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 2. ADMINISTRATION

CHAPTER 10. DEPARTMENT OF ADMINISTRATION
RISK MANAGEMENT SECTION

[R08-382]

PREAMBLE

1. Sections Affected — **Rulemaking Action**
R2-10-108 — Amend

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

Authorizing statute: A.R.S. § 41-703(3)

Implementing statute: A.R.S. § 41-621

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

Notice of Rulemaking Docket Opening: 13 A.A.R. 2528, July 13, 2007

Notice of Rulemaking Docket Opening: 14 A.A.R. 1752, May 9, 2008

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

Name:	Julie Cruse, Administrative Manager Risk Management Division
Address:	Department of Administration 100 N. 15th Ave., Third Floor, Suite 301 Phoenix, AZ 85007
Telephone:	(602) 542-1492
Fax:	(602) 542-1473
E-mail:	Julie.Cruse@azdoa.govor
or	
Name:	Rob Smook, Rules Administrator
Address:	Department of Administration 1501 W. Madison St. Phoenix, AZ 85007
Telephone:	(602) 542-6161
Fax:	(602) 542-3125
E-mail:	Robert.Smook@azdoa.gov

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

Risk Management rule R2-10-108 became effective on January 6, 2007 as a result of a rulemaking. This revision is to make minor technical corrections to Deductibles and Waivers, R2-10-108(A)(1) to make the rule more clear, concise and understandable.

6. A reference to any study relevant to the rule that the agency reviewed and either proposes to rely on or not to 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:

The agency did not utilize a study for evaluating or justifying the rulemaking.

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. Identification of Rule

R2-10-108, Deductibles and Waivers, which is contained in Title 2, Chapter 10, Article 1, Coverage and Claims Procedure.

B. Background and Summary

In the last rulemaking, Risk Management removed the rule language regarding charging the agency a deductible of up to $10,000 on each claim identified as having the most significant opportunity for loss prevention actions. However, in the process of finalizing the document an error was noted after the final rulemaking process where a few words were left off inadvertently which changed the context and intent of the rule. In addition, this will also remove any decimal and following zeros on dollar amounts in the rule to ensure consistency in appearance.

C. Entities Directly Impacted

All state agencies could be impacted by these changes. Small business and consumers are not impacted by the rule.

D. Potential Costs and Benefits

There will be no change in cost to the agencies for this change.

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:	Julie Cruse, Administrative Manager Risk Management Division
Address:	Department of Administration 100 N. 15th Ave., Third Floor, Suite 301 Phoenix, AZ 85007
Telephone:	(602) 542-1492
Fax:	(602) 542-1473
E-mail:	Julie.Cruse@azdoa.govor
or	
Name:	Rob Smook, Rules Administrator
Address:	Department of Administration 1501 W. Madison St. Phoenix, AZ 85007
Telephone:	(602) 542-6161
Fax:	(602) 542-3125
E-mail:	Robert.Smook@azdoa.gov

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:

Written comments will be received at the address listed in item 9 for 30 days after the Notice of Proposed Rulemaking is published in the *Register*. An oral proceeding will be scheduled if one is requested, otherwise, the record will be closed at the end of the 30-day period after publication in the *Register*. Should a request for an oral proceeding be received, notice of that proceeding will be published in a future edition of the *Register*.

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

None

12. Any material incorporated by reference and its location in the rule:

None

13. The full text of the rule follows:

TITLE 2. ADMINISTRATION

CHAPTER 10. DEPARTMENT OF ADMINISTRATION
RISK MANAGEMENT ~~SECTION~~ DIVISION

ARTICLE 1. COVERAGE AND CLAIMS PROCEDURE

Section
R2-10-108. Deductibles and Waivers

ARTICLE 1. COVERAGE AND CLAIMS PROCEDURE

R2-10-108. Deductibles and Waivers

A. Agency Claim Settlement or Judgment More Than $150,000.
1. The Department shall charge each agency a deductible of not more than $10,000 on each claim settlement or judgment approved for payment of ~~$150,000.00.~~ more than $150,000.
2. RM shall waive the deductible if the agency provides a response to RM containing an agency action plan to be taken to eliminate or limit similar future risk to the state, and:
   a. The agency action plan is submitted to RM within 60 days of the agency's notification of claim approval or payment. The agency action plan shall include the following~~:~~;
      i. Findings outlining the cause or causes of the claim;
      ii. Actions that will be implemented to prevent recurrence of similar losses or claims;
      iii. Development of action items and time lines for completion; and
      iv. Appointment of an agency contact to act as a liaison for all matters relating to the plan.
   b. RM approves the agency action plan as reasonable and effective; and
   c. The agency implements the plan within 30 days of RM approval, and provides periodic status reports as outlined in the approved Agency Action Plan.
3. If the agency fails to comply with all the conditions outlined in subsection (A)(2), RM shall charge a deductible of $10,000 on the subject judgment or claim settlement as well as each subsequent claim resulting from that cause or exposure until the agency fully complies with subsection (A)(2).

B. RM may waive any deductible to any agency for just cause. Just cause may exist when the application of a deductible is not warranted due to the circumstances of the claim, or is in the best interest of the state.

C. If a dispute arises between RM and the agency pertaining to this Section, one or more meetings shall be held at progressively upward, incremental Department of Administration management levels until the agency and RM reach a solution.

NOTICE OF PROPOSED RULEMAKING

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 23. BOARD OF PHARMACY

[R08-373]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R4-23-422	Amend
R4-23-423	Repeal

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

Authorizing statutes: A.R.S. § 32-1904(A)(1)

Implementing statutes: A.R.S. § 32-1970

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

Notice of Rulemaking Docket Opening: 14 A.A.R. 34, January 4, 2008

Notice of Proposed Rulemaking: 14 A.A.R. 1487, May 2, 2008

Notice of Termination of Rulemaking: 14 A.A.R. 4308, November 21, 2008 *(in this issue)*

Notice of Rulemaking Docket Opening: 14 A.A.R. 4341, November 21, 2008 *(in this issue)*

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

Name: Dean Wright, Compliance Officer

Address: Board of Pharmacy
1700 W. Washington St., Suite 250
Phoenix, AZ 85007

Telephone: (602) 771-2727

Fax: (602) 771-2749

E-mail: dwright@azpharmacy.gov

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

Recruiting members to serve on volunteer committees is always difficult. Busy healthcare providers are even more challenging to identify, and the shortage of healthcare providers in Arizona just adds to the difficulty. Finding qualified individuals who can attend meetings regularly has been almost impossible. For this reason, the Board proposes that the Drug Therapy Management Advisory Committee be eliminated. The use of a drug therapy management advisory committee does not afford any additional layer of protection to the public, as the supervising physician has final authority and responsibility over the actions of a pharmacist under a drug therapy management agreement. A Board staff pharmacist has been serving on the committee and will continue to review the initial and renewal drug therapy management agreement applications for the Board's approval. Section R4-23-422 (Drug Therapy Management - Duties of the Board) will be amended to remove the requirements that the Board appoint a Drug Therapy Management Advisory Committee and consult with the appointed committee in subsections (A)(1) and (2). Section R4-23-422 will be further amended by adding language in a new subsection (C) that requires the Board staff to review initial and renewal drug therapy management agreement applications and advise the Board regarding the approval or denial of reviewed drug therapy management agreement applications. Section R4-23-423 (Drug Therapy Management Advisory Committee) will be repealed. The rules will include format, style, and grammar necessary to comply with the current rules of the Secretary of State and Governor's Regulatory Review Council.

The Board believes that approval of these rules will benefit the public health and safety by expanding the use of pharmacists' under-utilized knowledge of drugs and drug therapy to manage a specific patient under written protocol from the patient's physician. Because a pharmacist is more accessible than a physician, a patient whose drug therapy is managed by a pharmacist benefits by receiving drug therapy monitoring and adjustment that reduces health care costs, including the use of fewer or less costly drugs, more effective or better tolerated drugs, early recognition and treatment of adverse drug reactions, and fewer hospital admissions.

6. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to 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:

The agency did not review or rely on any study relevant to the rule.

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:

The proposed rules will impact the Board and pharmacists. The proposed rule's impact on the Board will be the usual rulemaking-related costs, which are minimal.

The Board estimates the proposed rules will have no economic impact on pharmacists. The rulemaking is eliminating the requirement that the Board appoint a Drug Therapy Management Advisory Committee. This committee is not required in statute and the Board feels that it is not necessary to the process of evaluating and approving drug therapy management agreements. The use of a drug therapy management advisory committee does not afford any additional layer of protection to the public, as the supervising physician has final authority and responsibility over the actions of a pharmacist under a drug therapy management agreement.

The proposed rules will have no economic impact on the public.

The Board believes that approval of these rules will benefit the public health and safety by expanding the use of pharmacists' under-utilized knowledge of drugs and drug therapy to manage a specific patient under written protocol from the patient's physician. Because a pharmacist is more accessible than a physician, a patient whose drug therapy is managed by a pharmacist benefits by receiving drug therapy monitoring and adjustment that reduces health care costs, including the use of fewer or less costly drugs, more effective or better tolerated drugs, early recognition and treatment of adverse drug reactions, and fewer hospital admissions.

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:	Dean Wright, Compliance Officer
Address:	Board of Pharmacy 1700 W. Washington St., Suite 250 Phoenix, AZ 85007
Telephone:	(602) 771-2727
Fax:	(602) 771-2749
E-mail:	dwright@azpharmacy.gov

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:

Comments may be written or presented orally. Written comments must be received by 5:00 p.m., Monday, December 22, 2008. An oral proceeding is scheduled for:

Date:	December 22, 2008
Time:	10:00 a.m.
Location:	1700 W. Washington St., Third Floor Board Room Phoenix, AZ 85007

A person may request information about the oral proceeding by contacting the person listed above.

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 rules:

None

13. The full text of the rules follows:

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 23. BOARD OF PHARMACY

ARTICLE 4. PROFESSIONAL PRACTICES

Section
R4-23-422. Drug Therapy Management – Duties of the Board
R4-23-423. ~~Drug Therapy Management Advisory Committee~~ Repealed

ARTICLE 4. PROFESSIONAL PRACTICES

R4-23-422. Drug Therapy Management – Duties of the Board

A. The Board shall:
~~1. Appoint a Drug Therapy Management Advisory Committee;~~
~~2.~~1. In consultation with Board staff ~~and the Drug Therapy Management Advisory Committee~~, approve or deny an initial drug therapy management agreement and the annual renewal of an existing drug therapy management agreement;
~~3.~~2. Terminate a pharmacist's drug therapy management agreement if the pharmacist:
a. Does not renew the agreement on or before the approval date anniversary; or
b. Is found by the Board to lack the qualifications required in R4-23-424; and
~~4.~~3. In processing a drug therapy management agreement application, comply with the application process established in R4-23-602, except the substantive review time-frame is 180 days and the overall time-frame is 200 days.

B. The Board may terminate a pharmacist's drug therapy management agreement if the Board determines that the pharmacist is violating the requirements of the drug therapy management agreement or federal or state drug laws.

C. The Board staff shall:
1. Review initial and renewal drug therapy management agreement applications; and
2. Advise the Board regarding the approval or denial of reviewed drug therapy management agreement applications.

R4-23-423. ~~Drug Therapy Management Advisory Committee~~ Repealed

~~**A.** The Drug Therapy Management Advisory Committee shall:~~

~~1. Consist of an osteopathic physician, an allopathic physician, and two pharmacists with prior or current experience in drug therapy management;~~

~~2. Serve at the pleasure of the Board;~~

~~3. Serve for a term of two years unless removed or reappointed by the Board;~~

~~4. Review initial and renewal drug therapy management agreement applications; and~~

~~5. Advise the Board regarding the approval or denial of reviewed drug therapy management agreement applications.~~

~~**B.** The Drug Therapy Management Advisory Committee members are not eligible for compensation from the Board.~~

NOTICE OF PROPOSED RULEMAKING

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

[R08-385]

PREAMBLE

1. Sections Affected **Rulemaking Action**

R20-6-214 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. § 20-143

Implementing statutes: A.R.S. § 20-143, 20-1134

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

Notice of Rulemaking Docket Opening: 14 A.A.R. 4346, November 21, 2008 *(in this issue)*

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

Name: Margaret L. McClelland

Address: Department of Insurance
2910 N. 44th St., Suite 210
Phoenix, AZ 85018

Telephone: (602) 364-3471

Fax: (602) 364-3470

E-mail: mmcclelland@azinsurance.gov

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

R20-6-214 was included in a 2007 Notice of Final Rulemaking that revised Article 2 and became effective on August 4, 2007. The Department recently discovered that, during the drafting process of that rulemaking, in manipulating the text to make changes in response to comments received on R20-6-214, the word "not" was inadvertently dropped from R20-6-214(C)(2) before the word "apply" at the end of the subsection. This rulemaking restores the word "not" to reflect when the method for determining the order of benefits under this subsection applies and makes the rule consistent with the National Association of Insurance Commissioners Coordination of Benefits Model Regulation.

The Department might request immediate effectiveness of the final rule under A.R.S. § 41-1032.

Specific Section-By-Section Explanation of This Proposal

R20-6-214 establishes requirements for coordination of benefits.

6. A reference to any study relevant to the rules that the agency reviewed and proposes either to rely on or not to 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:

Not applicable

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 Department is not aware of small businesses that will be impacted by this rulemaking; therefore, the Department does not believe it is necessary to reduce the impact on small businesses. The Department does not believe that this rule will have economic impacts on consumers as it only affects the order of payment of benefits, not payment amounts. The Department does not expect economic impacts to the Department or other governmental agencies.

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 L. McClelland

Address: Department of Insurance
2910 N. 44th St., Suite 210
Phoenix, AZ 85018

Telephone: (602) 364-3471

Fax: (602) 364-3470

E-mail: mmcclelland@azinsurance.gov

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 December 22, 2008 at 9:00 a.m. at the Arizona Department of Insurance, 2910 N. 44th St., Phoenix, AZ, Third-floor Training Room. ADOI will accept oral or written comments that are received at the Department by 12:00 p.m. on December 22, 2008. The comment period will end and the record will close at 12:00 p.m. on December 22, 2008.

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:

None

13. The full text of the rules follows:

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

ARTICLE 2. TRANSACTION OF INSURANCE

Section
R20-6-214. Coordination of Benefits

ARTICLE 2. TRANSACTION OF INSURANCE

R20-6-214. Coordination of Benefits

A. Applicability.
1. This Section applies to all:
   a. Group disability insurance policies;
   b. Group subscriber contracts of hospital and medical service corporations and health care services organizations;
   c. Group disability policies of benefit insurers; and
   d. Group-type contracts that contain a coordination of benefits provision, are not available to the general public, and can be obtained and maintained only because of the covered person's membership in or connection with a particular organization. Group-type contracts that meet this description are included regardless of whether denominated as "franchise," "blanket," or some other designation.
2. This Section does not apply to:
   a. Individual or family policies or individual or family subscriber contracts except as provided for in subsection (A)(1);
   b. Group or group-type hospital indemnity benefits, written on a non-expense incurred basis, of $30 per day or less unless characterized as reimbursement-type benefits and designed or administered to give the insured the right to elect indemnity-type benefits, instead of the reimbursement type benefits at the time of claim; or
   c. School accident type coverages, written on a blanket, group, or franchise basis.

B. Definitions. In this Section, the following definitions apply:

1. "Allowable expense" means any necessary, reasonable, and customary item of expense, at least a portion of which is covered under one or more of the plans covering the person for whom claim is made or service provided.
   a. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered is deemed to be both an allowable expense and a benefit paid.
   b. A plan that takes Medicare or similar government benefits into consideration when determining the application of its coordination of benefits provision does not expand the definition of an allowable expense.
2. "Claim determination period" means an appropriate period of time such as "calendar year" or "benefit period" as defined in the policy.
3. "Plan," within the coordination of benefits provisions of a group policy or subscriber contract, means the types of coverage that the insurer may consider in determining whether overinsurance exists with respect to a specific claim.
4. "School accident-type coverage" means coverage of grammar school and high school students for accidents only, including athletic injuries, either on a 24-hour basis or "to-and-from school," for which the parent pays the entire premium.

C. Order-of-benefit determination.
1. When a claim under a plan with a coordination of benefit provision involves another plan that also has a coordination of benefit provision, the insurer shall make the order-of-benefit determination as follows:
   a. The plan that covers the person claiming benefits other than as a dependent shall determine benefits before those of the plan that covers the person as a dependent.
   b. The plan of a parent whose birthday occurs earlier in a calendar year shall cover a dependent child before the benefits of a plan of a parent whose birthday occurs later in a calendar year. The word "birthday" as used in this subsection refers only to month and day in a calendar year, not the year in which the person was born.
   c. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in the following order:
      i. First, the plan of the parent with custody of the child;
      ii. Then, the plan of the spouse of the parent with custody of the child; and
      iii. Finally, the plan of the parent not having custody of the child.
   d. Notwithstanding subsection ~~(c)~~ (C)(1)(c), if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first.
2. The benefits of a plan that covers a person as an employee (or as that employee's dependent) are determined before those of a plan that covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this provision and if, as a result, the plans do not agree on the order of benefits, this subsection does not apply.
3. If none of the provisions of subsection (C) determines the order of benefits, the benefits of the plan that covered a claimant longer are determined before those of the plan that covered that person for the shorter time.
4. If one of the plans is issued out of this state and determines the order of benefits based upon the gender of a parent and, as a result, the plans do not agree on the order of benefits, the plan with the gender rule shall determine the order of benefits.

D. Excess and other nonconforming provisions. A plan with an order of benefit determination provision that complies with this Section, a complying plan, may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses an order-of-benefit determination provision that is inconsistent with this Section, a noncomplying plan, on the following basis:
1. If the complying plan is the primary plan, it shall pay or provide its benefits on a primary basis.
2. If the complying plan is the secondary plan, it shall pay or provide its benefits first, as the secondary plan. The payment shall be the limit of the complying plan's liability, except as provided in subsection ~~(4)~~ (D)(4).
3. If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the noncomplying plan are identical to its own, and shall pay benefits accordingly. The complying plan shall adjust any payments it makes based on the assumption whether information becomes available as the actual benefits of the noncomplying plan.
4. If the noncomplying plan pays benefits so that the claimant receives less in benefits than the claimant would have received had the noncomplying plan paid or provided its benefits as the primary plan, the complying plan shall advance to or on behalf of the claimant an amount equal to the difference. The complying plan shall not have a right to reimbursement from the claimant.