn aluminum tubing. Each probe is fitted with a heavy sheet metal point having 4 slots 1/16 inch wide by 5 inches long through which air is taken into the duct system. Each probe is attached to the duct system by a section of 1-1/2 inch flexible tubing. (See diagram.)

iv. Procedure:

(1) Lay out the inside probe and duct system on top of the load. Insert probes down the center of the load at four-foot intervals to a depth near the floor (both end probes to be placed two feet from the end of the car). Seal door of car through which intake and exhaust tubes from the blower will connect to the probe-duct system as follows:

(a) Heavy laminated paper is placed in the doorway on the outer side of the wooden grain door and sealed to the doorfacing and doorsill by Scotch masking tape. The top edge of this paper is lapped over and fastened to the top edge of the wooden grain door. The remainder of the door opening is covered by a paper grain door to the ceiling of the car.

(b) Loosen the wooden grain door and slip the bottom edge of the paper door down so as to overlap the paper on the wooden door. Then, renail the wooden grain door in place. Seal this lap of paper grain door to the paper covering the wooden door using Scotch masking tape. Nail a 1-inch by 4-inch plank across the top of the paper grain door inside of the car, leaving a sufficient edge of paper above the plank to seal it with masking tape or "bug" putty. (Available from fumigant supply companies, or can be made from 8 parts asbestos, 3 parts calcium chloride and 4 parts water.) Seal with the ends of the paper grain door to the inside wall of the car with masking tape. Cut holes in paper grain door (one 8-inch diameter, one 6-inch diameter). These holes should be cut just above the edge of the wooden grain door so that ducts will rest on the top of the wooden grain door. Seal an 8-inch collar inserted through the hole through which the exhaust duct may be inserted. Then insert the end of the inside duct system out through the 6-inch hole so as to protrude about 2 inches beyond the paper grain door and to which the intake duct from the blower may be attached. Close the opposite door and all other apertures in the car and seal with masking tape and "bug" putty so as to make the entire car gastight. Connect intake duct from blower to the end of the inside probe system extending through the paper car door. Insert the end of the exhaust duct through the 8-inch collar in the paper grain door and seal with masking tape or "bug" putty. Start blower and introduce the required amount of fumigant. Allow blower to operate continuously for at least 10 minutes after fumigant has been discharged. Disconnect intake and exhaust ducts, seal up openings, and close car

door. Allow car to remain undisturbed for a period of 16 hours.

v. Dosage schedule: Atmospheric fumigation for a period of 16 hours using methyl bromide at the following rates to be determined by the temperature of the product and interior of the car during the period of exposure.

Temperature	Lbs. per 1,000 cu. ft.
60° F & above	4
55-59° F	4.5
50-54° F	5
45-49° F	5.5
40-44° F	6
35-39° F	6.5 (Hot gas method of application must be used at temperatures below 40° F.)
30-34° F	7
25-29° F	7.5
20-24° F (minimum)	8

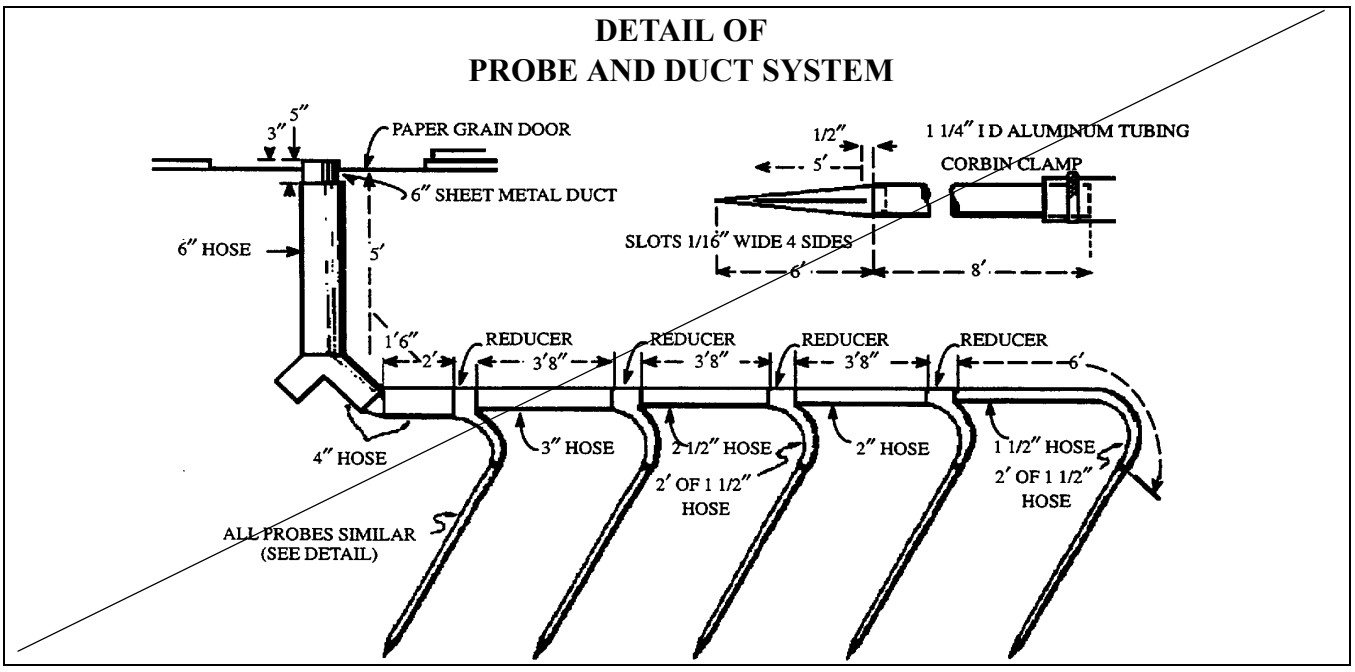
vi. Supervision: All fumigation treatments applied as a basis for certification to meet destination state European corn borer quarantines shall be under the direct supervision of the origin State Entomologist or his official inspector. The origin State Entomologist must also determine that all such fumigation equipment and materials used meet the standard established herein.

vii. Certification: Certificates must affirm that the grain or seed accompanied thereby has been fumigated using the approved "Forced Circulation Method" and set forth the date of fumigation, dosage schedule, kind of fumigant used, period of exposure, and temperature. Each such certificate must also set forth the kind and quantity of the commodity, the initials and number of the railway car or license numbers of vans or trailers and the name and address of the shipper and consignee.

(CAUTION: Methyl bromide (CH_3Br) is a colorless, odorless, volatile liquid which when released at ordinary temperatures is a gas injurious to all forms of animal life. Proper precautions should be observed by all persons when handling it. For further information, consult the State Entomologist.)

F. Sulphur treated corn shucks: It has been determined that the sulphuring process used in bleaching corn shucks intended for use in wrapping tamales, etc., will eliminate all danger of such shucks carrying live European corn borer larvae. Such shucks, therefore, are admissible without certificate from the area under quarantine.

G. General rules: See "General Rules and Definitions, Article 1."



A. Definitions. The following terms apply to this Section:

"Corn" means *Zea* spp.

"Fragment" means a portion of a regulated commodity that cannot pass through a 1/2" aperture or a completely whole, round uncrushed piece of cob, stalk, or stem of at least 1" in length and 3/16" in diameter.

"Pest" means all life stage of the European corn borer, *Ostrinia nubilalis*.

"Shelled grain" means the seed or kernel of corn or sorghum that has been separated from every other plant part.

"Sorghum" means *Sorghum* spp.

B. Area under quarantine.

1. The entire states of Alabama, Arkansas, Colorado, Connecticut, Delaware, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Vermont, Virginia, West Virginia, Wisconsin, and Wyoming.
2. The District of Columbia.
3. In the state of Florida, the following counties: Calhoun, Escambia, Gadsden, Hamilton, Holmes, Jackson, Jefferson, Madison, Okaloosa, and Santa Rosa.
4. In the state of Louisiana, the following parishes: Bossier, Caddo, Concordia, East Carroll, Franklin, Madison, Morehouse, Natchitoches, Ouachita, Red River, Richland, Tensas, and West Carroll.
5. In the state of New Mexico, the following counties: Chaves, Curry, Quay, Roosevelt, San Juan, Santa Fe, Torrance, Union, and Valencia.
6. In the state of Texas, the following counties: Bailey, Carson, Castro, Dallam, Deaf Smith, Floyd, Gray, Hale, Hansford, Hartley, Hutchinson, Lamb, Lipscomb, Moore, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, and Swisher.

C. Regulated commodities. The plants corn and sorghum and every plant part, including seed, shelled grain, stalks, ears, cobs, fragments, and debris.

D. Restrictions. A person shall not ship into Arizona a regulated commodity from an area under quarantine unless each shipment is accompanied by an original certificate issued by a plant regulatory official of the state of origin attesting that the regulated commodity was treated by a method listed in subsection (F), under the official's supervision.

E. Exemption.

1. Treatment prescribed in subsection (F) is waived for the following regulated commodities:
   a. Shelled grain when accompanied by an original certificate issued by a plant regulatory official of the state of origin attesting that:
      i. The shelled grain was passed through a 1/2" or smaller-size mesh screen at origin, and
      ii. The shipment is free of plant fragments capable of harboring the larval life stage of the pest;
   b. Commercially packaged shelled popcorn, planting seed, or grain for human consumption; or
   c. One manufactured or processed by a method that eliminates the pest.
2. The Director may issue a permit to allow a regulated commodity from an area under quarantine, other than one exempt under subsection (E)(1), to enter Arizona without treatment as prescribed in subsection (F) if the regulated commodity originates from an area that a plant regulatory official of the state of origin certifies as pest-free.

F. Treatment.

1. Methyl bromide fumigation (Q label) applied at label rates.
2. Any other treatment approved by the Director.

G. Disposition of regulated commodity not in compliance. A regulated commodity shipped into Arizona in violation of this Section shall be destroyed, treated, or transported out-of-state as prescribed at A.R.S. Title 3, Chapter 2, Article 1.

NOTICE OF PROPOSED RULEMAKING

TITLE 3. AGRICULTURE

CHAPTER 5. DEPARTMENT OF AGRICULTURE
STATE AGRICULTURAL LABORATORY

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R3-5-101	Amend
R3-5-102	Amend
R3-5-103	Amend
R3-5-104	Amend
R3-5-105	Amend
R3-5-106	Amend
R3-5-107	Amend
R3-5-110	Amend
R3-5-111	New Section
R3-5-112	New Section
Table 1	Amend

2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. § 3-107(A)(1)

Implementing statutes: A.R.S. §§ 3-146 and 3-147

3. A list of all previous notices appearing in the Register addressing the proposed rules:

Notice of Rulemaking Docket Opening: 9 A.A.R. 5333, December 12, 2003

4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Sherry D. Blatner, Rules Analyst

Address: Arizona Department of Agriculture
1688 West Adams, Room 235
Phoenix, AZ 85007

Telephone: (602) 542-0962

Fax: (602) 542-5420

E-mail: sherry.blatner@agric.state.az.us

5. An explanation of the rules, including the agency's reasons for initiating the rules:

The Department committed to update these rules in a five-year review report accepted by the Governor's Regulatory Review Council on November 5, 2002.

Language usage is conformed to the current rulewriting standards of the Office of the Secretary of State.

Definitions of "embossing seal," "PTP," "SAL," and "testing" are added for clarity and to provide conciseness within the rules.

Additional certified agricultural services are identified at R3-5-103(A)(7). They are noxious weed identification and noxious weed seed identification.

A laboratory is now required to provide an employee organization chart as part of the application. The elements of the quality assurance manual maintained by a certified laboratory, R3-5-105(B), are amended.

Material incorporated by reference at R3-5-105(F) is updated to include the most recent amendments.

Former subsection R3-5-102(H) is established as a separate rule, R3-5-112, Licensing Time-frames. It is now compatible with the structure used by the Department divisions, a separate rule to discuss time-frames, followed by the Table that establishes the specific licenses and the calendar days for each review category. The time–frames Table is amended to provide adequate time for the SAL to review requests for certification of services not currently offered. The longer time-frames are prescribed at R3-5-112.

R3-5-111 is a new Section that details the status of a certification if a laboratory is moved; the existing certification expires and an initial application is required.

6. A reference to any study relevant to the rules that the agency reviewed and either proposes to rely on or not rely on in its evaluation of or justification for the rules, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

None

7. A showing of good cause why the rules are necessary to promote a statewide interest if the rules will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

8. The preliminary summary of the economic, small business, and consumer impact:

A. *The Arizona Department of Agriculture*.

The Department will incur modest expenses related to training staff and educating the regulated community on the amendments. An increase in laboratory certification fees will provide a slight increase in revenue.

B. *Political Subdivision.*

Other than the Department, no other agency will be affected by these rules.

C. *State Revenue*

This rulemaking has no impact on state revenue.

D. *Businesses Directly Affected by the Rulemaking.*

Laboratories regulated by the SAL will have the option of seeking certification to identify noxious weeds or noxious weed seeds.

The documentation required in the master file and the quality assurance manual are revised and restated.

Laboratories seeking certification for a service not currently established will be licensed under the time-frame stated in rule and the time-frame table is corrected to match the rule.

The rulemaking clarifies the SAL position that a certification is for a specific physical location and a laboratory that is moved during its 12-month certification period must apply for initial certification of the new location.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name:	Sherry D. Blatner, Rules Analyst
Address:	Arizona Department of Agriculture 1688 West Adams, Room 235 Phoenix, AZ 85007
Telephone:	(602) 542-0962
Fax:	(602) 542-5420
E-mail:	sherry.blatner@agric.state.az.us

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rules, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rules:

An oral proceeding is not scheduled for these proposed rules. To request an oral proceeding or to submit comments, please contact the rules analyst listed in item #4 between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday, except legal holidays. If a request for an oral proceeding is not made, the public record in this rulemaking will close at 5:00 p.m. on April 26, 2004.

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

None

12. Incorporations by reference and their location in the rules:

40 CFR 261, amended July 1, 2003 at R3-5-105(F)

40 CFR 262, amended July 1, 2003 at R3-5-105(F)

13. The full text of the rules follows:

TITLE 3. AGRICULTURE

CHAPTER 5. DEPARTMENT OF AGRICULTURE
STATE AGRICULTURAL LABORATORY

ARTICLE 1. SAMPLING AND LABORATORY CERTIFICATION

ARTICLE 1. SAMPLING AND LABORATORY CERTIFICATION

R3-5-101. Definitions

In addition to the definitions ~~provided~~ in A.R.S. §§ 3-101 and 3-141, the following terms apply to this Chapter:

~~1.~~ "Accuracy" means the closeness of an ~~observed measurement~~ observation to the true value.

"Embossing Seal" means a seal approved by the SAL.

~~2.~~ "Person" means an individual, partnership, corporation, or other legal entity.

~~3.~~ "Precision" means the agreement of repeated observations made under the same conditions.

"Proficiency Testing Program" or "PTP" means a check sample testing program.

~~4.~~ "Quality assurance" means an integrated system of management activities involving planning, implementation, assessment, reporting, and quality improvement to ensure that a process, item, or service is of definable quality.

"SAL" means Arizona Department of Agriculture State Agricultural Laboratory.

"Testing" means a process employed to achieve a result for a certified agricultural laboratory service.

R3-5-102. Certification; Renewal; Termination

A. Laboratory certification. ~~Any~~ A person ~~who operates~~ operating a laboratory ~~performing~~ and seeking certification to provide certified agricultural laboratory services ~~pursuant to~~ as prescribed at A.R.S. § 3-145 shall:

1. Provide the following information on ~~the Application For Laboratory Certification~~ a form obtained from the Department ~~and submit it with the appropriate fee to the State Agricultural Laboratory~~:
   a. ~~The name~~ Name, business and mailing address, ~~and~~ telephone and ~~facsimile~~ fax numbers, and e-mail address of the laboratory;
   b. ~~The name~~ Name, address, telephone number, e-mail address, social security number, and signature of the owner; and
   c. ~~The name~~ Name, address, telephone number, e-mail address, and signature of ~~each person supervising the agricultural~~ the laboratory ~~service.~~ manager;
2. Provide a ~~comprehensive~~ description of all programs, services, and functions performed at the laboratory;
3. List ~~each~~ the service requested for certification by commodity or sample-type, detailing the method or procedure used, including specific references to any publication where the method or procedure is described~~.~~;
4. Provide a current employee organization chart that includes employee name, title, and laboratory responsibility; and
5. Include the fee prescribed in R3-5-104 with the application.

B. The laboratory ~~supervisor~~ shall ~~notify~~ provide written notification to the Assistant Director ~~in writing within 30 days~~ of any change ~~in the certification, including location, laboratory supervisor, owner, or other~~ to the information provided under subsection (A)(1) within 30 days after the change.

C. If the application for certification is for a service not currently conducted by the ~~State Agricultural Laboratory~~ SAL and the necessary expertise for review does not exist within the ~~State Agricultural Laboratory~~ SAL, the Director shall establish a committee ~~pursuant to~~ as prescribed at A.R.S. § 3-106 to advise the Department of the proper procedures for certification in that area.

~~**D.** Certified sampler.~~

~~Any person who collects certified samples shall provide the following information on the Sampler Certification Application and score at least 90% on a written sampling test determined by the type of sample certification requested~~:

~~1. The name and social security number of the sampler;~~
~~2. The name, street and mailing address, and telephone and facsimile number of the applicant's employer;~~

3. ~~The name and signature of the employer;~~
4. ~~The mailing address and telephone number of the owner, if different than subsection (D)(1)(b);~~
5. ~~The date of the application;~~
6. ~~The name and signature of the applicant's supervisor or manager;~~
7. ~~The current certification number, if applicable;~~
8. ~~Whether the applicant possesses a State Agricultural Laboratory-approved embossing seal;~~
9. ~~A list of each service requested for certification.~~
10. ~~A signature affirming that the sampler will collect samples as prescribed by the State Agricultural Laboratory and affix the embossing seal on each sample collection report.~~

~~E.~~**D.** Certification renewal.

1. A laboratory owner ~~or sampler~~ shall file a renewal application obtained from the Department at least 30 days before the expiration date of the current certification and provide the ~~following~~ information required at subsection (A)(1)~~:~~.
   a. ~~The name, business and mailing address, and telephone and facsimile numbers of the laboratory;~~
   b. ~~The name, address, telephone number, social security number, and signature of the owner;~~
   c. ~~The name, address, telephone number, and signature of each person supervising a certified agricultural service.~~
2. An application received less than 30 days before the expiration date is untimely and the applicant shall reapply as an initial applicant.
3. ~~Any~~ An application received more than 60 days before the expiration date of the current certification shall be returned to the applicant for resubmittal.
4. The current certification shall remain valid until a determination is made on the renewal application.
5. Include the fee prescribed at R3-5-104 with the renewal application.

~~F.~~**E.** Certification termination. A laboratory owner ~~or sampler~~ may terminate the certification, either in part or in its entirety, by notifying the Assistant Director in writing within 30 days before the effective date of the termination.

~~G. Additional services. A laboratory owner may add services to the current certification by following the certification procedure in subsections through (C), except that the Assistant Director may waive the on-site survey requirement.~~

~~H. Time-frames.~~

1. ~~Overall time frame. The State Agricultural Laboratory shall issue or deny a certification within the overall time-frames listed in Table 1 after receipt of the complete application. The overall time-frame is the total of the number of days provided for the administrative completeness review and the substantive review.~~
2. ~~Administrative completeness review.~~
   a. ~~The appropriate administrative completeness review time-frame established in Table 1 begins on the date the State Agricultural Laboratory receives an application. The State Agricultural Laboratory shall notify the applicant in writing within the administrative completeness review time-frame whether the application is incomplete. The notice shall specify what information is missing. If the State Agricultural Laboratory does not provide notice to the applicant within the administrative completeness review time-frame, the application is complete.~~
   b. ~~An applicant with an incomplete certification application shall supply the missing information within the completion request period established in Table 1. The administrative completeness review time-frame is suspended from the date the State Agricultural Laboratory mails the notice of missing information to the applicant until the date the State Agricultural Laboratory receives the information.~~
   c. ~~If the applicant fails to submit the missing information before the expiration of the completion request period, the State Agricultural Laboratory shall close the file, unless the applicant requests an extension. An applicant whose file has been closed may obtain a certification by submitting a new application.~~
   d. ~~If a laboratory requests certification of a service not currently offered, 90 additional days shall be added to the administrative completeness review to establish a protocol for granting certification.~~
3. ~~Substantive review. The substantive review time frame established in Table 1 shall begin after the application is administratively complete.~~
   a. ~~On-site survey.~~
      i. ~~Within 30 days of receipt of a complete application, the State Agricultural Laboratory shall schedule an on-site survey of the applicant's laboratory facilities; or~~
      ii. ~~The Assistant Director may waive the on-site survey required for a renewal applicant if the renewal applicant is in compliance with this Article.~~
   b. ~~If the State Agricultural Laboratory makes a comprehensive written request for additional information, the applicant shall submit the additional information identified by the request within the additional information period provided in Table 1. The substantive completeness review is suspended from the date the State Agricultural Laboratory mails the request until the information is received by the State Agricultural Laboratory. If the applicant fails to provide the information identified in the written request within the response to additional information period, the State Agricultural Laboratory shall deny the license.~~
   c. ~~If the application is denied, the State Agricultural Laboratory shall send the applicant written notice explaining the reason for the denial with citations to supporting statutes or rules, the applicant's right to seek a fair hearing,~~

~~and the time period in which the applicant may appeal the denial.~~

R3-5-103. Certified Services

A. In addition to certification for the services established in A.R.S. § 3-141(1), the applicant may apply for certification for any ~~or all~~ of the following agricultural laboratory services:

1. Determination of specific element and ion content of water for irrigation or livestock purposes;
2. Determination of specific element and ion content of plant tissue for the evaluation of plant nutrients;
3. Determination of specific element and ion content of soil for the evaluation of soil fertility and for element and ion content that may cause plant growth limitations;
4. Determination of ~~contents~~ content of processed ~~meats and~~ meat or meat food ~~products~~ product including the percentage of meat and nonmeat ~~ingredients~~ ingredient;
5. Verification of an analysis for the accuracy of the label ~~guarantees~~ guarantee of ~~feeds~~ feed, ~~fertilizers~~ fertilizer, animal ~~manures~~ manure, plant growth ~~stimulants~~ stimulant, soil ~~amendments~~ amendment, soil ~~conditioners~~ conditioner, or ~~pesticides~~ pesticide;
6. Verification of planting seed germination~~,~~ percentages, purity analysis, or other named seed or plant propagative material testing ~~procedures~~ procedure;
7. Identification of insects, plant pathogens, animal pathogens, nematodes, noxious weeds, noxious weed seeds, or animal parasites;
8. Testing of milk or milk ~~products~~ product for quality and market standards;
9. Determination of ~~mycotoxins~~ mycotoxin, ~~antibiotics~~ antibiotic, or drug ~~residues~~ residue in plant or animal tissue;
10. Determination of ~~mycotoxins~~ mycotoxin, ~~antibiotics~~ antibiotic, or drug ~~residues~~ residue in plant or animal ~~products~~ product, animal feed, or feed ~~ingredients~~ ingredient;
11. Determination of a specific pesticide, or hazardous or toxic ~~elements~~ element in plant or animal tissue;
12. Determination of a specific pesticide or hazardous or toxic ~~elements~~ element in air, water used in livestock production, irrigation water, soil, agricultural product, or animal feed; or
13. Collection of samples.

B. An applicant may submit a written request to the ~~State Agricultural Laboratory~~ SAL for a certified agricultural service not already established.

R3-5-104. Fees

The applicant shall provide the Department ~~with~~ the following nonrefundable fees before the certification review is ~~granted~~ initiated:

1. Initial fee, $200 per certified service; or
2. Renewal fee, $100 per certified service~~; and~~
3. ~~Time and mileage as prescribed in A.R.S. Title 38, Chapter 4, Articles 1 and 2~~.

R3-5-105. Laboratory Requirements

A. A laboratory certified under this ~~Section~~ Article shall maintain ~~and update~~ a separate master file for ~~all~~ each certified ~~agricultural laboratory services~~ service. The master file shall be updated within 30 days of any change. The master file shall contain:

1. ~~A~~ The most current letter of certification stating the period of validity;
2. A quality assurance manual as described in subsection (B) ~~and all updates, approved by the Assistant Director~~;
3. ~~Documentation of competence and experience in testing for the service requested;~~
3. An organizational chart indicating:
   a. Every personnel position with responsibility for the certified agricultural laboratory service; and
   b. The reporting relationship of the positions identified in subsection (A)(3)(a), including every administrative, operational, and quality control relationship;
4. ~~Documentation that establishes the laboratory personnel's capabilities;~~
4. The name and resume of the individual assigned to each position identified in subsection (A)(3)(a);
5. Documentation ~~for working knowledge of the applicable test standards and methods for approval of the service and the testing analyses for each service~~ of training for each staff member performing all or part of the certified service;
6. ~~A written standard operating procedure for testing when required and approved by the Assistant Director;~~
6. Documentation of the laboratory's competence and experience in the applicable test method for the service requested;
7. Reports of ~~all sample results~~ each sample result for the last ~~3~~ three years and all data generated during the testing. After three years, records shall be maintained as prescribed in subsection (D). The Assistant Director must provide approval to a laboratory before records may be maintained in electronic format;
8. Laboratory equipment lists, including:
   a. ~~The type~~ Type and manufacturer;
   b. ~~The serial~~ Serial and model number; ~~and~~
   c. ~~The date~~ Date of the last calibration, if applicable~~.~~; and

d. Maintenance records;
9. Receiving and shipping records of all samples and supplies relating to the certification;
10. Quality control documentation;
~~12. Calibration certificates; and~~
11. Documentation of reference material, standards, and biological specimens listed in subsection (B)(5); and
~~13.~~12. All correspondence relating to the certification and operation of the program.

B. The ~~testing~~ laboratory shall maintain ~~and update~~ a quality assurance manual ~~that describes actions taken by the laboratory to ensure that routinely generated analytical data are scientifically valid and defensible and are of known and acceptable precision and accuracy~~. The manual shall be updated within 30 days of any change, except that any change to subsection (B)(4) requires pre-approval from the Assistant Director and a request shall be made at least 30 days before the proposed implementation date. The manual shall contain:

1. A description of ~~the~~ laboratory management and the responsibilities of personnel related to the certification that includes:
   a. The legal name, address, and telephone number of the main office or parent company;
   b. The name, location of the laboratory, and telephone number, if different from subsection (B)(1)(a);
   ~~c. An organization outline or chart showing the titles or positions of all personnel relating to the certification and their reporting relationships relative to a certification request, including relationship between administration, operation, and quality control;~~
   c. The education, skill, and experience required of an individual to hold a position listed in subsection (A)(3)(a); and
   ~~d. The names and resumes of the individuals assigned to each of the positions identified in subsection (B)(1)(c), or the personnel requirements for the individuals employed in those positions;~~
   d. A description of the method used to train each person holding a position listed in subsection (A)(3)(a);
   ~~e. Verification that personnel have a working knowledge of the applicable test standards and test methods, and are qualified by education, training, or experience to conduct tests and analyze data to ensure the accuracy, performance, and timeliness of testing and follow-up inspections.~~

~~2. A description of the receiving, handling, and shipping controls that includes:~~
   ~~a. The visual examination of samples, upon receipt, for evidence of shipping damage;~~
   ~~b. The storage of items, while awaiting disposition, regarding the safety of personnel and the degree of protection to preclude the possibility of damage to the shipment; and~~
   ~~c. The shipping and receiving data containing the date of receipt, the name of the manufacturer, and any other data necessary to accurately record and identify samples at the laboratory.~~

2. Procedures for receiving and handling samples, including:
   a. Transporting samples to the laboratory in a manner that protects the integrity of the sample;
   b. Performing a visual examination upon receipt for evidence of shipping damage;
   c. Recording date and time of sample receipt, carrier name, and method of shipment;
   d. Recording sample weight, temperature, or other physical parameters, as applicable;
   e. Completing chain of custody documentation for receipt, as applicable;
   f. Identifying a sample with a unique identification number;
   g. Storing sample prior to and subsequent to testing; and
   h. Disposing of samples following completion of testing, including holding time;
3. Procedures to purchase, receive, and store reagents and laboratory consumable material that affect the quality of tests;
~~3.~~4. ~~A description of testing information that includes a written list of test procedures~~ A written standard operating procedure for each test as prescribed in R3-5-106. A test procedure shall, when applicable, contain:
   ~~a. The nomenclature and identification of the sample;~~
   ~~b. Detailed steps and operations in sequence, including verifications made before each stage of testing;~~
   ~~c. Values for acceptance or rejection of analytical results based on permissible analytical variations;~~
   ~~d. A list of measuring equipment, specifying range, type, accuracy, and the name of the test;~~
   ~~e. An identification of any hazardous situations or operations;~~
   ~~f. A list of the precautions taken to ensure safety of personnel, and to prevent damage to test items and measuring equipment;~~
   ~~g. Test environments, conditions, and tolerances;~~
   ~~h. Special instructions for inspection or testing, such as special handling of fragile test items;~~
   ~~i. The nomenclature and designation of an applicable reference standard on which the test procedure is based;~~
   ~~j. Quality control measures for precision and accuracy using appropriate spikes, blanks, multiple sample analysis, or standard reference material controls to assure validity of test results.~~
   a. Identification of the standard operating procedure including title, revision number, effective date, and authorizing signature;
   b. Purpose of the procedure including a description of the expected outcome;

c. Scope of the procedure including a description of the type of samples and test parameters for which the procedure is applicable;
d. List of reagents, apparatus, and equipment used including technical performance requirements;
e. List of necessary reference standards or reference materials;
f. Description of acceptable environmental conditions;
g. Sequential listing, in detail, of the steps and operations of the procedure;
h. Identification of any hazardous situation or operation;
i. List of necessary worker safety precautions;
j. List of precautions needed to prevent damage or contamination to a sample or testing equipment;
k. Quality control measures to determine acceptability of test result including acceptance criteria;
l. List of data to be recorded and method for reporting result; and
m. Method uncertainty or procedure for reporting uncertainty;

~~4.~~5. ~~Reference standards documenting that~~ Procedures for documenting applicable reference material, standards, and biological specimens that provide:
a. ~~The accuracy of all measurement~~ Traceability of each chemical ~~standards are traceable~~ standard of measurement to a primary ~~standards~~ standard;
b. ~~The biological specimens are verified by the Assistant Director or the Assistant Director's designee.~~ Verified and traceable biological specimens; and
c. Origin and traceability of reference material;

~~5.~~6. A description of an equipment maintenance program that includes:
a. Manufacturer's recommendations for the set-up and normal operation of each ~~instrument and, if appropriate, the specific instructions for periodic checking of the reproducibility of the system~~ piece of equipment;
b. A separate maintenance schedule for each piece of equipment, and a procedure for recording the date maintenance is performed and the date of any damage, malfunction, modification, or repair to the equipment; and
~~b.~~c. Quality control procedures for determining ~~instrument~~ equipment performance; and

7. Procedures for quality control activity including:
~~c.~~a. Monitoring ~~of~~ temperature-controlled spaces;
~~d.~~b. ~~Certification that thermometers~~ Certifying that each thermometer, ~~and~~ analytical ~~balances meet~~ balance, and biological hood meets federal or nationally-recognized standards, ~~if~~ as applicable;
~~e.~~c. ~~Calibration of~~ Calibrating glassware and volumetric equipment~~.~~ , as applicable; and
d. Validating the quality of reagents and laboratory consumable material, as applicable.

C. The ~~testing~~ laboratory is responsible for the accurate calibration of testing equipment.

D. The ~~testing~~ laboratory shall maintain records for ~~5~~ five years, except pesticide residue sample results and data, which shall be ~~7~~ maintained for seven years;

E. The construction and operation of the laboratory shall comply with the standards established by the Occupational Safety and Health Administration and any other applicable federal, state, ~~county~~ and ~~municipal~~ local building, sanitary, safety, electrical, and fire ~~codes~~ code for the area in which the laboratory is located.

F. The laboratory shall ~~comply with the disposal~~ dispose of hazardous waste ~~materials established~~ material cited in the Identification and Listing of Hazardous Waste, 40 CFR 261, amended ~~August 12, 1997~~ July 1, 2003, ~~and~~ as prescribed in the Standards Applicable to Generators of Hazardous Waste, 40 CFR 262, amended ~~August 12, 1997~~ July 1, 2003. This material is incorporated by reference, does not include any later amendments or editions, and is on file with the ~~Office of the Secretary of State, and does not include any later amendments or editions of the incorporated matter~~ Department.

R3-5-106. Methods of ~~Analyzing and~~ Testing

A laboratory shall, when complying with this Article:
1. Use the methods and procedures for ~~analyzing and~~ testing ~~which~~ that are referenced in professional journals or manuals and obtain the approval of the Assistant Director, or
2. Use the methods and procedures established by the ~~State Agricultural Laboratory~~ SAL.

R3-5-107. ~~Check Sample~~ Proficiency Testing Program

A. A laboratory applying for certification shall ~~praticipate~~ participate in a ~~check sample program~~ ~~approved~~ PTP as required by the Assistant Director to demonstrate its ability to provide those services for which certification is requested.

B. An applying laboratory participating in an outside PTP shall provide the Assistant Director with its identification number and a copy of the results. The applying laboratory shall pay the cost of the PTP testing service used to determine proficiency.

~~B.~~**C.** Individual laboratory evaluation shall be based on the results obtained for each ~~check~~ sample in relationship to results, grouped by methods, received from all laboratories participating in that ~~check sample program~~ PTP. If a deficiency is noted ~~during an on-site evaluation or in the examination of split samples~~, the ~~applying~~ laboratory shall submit a ~~plan of~~ corrective action plan ~~designated to eliminate the deficiency~~ to the Assistant Director. ~~The applying laboratory shall pro-~~

~~vide the Assistant Director with its identification number and a copy of the results for all analysis submitted to the check sample program~~.

~~**C.** The applying laboratory shall bear the costs of all analyses performed and the cost of all subsequent check samples, including the cost of any check sample service used to determine proficiency.~~

R3-5-110. Referee Laboratory

If ~~2~~ two certified laboratories have differing testing results or if the results of a certified laboratory are challenged by the contracting ~~agency~~ person or other state agency, the Director may designate a laboratory to serve as a referee to assist in making a determination. In the case of a challenge of test results, all costs incurred by the referee laboratory shall be ~~borne~~ paid by the party losing the dispute.

R3-5-111. Certification Expiration; Laboratory Relocation

A laboratory certification is valid for the physical location approved by the SAL in the initial application or renewal. If a laboratory relocates after certification or renewal, the existing 12-month certification expires on the date of the move. The laboratory shall file an initial certification application to become certified at the new physical location and an on-site review shall be required.

R3-5-112. Licensing Time-frames

A. Overall time-frame. The Department shall issue or deny a certification within the overall time-frames listed in Table 1 after receipt of the complete application. The overall time-frame is the total of the number of days provided for the administrative completeness review and the substantive review.

B. Administrative completeness review.

1. The appropriate administrative completeness review time-frame established in Table 1 begins on the date the Department receives an application. The Department shall notify the applicant in writing within the administrative completeness review time-frame whether the application is incomplete. The notice shall specify what information is missing. If the Department does not provide notice to the applicant within the administrative completeness review time-frame, the application is complete.
2. An applicant with an incomplete certification application shall supply the missing information within the completion request period established in Table 1. The administrative completeness review time-frame is suspended from the date the Department mails the notice of missing information to the applicant until the date the Department receives the information.
3. If the applicant fails to submit the missing information before the expiration of the completion request period, the Department shall close the file, unless the applicant requests an extension. An applicant whose file has been closed may obtain a certification by submitting a new application.
4. If a laboratory requests certification of a service not currently offered, 90 additional days shall be added to the administrative completeness review to establish a protocol for granting certification.

C. Substantive review. The substantive review time-frame established in Table 1 shall begin after the application is administratively complete.

1. On-site survey.
   a. Within 30 days of receipt of a complete application, the SAL shall schedule an on-site survey of the applicant's laboratory facilities; or
   b. The Assistant Director may waive the on-site survey required for a renewal applicant if the renewal applicant is in compliance with this Article.
2. If the Department makes a comprehensive written request for additional information, the applicant shall submit the additional information identified by the request within the additional information period provided in Table 1. The substantive completeness review is suspended from the date the Department mails the request until the information is received by the Department. If the applicant fails to provide the information identified in the written request within the response to additional information period, the Department shall deny the certificaton.
3. If the application is denied, the Department shall send the applicant written notice explaining the reason for the denial with citations to supporting statutes or rules, the applicant's right to seek a fair hearing, and the time period in which the applicant may appeal the denial.

Table 1. Time-frames (Calendar Days)

Certification	Authority	Administrative Completeness Review	Response to Completion ~~Period~~ Request	Substantive Completeness Review	Response to Additional Information	Overall Time-frame
Laboratory Certification New Renewal Certification request for service not ~~currently offered~~ previously certified	A.R.S. § 3-145 R3-5-102	 14 14 ~~14~~ 104	 30 ~~7~~ 14 ~~30~~ 90	 60 30 60	 90 14 ~~90~~ 30	 74 44 ~~74~~ 164
~~Sampler Certification~~	~~A.R.S. § 3-145 R3-5-102~~	~~14~~	~~30~~	~~90~~	~~90~~	~~104~~

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-22-1101	Amend
R9-22-1102	Repeal
R9-22-1102	New Section
R9-22-1103	Repeal
R9-22-1103	New Section
R9-22-1104	Repeal
R9-22-1104	New Section
R9-22-1105	New Section
R9-22-1106	New Section
R9-22-1107	New Section
R9-22-1108	New Section
R9-22-1109	New Section
R9-22-1110	New Section
R9-22-1111	New Section

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statutes: A.R.S. §§ 36-2905.04, 36-2918, 36-2957, 36-2991, 36-2912, 36-2993

Implementing statutes: A.R.S. §§ 36-2991, 36-2903.01, 36-2932, 36-2986

3. A list of all previous notices appearing in the Register addressing the proposed rule:

Notice of Rulemaking Docket Opening: Volume 9 A.A.R. 2118, June 27, 2003

4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Barbara Ledder

Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4580

Fax: (602) 253-9115

5. An explanation of the rule, including the agency's reasons for initiating the rule:

AHCCCS proposes to change 9 A.A.C. 22, Article 11 to provide additional clarity, specificity, and conciseness to existing rule language and to comply with the five-year review report made in January 2003.

6. A reference to any study relevant to the rule that the agency reviewed and either proposes to rely on or not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

No studies were reviewed.

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

8. The preliminary summary of the economic, small business, and consumer impact:

These rules describe the process and circumstances under which AHCCCS imposes a penalty, assessment, or a penalty and assessment on a provider or non-contracting provider. The rules also include the provider or non-contracting provider's right to file a request for a State Fair Hearing. It is anticipated that contractors, providers, non-contracting providers and AHCCCS will be nominally impacted by the changes to the rule language. AHCCCS anticipates that these rules will benefit contractors, providers, non-contracting providers and AHCCCS by more clearly describing the process and circumstances, and timelines under which a penalty, assessment, or penalty and assessment is determined including more clearly describing the process used by a provider or non-contracting provider to request a State Fair Hearing.

It is anticipated that members, private sector, including small businesses or political subdivisions will not be impacted since the proposed rule language is intended to streamline and clarify the existing rules and process which relate only to providers and non-contracting providers.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name:	Barbara Ledder
Address:	AHCCCS Office of Legal Assistance 701 E. Jefferson, Mail Drop 6200 Phoenix, AZ 85034
Telephone:	(602) 417-4580
Fax:	(602) 253-9115
E-mail:	proposedrules@ahcccs.state.az.us

Proposed rule language will be available on the AHCCCS web site www.ahcccs.state.az.us the week of March 8, 2004. Written comments may be sent to the above address by 5:00 p.m., April 28, 2004.

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date:	April 28, 2004
Time:	1:00 p.m.
Location:	AHCCCS 701 East Jefferson Phoenix, AZ 85034
Nature:	Public Hearing
Date:	April 28, 2004
Time:	1:00 p.m.
Location:	ALTCS: Arizona Long-Term Care System 110 South Church, Suite 1360 Tucson, AZ 85701
Nature:	Public Hearing
Date:	April 28, 2004

Time:	1:00 p.m.
Location:	ALTCS: Arizona Long-Term Care System 3480 East Route 66 Flagstaff, AZ 86004
Nature:	Public Hearing

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

None

12. Incorporations by reference and their location in the rules:

None

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS

Section

ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS

R9-22-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims

~~**A.** Circumstances for imposing a penalty and assessment. The Director or designee shall impose a penalty and assessment under the circumstances described in A.R.S. § 36-2918. For the purposes of this Article, the term "reason to know" means that a person, with respect to information, acts in deliberate ignorance of the truth or falsity of the information or with reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.~~

~~**B.** Violation of agreement. The Director's or designee's determination of whether a person knew or had reason to know that each claim or request for payment was claimed in violation of an agreement with Arizona, the Administration, or a contractor may be based on the terms of the agreement.~~

A. Scope. This Article applies to a provider or non-contracting provider who meets the conditions under this Article and who submits a claim under Medicaid (Title XIX of the Social Security Act), KidsCare (Title XXI of the Social Security Act), or the Health Care Group under A.R.S. § 36-2912.

B. Purpose. This Article describes the circumstances and process that AHCCCS uses to determine the amount of a penalty, assessment, or penalty and assessment as required under A.R.S. § 36-2918. This Article includes the process and timeframes used by a provider or non-contracting provider to request a State Fair Hearing.

C. Definitions. The following definitions apply to this Article:

1. "Assessment" means a monetary amount not to exceed twice the dollar amount claimed by the provider or non-contracting provider for each service.
2. "Claim" means a request for payment submitted by a provider or non-contracted provider for payment for a service or line item of service.
3. "Day" means calendar day unless otherwise specified.
4. "File" means the date that AHCCCS receives the written acceptance, request for compromise, request for a counter proposal, or a request for a State Fair Hearing as established by a date stamp on the written document or other record of receipt.
5. "Penalty" means a monetary amount based on the number of items of service claimed. A penalty shall not exceed two

thousand dollars times the number of line items of service.

6. "Reason to know" or "had reason to know" means that a provider non-contracting provider, with respect to information, acts in deliberate ignorance of the truth or falsity of the information or with reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

R9-22-1102. ~~Determinations Regarding the Amount of the Penalty and Assessment~~ Determining the Amount of a Penalty

~~**A.** Factors for determining a penalty and assessment. The Director or designee shall take into account the following factors in determining the amount of a penalty and assessment:~~

~~1. The nature of each claim or request for payment and the circumstances under which it is presented or caused to be presented,~~
~~2. The degree of culpability of a person who presents or causes to present each claim or request for payment,~~
~~3. The history of prior offenses of a person who presents or causes to present each claim or request for payment,~~
~~4. The financial condition of a person who presents or causes to present each claim or request for payment,~~
~~5. The effect on patient care resulting from the failure to provide medically necessary care by a person who presents or causes to present each claim or request for payment, and~~
~~6. Other matters as justice may require.~~

~~**B.** Types of claim circumstances. In determining the amount of a penalty and assessment, the Director or designee shall consider both mitigating circumstances and aggravating circumstances surrounding the presentation or cause for presentation of each claim or request for payment.~~

~~**C.** Mitigating circumstance guidelines. The Director or designee shall consider the following mitigating circumstance guidelines when determining the amount of a penalty and assessment:~~

~~1. Nature and circumstances of each claim or request for payment. The nature and circumstances of each claim or request for payment and the circumstances under which it is presented or is caused to be presented are a mitigating circumstance if:~~
~~a. All the items and services subject to a penalty and assessment are of the same type,~~
~~b. All the items and services subject to a penalty and assessment occurred within a short period of time,~~
~~c. There are few items and services, and~~
~~d. The total amount claimed for the items and services is less than $1,000;~~
~~2. Degree of culpability. The degree of culpability of a person who presents or causes to present a claim or request for payment is a mitigating circumstance if:~~
~~a. Each item or service is the result of an unintentional and unrecognized error in the process the person followed in presenting or in causing to present the item or service,~~
~~b. Corrective steps were taken promptly after the error was discovered, and~~
~~c. A fraud and abuse control plan was adopted and operating effectively at the time each claim or request for payment was presented or caused to be presented;~~
~~3. Financial condition. The financial condition of a person who presents or causes to present a claim or request for payment is a mitigating circumstance if the imposition of a penalty and assessment without reduction will jeopardize the ability of the person to continue as a health care provider. The resources available to the person may be considered when determining the amount of the penalty and assessment; or~~
~~4. Other matters as justice may require. Other circumstances of a mitigating nature will be taken into account if, in the interest of justice, the circumstances require a reduction of the penalty and assessment.~~

~~**D.** Aggravating circumstance guidelines. The Director or designee shall consider the following aggravating circumstance guidelines when determining the amount of a penalty and assessment:~~

~~1. Nature and circumstances of each claim or request for payment. The nature and circumstances of each claim or request for payment and the circumstances under which it is presented or caused to be presented are an aggravating circumstance if:~~
~~a. The items and services subject to a penalty and assessment are of several types,~~
~~b. The items and services subject to a penalty and assessment occurred over a lengthy period of time,~~
~~c. There are many items or services (or the nature and circumstances indicate a pattern of claims for the items or services), or~~
~~d. The total amount claimed for the items and services is $1,000 or greater;~~
~~2. Degree of culpability. The degree of culpability of a person who presents or causes to present each claim or request for payment is an aggravating circumstance if:~~
~~a. The person knew that each item or service was not provided as claimed,~~
~~b. The person knew that no payment could be made because the person had been excluded from System reimbursement, or~~
~~c. Payment would violate the terms of an agreement between the person and Arizona, the Administration, or a contractor;~~

~~3. Prior offenses. The prior offenses of a person who presents or causes to present each claim or request for payment is an aggravating circumstance if, at any time before the presentation of any claim or request for payment subject to a penalty and assessment under this Article, the person was held liable for a criminal, civil, or administrative sanction in connection with:~~
~~a. A Medicaid program,~~
~~b. A Medicare program, or~~
~~c. Any other public or private program of reimbursement for medical services;~~
~~4. Effect on patient care. The seriousness of an adverse effect that resulted, or could have resulted, from the failure of a person who presents or causes to present a claim or request for payment to provide medically necessary care is an aggravating circumstance; or~~
~~5. Other matters as justice may require. Other circumstances of a aggravating nature will be taken into account if, in the interest of justice, the circumstances require an increase of the penalty and assessment.~~

~~**E.** Amount of Penalty and Assessment. The aggregate amount of a penalty and assessment shall never be less than double the approximate amount of damages sustained by Arizona, the Administration, or contractor, unless there are extraordinary mitigating circumstances.~~

~~**F.** Compromise. The Director or designee may compromise a penalty and assessment using the guidelines in subsections (C) and (D).~~

A. AHCCCS shall determine the amount of a penalty according to A.R.S. § 36-2918(B) and (C), R9-22-1104, and R9-22-1105.

B. The amount of the penalty shall include the cost incurred by AHCCCS for conducting an investigation, audit, or inquiry.

R9-22-1103. ~~Notice of Proposed Determination and Rights of Parties~~ Determining the Amount of an Assessment

~~**A.** Administration's Responsibilities. If the Director or designee proposes to impose a penalty and assessment, the Director or designee shall deliver or send by certified mail, return receipt requested, to a person, written notice of intent to impose a penalty and assessment. The notice shall include:~~
~~1. Reference to the statutory basis for the penalty and assessment,~~
~~2. A description of each claim or request for payment for which the penalty and assessment are proposed,~~
~~3. The reason why each claim or request for payment subjects the person to a penalty and assessment, and~~
~~4. The amount of the proposed penalty and assessment.~~

~~**B.** Individual's Responsibilities. A person may submit within 35 days from the date of the notice of intent to impose a penalty and assessment:~~
~~1. A written statement accepting imposition of the penalty and assessment;~~
~~2. A written request for a compromise of the penalty and assessment stating any reasons that the person contends should result in a reduction or modification of the penalty and assessment. If a request is submitted, the time period for filing an appeal and request for hearing according to subsection (C) shall be tolled until the Director's or designee's decision on the request for compromise; or~~
~~3. A grievance in accordance with the provider grievance provision in Article 8 of this Chapter.~~

~~**C.** The Director or designee may impose a proposed penalty and assessment or any less severe penalty and assessment if a person does not request a hearing within the time prescribed by subsections (B)(2) or (B)(3). A person has no right to appeal a penalty and assessment if the person has not timely requested a hearing.~~

A. AHCCCS shall determine the amount of an assessment according to A.R.S. § 36-2918(B) and (C), R9-22-1104, and R9-22-1105.

B. The amount of the assessment shall include the cost incurred by AHCCCS for conducting an investigation, audit, or inquiry.

R9-22-1104. ~~Issues and Burden of Proof~~ Mitigating Circumstances

~~**A.** Preponderance of Evidence. In any hearing conducted according to this Article, the Director or designee shall prove by a preponderance of the evidence that a person who requested a hearing presented or caused to be presented each claim or request for payment in violation of R9-22-1101. A person who requests a hearing shall bear the burden of producing and proving by a preponderance of the evidence any circumstance that would justify reducing the amount of the penalty and assessment.~~

~~**B.** Statistical sampling.~~
~~1. The Director or designee may introduce the results of a statistical sampling study as evidence of the number and amount of claims or requests for payment that were presented or caused to be presented by the person in meeting the burden of proof described in subsection (A). A statistical sampling study shall constitute prima facie evidence of the number and amount of claims or requests for payment, if based upon an appropriate sampling and computed by valid statistical methods.~~
~~2. The burden of proof shall shift to the person to produce evidence reasonably calculated to rebut the findings of the statistical sampling study once the Director or designee has made a prima facie case as described in subsection (A).~~

~~The Director or designee will be given the opportunity to rebut this evidence.~~

AHCCCS shall consider the following mitigating circumstances when determining the amount of a penalty, assessment, or penalty and assessment.

1. Nature and circumstances of each claim. The nature and circumstances of each claim and the circumstances under which the claim is presented or is caused to be presented is a mitigating circumstance if:
   a. All the services are of the same type,
   b. All the services occurred within a short period of time,
   c. There are few services,
   d. The nature and circumstances indicate a pattern of inappropriate claims for the services; and
   e. The total amount claimed for the services is less than $1,000.
2. Degree of culpability. The degree of culpability of a provider or non-contracting provider who presents or causes to present a claim is a mitigating circumstance if:
   a. Each service is the result of an unintentional and unrecognized error in the process that the provider or non-contracting provider followed in presenting or in causing to present the service,
   b. Corrective steps were taken promptly by the provider or non-contracting provider after the error was discovered, and
   c. A fraud and abuse control plan was adopted and operating effectively by the provider or non-contracting provider at the time each claim was presented or caused to be presented.
3. Financial condition. The financial condition of a provider or non-contracting provider who presents or causes to present a claim is a mitigating circumstance if the imposition of a penalty, assessment, or penalty and assessment without reduction jeopardizes the ability of the provider or non-contracting provider to continue as a health care provider. The resources available to the provider or non-contracting provider shall be considered when determining the amount of the penalty, assessment, or penalty and assessment.
4. Other matters as justice may require. Other circumstances of a mitigating nature shall be taken into account if, in the interest of justice, the circumstances require a reduction of the penalty, assessment, or penalty and assessment.

R9-22-1105. Aggravating Circumstances.

AHCCCS shall consider the following aggravating circumstances when determining the amount of a penalty, assessment, or penalty and assessment.

1. Nature and circumstances of each claim. The nature and circumstances of each claim and the circumstances under which the claim is presented or caused to be presented is an aggravating circumstance if:
   a. A provider or non-contracting provider has forged, altered, recreated, or destroyed the records,
   b. The provider or non-contracting provider had refused to provide pertinent documentation for a claim or refused to cooperate with investigators for other than constitutional reasons,
   c. The services are of several types,
   d. The services occurred over a lengthy period of time,
   e. There are many services,
   f. The nature and circumstances indicate a pattern of claims for the services, or
   g. The total amount claimed for the services is $1,000 or greater.
2. Degree of culpability. The degree of culpability of a provider or non-contracting provider who presents or causes to present each claim is an aggravating circumstance if:
   a. The provider or non-contracting provider knew that each service was not provided as claimed,
   b. The provider or non-contracting provider knew that no payment could be made because the provider or non-contracting provider had been excluded from reimbursement by AHCCCS, or
   c. The provider or non-contracting provider knew that the payment would violate the terms of an agreement between the provider or non-contracting provider and AHCCCS system.
3. Prior offenses. The prior offenses of a provider or non-contracting provider who presents or causes to present each claim is an aggravating circumstance if:
   a. At any time before the submittal of the claim the provider or non-contracting provider was held liable for a criminal or civil act; or
   b. The provider or non-contracting provider had received an administrative sanction in connection with:
      i. A Medicaid program,
      ii. Medicare program, or
      iii. Any other public or private program of reimbursement for medical services.
      iv. Effect on patient care. The seriousness of an adverse effect that resulted, or could have resulted, from the failure of a provider or non-contracting provider who presents or causes to present a claim to provide medically necessary care is an aggravating circumstance.
      v. Other matters as justice may require. Other circumstances of an aggravating nature shall be taken into account if, in the interest of justice, the circumstances require an increase of the penalty, assessment, or penalty and assessment.

R9-22-1106. Notice of Intent

If AHCCCS imposes a penalty, assessment, or a penalty and assessment, AHCCCS shall hand deliver or send by to certified mail return receipt requested, or Federal Express to the provider or non-contracting provider, a written Notice of Intent to impose a penalty, assessment, or a penalty and assessment. The Notice of Intent shall include:

1. Reference to the statutory basis for the penalty, assessment, or the penalty and assessment,
2. A summary of the reasons why the penalty, assessment, or the penalty and assessment are requested,
3. The amount of the penalty, assessment, or penalty and assessment,
4. The process to accept or request a compromise for the provider or non-contracting provider for the penalty, assessment, or penalty and assessment, and
5. The process for requesting a State Fair Hearing.

R9-22-1107. Acceptance of the Penalty, Assessment, or Penalty and Assessment

To accept the penalty, assessment, or penalty and assessment, the provider or non-contracting provider shall file a written acceptance with AHCCCS within 30 days from the date of the Notice of Intent.

R9-22-1108. Request for a Compromise

A. To requests a compromise, the provider or non-contracting provider shall file a written request with AHCCCS within 30 days from the date of the Notice of Intent. The written request for compromise shall contain the provider or non-contracting provider's reasons for the reduction or modification of the penalty, assessment or penalty and assessment.

B. Within 30 days from the receipt of the request for compromise from the provider or non-contracting provider, AHCCCS shall send a Notice of Compromise Decision and accept, deny, or offer a counter proposal to the provider or non-contracting provider's request for compromise.

1. To accept a counter proposal, the provider or non-contracting provider shall file a written acceptance with AHCCCS within 30 days from the date of the Notice of Compromise Decision.
2. If AHCCCS denies the request for compromise or if the provider or non-contracting provider does not respond to AHCCCS' denial of compromise, the original penalty, assessment, or penalty and assessment is upheld.
3. If the provider or non-contracting provider does not respond to AHCCCS' counter proposal within 30 days from the date of the Notice of Compromise Decision, the counter proposal is upheld.
4. The provider or non-contracting provider may file a request a State Fair Hearing under R9-22-1110 within 30 days from the date of the Notice of Compromise Decision.

R9-22-1109. Failure to Respond to the Notice of Intent

If a provider or non-contracting provider fails to respond timely to the Notice of Intent, the original penalty, assessment, or penalty and assessment is upheld.

R9-22-1110. Request for State Fair Hearing

A. To request a State Fair Hearing regarding a dispute for an penalty, assessment or an penalty and assessment, the provider or non-contracting provider shall file a written request for a State Fair Hearing with AHCCCS within 30 days from the date of the Notice of Intent under R9-22-1106 or within 30 days from the Notice of Compromise Decision under R9-22-1108, if applicable.

B. If the provider or non-contracting provider did not receive a timely written Notice of Compromise Decision from AHCCCS and the provider or non-contracting provider wishes to request a State Fair Hearing, the provider or non-contracting provider shall file a written request for a State Fair Hearing within 30 days after the date that the Notice of Compromise Decision should have been mailed.

C. AHCCCS shall mail a Notice of Hearing under A.R.S. § 41-1092.05 if AHCCCS receives a timely request for a State Fair Hearing from the provider or non-contracting provider.

D. AHCCCS shall mail a Director's Decision to the provider or non-contracting provider no later than 30 days after the date the Administrative Law Judge sends the Office of Administrative Hearings (OAH) decision to AHCCCS.

E. AHCCCS shall accept a written request for withdrawal if the written request for withdrawal is received from the provider or non-contracting provider before AHCCCS mails a Notice of Hearing under A.R.S. § 41-1092 et seq. If AHCCCS mailed a Notice of Hearing under A.R.S. § 41-1092 et seq., a provider or non-contracting provider shall send a written request for withdrawal to OAH.

R9-22-1111. Issues and Burden of Proof

A. Preponderance of Evidence. In any State Fair Hearing conducted under R9-22-1110, AHCCCS shall prove by a preponderance of the evidence that a provider or non-contracting provider who requested a State Fair Hearing presented or caused to be presented each claim in violation of this Article. A provider or non-contracting provider who requests a State Fair Hearing shall bear the burden of producing and proving by a preponderance of the evidence any circumstance that would justify reducing the amount of the penalty, assessment, or penalty and assessment.

B. Statistical sampling.

1. AHCCCS may introduce the results of a statistical sampling study as evidence of the number and amount of claims

that were presented or caused to be presented by the provider or non-contracting provider in meeting the burden of proof described in subsection (A). A statistical sampling study shall constitute prima facie evidence of the number and amount of claims, if based upon an appropriate sampling and computed by valid statistical methods.

2. The burden of proof shall shift to the provider or non-contracting provider to produce evidence reasonably calculated to rebut the findings of the statistical sampling study once AHCCCS has made a prima facie case as described in subsection (A). AHCCCS shall be given the opportunity to rebut this evidence.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ARIZONA LONG-TERM CARE SYSTEM

PREAMBLE

1. Sections Affected **Rulemaking Action**
R9-28-1001 Amend

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):
Authorizing statute: A.R.S. § 36-2932

Implementing statute: A.R.S. § 36-2957

3. A list of all previous notices appearing in the Register addressing the proposed rule:
Notice of Rulemaking Docket Opening: Volume 9 A.A.R. 2119, June 27, 2003

4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name:	Barbara Ledder
Address:	AHCCCS Office of Legal Assistance 701 E. Jefferson, Mail Drop 6200 Phoenix, AZ 85034
Telephone:	(602) 417-4580
Fax:	(602) 253-9115

5. An explanation of the rule, including the agency's reasons for initiating the rule:
AHCCCS made changes to 9 A.A.C. 28 to provide additional clarity and conciseness to existing rule language and to comply with the five-year review report made in January 2003.

6. A reference to any study relevant to the rule that the agency reviewed and either proposes to rely on or not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:
No studies were reviewed.

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:
Not applicable

8. The preliminary summary of the economic, small business, and consumer impact:
The contractors, members, providers, and AHCCCS are nominally impacted by the changes to the rule language. These rules define specific facets of Civil Monetary Penalties for the AHCCCS Arizona long-term care program. AHCCCS is amending these rules to make the rules more clear, concise, and understandable by grouping like concepts to provide clarity and conciseness to the rule language.

It is anticipated that the private sector, including small businesses or political subdivisions will not be impacted since the proposed rule language changes are intended to streamline and clarify the existing rules. AHCCCS, contractors, and providers will benefit because the changes provide clarification of the rule language.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name: Barbara Ledder

Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4580

Fax: (602) 253-9115

Proposed rule language will be available on the AHCCCS web site www.ahcccs.state.az.us the week of March 8, 2004, send written comments to the above address by 5:00 p.m., April 28, 2004.

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date: April 28, 2004

Time: 1:00 p.m.

Location: AHCCCS
701 East Jefferson
Phoenix, AZ 85034

Nature: Public Hearing

Date: April 28, 2004

Time: 1:00 p.m.

Location: ALTCS: Arizona Long-Term Care System
110 South Church, Suite 1360
Tucson, AZ 85701

Nature: Public Hearing

Date: April 28, 2004

Time: 1:00 p.m.

Location: ALTCS: Arizona Long-Term Care System
3480 East Route 66
Flagstaff, AZ 86004

Nature: Public Hearing

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

None

12. Incorporations by reference and their location in the rules:

None

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ARIZONA LONG-TERM CARE SYSTEM

ARTICLE 10. CIVIL MONETARY PENALITES AND ASSESSMENTS

Section
R9-28-1001. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims

ARTICLE 10. CIVIL MONETARY PENALTIES AND ASSESSMENTS

R9-28-1001. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims

~~The Director or designee shall impose a penalty and assessment under the circumstances described in A.R.S. § 36-2957. The Administration shall use the procedures detailed in 9 A.A.C. 22, Article 11 for the determination and collection of civil penalties and assessments.~~ AHCCCS shall use the provisions set forth in 9 A.A.C. 22, Article 11 for the determination and collection of penalties, assessments, or penalty and assessments.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM CHILDREN'S HEALTH INSURANCE PROGRAM

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-31-1101	Amend
R9-31-1102	Repeal
R9-31-1103	Repeal
R9-31-1104	Repeal

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statutes: A.R.S. §§ 36-2991 and 36-2993

Implementing statute: A.R.S. § 36-2991

3. A list of all previous notices appearing in the Register addressing the proposed rule:

Notice of Rulemaking Docket Opening: Volume 9 A.A.R. 2119, June 27, 2003

4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Barbara Ledder

Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4580

Fax: (602) 253-9115

5. An explanation of the rule, including the agency's reasons for initiating the rule:

AHCCCS made changes to 9 A.A.C. 31 to provide additional clarity and conciseness to existing rule language.

6. A reference to any study relevant to the rule that the agency reviewed and either proposes to rely on or not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

No studies were reviewed.

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

8. The preliminary summary of the economic, small business, and consumer impact:

The contractors, members, providers, and AHCCCS are nominally impacted by the changes to the rule language. These rules define specific facets of Civil Monetary Penalties for the AHCCCS KidsCare program. AHCCCS is amending these rules to make the rules more clear, concise, and understandable by grouping like concepts to provide clarity and conciseness to the rule language.

It is anticipated that the private sector, including small businesses or political subdivisions will not be impacted since the proposed rule language changes are intended to streamline and clarify the existing rules. AHCCCS, contractors and providers will benefit because the changes provide clarification of the rule language.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name: Barbara Ledder

Address: AHCCCS
Office of Legal Assistance
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034

Telephone: (602) 417-4580

Fax: (602) 253-9115

Proposed rule language will be available on the AHCCCS web site www.ahcccs.state.az.us the week of March 8, 2004, send written comments to the above address by 5:00 p.m., April 28, 2004.

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date: April 28, 2004
Time: 1:00 p.m.
Location: AHCCCS
701 East Jefferson
Phoenix, AZ 85034
Nature: Public Hearing

Date: April 28, 2004
Time: 1:00 p.m.
Location: ALTCS: Arizona Long-Term Care System
110 South Church, Suite 1360
Tucson, AZ 85701
Nature: Public Hearing

Date: April 28, 2004
Time: 1:00 p.m.
Location: ALTCS: Arizona Long-Term Care System
3480 East Route 66
Flagstaff, AZ 86004
Nature: Public Hearing

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

None

12. Incorporations by reference and their location in the rules:

None

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM CHILDREN'S HEALTH INSURANCE PROGRAM

ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS

Section
R9-31-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims
R9-31-1102. ~~Determinations Regarding the Amount of the Penalty and Assessment~~ Repealed
R9-31-1103. ~~Notice of Proposed Determination and Rights of Parties~~ Repealed
R9-31-1104. ~~Issues and Burden of Proof~~ Repealed

ARTICLE 11. CIVIL MONETARY PENALTIES AND ASSESSMENTS

R9-31-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims

~~**A.** Establishment and management of a system to prevent fraud. As specified in A.R.S. § 36-2986(A), the Director has full operational authority to adopt rules for the establishment and management of a system to prevent fraud by members, contractors, and health care providers.~~

~~**B.** Determination and collection of civil penalties. As specified in A.R.S. §§ 36-2991 and 36-2993 the Director may adopt rules that prescribe procedures for the determination and collection of civil penalties.~~

~~C.~~ ~~Federal fraud and abuse controls. As specified in A.R.S. § 36-2991, in addition to the requirements of state law, any applicable fraud and abuse controls that are enacted under federal law apply to a person who is eligible for services under this Chapter and to contractors and noncontracting providers who provide services under this Chapter.~~

~~D.~~ ~~Unpaid civil penalties. As specified in A.R.S. § 36-2991, if a civil penalty imposed according to this Article is not paid, the state may file an action to collect the civil penalty in the superior court in Maricopa county.~~

~~E.~~ ~~Circumstances for imposing a penalty and assessment. The Director or designee shall impose a penalty and assessment under the circumstances described in A.R.S. § 36-2991. For the purposes of this Article, the term "reason to know" means that a person, with respect to information, acts in deliberate ignorance of the truth or falsity of the information or with reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.~~

~~F.~~ ~~Violation of agreement. As specified in A.R.S. § 36-2992, the Director's or designee's determination of whether a person knew or had reason to know that each claim or request for payment was claimed in violation of an agreement with the Administration or a contractor may be based on the terms of the agreement.~~

AHCCCS shall use the provisions set forth in 9 A.A.C. 22, Article 11 for the determination and collection of penalties, assessments, or penalty and assessments.

R9-31-1102. ~~Determinations Regarding the Amount of the Penalty and Assessment~~ Repealed

~~A.~~ ~~Factors for determining a penalty and assessment. The Director or designee shall take into account the following factors in determining the amount of a penalty and assessment:~~

1. ~~The nature of each claim or request for payment and the circumstances under which it is presented,~~
2. ~~The degree of culpability of a person submitting each claim or request for payment,~~
3. ~~The history of prior offenses of a person submitting each claim or request for payment,~~
4. ~~The financial condition of a person presenting each claim or request for payment,~~
5. ~~The effect on patient care resulting from the failure to provide medically necessary care by a person submitting each claim or request for payment, and~~
6. ~~Other matters as justice may require.~~

~~B.~~ ~~Types of claim circumstances. As specified in A.R.S. § 36-2991, in determining the amount of a penalty and assessment, the Director or designee shall consider both mitigating circumstances and aggravating circumstances surrounding submission of each claim or request for payment.~~

~~C.~~ ~~Mitigating circumstance guidelines. The Director or designee shall consider the following mitigating circumstance guidelines when determining the amount of a penalty and assessment:~~

1. ~~Nature and circumstances of each claim or request for payment. The nature and circumstances of each claim or request for payment and the circumstances under which it is presented are a mitigating circumstance if:~~
   a. ~~All the items and services subject to a penalty and assessment are of the same type,~~
   b. ~~All the items and services subject to a penalty and assessment occurred within a short period of time,~~
   c. ~~There are few items and services, and~~
   d. ~~The total amount claimed for the items and services was less than $1,000.~~
2. ~~Degree of culpability. The degree of culpability of a person submitting a claim or request for payment is a mitigating circumstance if:~~
   a. ~~Each item or service is the result of an unintentional and unrecognized error in the process the person followed in presenting the item or service,~~
   b. ~~Corrective steps were taken promptly after the error was discovered, and~~
   c. ~~A fraud and abuse control plan was adopted and operating effectively at the time each claim or request for payment was submitted.~~
3. ~~Financial condition. The financial condition of a person presenting a claim or request for payment is a mitigating circumstance if the imposition of a penalty and assessment without reduction will jeopardize the ability of the person to continue as a health care provider. The resources available to the person may be considered when determining the amount of the penalty and assessment; or~~
4. ~~Other matters as justice may require. Other circumstances of a mitigating nature will be taken into account if, in the interest of justice, the circumstances require a reduction of the penalty and assessment.~~

~~D.~~ ~~Aggravating circumstance guidelines. The Director or designee shall consider the following aggravating circumstance guidelines when determining the amount of a penalty and assessment:~~

1. ~~Nature and circumstances of each claim or request for payment. The nature and circumstances of each claim or request for payment and the circumstances under which it is presented are an aggravating circumstance if:~~
   a. ~~The items and services subject to a penalty and assessment are of several types,~~
   b. ~~The items and services subject to a penalty and assessment occurred over a lengthy period of time,~~
   c. ~~There are many items or services (or the nature and circumstances indicate a pattern of claims for the items or services), or~~
   d. ~~The total amount claimed for the items and services is $1,000 or greater.~~
2. ~~Degree of culpability. The degree of culpability of a person submitting each claim or request for payment is an aggra-~~

~~vating circumstance if:~~
~~a. The person knew that each item or service was not provided as claimed;~~
~~b. The person knew that no payment could be made because the person had been excluded from system reimbursement; or~~
~~c. Payment would violate the terms of an agreement between the person and the state, the Administration or a contractor.~~
~~3. Prior offenses. The prior offenses of a person submitting each claim or request for payment is an aggravating circumstance if, at any time before the presentation of any claim or request for payment subject to a penalty and assessment under this Article, the person was held liable for a criminal, civil, or administrative sanction in connection with:~~
~~a. A Medicaid program,~~
~~b. A Medicare program,~~
~~c. A Title XXI program, or~~
~~d. Any other public or private program of reimbursement for medical services.~~
~~4. Effect on patient care. The seriousness of an adverse effect that resulted, or could have resulted, from the failure of a person submitting a claim or request for payment to provide medically necessary care is an aggravating circumstance; or~~
~~5. Other matters as justice may require. Other circumstances of an aggravating nature shall be taken into account if, in the interest of justice, the circumstances require an increase of the penalty and assessment.~~
~~**E.** Amount of penalty and assessment. As specified in A.R.S. § 36-2993 and this Article, the aggregate amount of a penalty and assessment shall never be less than double the approximate amount of damages sustained by the state, the Administration or contractor, unless there are extraordinary mitigating circumstances.~~
~~**F.** Compromise. The Director or designee may compromise a penalty and assessment using the guidelines in subsections (C) and (D).~~

R9-31-1103. ~~Notice of Proposed Determination and Rights of Parties~~ Repealed

~~**A.** Administration's responsibilities. If the Director or designee proposes to impose a penalty and assessment, the Director or designee shall deliver or send by certified mail, return receipt requested, to a person, written notice of intent to impose a penalty and assessment. The notice shall include:~~
~~1. Reference to the statutory basis for the penalty and assessment,~~
~~2. A description of each claim or request for payment for which the penalty and assessment are proposed,~~
~~3. The reason why each claim or request for payment subjects the person to a penalty and assessment, and~~
~~4. The amount of the proposed penalty and assessment.~~
~~**B.** Individual's responsibilities. A person may submit within 35 days from the date of the adverse action:~~
~~1. A written statement accepting imposition of the penalty and assessment,~~
~~2. As specified in A.R.S. § 36-2993 a written request for a compromise of the penalty and assessment stating any reasons that the person contends should result in a reduction or modification of the penalty and assessment. If a request is submitted, the time period for filing an appeal and request for hearing according to subsection (C) shall be tolled until the Director's or designee's decision on the request for compromise, or~~
~~3. A grievance in accordance with the provider grievance provision in 9 A.A.C. 31, Article 8 of this Chapter.~~
~~**C.** The Director or designee may impose a proposed penalty and assessment or any less severe penalty and assessment if a person does not request a hearing within the time prescribed by subsections (B)(2) or (3). A person has no right to appeal a penalty and assessment if the person has not timely requested a hearing.~~

R9-31-1104. ~~Issues and Burden of Proof~~ Repealed

~~**A.** Preponderance of evidence. In any hearing conducted according to this Article, the Director or designee shall prove by a preponderance of the evidence that a person who requested a hearing presented or caused to be presented each claim or request for payment in violation of R9-31-1101. A person who requests a hearing shall bear the burden of producing and proving by a preponderance of the evidence any circumstance that would justify reducing the amount of the penalty and assessment.~~
~~**B.** Statistical sampling.~~
~~1. The Director or designee may introduce the results of a statistical sampling study as evidence of the number and amount of claims or requests for payment that were presented or caused to be presented by the person in meeting the burden of proof described in subsection (A). A statistical sampling study shall constitute prima facie evidence of the number and amount of claims or requests for payment, if based upon an appropriate sampling and computed by valid statistical methods.~~
~~2. The burden of proof shall shift to the person to produce evidence reasonably calculated to rebut the findings of the statistical sampling study once the Director or designee has made a prima facie case as described in subsection (A). The Director or designee will be given the opportunity to rebut this evidence.~~

NOTICE OF PROPOSED RULEMAKING

TITLE 15. REVENUE

CHAPTER 5. DEPARTMENT OF REVENUE
TRANSACTION PRIVILEGE AND USE TAX SECTION

PREAMBLE

1. Sections Affected **Rulemaking Action**

R15-5-617 Repeal

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. § 42-1005

Implementing statute: A.R.S. § 42-5075

3. A list of all previous notices appearing in the Register addressing the proposed rules:

Notice of Rulemaking Docket Opening: 10 A.A.R. 1166, March 26, 2004 (in this issue)

4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Hsin Pai, Tax Analyst

Address: Tax Policy and Research Division
Arizona Department of Revenue
1600 W. Monroe, Room 810
Phoenix, AZ 85007

Telephone: (602) 716-6851

Fax: (602) 716-7995

E-mail: paih@revenue.state.az.us

Please visit the ADOR Web site to track the progress of these rules and other agency rulemaking matters at www.revenue.state.az.us/tra/draftdoc.htm.

5. An explanation of the rules, including the agency's reasons for initiating the rule:

Currently, R15-5-617: (a) discusses the two ways that contractors must report ("progressive billing" or "cash receipts"), (b) states that unused portions of allowable deductions may be carried forward to succeeding months, and (c) provides that home builders must report the total selling price as income "at the time of closing of escrow or transfer of title." Deductions related to the income from the selling price cannot be taken before the time it is reported.

The rule contains redundant, erroneous, and misleading information that warrants repeal rulemaking action. R15-5-617(A)'s statement that contractors must report on a progressive billing (work-in-progress, which is subsumed by the accrual method) or cash receipts basis is already apparent from R15-5-2211, which applies to administration of all transaction privilege tax classifications. The statement as it exists in R15-5-617(A) is thus redundant and even confusing due to the lack of definitions for "progressive billing" and "cash receipts."

In allowing a taxpayer to carry forward unused portions of allowable deductions to succeeding months, R15-5-617(B) is incorrect because a deduction arises from and operates on the gross proceeds or gross income of an individual transaction. It is thus illogical to allow a deduction to be applied or "carried forward" to a different transaction that occurs at a different point in time.

Finally, R15-5-617(C)'s statement that home builders "shall report as income the total selling price at the time of closing of escrow or transfer of title" is misleading because it assumes that the taxpayer is a party to the close of escrow or transfer of title. If the taxpayer receives its income from the selling price before the close of escrow, it is due and payable at that earlier date. The rule is misleading because it allows all taxpayers to delay reporting of transaction privilege tax until the time of a project's completion.

6. A reference to any study relevant to the rules that the agency reviewed and either proposes to rely on or not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

None

7. A showing of good cause why the rules are necessary to promote a statewide interest if the rules will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

8. The preliminary summary of the economic, small business, and consumer impact:

There should not be any significant economic impact as a result of repealing the rule. Because the repeal eliminates provisions that are misleading or incorrect, a minimal impact may occur for certain contractors due to increased compliance measures. The agency expects that the benefits of the repeal to the public and the agency from achieving a better understanding of reporting obligations will be greater than the costs.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name:	Hsin Pai, Tax Analyst
Address:	Tax Policy and Research Division Arizona Department of Revenue 1600 W. Monroe, Room 810 Phoenix, AZ 85007
Telephone:	(602) 716-6851
Fax:	(602) 716-7995
E-mail:	paih@revenue.state.az.us

10. The time, place, and nature of the proceedings for the adoption, amendment, or repeal of the rule or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rules:

An oral proceeding on the proposed rulemaking is scheduled as follows:

Date:	Monday, April 26, 2004
Time:	9:00 a.m.
Location:	Arizona Department of Revenue, North Valley Office Conference Room One 2902 W. Agua Fria Freeway Phoenix, AZ 85027

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

None

12. Incorporations by reference and their location in the rules:

None

13. The full text of the rules follows:

TITLE 15. REVENUE

CHAPTER 5. DEPARTMENT OF REVENUE
TRANSACTION PRIVILEGE AND USE TAX SECTION

ARTICLE 6. PRIME CONTRACTING CLASSIFICATION

Section
R15-5-617. ~~Basis of reporting~~ Repealed

ARTICLE 6. PRIME CONTRACTING CLASSIFICATION

R15-5-617. ~~Basis of reporting~~ Repealed

~~**A.** Contractors shall report on a progressive billing basis or cash receipts basis.~~

~~**B.** Unused portions of allowable deductions may be carried forward to succeeding months.~~

~~**C.** Home builders, speculative or otherwise, shall report as income the total selling price at the time of closing of escrow or transfer of title. Deductions pertaining to this income may not be taken prior to the time the gross income is reported.~~

NOTICE OF PROPOSED RULEMAKING

TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

PREAMBLE

1. Sections Affected	Rulemaking Action
R20-6-1001	Amend
R20-6-1002	Amend
R20-6-1003	Amend
R20-6-1004	Amend
R20-6-1005	Renumber
R20-6-1005	New Section
R20-6-1006	Renumber
R20-6-1006	Amend
R20-6-1007	Renumber
R20-6-1007	Amend
R20-6-1008	Renumber
R20-6-1008	New Section
R20-6-1009	Renumber
R20-6-1009	New Section
R20-6-1010	Renumber
R20-6-1010	Amend
R20-6-1011	Renumber
R20-6-1011	Amend
R20-6-1012	Renumber
R20-6-1012	Amend
R20-6-1013	Renumber
R20-6-1013	Amend
R20-6-1014	Repeal
R20-6-1014	Renumber
R20-6-1014	Amend
R20-6-1015	Renumber
R20-6-1015	New Section
R20-6-1016	Renumber
R20-6-1016	Amend
R20-6-1017	Renumber
R20-6-1017	Amend
R20-6-1018	New Section
R20-6-1019	New Section
R20-6-1020	New Section
R20-6-1021	New Section
R20-6-1022	Renumber
R20-6-1022	Amend
R20-6-1023	Renumber
R20-6-1023	Amend
R20-6-1024	New Section
Appendix A	Renumber
Appendix A	New Appendix
Appendix B	Renumber
Appendix B	New Appendix
Appendix C	Renumber
Appendix C	Amend
Appendix D	Renumber
Appendix D	Amend
Appendix E	New Appendix
Appendix F	New Appendix
Appendix G	New Appendix
Appendix H	New Appendix
Appendix I	New Appendix
Appendix J	Renumber
Appendix J	Amend

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statutes: A.R.S. §§ 20-143, 20-1691.02

Implementing statutes: A.R.S. §§ 20-143, 20-1691.01, 20-1691.04, 20-1691.06, 20-1691.11

3. List all previous notices appearing in the register addressing the proposed rules:

Notice of Rulemaking Docket Opening: 10 A.A.R. 323, January 23, 2004

4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Margaret McClelland

Address: Arizona Department of Insurance
2910 North 44th Street, Second Floor
Phoenix, AZ 85018

Telephone: (602) 912-8456

Fax: (602) 912-8452

5. An explanation of the rule, including the agency's reasons for initiating the rule:

This rule carries out the mandates of Laws 2003, Ch. 133, which became effective on September 18, 2003 and amended the Arizona long-term care insurance statutes for closer conformity with the National Association of Insurance Commissioners' (NAIC) Long-Term Care (LTC) Insurance Model Act. The NAIC LTC insurance model regulation is already in effect in a number of states and this rulemaking will result in greater uniformity for insurers that operate in other states and may obviate the need to re-file and seek approval for forms used after these rules become effective in Arizona.

Specific Section-by-Section Explanation of This Proposal

R20-6-1001 establishes applicability and scope of this Article.

R20-6-1002 establishes definitions for terms used in this Article.

R20-6-1003 establishes terms and definitions to be used in a long-term care policy.

R20-6-1004 sets forth required policy provisions for renewability, limitations and exclusions, extension of benefits, continuation or conversion, discontinuance and replacement, premium increases, electronic enrollment, minimum standards for home health benefits, and appeals.

R20-6-1005 sets forth requirements for designating a person to receive notice of lapse and termination of a long-term care insurance policy.

R20-6-1006 sets forth requirements for the insurer to offer long-term care insurance inflation protection.

R20-6-1007 sets forth requirements for disclosure provisions regarding riders and endorsements, payment of benefits, tax consequences, benefit triggers, and qualified long-term care insurance contracts.

R20-6-1008 sets for the requirements for disclosure of rating practices to consumers.

R20-6-1009 sets forth requirements for insurers making initial filings.

R20-6-1010 sets forth requirements for an insurers application form for a long-term care insurance policy and replacement coverage.

R20-6-1011 sets for the prohibition against post-claims underwriting.

R20-6-1012 sets forth some of the discretionary powers of the director to modify or suspend provisions of this Article regarding a specific long-term care insurance policy or certificate.

R20-6-1013 contains requirements for policy reserves for long-term care benefits.

R20-6-1014 contains requirements for loss ratios for policies and certificates issued up to 120 days after this Section becomes effective.

R20-6-1015 contains requirements for premium rate schedule increases for individual long-term care policies or certificates.

R20-6-1016 sets forth filing requirements for out of state group insurance policies.

R20-6-1017 sets forth requirements for marketing long-term care insurance in the state.

R20-6-1018 sets forth requirements for developing and using suitability requirements to determine whether an applicant meets the suitability requirements.

R20-6-1019 sets forth requirements for offering a nonforfeiture benefit.

R20-6-1020 sets forth requirements for determining conditions for payment of benefits.

R20-6-1021 sets forth additional requirements for benefit triggers for qualified long-term care insurance contracts.

R20-6-1022 sets forth the standard format for the outline of coverage.

R20-6-1023 contains requirements for delivery of a shoppers guide approved by the director to prospective applicants.

R20-6-1024 clarifies applicability of the "Drafting Instruction" appendices.

Appendix A is the Long-term care Insurance Personal Worksheet.

Appendix B contains information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Appendix C is the notice to an applicant regarding replacement of individual health or long-term care insurance.

Appendix D is the notice to an applicant regarding replacement of health or long-term care insurance.

Appendix E is the long-term care insurance replacement and lapse reporting form.

Appendix F is the claims denial reporting form for long-term care insurance.

Appendix G is the rescission reporting form for long-term care policies.

Appendix H lists things a prospective purchaser should know before purchasing long-term care insurance.

Appendix I is the form for the long-term care insurance suitability letter.

Appendix J is the form the insurer must use to outline coverage under the policy.

6. A reference to any study relevant to the rule that the agency reviewed and either proposes to rely on or not rely on in its evaluation of or justification for the rule, where the public may obtain or review the study, all data underlying each study, any analysis of each or study and other supporting material:

None

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

8. The preliminary summary of the economic, small business and consumer impact:

Long-term care insurers will have some increased disclosure requirements under these rules. As a result, the insurers may have to produce disclosure documents that they do not currently produce and may incur additional costs for printing, copying and mailing. The economic impact per policyholder will likely be insignificant, and the overall economic impact as a result of this rulemaking should be minimal to moderate. Additionally, under these rules, insurers will have to provide more information to justify rate increases. This could result in less frequent rate increases.

The consumers involved are consumers of long-term care insurance. Policyholders may have somewhat higher rates initially, but, as a result of these rules, rates for long-term care insurance should stabilize with a resulting cost savings over the life of the policy. The rules will provide protections to the consumer through better disclosure of information about the insurer and enhanced suitability requirements. Consumers will have an unquantifiable benefit of being more aware of what they are purchasing, making them better able to make decisions about their purchase and making them better protected consumers.

Few small businesses will be directly impacted by this rule. The insurers that offer long-term care insurance are large corporations that can absorb the costs of paying out long-term care benefits. There may be some small business who might benefit from additional printing and copying opportunities, but is it possible that many insurers will print and copy in-house. Some consulting actuarial businesses may receive additional business as a result of these rules.

The Department has not identified small businesses that will be directly impacted by this rule, therefore, the Department does not believe it is necessary to reduce the impact on small businesses.

There will be a minimal economic impact on the Department, the Secretary of State and the Governor's Regulatory Review Council for costs associated with the rulemaking process.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name: Margaret McClelland

Address: Arizona Department of Insurance
2910 North 44th Street, Second Floor
Phoenix, AZ 85018

Telephone: (602) 912-8456

Fax: (602) 912-8452

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

ADOI will hold an oral proceeding to receive public comments in accordance with A.R.S. § 41-1023 on Wednesday, May 5, 2004 at 10:00 a.m. at the Arizona Department of Insurance, 2910 North 44th Street, Phoenix Arizona, 3rd floor training room. ADOI will accept written comments that are received by 5:00 p.m. on, Friday, May 7, 2004 or which are postmarked by that date. The comment period will end and the record will close at 5:00 p.m. on Friday May 7, 2004.

ADOI is committed to complying with the Americans with Disabilities Act. If any individual with a disability needs any type of accommodation, please contact ADOI at least 72 hours before the hearing.

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

12. Incorporations by reference and their location in the rule:

Not applicable

13. The full text of the rules follows:

TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

ARTICLE 10. LONG-TERM CARE INSURANCE

Section
R20-6-1001. Applicability and Scope
R20-6-1002. Definitions
R20-6-1003. Policy ~~Definitions~~ Terms
R20-6-1004. Required Policy Provisions ~~and Practices: Renewability; Exclusions and Limitations; Extension of Benefits Continuation or Conversion; Discontinuance and Replacement; Home Health Care~~
R20-6-1005. Unintentional Lapse
~~R20-6-1005.~~R20-6-1006. Inflation Protection
~~R20-6-1006.~~R20-6-1007. Required Disclosure Provisions
R20-6-1008. Required Disclosure of Rating Practices to Consumers
R20-6-1009. Initial Filing Requirements
~~R20-6-1007.~~R20-6-1010. Requirements for Application Forms and Replacement Coverage
~~R20-6-1008.~~R20-6-1011. Prohibition Against Post-claims Underwriting
~~R20-6-1009.~~R20-6-1012. Discretionary Powers of Director
~~R20-6-1010.~~R20-6-1013. Reserve Standards
~~R20-6-1014. Filing Requirements for Advertising~~
~~R20-6-1011.~~R20-6-1014. Loss Ratio
R20-6-1015. Premium Rate Schedule Increase
~~R20-6-1012.~~R20-6-1016. Filing ~~Requirement~~ Requirements for Group ~~Policy~~ Policies ~~Issued in Another State~~
~~R20-6-1013.~~R20-6-1017. Standards for Marketing
R20-6-1018. Suitability
R20-6-1019. Nonforfeiture Benefit Requirement
R20-6-1020. Standards for Benefit Triggers
R20-6-1021. Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts
~~R20-6-1015.~~R20-6-1022. Standard Format Outline of Coverage
~~R20-6-1016.~~R20-6-1023. Requirement to Deliver Shopper's Guide
R20-6-1024. Instructions for Appendices
Appendix A. Long-Term Care Insurance Personal Worksheet
Appendix B. Long-Term Care Insurance Potential Rate Increase Disclosure Form
~~Appendix A.~~Appendix C. Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-term Care Insurance
~~Appendix B.~~Appendix D. Notice to Applicant Regarding Replacement of Accident and Sickness or Long-term Care Insurance
Appendix E. Replacement and Lapse Reporting Form
Appendix F. Claims Denial Reporting Form

Appendix G. Rescission Reporting Form for Long-Term Care Policies
Appendix H. Things You Should Know Before You Buy Long-Term Care Insurance
Appendix I. Long-Term Care Insurance Suitability Letter
~~Appendix C.~~Appendix J. Long-term Care Insurance Outline of Coverage

ARTICLE 10. LONG-TERM CARE INSURANCE

R20-6-1001. Applicability and Scope
Except as otherwise specifically provided, this Article applies to all long-term care insurance policies delivered or issued for delivery in this state on or after the effective date ~~hereof~~ of this Article. ~~by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health care services organizations and all similar organizations.~~

R20-6-1002. Definitions
~~**A.** For purposes of~~ The definitions in A.R.S. § 20-1691 and the following definitions apply in this Article~~, the terms "long-term care insurance", "group long-term care insurance", "director", "applicant", "policy" and "certificate" shall have the meanings as set forth in A.R.S. § 20-1691~~.

A. "Incidental" means that the value of the long-term care benefits provided is less than 10% of the total value of the benefits provided over the life of the policy, with value measured as of the date of issue.

B. "Long-term care benefit classification" means one of the following:
1. Institutional long-term care – benefits only;
2. Non-institutional long-term care – benefits only; or
3. Comprehensive long-term care benefits.

~~**B.**~~**C.**~~A~~ "~~managed~~ Managed care plan" ~~is~~ means a health care or assisted living agreement designed to coordinate patient care or control costs through utilization review, case management, ~~or~~ use of specific provider networks, or some combination of these methods.

D. "Personal information" has the same meaning prescribed in A.R.S. § 20-2102(18).

E. "Privileged information" has the same meaning prescribed in A.R.S. § 20-2102(21).

F. "Qualified actuary" means a member in good standing of the American Academy of Actuaries.

G. "Similar policy forms" means all long-term care insurance policies and certificates that are issued by a particular insurer and that have the same long-term care benefit classification as a policy form being reviewed.

R20-6-1003. Policy ~~Definitions~~ Terms
A. No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:
1. "Activities of daily living" means eating, toileting, transferring, bathing, dressing, or continence.
~~1.~~2. "Acute condition" means that ~~the~~ an individual is medically unstable~~. Such an individual~~ and requires frequent monitoring by medical professionals, such as physicians and registered nurses, ~~in order~~ to maintain ~~his or her~~ the individual's health status.
3. "Adult day care" means a program of social and health related services for six or more individuals, that is 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 the services and care in a setting outside the home.
4. "Bathing" means washing oneself by sponge bath, or in a shower or tub, and includes the act of getting in and out of the tub or shower.
5. "Cognitive impairment' means a deficiency in a person's:
   a. Short or long-term memory;
   b. Orientation as to person, place, or time;
   c. Deductive or abstract reasoning; or
   d. Judgment as it relates to safety awareness.
6. "Continence" means the ability to maintain control of bowel and bladder function, or when unable to maintain control, the ability to perform associated personal hygiene, such as caring for a catheter or colostomy bag.
7. "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
8. "Eating" means feeding oneself by getting food into the body from a receptacle such as a plate or cup, or by a feeding tube or intravenously.
~~2.~~9. "Guaranteed renewable" means the insured has the right to continue ~~the~~ a 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 the insurer may revise rates ~~may be revised by the insurer~~ on a class basis.
10. "Hands-on assistance" means physical help to an individual who could not perform a particular activity without help

from another individual, and includes minimal, moderate, or maximal help.

~~3.~~11. "Home health services" means ~~those~~ the services described A.R.S. § 36-151.

12. "Level premium" means that an insurer does not have any right to change the premium, even at renewal.

~~4.~~13. "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.

~~5. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.~~

~~6.~~14. "Noncancellable" means 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.

15. "Personal care" means the provision of hands-on assistance to help an individual with activities of daily living and shall be defined in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.

16. "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing tasks associated with personal hygiene.

17. "Transferring" means moving into or out of a bed, chair, or wheelchair.

B. Any long-term care policy delivered or issued for delivery in this state shall include the following policy terms and provisions as specified in this subsection:

1. "Home care" shall be defined in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.
2. "Intermediate care" shall be defined in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.
3. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.
4. "Skilled nursing care," ~~"intermediate care," "personal care," "home care," and other services~~ shall be defined in relation to the level of skill required, the nature of the care and the setting in which care is delivered.

~~**C.**~~ 5. ~~All~~ Service providers ~~of services~~, including ~~but not limited to~~ "skilled nursing facility," "extended care facility," "intermediate care facility" "convalescent nursing home," "personal care facility," and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services~~. The definition~~ and may require that the provider be appropriately licensed or certified.

R20-6-1004. Required Policy Provisions ~~and Practices: Renewability; Exclusions and Limitations; Extension of Benefits; Continuation or Conversion; Discontinuance and Replacement; Home Health Care~~

A. Renewability ~~provisions.~~

1. An individual ~~Individual~~ long-term care insurance ~~policies~~ policy shall contain a renewability provision~~. No policy issued to an individual shall contain renewal provisions other than~~ which shall be either "guaranteed renewable" or "noncancellable." ~~Such~~ The renewability provision shall be appropriately captioned, shall appear on the first page of the policy, and shall ~~clearly~~ state ~~the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed~~ that the coverage is guaranteed renewable or noncancellable.

   This requirement ~~shall~~ does not apply to ~~those~~ a long-term care insurance ~~policies which are~~ policy that is part of or combined with a life insurance ~~policies which do~~ policy that does not contain a renewability provision and ~~under~~ which reserves the right not to renew ~~is reserved~~ solely to the policyholder.
2. An insurer shall not use the ~~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 this Article.
3. A qualified long-term care insurance policy shall have the guaranteed renewability provisions specified in Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986.
4. A long-term care insurance policy or certificate shall include a statement that premium rates are subject to change, unless the policy does not afford the insurer the right to raise premiums.

B. Limitations and Exclusions.

1. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."
2. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility ~~other than those~~ not prohibited by A.R.S. §§ ~~20-1691.02 and~~ 20-1691.03 and 20-1691.05 shall ~~set forth a description of such~~

describe 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~~ the paragraph "Limitations or Conditions on Eligibility for Benefits."

3. No policy may be delivered or issued for delivery in this state as long-term care insurance if ~~such~~ the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:
   a. Preexisting conditions or disease;
   b. Mental or nervous disorders; however, this shall not permit exclusion or limitation of the benefits on the basis of Alzheimer's Disease;
   c. Alcoholism and drug addiction;
   d. Illness, treatment or medical condition arising out of:
      i. War, declared or undeclared, or act of war;
      ii. Participation in a felony, riot or insurrection~~.~~**;**
      iii. Service in the armed forces or auxiliary units ~~auxiliary thereto~~;
      iv. Suicide, attempted suicide, or intentionally self-inflicted injury; or
      v. Aviation, if non-fare-paying passenger.
   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 policy, 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.
   ~~f.~~h. Subsection (B)(2) ~~of this rule is not intended to~~ does not prohibit exclusions and limitations by type of provider or territorial limitations.

C. Extension of benefits.

A ~~Long-term~~ long-term care insurance ~~policies~~ policy shall provide that termination of long-term care insurance ~~shall be~~ is without prejudice to any benefits payable for institutionalization if ~~such~~ the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. An insurer may limit this ~~Such~~ 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~~ The insurer may still apply any policy waiting period and all other applicable provisions of the policy.

D. Reinstatement.

A long-term care insurance policy shall include a provision for reinstatement of coverage if a lapse occurs if the insurer receives proof that the insured was cognitively impaired or had a loss of functional capacity before expiration of the grace period in the policy. The option to reinstate shall be available to the insured for at least five months after the date of termination and shall allow for the collection of past due premium, as appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria for these conditions as set forth in the policy.

~~**D.**~~**E.** Continuation or conversion ~~provisions~~.

1. A group ~~Group~~ long-term care insurance policy ~~issued in this state on or after the effective date of this Section~~ shall provide covered individuals with a basis for continuation or conversion of coverage as specified in this subsection.
2. ~~A~~ The policy ~~providing a basis for continuation of coverage~~ shall include a ~~policy~~ provision ~~which~~ that maintains coverage under the existing group policy when ~~such~~ the coverage would otherwise terminate, ~~and which is~~ subject only to the continued timely payment of premium when due. ~~Group policies which restrict~~ A group policy that restricts provision of benefits and services to, or ~~contain~~ has incentives to use certain providers ~~and/or~~ or facilities, may provide continuation benefits ~~which~~ that are substantially equivalent to the benefits of the existing group policy. The Director shall make a determination as to the substantial equivalency of benefits and, in doing so, shall take into consideration the differences between managed care and non-managed care plans, including~~, but not limited to,~~ provider system arrangements, service availability, benefit levels and administrative complexity.
3. ~~A~~ The policy ~~providing a basis for conversion of coverage~~ shall include a ~~policy~~ provision that an individual, whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuation of the group policy in its entirety or with respect to an insured class, who has been insured under the group policy (and any group policy which it replaced), ~~shall be~~ is entitled to the issuance of a converted policy by the insurer under whose group policy ~~he or she~~ the individual is covered, without evidence of insurability.

~~a.~~4. A converted policy shall be an individual policy of long-term care insurance providing benefits identical to or benefits determined by the Director to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of bene-

fits and services to, or contains incentives to use certain providers ~~and/or~~ or facilities, the Director, 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 but not limited to,~~ provider system arrangements, service availability, benefit levels and administrative complexity, and other plan elements.

~~b.~~5. An insurer may require an individual seeking a conversion policy to make a written ~~Written~~ application for the converted policy ~~shall be made~~ and pay 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 insurer shall issue the converted policy ~~shall be issued~~ effective on the day following the termination of coverage under the group policy. The converted policy ~~and~~ shall be renewable annually.

~~c.~~6. Unless the group policy from which conversion is made replaced previous group coverage, the insurer shall calculate the premium for the converted policy ~~shall be calculated~~ on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. ~~Where~~ If 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 at inception of coverage under the group policy replaced.

~~4.~~7. An insurer is required to provide continuation ~~Continuation~~ of coverage or issuance of a converted policy ~~shall be mandatory, except where~~ as provided in this subsection, unless:

a. Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

b. The terminating coverage is replaced not later than 31 days after termination, by group coverage that

i. Is effective on the day following the termination of coverage:

~~i.~~ii. ~~Providing~~ Provides benefits identical to or benefits determined by the Director to be substantially equivalent to or in excess of those provided by the terminating coverage; and

~~ii.~~iii. ~~The~~ Has a premium ~~for which is~~ calculated in a manner consistent with the requirements of ~~paragraph (D)(3)(c) of this Section~~ subsection (E)(6).

~~5.~~8. Notwithstanding any other provision of this Section, a converted policy that is issued to an individual who at the time of conversion is covered by another long-term care insurance policy ~~which provides~~ providing benefits on the basis of incurred expenses, may contain a provision ~~which results in a reduction of~~ that reduces 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% of incurred expenses. ~~Such~~ An insurer may include this provision ~~shall only be included~~ in the converted policy only if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

~~6.~~9. 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 remained in force and effect.

~~7.~~10. Notwithstanding any other provision of this Section, any insured individual whose eligibility for group long-term care coverage is based upon ~~his or her~~ the individual's relationship to another person, ~~shall be~~ is entitled to continuation of coverage under the group policy ~~upon termination of~~ if the qualifying relationship terminates by death or dissolution of marriage.

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

1. Shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and
2. Shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.

G. Premium Increases

1. An insurer shall not increase the premium charged to an insured because of:
   a. The insured aging beyond age 65 or older; or
   b. The duration of coverage under the policy.
2. Purchase of additional coverage is not considered a premium rate increase, however, for the calculation required under R20-6-1019, an insurer shall add to and consider the portion of the premium attributable to the additional coverage as part of the initial annual premium.
3. A reduction in benefits is not considered a premium change, however, for the calculation required under R20-6-1019, an insurer shall base the initial annual premium on the reduced benefits.

H. Electronic enrollment for group policies

1. For coverage offered to a group as defined in A.R.S. § 20-1691(5)(a), any requirement that an insurer or producer obtain an insured's signature is satisfied if:
   a. The group policyholder or insurer obtains the insured's consent by telephonic or electronic enrollment, and pro-

vides the enrollee with verification of enrollment information within three business days of enrollment; and

b. The telephonic or electronic enrollment process has safeguards to assure the accuracy, retention, and prompt retrieval of records, and the confidentiality of personal and privileged information.

2. If the Director so requests, the insurer shall make available records showing the insurer's ability to confirm enrollment and coverage amounts.

~~F.~~**I.** Minimum standards for home health care benefits

1. ~~A~~ If a long-term care insurance policy or certificate ~~may not, if it~~ provides benefits for home-health services, the policy shall not limit or exclude benefits by any of the following:
   a. ~~By requiring~~ Requiring that the insured~~/claimant~~ would need skilled care in a skilled nursing facility if home health services were not provided;
   b. ~~By requiring~~ Requiring that the insured~~/claimant~~ first or simultaneously receive nursing ~~and/or~~ or therapeutic services in a home or community setting before home health services are covered;
   c. ~~By limiting~~ Requiring eligible services to services provided by registered nurses or licensed practical nurses;
   d. ~~By requiring~~ Requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide or other licensed or certified home care worker acting within the scope of his or her licensure or certification~~.~~;
   e. ~~By requiring~~ Requiring that the insured~~/claimant~~ have an acute condition before home health services are covered;
   f. ~~By limiting~~ Requiring benefits to services provided by Medicare-certified agencies or providers~~.~~;
   g. Excluding coverage for personal care services provided by a home health aid;
   h. Requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service; or
   i. Excluding coverage for adult day care services.
2. An insurer may apply home ~~Home~~ health care coverage ~~may be applied~~ to ~~the~~ non-home health care benefits ~~provided~~ in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

J. Appeals. A policy shall include a clear description of the process for appealing and resolving benefit determinations.

R20-6-1005. Unintentional Lapse

A. An insured may designate at least one person to receive notice of lapse and termination of a long-term care insurance policy for nonpayment of premium, in addition to the insured. Designation shall not constitute acceptance of any liability by the third party notice recipient for services provided to the insured.

B. An insurer shall not issue a long-term care insurance policy until the applicant has provided either a written designation of at least one person, in addition to the applicant, who shall receive notice of lapse or termination, with the person's full name and home address, or the applicant's written waiver, dated and signed, indicating that the applicant chooses not to designate a notice recipient.

C. The form used for written designation or waiver shall provide space clearly delineated for the designation. The form shall include the following language for waiver of the right to name a designated recipient: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that this notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

D. At least once every two years, an insurer shall notify the insured of the right to change the designation. An insured may add a designated recipient or change a designated recipient at any time by notifying the insurer in writing, and providing the name and home address for the new designated recipient.

E. When the insured pays premium for the long-term care insurance policy through a payroll or pension deduction plan, an insurer is not required to comply with the requirements in subsections (A) through (D) until 60 days after the insured is no longer on the payment plan.

F. An individual long-term care insurance policy shall not lapse or be terminated for nonpayment of premium unless the insurer gives the insured and any recipient designated under subsections (A) through (D) written notice at least 30 days before the effective date of termination or lapse, by first class mail, postage prepaid. An insurer may not give notice until 30 days after the date on which a premium is due and unpaid. Notice is deemed given five days after the date of mailing.

~~R20-6-1005.~~R20-6-1006. Inflation Protection

A. ~~No~~ An insurer ~~may~~ shall not offer a long-term care insurance policy unless the insurer offers, at the time of purchase, in addition to any other inflation protection, the option to purchase a policy with an inflation protection provision to address the reduction or limitation on the value of benefits that may result from inflation over time. The terms of ~~such~~ the required provision shall be no less favorable than the following:

1. A ~~term~~ provision providing for increases in benefit levels compounding annually at a rate of no less than 5%;
2. A ~~term providing for guaranteed periodic increases in~~ provision that allows an insured to periodically increase benefit levels without ~~requiring~~ providing evidence of insurability or health status, ~~provided~~ if the insured did not decline the

option for the previous period ~~had not been declined~~. The increased benefit shall be no less than the difference between the existing benefit and that benefit compounded annually at a rate of no less than 5% from the purchase of the existing benefit until the year in which the offer is made; or

3. A ~~term providing for~~ provision for coverage of a specified percentage of actual or reasonable charges that is not ~~limited~~ subject to a maximum indemnity amount or limit.

B. ~~Where~~ If the policy is issued to a group, the insurer shall extend the offer required ~~offer in~~ by subsection (A) ~~shall be made~~ to the group policyholder; except, if the policy is issued under A.R.S. § 20-1691.04(C) to a group ~~authorized by A.R.S. § 20-1691.02(D),~~ other than to a continuing care retirement community, the insurer shall make the offer ~~offering shall be made~~ to each proposed certificate holder.

C. The offer in subsection (A) ~~shall~~ is not ~~be~~ required ~~of~~ for life insurance policies or riders ~~containing~~ with accelerated long-term care benefits.

D. Insurers shall include the ~~following~~ information listed in this subsection in or with the outline of coverage~~:~~.

1. A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period.
2. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases. An insurer may use a hypothetical or a graphic demonstration for ~~the purposes of~~ this disclosure.

E. Inflation protection benefit increases shall continue without regard to an insured's age, claim status, claim history, or length of time insured under the policy.

F. An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium that the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

G. A long-term care insurance policy shall include inflation protection as provided in subsection (A)(1) unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in subsection (H). The rejection may be either in the application or on a separate form.

H. A rejection of inflation protection is deemed part of an application and shall state: "I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans [insert description of plans], and I reject inflation protection."

~~R20-6-1006.~~R20-6-1007. Required Disclosure Provisions

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

B. Payment of Benefits. A long-term care insurance policy ~~which~~ 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 such~~ define the terms and ~~an explanation of such terms~~ explain them in its accompanying outline of coverage.

C. Disclosure of tax consequences. ~~With regard to~~ For life insurance policies ~~which~~ 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 adviser. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.

D. Benefit triggers. A long-term care insurance policy shall use activities of daily living and cognitive impairment to measure an insured's need for long-term care. The policy or certificate shall describe these terms and provisions in a separate paragraph labeled "Eligibility for the Payment of Benefits." The paragraph shall include and explain:

1. Any additional benefit triggers;
2. Benefit triggers that result in payment of different benefit levels;
3. Any requirement that an attending physician or other specified person certify a certain level of functional dependency for the insured to be eligible for benefits.

E. A long-term care insurance policy or certificate shall contain a disclosure statement in the policy and in the outline of coverage indicating whether or not it is intended to be a qualified long-term care insurance contract as specified in the outline of coverage in Appendix J, paragraph 3.

R20-6-1008. Required Disclosure of Rating Practices to Consumers

A. This Section shall apply as follows:
1. Except as provided in subsection (A)(2), this Section applies to any long-term care policy or certificate issued in this state on or after 120 days following the effective date of this Section.
2. For certificates issued on or after the effective date of this rule under an in-force, long-term care insurance policy issued to a group as defined in A.R.S. § 20-1691(5)(a), the provisions of this Section apply on the first policy anniversary that occurs ten months after the effective date of this Section.

B. Unless a policy is one for which an insurer cannot increase the applicable premium rate or rate schedule, the insurer shall provide the information listed in this subsection to the applicant at the time of application or enrollment. If the method of application does not allow for delivery at that time, the insurer shall provide the information to the applicant no later than at the time of delivery of the policy or certificate.
1. A statement that the policy may be subject to rate increases in the future.
2. An explanation of potential future premium rate revisions, and the policyholder's or certificate holder's option if a premium rate revision occurs.
3. The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase.
4. A general explanation for applying premium rate or rate schedule adjustments that shall include:
   a. A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date); and
   b. The right to a revised premium rate or rate schedule as provided in subsection (B)(3) if the premium rate or rate schedule is changed.
5. Information regarding each premium rate increase on this policy form or similar policy forms over the past ten 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 percent of each increase, which may be expressed as a percentage of the premium rate before the increase, or as minimum and maximum percentages if the rate increase is variable by rating characteristics.
6. The insurer may, in a fair manner, provide explanatory information related to the rate increases in addition to the information required under subsection (B)(5).

C. From the disclosure required under subsection (B)(5), an insurer may exclude premium rate increases applicable to:
1. Blocks of business acquired from other nonaffiliated insurers; and
2. Policies acquired from other nonaffiliated insurers if the increases occurred before the acquisition.

D. If an acquiring insurer files for a rate increase on a long-term care insurance policy form or a block of policy forms acquired from a nonaffiliated insurer on or before the later of the effective date of this Section or the end of a twenty-four-month period following the acquisition of the policies or block of policies, the acquiring insurer may exclude that rate increase from the disclosure required under subsection (B)(5). However, the nonaffiliated insurer that sells the business shall include that rate increase in the disclosure required under subsection (B)(5). If the acquiring insurer files for a subsequent rate increase, even within the twenty-four-month period, on the same policy form acquired from a nonaffiliated insurer or block of policy forms acquired from nonaffiliated insurers, the acquiring insurer shall make all disclosures required by subsection (B)(5), including disclosure of the earlier rate increase.

E. Unless the method of application does not allow an insured to sign an acknowledgement that the insurer made the disclosures required under subsection (B) at the time of application, the applicant shall sign an acknowledgement of disclosure at that time. Otherwise, the applicant shall sign a disclosure acknowledgement no later than at the time of delivery of the policy or certificate.

F. An insurer shall use the forms in Appendix A and Appendix B to comply with the requirements of subsections (B) through (E) of this Section. The text and format of an insurer's forms shall be substantially similar to the text and format of Appendices A and B.

G. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, if applicable, at least 45 days before the effective date of the increase. The notice shall include the information required by subsection (B).

R20-6-1009. Initial Filing Requirements

A. This Section applies to any long-term care policy issued in this state on or after 120 days following the effective date of this Section.

B. At the time of making a filing under A.R.S. § 20-1691.08, an insurer shall provide the Director with a copy of the disclosure documents required under R20-6-1008 and 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 contain reasonable margins for adverse experience;
   c. A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); 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, the Director may request a demonstration under subsection (C) based on a standard age distribution; and
5. 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 a comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

C. The Director may require an insurer to provide an actuarial demonstration that benefits provided under a long-term care policy are reasonable in relation to premiums charged. 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.

~~R20-6-1007.~~R20-6-1010. Requirements for Application Forms and Replacement Coverage

A. An insurer's application form for a long-term care insurance policy ~~Application forms~~ shall include the ~~following~~ questions listed in this Section ~~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~~ health or long-term care policy or certificate presently in force. An insurer may include the questions in a ~~A~~ supplementary application or other form to be signed by the applicant and ~~agent~~ producer, except where the coverage is sold without ~~an agent~~ a producer~~, containing such questions may be used~~. ~~With regard to~~ For a replacement policy issued to a group as defined ~~by~~ in A.R.S. § ~~20-1691(4)(a)(i)~~ 20-1691(5)(a), the insurer may modify 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, however, that~~ if the certificate holder has been notified of the replacement.

1. Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?
2. Did you have another long-term care insurance policy or certificate in force during the last 12 months?
   a. If so, with which company?
   b. If that policy lapsed, when did it lapse?
3. Are you covered by Medicaid?
4. Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

B. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan the applicant selects.

~~B.~~C. ~~Agents~~ A producer shall list any other health insurance policies ~~they have~~ the producer has sold to the applicant, including:~~.~~

1. ~~List policies sold which~~ Policies that are still in force.
2. ~~List policies~~ Policies sold in the past five years ~~which~~ that are no longer in force.

~~C.~~D. ~~Solicitations other than direct response. Upon~~ On determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its ~~agent~~ producer 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~~ health or long-term care coverage. The applicant shall keep one ~~One~~ copy of ~~such~~ the notice ~~shall be retained by the applicant~~ and the insurer shall keep an additional copy signed by the applicant ~~shall be retained by the insurer~~. The required notice shall ~~be in~~ substantially conform to the form prescribed in Appendix ~~A~~ C.

~~D.~~E. Direct response solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of ~~accident and sickness~~ health or long-term care coverage to the applicant upon issuance of the policy. The required notice shall ~~be in~~ substantially conform to the form prescribed in Appendix ~~B~~ D.

~~E.~~F. ~~Where~~ If replacement is intended, the replacing insurer shall ~~notify, in writing,~~ send the existing insurer written notice of

the proposed replacement within five work days from the date the replacing insurer receives the application or issues the policy, whichever is sooner. The notice shall identify the existing policy ~~shall be identified~~ by name of the insurer~~, name of~~ and the insured, and policy number or insured's address including zip code. ~~Such 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.~~

G. Life insurance policies that accelerate benefits for long-term care shall comply with this Section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of Title 20, Chapter 6, Article 1.1. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the requirements of this Section and with Title 20, Chapter 6, Article 1.1.

~~F.~~H. 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.

~~G.~~I. Reporting requirements.

1. ~~Every~~ An insurer shall maintain the following records for each ~~agent~~ producer: ~~of that agent's~~
   a. The amount of the producer's replacement sales as a percent of the ~~agent's~~ producer's total annual sales; and
   b. The ~~the~~ amount of lapses of long-term care insurance policies sold by the ~~agent~~ producer as a percent of the ~~agent's~~ producer's total annual sales.
2. ~~Each~~ No later than June 30 of each year, on the forms specified in Appendix E and Appendix F, an insurer shall report the following information for the prior calendar year to the Department: ~~annually by June 30~~
   a. The ~~the~~ 10% of its ~~agents~~ producers licensed in Arizona with the greatest percentages of lapses and replacements as measured by ~~paragraph~~ subsection (H)(1) ~~of this subsection~~; and~~.~~
3. ~~Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.~~
4. b. ~~Every insurer shall report annually by June 30 the~~ The number of lapsed policies as a percent of ~~it's~~ the insurer's total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.
5. c. ~~Every insurer shall report annually by June 30 the~~ The number of replacement policies sold as a percent of ~~it's~~ the insurer's total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year; and~~.~~
   d. For qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied.

6.**J.** ~~For purposes of this Section~~ In subsection (H),

1. "Claim" means 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;
2. "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;
3. ~~"policy" shall mean~~ "Policy" means only long-term care insurance; and
4. ~~"report"~~ "Report" means on a statewide basis.

~~R20-6-1008.~~R20-6-1011. Prohibition Against Post-claims Underwriting

A. ~~All applications~~ An application for a long-term care insurance ~~policies or certificates except those which are~~ policy or certificate that is not guaranteed issue shall meet the requirements of this Section.

1. The application shall contain ~~contain~~ clear and unambiguous questions designed to ascertain the applicant's health condition ~~of the applicant~~.
   ~~1.~~a. If ~~an~~ the application ~~for long-term care insurance contains~~ has a question ~~which asks~~ asking whether the applicant has had medication prescribed by a physician, ~~it must~~ the application shall also ask the applicant to list the prescribed medication ~~that has been prescribed~~.
   ~~2.~~b. If the insurer knew or reasonably should have known that the medications listed in ~~such~~ the application ~~were known by the insurer, or should have been known at the time of application, to be directly~~ are related to a medical condition for which coverage would otherwise be denied, ~~then~~ the insurer shall not rescind the policy or certificate ~~shall not be rescinded~~ for that condition.

~~B.~~ ~~Except for policies or certificates which are guaranteed issue:~~

~~1.~~2. The application shall include the following language which shall be set out conspicuously and in close conjunction with the applicant's signature block ~~on an application for a long-term care insurance policy or certificate~~: "Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy."

~~2.~~3. The policy or certificate shall contain 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~~ on your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! ~~if~~ If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]."

~~3.~~**B.** ~~Prior to issuance of~~ Before issuing a long-term care insurance policy or certificate that is not guaranteed issue to an applicant age 80 or older, the insurer shall obtain ~~1~~ one of the following:

a. A report of a physical examination;
b. An assessment of functional capacity;
c. An attending physician's statement; or
d. Copies of medical records.

C. ~~A~~ The insurer or its producer shall deliver 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 the applicant kept it ~~was retained by the applicant~~ at the time of application.

D. ~~Every~~ An insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state- and countrywide, except those which the insured voluntarily effectuated.

E. On or before March 31 of each year, ~~insurers~~ an insurer shall report the following information to the Director for the prior calendar year, using the form prescribed in Appendix G:

1. Company name, address, phone number;
2. As to each rescission except those voluntarily effectuated by the insured:
   a. Policy form number;
   b. Policy and certificate number;
   c. Name of the insured;
   d. Date of policy issuance;
   e. Date(s) claim(s) submitted;
   f. Date of rescission; and
   g. Detailed reason for rescission.
3. Signature, name and title of the preparer, and date prepared.

~~R20-6-1009.~~R20-6-1012. Discretionary Powers of Director

The Director may, ~~upon~~ on written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provision of this Article with respect to a specific long-term care insurance policy or certificate upon a written finding that:

1. The modification or suspension would be in the best interest of the insureds; and
2. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and
   a. The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or
   b. The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or
   c. The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

~~R20-6-1010.~~R20-6-1013. Reserve Standards

A. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders ~~to such policies~~, policy reserves for ~~such~~ long-term care benefits ~~shall be~~ are determined ~~in accordance with~~ under A.R.S. § 20-510. Claim reserves shall ~~also~~ be established ~~in the case when such~~ for a policy or rider ~~is~~ in claim status.

B. An insurer shall base reserves ~~Reserves~~ for policies and riders ~~subject to this~~ under subsection (A) ~~may be based~~ on the multiple decrement model ~~utilizing~~ using all relevant decrements except for voluntary termination rates. An insurer may use single ~~Single~~ decrement approximations ~~may be acceptable~~ if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, ~~in no event shall~~ the reserves for the long-term care benefit and the life insurance benefit shall not 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 subject to this ~~subsection~~ Section, an insurer shall give 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~~, but not limited to,~~ 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.
20. Other similar or comparable factors affecting risk.

D. A member of the American Academy of Actuaries shall certify an insurer's use of any ~~Any~~ applicable valuation morbidity table ~~shall be certified~~ as appropriate as a statutory valuation table ~~by a member of the American Academy of Actuaries~~.

E. When long-term care benefits are provided other than as described in subsection (A), an insurer shall determine reserves ~~shall be determined in accordance with~~ under A.R.S. § 20-508.

~~R20-6-1014. Filing Requirements for Advertising~~

~~Every insurer, health care service organization or other entity providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio or television medium to the Director for review and approval by the Director pursuant to A.R.S. § 20-1110(E). In addition, all advertisements shall be retained by the insurer, health care service organization or other entity for at least 3 years from the date the advertisement was first used.~~

~~R20-6-1011.~~R20-6-1014. Loss ratio

A. This Section applies to policies and certificates issued any time prior to 120 days after the effective date of this Section.

B. Benefits under individual long-term care insurance policies ~~shall be~~ are deemed reasonable in relation to premiums if ~~provided~~ the expected loss ratio is at least 60% calculated in a manner ~~which~~ that provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

1. Statistical credibility of incurred claims experience and earned premiums;
2. The period for which rates are computed to provide coverage;
3. Experienced and projected trends;
4. Concentration of experience within early policy duration;
5. Expected claim fluctuation;
6. Experience refunds, adjustments or dividends;
7. Renewability features;
8. All appropriate expense factors;
9. Interest;
10. Experimental nature of the coverage;
11. Policy reserves;
12. Mix of business by risk classification; and
13. Product features such as long elimination periods, high deductibles and high maximum limits.

C. Subsection (B) does not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is deemed to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following:

1. The interest credited internally to determine cash value accumulations, including long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy.
2. The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of A.R.S. § 20-1231;
3. The policy meets the disclosure requirements of A.R.S. § 20-1691.06(A) through (E);

4. At the time of making a filing under A.R.S. § 20-1691.08, the insurer files an actuarial memorandum that includes the following information:
   a. A description of the basis on which the long-term care rates were determined;
   b. A description of the basis for the reserves;
   c. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
   d. A description and a table of each actuarial assumption used; for expenses, an insurer shall include percent of premium dollars per policy and dollars per unit of benefits, if any;
   e. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
   f. The estimated average annual premium per policy and the average issue age;
   g. A statement as to whether underwriting is performed, including: the time of underwriting; a description of the type of underwriting used, such as medical underwriting or functional assessment underwriting; and for a group policy, whether an enrollee's dependents are subject to underwriting; and
   h. A description of the effect of the long-term care policy provisions on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care status.

R20-6-1015. Premium Rate Schedule Increase

A. In this Section, "exceptional increase" means a rate increase that an insurer has filed and that the Director has determined is justified because of changes in laws applicable to long-term care insurance, or increased and unexpected utilization that affects the majority of insurers of similar products. The Director may request independent actuarial review on the issue of whether an increase should be deemed an exceptional increase. The Director may also determine whether there are any potential offsets to higher claims costs.

B. This Section applies to any individual long-term care policy or certificate issued in this state on or after 120 days after the effective date of this Section.

C. An insurer shall notify the Director of a proposed premium rate schedule increase, including an exceptional increase, at least 30 days before issuing notice to its policyholders. The notice to the Director shall include:
   1. Information required by R20-6-1008;
   2. Certification by a qualified actuary that:
      a. If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;
      b. The premium rate filing complies with the provisions of this Section;
   3. An actuarial memorandum justifying the rate schedule change request that includes:
      a. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including the following:
         i. Any assumptions that deviate from those used for pricing other forms currently available for sale;
         ii. Annual values for the five years preceding and the three years following the valuation date, provided separately,
         iii. Development of the lifetime loss ratio, unless the rate increase is an exceptional increase;
         iv. A demonstration of compliance with subsection (D); and
      b. For exceptional increases, the actuarial memorandum shall also include:
         i. The projected experience shall be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and
         ii. If the Director determines under subsection (A) that offsets may exist, the insurer shall use appropriate net projected experience;
      c. Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;
      d. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and any other actions of the insurer on which the actuary has relied;
      e. A statement that the actuary has considered policy design, underwriting and claims adjudication practices; and
   4. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless the insurer provides the Director with documentation justifying the greater rate; and
   5. Upon the Director's request, other similar and related information the Director may require to evaluate the premium rate schedule increase.

D. The following requirements apply to all premium rate schedule increases:
   1. The insurer shall return 70% of the present value of projected additional premiums from an exceptional increase to policyholders in benefits;
   2. 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, shall not be less than the sum of the following:

a. The accumulated value of the initial earned premium times 58%;
b. 85% of the accumulated value of prior premium rate schedule increases on an earned basis;
c. The present value of future projected initial earned premiums times 58%; and
d. 85% of the present value of future projected premiums not in subsection (D)(2)(c) on an earned basis;

3. If a policy form has both exceptional and other increases, the values in subsection (D)(2)(b) and (d) shall also include 70% for exceptional rate increase amounts; and
4. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in the NAIC Accounting Practices and Procedures Manual to which insurers are subject under A.R.S. § 20-223. The actuary shall disclose the use of any appropriate averages in the actuarial memorandum required under subsection (B)(3).

E. For each rate increase that is implemented, the insurer shall file for approval by the Director updated projections, as defined in subsection (C)(3)(a), annually for the next three years and shall include a comparison of actual results to projected values. The Director may extend the reporting period beyond three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection (K), the insurer shall provide the projections required by this subsection to the policyholder in lieu of filing with the Director.

F. If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, the insurer shall file lifetime projections, as defined in subsection (C)(3)(a), for the Director's approval every five years following the end of the required period in subsection (E). For group insurance policies that meet the conditions in subsection (L), the insurer shall provide the projections required by this subsection to the policyholder in lieu of filing with the Director.

G. If the Director finds that the actual experience following a rate increase does not 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 (D), the Director may require the insurer to implement premium rate schedule adjustments or other measures to reduce the difference between the projected and actual experience. In determining whether the actual experience matches the projected experience, the Director shall consider subsection (C)(3)(e), if applicable.

H. If the majority of the policies to which the increase applies are eligible for the contingent benefit upon lapse, the insurer shall file:

1. A plan, subject to Director 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 Director may impose the condition in subsections (I) through (K); and
2. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection (D) had the greater of the original anticipated lifetime loss ratio or 58% been used in the calculations described in subsection (D)(2)(a) and (c).

I. For a rate increase filing that meets the criteria listed in this subsection, the Director 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 lapsation in excess of projected 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 applies are eligible for the contingent benefit upon lapse.

J. If the Director finds excess lapsation under subsection (I), the Director may find that a rate spiral exists and may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase, the option to replace existing coverage with one or more comparable products offered by the insurer or its affiliates. The terms of the offer and the information communicating the offer are subject to the Director's approval. The offer shall:

1. Be based on actuarially sound principles, but not on attained age; and
2. Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy; and
3. Allow the insured the option of retaining the existing coverage.

K. The insurer shall maintain the experience of the insureds whose coverage was replaced under subsection (J) separate from the experience of insureds originally issued the policy forms. If the insurer requests a rate increase on the policy form, the rate increase shall be limited to the lesser of:

1. The maximum rate increase determined based on the combined experience; and
2. The maximum rate increase determined based only on the experience of the insureds originally issued the form, plus ten percent.

L. If the Director finds that an insurer has exhibited a history or pattern of filing inadequate initial premium rates for long-term care insurance, after considering the total number of policies filed over a period of time and the percentage of poli-

cies with inadequate rates, the Director may, in addition to remedies available under subsections (I) through (K), prohibit the insurer from the following:

1. Filing and marketing comparable coverage for a period of up to five years; and
2. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

M. Subsections (B) through (L) shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as provided under subsection (A), if the policy complies with all of the following provisions:

1. 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;
2. The portion of the policy that provides insurance benefits other than long-term care coverage meets the applicable nonforfeiture requirements under state law, including A.R.S. §§ 20-1231 through 20-1232 and 20-2636;
3. The policy meets the disclosure requirements of A.R.S. § 20-1691.06;
4. The portion of the policy that provides insurance benefits other than long-term care coverage meets the disclosure requirements as applicable in the following:
   a. Title 20, Chapter 6, Article 1.2; and
   b. Title 20, Chapter 16, Article 2.
5. At the time of making a filing under A.R.S. § 20-1691.08, the insurer files an actuarial memorandum that includes:
   a. Description of the bases on which it determined the long-term care rates and the reserves;
   b. A summary of the type of policy, benefits, renewability provisions, general marketing method, and limits on ages of issuance;
   c. A description and a table of each actuarial assumption used, with the percent of premium dollars per policy and dollars per unit of benefits, if any, for expenses;
   d. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
   e. The estimated average annual premium per policy and the average issue age;
   f. A statement as to whether the insurer performs underwriting at the time of application with an explanation of the following:
      i. Whether underwriting is used, and, if used, a description of the type of underwriting, such as medical underwriting or functional assessment underwriting; and
      ii. For a group policy, whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
   h. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values, and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

~~R20-6-1012.~~R20-6-1016. Filing ~~Requirement~~ Requirements for Group ~~Policy~~ Policies ~~Issued in Another State~~

A. Out of State Policies. ~~Prior to~~ Before an insurer or similar organization ~~offering~~ may offer group long-term care insurance to a resident of this state ~~pursuant to~~ under A.R.S. § 20-1691.02(D), ~~it~~ the insurer or organization shall file with the Director evidence that ~~the group policy or certificate thereunder has been approved by~~ a state ~~having~~ with statutory or regulatory long-term care insurance requirements substantially similar to those ~~adopted in~~ of this state has approved the group policy or certificate for use in that state.

B. Associations. For long-term policies marketed or issued to associations, the insurer or organization shall file with the insurance department the policy, certificate, and corresponding outline of coverage.

~~R20-6-1013.~~R20-6-1017. Standards for Marketing

A. Every insurer~~, health care service organization~~ or other entity marketing long-term care insurance coverage in this state, directly or through ~~its producers~~ a producer shall:

1. Establish marketing procedures to assure that any comparison of policies by its ~~agents or other~~ producers ~~will be~~ is fair and accurate, and ~~to assure~~ that excessive insurance is not sold or issued.
2. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy, the following language: "Notice ~~of~~ to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."
3. Provide the applicant with copies of the disclosure forms in Appendices A and B.

~~3.~~4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has ~~accident and sickness~~ health or long-term care insurance and the types and amounts of any such insurance.

5. Provide an explanation of contingent benefit upon lapse as provided for in R20-6-1019(E).
6. Provide written notice to an applicant or prospective policyholder or certificate holder advising of this state's senior

insurance counseling program (SHIP), and the name, address, and phone number for the SHIP, at the time of solicitation.

~~**B.**~~ 7. ~~Every insurer or entity marketing long-term care insurance shall establish~~ Establish auditable procedures for verifying compliance with this ~~subsection~~ Section.

~~**C.**~~**B.** In addition to the practices prohibited in A.R.S. § 20-441 et seq., the following acts and practices are prohibited:

1. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convent any insurance policy or to take out a policy of insurance with another insurer.
2. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
3. Cold lead advertising. Making use directly or indirectly or any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.
4. Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

C. An insurer shall not market or issue a long-term care policy or certificate to an association unless the insurer files the information required under R20-6-1016(B) and annually certifies that the association has complied with the requirements of this Section.

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

R20-6-1018. Suitability

A. This Section does not apply to life insurance policies that accelerate benefits for long-term care.

B. Every insurer or other person marketing long-term care insurance, including a producer or managing general agent, (the "issuer") shall:

1. 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;
2. Train its producers in the use of its suitability standards; and
3. Maintain a copy of its suitability standards and make them available for inspection upon the Director's request.

C. To determine whether an applicant meets an issuer's suitability standards, the producer and issuer shall develop procedures that take the following into consideration:

1. The applicant's 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.

D. The issuer shall make reasonable efforts to obtain the information set out in subsection (C)(1), including giving the applicant the "Long-Term Care Insurance Personal Worksheet" prescribed in Appendix A, to complete before or at the time of application. The issuer shall use a personal worksheet that shall contain, at a minimum, the information contained in Appendix A, in substantially the same text and format, in not less than 12 point type. The issuer may ask the applicant to provide additional information to comply with its suitability standards. An issuer shall file a copy of its personal worksheet with the director.

E. An issuer shall not consider an applicant for coverage until the issuer has received the applicant's completed personal worksheet, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

F. No one shall sell or disseminate information obtained through the personal worksheet outside the issuer that obtains the worksheet.

G. The issuer shall use its suitability standards to determine whether issuance of long-term care insurance coverage to a particular applicant is appropriate.

H. A producer shall use the suitability standards developed by the issuer in marketing long-term care insurance.

I. When giving an applicant a personal worksheet, the issuer shall also provide the applicant with a disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance." The form shall be in substantially the same format and text contained in Appendix H, in not less than 12 point type.

J. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter that is substantially similar to Appendix I. However, if the applicant has declined to provide financial information, the

issuer may use some other method to verify the applicant's intent. The issuer shall have either the applicant's returned letter or a record of the alternative method of verification as part of the applicant's file.

K. The issuer shall report annually to the Director the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter as prescribed in subsection (K).

R20-6-1019. Nonforfeiture Benefit Requirement

A. This Section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

B. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of A.R.S. § 20-1691.11, an insurer shall meet the requirements listed in this subsection.

1. A policy or certificate offered with nonforfeiture benefits shall have the same coverage elements, eligibility, benefit triggers and benefit length as a policy or certificate issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection (I).
2. The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.

C. If the offer required to be made under A.R.S. § 20-1691.11 is rejected, the insurer shall provide the contingent benefit upon lapse described in this Section.

D. If a prospective policyholder rejects the offer of a nonforfeiture benefit, the insurer shall provide the contingent benefit upon lapse described in this Section for individual and group policies without the nonforfeiture benefit, issued after the effective date of this Section.

E. If a group policyholder elects to make the nonforfeiture benefit an option to a certificate holder, the certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

F. The contingent benefit on lapse is triggered when:

1. An insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in the chart below, based on the insured's issue age; and
2. The policy or certificate lapses within 120 days of the due date of the premium so increased.

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%

G. Unless otherwise required, an insurer shall notify policyholders at least 30 days before the due date of the premium reflecting the rate increase.

H. On or before the effective date of a substantial premium increase as defined in subsection (F), an insurer shall:

1. Offer the insured the option of reducing policy benefits under the current coverage without additional underwriting so that required premium payments are not increased;
2. Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection (I), which the insured may elect at any time during the 120-day period referenced in subsection (F)(2); and
3. Notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in subsection (F)(2) is deemed to be the election of the offer to convert under subsection (H)(2).

I. In this Section, "benefits continued as nonforfeiture benefits," including contingent benefits upon lapse, mean any of the following:

1. Attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one percent per year prior to age 50, and at least three percent per year beyond age 50.
2. The nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in subsection (I)(3).
3. The standard nonforfeiture credit equals 100% of the sum of all premiums paid, including the premiums paid before any change in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subsection J.
4. The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three years, and thereafter.
5. Notwithstanding subsection (I)(4), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:
   a. The end of the tenth year following the policy or certificate issue date; or
   b. The end of the second year following the date the policy or certificate is no longer subject to attained age rating.
6. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

J. All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status shall not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.

K. There shall be no difference in the minimum nonforfeiture benefits for group and individual policies.
L. The requirements in this Section are effective ten months after the effective date of this Section and shall apply as follows:
1. Except as provided in subsection (L)(2), this Section applies to any long-term care policy issued in this state on or after the effective date of this Section.
2. The provisions of this Section do not apply to certificates issued on or after the effective date of this Section, under a group long-term care insurance policy as defined in A.R.S. § 20-1691(5)(a), that was in force on the effective date of this Section.

M. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of R20-6-1014 treating the policy as a whole.
N. To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection (F), a replacing insurer that purchased or otherwise assumed a block of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium the insured paid when first buying the policy from the original insurer.
O. An insurer is required to offer a nonforfeiture benefit for a qualified long-term care insurance contract that is a level premium contract; the benefit shall meet the following requirements:
1. The nonforfeiture provision shall be separately captioned using the term "nonforfeiture benefit" or a substantially similar caption.
2. The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the insurer may adjust the amount of the benefit initially granted only as needed to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the Director pursuant to A.R.S. § 20-1691.08 for the same contract form; and
3. The nonforfeiture provision shall provide at least one of the following:
   a. Reduced paid up premiums,
   b. Extended term insurance,
   c. Shortened benefit period; or'
   d. Other similar offerings that the Director has approved.

R20-6-1020. Standards for Benefit Triggers
A. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Except as otherwise provided in R20-6-1021, eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.
B. Activities of daily living shall include at least the following as defined in R20-6-1003 and in the policy:
1. Bathing;
2. Continence;
3. Dressing;
4. Eating;
5. Toileting; and
6. Transferring;

C. An insurer may use additional activities of daily living to trigger covered benefits if the activities are defined in the policy.
D. An insurer may use additional provisions to determine when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements in subsections (A) and (B).
E. For purposes of this Section the determination of a deficiency shall not be more restrictive than:
1. Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or
2. If the deficiency is due to the presence of a cognitive impairment, requiring supervision or verbal cueing by another person to protect the insured or others.

F. Licensed or certified professionals, such as physicians, nurses or social workers, shall perform assessments of activities of daily living and cognitive impairment.
G. The requirements in this Section are effective ten months after the effective date of this Section and shall apply as follows:
1. Except as provided in subsection (G)(2), the provisions of this Section apply to a long-term care policy issued in this state on or after the effective date of this Section.
2. The provisions of this Section do not apply to certificates issued on or after the effective date of this Section, under a long-term care insurance policy issued to a group as defined in A.R.S. § 20-1691(5)(a), which policy was in force at the time this Section became effective.

R20-6-1021. Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts
A. 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.
B. A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's

inability to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.

C. Licensed or certified professionals, including physicians, registered professional nurses, and licensed social workers, shall perform the certifications regarding activities of daily living and cognitive impairment required under subsection (B).

D. Certifications required pursuant to subsection (B) may be performed at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that 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 may not be rescinded and additional certifications may not be performed until after the expiration of the 90-day period.

~~R20-6-1015.~~R20-6-1022. Standard Format Outline of Coverage

~~**A.** The outline of coverage shall be delivered to applicants as required by A.R.S. § 20-1691.04.~~

~~**B.**~~**A.** The outline of coverage prescribed in A.R.S. § 20-1691.04 shall be a free-standing document, using no smaller than 10 point type, and shall contain no advertising or promotional material ~~of an advertising nature~~.

~~**C.**~~**B.** Text ~~which~~ that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means ~~which provide~~ that give prominence equivalent to ~~such~~ capitalization or underscoring.

~~**D.**~~**C.** An insurer shall use ~~Use of~~ the text and sequence of text ~~of~~ in the standard format outline of coverage prescribed in Appendix ~~C~~ J ~~is mandatory~~, unless otherwise specifically indicated.

~~R20-6-1016.~~R20-6-1023. Requirement to Deliver Shopper's Guide

A. All prospective applicants of a long-term care insurance policy or certificate shall ~~be provided~~ receive a long-term care shopper's guide approved by the Director. This requirement may be satisfied by delivery of the current edition of the long-term care shopper's guide in the format developed by the National Association of Insurance Commissioners.

1. In the case of ~~agent~~ producer solicitation, ~~an agent~~ a producer shall deliver the shopper's guide ~~prior to the presentation of~~ before presenting an application or enrollment form.
2. In the case of direct response solicitations, the insurer shall provide the shopper's guide ~~shall be presented in conjunction~~ with any application or enrollment form.

B. A prospective applicant for a life insurance policy or rider containing accelerated long-term care benefits is not required to receive the guide described in subsection A, but shall receive the policy summary required under A.R.S. § 20-1691.06.

R20-6-1024. Instructions for Appendices

Information that is designated as a "Drafting Instruction" in a form appended to this Article is not required to be included as part of the form. Any person using the form shall abide by the instructions when drafting, preparing, or completing the form.

APPENDIX A
Long-Term Care Insurance

Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information
Policy Form Numbers_____
The premium for the coverage you are considering will be [$_____ per month, or $_____ per year,] [a one-time single premium of $_____.]

Type of Policy (noncancellable/guaranteed renewable): _____

The Company's Right to Increase Premiums: _____
[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

Rate Increase History
The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never

raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.]

(Drafting Instruction: A company may use the first bracketed sentence above only if it has never increased rates under any prior policy forms in this state or any other state. The issuer shall list each premium increase it has instituted on this or similar policy forms in this state or any other state during the last 10 years. The list shall provide the policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.)

Questions Related to Your Income

How will you pay each year's premium?
❑From my Income ❑From my Savings/Investments ❑My Family will Pay

[❑ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?]

(Drafting Instruction: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.)

What is your annual income? (check one)❑Under $10,000 ❑$[10-20,000] ❑$[20-30,000] ❑$[30-50,000] ❑Over $50,000

(Drafting Instruction: The issuer may choose the numbers to put in the brackets to fit its suitability standards.)
How do you expect your income to change over the next 10 years? (check one)
❑No change ❑Increase ❑Decrease
If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ❑ Yes ❑ No
If not, have you considered how you will pay for the difference between future costs and your daily benefit amount? ❑From my Income ❑From my Savings/Investments ❑My Family will Pay
The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

(Drafting Instruction: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.)

What elimination period are you considering? Number of days _____Approximate cost $_____for that period of care.

How are you planning to pay for your care during the elimination period? (check one)
❑From my Income ❑From my Savings/Investments ❑My Family will Pay

Questions Related to Your Savings and Investments
Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)
❑Under $20,000 ❑$20,000-$30,000 ❑$30,000-$50,000 ❑Over $50,000

How do you expect your assets to change over the next ten years? (check one)
❑Stay about the same ❑Increase ❑Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

❑ The answers to the questions above describe my financial situation. or ❑ I choose not to complete this information. (Check one.)
❑ I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. I understand that the rates for this policy may increase in the future. (This box must be checked).

Signed: _____ _____

(Applicant) (Date)

[❑ I explained to the applicant the importance of completing this information.

Signed: _____ _____

(Producer) (Date)

Producer's Printed Name: _____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____ _____]

(Applicant) (Date)

(Drafting Instruction: Choose the appropriate sentences depending on whether this is a direct mail or producer sale.)
The company may contact you to verify your answers.

(Drafting Instruction: When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.)

APPENDIX B

Instructions:
This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Insurers shall provide all of the following information to the applicant:

Long-Term Care Insurance

Potential Rate Increase Disclosure Form

1. [Premium Rate] [Premium Rate Schedules]: [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [approved] for an increase [is][are] [on the application][$_____])
2. The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.
3. Rate Schedule Adjustments:
The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): _____.
4. Potential Rate Revisions:
This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:
• Pay the increased premium and continue your policy in force as is.
• Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
• Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
• Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

Contingent Nonforfeiture
If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:
You will keep some long-term care insurance coverage, if:
• Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
• You lapse (not pay more premiums) within 120 days of the increase.

Turn the Page

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you have paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

• You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.
• In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).
• Your "paid-up" policy benefits are $10,000 (provided you have a least $10,000 of benefits remaining under your policy.)

Turn the Page

Contingent Nonforfeiture
Cumulative Premium Increase over Initial Premium
That qualifies for Contingent Nonforfeiture
(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time 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%

APPENDIX ~~A~~ C

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ~~ACCIDENT AND SICKNESS~~

HEALTH OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

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

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing ~~accident and sickness~~ health or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides [thirty (30)] ~~[ten (10)]~~ days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

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

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

(Use additional sheets, as necessary.)

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

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

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

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

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

you sign it, reread it carefully to be certain that all information has been property recorded.

(Signature of ~~Agency, Broker~~ Producer or Other Representative) (Company Name)

(Typed Name and Address of ~~Agent or Broker~~ Producer)

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

_____

(Date)

_____

(Applicant's Signature)

APPENDIX ~~B~~ D

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

[Insurance company's name and address]

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

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

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

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

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

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

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

[COMPANY NAME]

APPENDIX E

Long-Term Care Insurance

Replacement and Lapse Reporting Form

For the State of _____

For the Reporting Year of _____

Company Name:_____Due: June 30 annually

Company Address:_____Company NAIC Number: _____

Contact Person:_____Phone Number: (____)_____

Instructions

The purpose of this form is to report on a statewide basis information regarding long-term care insurance policy replacements and lapses. Every insurer shall maintain the following records for each producer: (1) amount of long-term care insurance replacement sales as a percent of the producer's total annual sales and (2) the amount of lapses of long-term care insurance policies sold by the producer as a percent of the producer's total annual sales. The tables below should be used to report the ten percent (10%) of the insurer's producers with the greatest percentages of replacements and lapses.

Listing of the 10% of Producers with the Greatest Percentage of Replacements

Producer's Name	Number of Policies Sold By This Producer	Number of Policies Replaced By This Producer	Number of Replacements as % of Number of Policies Sold By This Producer

Listing of the 10% of Producers with the Greatest Percentage of Lapses

Producer's Name	Number of Policies Sold By This Producer	Number of Policies Lapsed By This Producer	Number of Lapses as % of Number Sold By This Producer

Company Totals

Percentage of Replacement Policies Sold to Total Annual Sales ____%

Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year) ____%

Percentage of Lapsed Policies to Total Annual Sales _____%

Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) _____%

APPENDIX F

Claims Denial Reporting Form

Long-Term Care Insurance

For the State of _____

For the Reporting Year of _____

Company Name:_____ Due: June 30 annually

Company Address:_____

_____

Company NAIC Number:_____

Contact Person: _____Phone Number: _____

Line of Business:IndividualGroup

Instructions

The purpose of this form is to report all long-term care claim denials under in-force long-term care insurance policies. "Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

		State Data	Nationwide Data1
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Long-Term Care Claim Denied due to:		
8	• Long-Term Care Services Not Covered under the Policy2		

9	• Provider/Facility Not Qualified under the Policy3		
10	• Benefit Eligibility Criteria Not Met4		
11	• Other		

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.
2. Example—home health care claim filed under a nursing home only policy.
3. Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
4. Examples—a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

APPENDIX G

RESCISSION REPORTING FORM FOR

LONG-TERM CARE POLICIES

FOR THE STATE OF _____

FOR THE REPORTING YEAR _____

Company Name_____

Address:_____

_____

Phone Number:_____

Due: March 1 annually

Instructions:
The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission:

_____

_____

_____

Signature

_____

Name and Title (please type)

_____

Date

APPENDIX H

Things You Should Know Before You Buy

Long-Term Care Insurance

Long-Term Care Insurance	• A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
	• [You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

(**Drafting Instruction:** For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.)

	The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
Medicare	• Medicare does not pay for most long-term care.
Medicaid	• Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.
	• Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
	• When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
	• Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.
Shopper's Guide	• Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.
Counseling	• Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

APPENDIX I
Long-Term Care Insurance Suitability Letter

Dear [Applicant]:
Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

(Drafting Instruction: Choose the paragraph that applies.)

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

❑ **Yes**, [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

Drafting Instruction: Delete the phrase in brackets if the applicant did not answer the questions about income.

❑ **No**. I have decided not to buy a policy at this time.

_____ _____

APPLICANT'S SIGNATURE DATE

Please return to [issuer] at [address] by [date].

APPENDIX ~~C~~ J

[COMPANY NAME]

[ADDRESS - CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

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

Caution: The issuance of this long-term care insurance [policy] ~~(~~[certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any 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]

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

3. FEDERAL TAX CONSEQUENCES

This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702(B)(b) of the Internal Revenue Code of 1986, as amended.

or

Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE].is not intended to be a federally tax-qualified long-term care insurance contract under Section 7702(B)(b) of the Internal Revenue Code of 1986, as amended. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED

(a) [For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:

(1) Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS POLICY [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

(c) [Describe waiver of premium provisions or state that there are not such provisions;]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

~~3~~6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return - "free look" provision of the policy.]

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

~~4.~~7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) [For ~~agents~~ producers] Neither [insert company name] nor its [agents or producers] represent Medicare, the federal government or any state government.

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

~~5.~~8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for ~~1~~ one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute-care unit of a hospital, such as in a nursing home, in the community or in the home.

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

~~6~~ 9. BENEFITS PROVIDED BY THIS POLICY

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

(b) [Institutional benefits, by skill level.]

(c) [Non-institutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be defined and described as part of the outline of coverage.]

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

~~7.~~10.LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Non-eligible ~~facilities/provider~~ facilities and providers;

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

(d) ~~Exclusions/exceptions~~ Exclusions and exceptions;

(e) Limitations.]

[This Section ~~should~~ shall provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in paragraph 6 above.]

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

~~8.~~11.RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. ~~(~~[As applicable, indicate the following:

(a) That the benefit level will not increase over time;

(b) Any automatic benefit adjustment provisions;

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

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

(e) ~~And finally, describe~~ Describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

~~9. TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.~~

~~[(a) Describe the policy renewability provisions;~~

~~(b) For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;~~

~~(c) Describe waiver of premium provisions or state that there are not such provisions;~~

~~(d) State whether or not the company has a right to change premium and, if such a right exists, describe clearly and concisely each circumstance under which premium may change.]~~

~~10.~~12.ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

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

~~11.~~13.PREMIUM.

[(a) State the total annual premium for the policy;

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

~~12.~~14. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.