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 9. AGRICULTURAL COUNCILS AND COMMISSIONS

Editor's Note: The following Notice of Proposed Rulemaking is exempt from Executive Order 2012-03 as issued by Governor Brewer. (See the text of the executive order on page 3586.)

[R13-198]

PREAMBLE

1. Article, Part, or Section Affected (as applicable) **Rulemaking Action:**
R3-9-303 New Section

2. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):
Authorizing statute: A.R.S. § 3-1083 (C)(2)

Implementing statute: A.R.S. § 3-1086 (B)

3. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the proposed rule:
Notice of Rulemaking Docket Opening: 19 A.A.R. 3581, November 15, 2013 (*in this issue*)

4. The agency's contact person who can answer questions about the rulemaking:

Name:	Leighton Liesner
Address:	Arizona Cotton Research and Protection Council 3721 E. Wier Ave. Phoenix, AZ 85040
Telephone:	(602) 438-0059
Fax:	(602) 438-0407
Web site:	www.azcotton.org

5. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:
The proposed rulemaking creates rule 303 to establish a mechanism whereby a cotton producer may request an extension of the tillage deadline in R3-4-204(E) based on a qualifying weather event that has delayed or prevented compliance. Historically, the practice of granting weather related extension requests was carried out under an informal procedure whereby a producer could appeal for an extension to the tillage deadline. In 2013, the Arizona Department of Agriculture began the task of updating R3-4-204 Pink Bollworm and the Cotton Boll Weevil Complex, which had not been substantially updated since 1999. During the review of R3-4-204 it was determined that the practice of weather related extensions should be formalized in rule. At the request of the cotton industry language was included in SB 1092 modifying 3-1086 (C) granting the Council authority to grant weather related extensions by rule.

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:
None

7. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking 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 economic impact of 303 would be for cotton producers who apply and are granted extensions to tillage deadlines. The economic impact would be to prevent forfeiture of the producers rebate, and avoid incurring a per acre fine of $100 for non-compliance (3-1086 (D)), with the tillage deadlines established in R3-4-204.

9. The agency's contact person who can answer questions about the economic, small business and consumer impact statement:

Name: Leighton Liesner

Address: Arizona Cotton Research and Protection Council
3721 E. Wier Ave.
Phoenix, AZ 85040

Telephone: (602) 438-0059

Fax: (602) 438-0407

Web site: www.azcotton.org

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

A person may request an oral proceeding on the proposed rules by contacting the individual identified in item #4 within 30 days of publication of this notice.

11. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

None

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

The rule does not include the use of a general permit as the weather related extension is a one time action performed on a case by case basis.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

None

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

No

12. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:

None

13. The full text of the rules follows:

TITLE 3. AGRICULTURE

CHAPTER 9. DEPARTMENT OF AGRICULTURE
AGRICULTURAL COUNCILS AND COMMISSIONS

ARTICLE 3. ARIZONA COTTON RESEARCH AND PROTECTION COUNCIL

Section
R3-9-303. Weather Related Extensions

ARTICLE 3. ARIZONA COTTON RESEARCH AND PROTECTION COUNCIL

R3-9-303. Weather Related Extensions

A. Definitions.

1. "Council" means the Arizona Cotton Research and Protection Council.
2. "Qualifying weather event" means substantial interference with post-harvest activities to detach the cotton root from the soil caused by significant rain or moisture or by sustained winds within an established PM10 nonattainment area.

B. A cotton producer may request an extension of the tillage deadline in R3-4-204(E) based on a qualifying weather event

that has delayed or prevented compliance.

C. A cotton producer requesting an extension shall submit the following information to the Council Staff Director:
1. The producer's name, address, and telephone number;
2. The registered Farm Service Agency (FSA) farm names of the farms for which the extension is requested;
3. The legal description of the fields or an accurate scale farm map of the fields for which the extension is requested;
4. A detailed description of the qualifying weather events supporting the extension request, including the dates of the events; and
5. The number of days requested as an extension of the tillage deadline.

D. Submission Deadline.
1. Extension requests shall be postmarked a minimum of one business day prior to the tillage deadline.
2. Extension requests that are illegible or missing information required by subsection (C) shall be considered incomplete and returned to the requestor with a written explanation of the deficiencies. Corrected extension requests shall also be postmarked a minimum of one business day prior to the tillage deadline.

E. Administrative Review.
1. The Council Staff Director may amend, grant or deny a request for extension based on the information provided and any other relevant information available, including but not limited to data collected from meteorological sources, staff recommendations, field notes and photographs.
2. The Council Staff Director shall issue a written notice granting or denying an extension request within ten business days of receipt of a complete request.

F. Blanket Extensions. The Council, by vote, may authorize a blanket weather-related extension for a county, cultural zone or a subset of either based on an area-wide qualifying weather event or events.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 27. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) HEALTH CARE GROUP COVERAGE

Editor's Note: The following Notice of Proposed Rulemaking was reviewed per Executive Order 2012-03 as issued by Governor Brewer. (See the text of the executive order on page 3586.) The Governor's Office authorized the notice to proceed through the rulemaking process on August 14, 2013.

[R13-206]

PREAMBLE

1. Article, Part, or Section Affected (as applicable)	**Rulemaking Action:**
Chapter 27	Repeal
Article 1	Repeal
R9-27-101	Repeal
Article 2	Repeal
R9-27-202	Repeal
R9-27-203	Repeal
R9-27-204	Repeal
R9-27-210	Repeal
Article 3	Repeal
R9-27-301	Repeal
R9-27-302	Repeal
R9-27-303	Repeal
R9-27-307	Repeal
R9-27-310	Repeal
R9-27-311	Repeal
R9-27-312	Repeal
Article 5	Repeal
R9-27-509	Repeal
Article 7	Repeal
R9-27-702	Repeal
R9-27-703	Repeal
R9-27-704	Repeal

2. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):

Authorizing statute: A.R.S. § 36-2912

Implementing statute: A.R.S. § 36-2912.01 and Laws 2013, First Special Session, Chapter 10, § 42

3. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the proposed rule:

Notice of Rulemaking Docket Opening: 19 A.A.R. 3582, November 15, 2013 (*in this issue*).

4. The agency's contact person who can answer questions about the rulemaking:

Name:	Mariaelena Ugarte
Address:	AHCCCS Office of Administrative Legal Services 701 E. Jefferson, Mail Drop 6200 Phoenix, AZ 85034
Telephone:	(602) 417-4693
Fax:	(602) 253-9115
E-mail:	AHCCCSRules@azahcccs.gov
Web site:	www.azahcccs.gov

5. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

Arizona Laws 2013, First Special Session, Chapter 10 (House Bill 2010), relates to the operation of the Arizona Health Care Cost Containment System. That act made changes to the program which requires rulemaking repealing the Health Care Group program.

This provision is necessary to comply with federal or state requirements that contain dates certain for compliance. The Health Care Group program will no longer have an appropriation as described under A.R.S. § 36-2912.01 and will cease to exist January 1, 2014. New enrollment into Health Care Group ceased August 1, 2013.

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:

A study was not referenced or relied upon when repealing the Health Care Group Coverage.

7. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking 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 Health Care Group program will no longer have an appropriation as described under A.R.S. § 36-2912.01 and will cease to exist January 1, 2014. The revenue acquired through premiums has self-sustained the Health Care Group program, but with the new tax subsidies and health care exchange in 2014 the Administration felt the HCG program would not be sustainable since the program cannot provide the tax subsidies. There are 1929 employer groups enrolled as of October, 2013, that the Administration believes will qualify for health care coverage through the Health Care Exchange and benefit from the tax subsidies.

9. The agency's contact person who can answer questions about the economic, small business and consumer impact statement:

Name:	Mariaelena Ugarte
Address:	AHCCCS Office of Administrative Legal Services 701 E. Jefferson, Mail Drop 6200 Phoenix, AZ 85034
Telephone:	(602) 417-4693
Fax:	(602) 253-9115
E-mail:	AHCCCSRules@azahcccs.gov
Web site:	www.azahcccs.gov

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

Proposed rule language will be available on the AHCCCS website www.azahcccs.gov the week of November 11, 2013. Please send written or email comments to the above address by the close of the comment period, 5:00 p.m., December 30, 2013.

Date:	December 30, 2013
Time:	10:00 a.m.
Location:	AHCCCS 701 East Jefferson Phoenix, AZ 85034
Nature:	Public Hearing

Date:	December 30, 2013
Time:	10:00 a.m.
Location:	ALTCS: Arizona Long-Term Care System 1010 N. Finance Center Dr, Suite 201 Tucson, AZ 85710
Nature:	Public Hearing

Date:	December 30, 2013
Time:	10:00 a.m.
Location:	2717 N. 4th St. STE 130 Flagstaff, AZ 86004
Nature:	Public Hearing

11. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

No other matters have been prescribed.

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

Not applicable

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

Not applicable

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

No analysis was submitted.

12. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:

None

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 27. ~~ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM HEALTHCARE GROUP COVERAGE~~ REPEAL

ARTICLE 1. ~~DEFINITIONS~~ REPEAL

Section
R9-27-101. ~~Location of Definitions~~ Repeal

ARTICLE 2. ~~SCOPE OF SERVICES~~ REPEAL

Section
R9-27-202. ~~Covered Services~~ Repeal
R9-27-203. ~~Exclusions and Limitations~~ Repeal
R9-27-204. ~~Emergency Medical Services~~ Repeal
R9-27-210. ~~Pre-existing Conditions~~ Repeal

ARTICLE 3. ~~ELIGIBILITY AND ENROLLMENT~~ REPEAL

Section
R9-27-301. ~~Eligibility Criteria for Employers~~ Repeal
R9-27-302. ~~Eligibility and Enrollment Criteria for Employees~~ Repeal
R9-27-303. ~~Dependent Eligibility Criteria~~ Repeal
R9-27-307. ~~Enrollment; Effective Date of Coverage~~ Repeal
R9-27-310. ~~Termination of HCG Coverage; Denial of Enrollment; Exclusion from Eligibility and Enrollment~~ Repeal
R9-27-311. ~~Effective Date of Termination of HCG Coverage~~ Repeal
R9-27-312. ~~Continuation Coverage~~ Repeal

ARTICLE 5. ~~GENERAL PROVISIONS AND STANDARDS~~ REPEAL

Section
R9-27-509. ~~Information to Subscribers~~ Repeal

ARTICLE 7. ~~STANDARDS FOR PAYMENTS~~ REPEAL

Section
R9-27-702. ~~Charges to Members~~ Repeal
R9-27-703. ~~Payments by an HCG Plan~~ Repeal
R9-27-704. ~~Liability of an HCG Plan to a Noncontracting Hospital for the Provision of Emergency and Post-stabilization Services to Members~~ Repeal

ARTICLE 1. ~~DEFINITIONS~~ REPEAL

R9-27-101. ~~Location of Definitions~~ Repeal

~~A.~~ ~~Location of definitions. Definitions applicable to this Chapter are found in the following:~~

~~Definition~~	~~Section or Citation~~
~~"Accountable health plan"~~	~~A.R.S. § 20-2301~~
~~"ADHS"~~	~~R9-27-101~~
~~"AHCCCS"~~	~~R9-27-101~~
~~"Ambulance"~~	~~A.R.S. § 36-2201~~
~~"Certification"~~	~~29 U.S.C. 1181~~
~~"Clean claim"~~	~~A.R.S. § 36-2904~~
~~"COBRA continuation provisions"~~	~~A.R.S. § 36-2912~~
~~"Coinsurance"~~	~~R9-27-101~~
~~"Copayment"~~	~~R9-27-101~~
~~"Covered services"~~	~~R9-27-101~~
~~"Creditable coverage"~~	~~A.R.S. § 36-2912~~
~~"Day"~~	~~R9-27-101~~
~~"Deductible"~~	~~R9-27-101~~
~~"Dependent"~~	~~R9-27-101~~
~~"Disability"~~	~~R9-27-303~~
~~"Effective date of coverage"~~	~~R9-27-101~~
~~"Eligible employee"~~	~~A.R.S. § 36-2912~~
~~"Emergency ambulance service"~~	~~R9-27-101~~
~~"Emergency medical services"~~	~~R9-27-101~~
~~"Employee"~~	~~R9-27-101~~
~~"Employer"~~	~~R9-27-101~~
~~"Employer group"~~	~~R9-27-101~~
~~"Enrollment"~~	~~R9-27-101~~
~~"Experimental services"~~	~~R9-27-101~~
~~"Full-time employee"~~	~~R9-27-101~~
~~"GSA"~~	~~R9-27-101~~
~~"HCG"~~	~~R9-27-101~~

~~"HCGA"~~	~~R9-27-101~~
~~"HCG plan"~~	~~R9-27-101~~
~~"Health care coverage"~~	~~R9-27-101~~
~~"Health care practitioner"~~	~~R9-27-101~~
~~"Hospital"~~	~~R9-27-101~~
~~"Inpatient hospital services"~~	~~R9-27-101~~
~~"Late enrollee"~~	~~R9-27-101~~
~~"Medical services"~~	~~A.R.S. § 36-401~~
~~"Medically necessary"~~	~~R9-27-101~~
~~"Member"~~	~~R9-27-101~~
~~"Member handbook and evidence of coverage" or "member handbook"~~	~~R9-27-101~~
~~"Network"~~	~~R9-27-101~~
~~"Network provider"~~	~~R9-27-101~~
~~"Political subdivision"~~	~~R9-27-101~~
~~"Post-stabilization services"~~	~~R9-27-101~~
~~"Pre-existing condition"~~	~~A.R.S. § 36-2912~~
~~"Pre-existing condition exclusion"~~	~~A.R.S. § 36-2912~~
~~"Premium"~~	~~R9-27-101~~
~~"Pre-payment"~~	~~R9-27-101~~
~~"Prior authorization"~~	~~R9-27-101~~
~~"Qualifying event"~~	~~R9-27-101~~
~~"Scope of services"~~	~~R9-27-101~~
~~"Spouse"~~	~~R9-27-101~~
~~"Subcontract"~~	~~R9-27-101~~
~~"Subscriber"~~	~~R9-27-101~~
~~"Subscriber enrollment form"~~	~~R9-27-101~~
~~"Substantial gainful activity"~~	~~R9-27-303~~
~~"United States"~~	~~R9-27-101~~
~~"Waiting period"~~	~~A.R.S. § 36-2912~~

~~**B.** Definitions. In addition to the definitions contained in A.R.S. Title 36, Chapter 29, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:~~

~~"ADHS" means the Arizona Department of Health Services, the state agency mandated to serve the public health needs of all Arizona residents.~~

~~"AHCCCS" means the Arizona Health Care Cost Containment System, which provides health services to an eligible member through the Administration, contractors, and other arrangements.~~

~~"Coinsurance" means a predetermined percentage of the cost of a covered service as specified in the GSA that a member agrees to pay for the provision of that service.~~

~~"Copayment" means a fixed-dollar amount that a member is required to pay directly to a provider at the time the services are rendered in order to receive the services.~~

~~"Covered services" means the health and medical services described in Article 2 of this Chapter, the GSA, and the member handbook.~~

~~"Day" means a calendar day unless otherwise specified.~~

~~"Deductible" means the annual fixed-dollar amount of covered expenses that the member must pay before the HCG Plan starts to pay for covered services, subject to copayments and coinsurance.~~

~~"Dependent" means the eligible child and spouse of a subscriber under Article 3 of this Chapter.~~

~~"Effective date of coverage" means the date on which a subscriber or dependent can receive HCG coverage.~~

~~"Emergency ambulance service" means transportation by a ground or an air ambulance company for a member requiring emergency medical services in which the emergency medical services are provided by a person certified or licensed by a state to provide the services before, during, or after the member is transported by a ground or an air ambulance company.~~

~~"Emergency medical services" means covered medical services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, may reasonably expect the absence of immediate medical attention to result in:~~

- ~~Placing a patient's health in serious jeopardy,~~
- ~~Serious impairment to bodily functions, or~~
- ~~Serious dysfunction of any bodily organ.~~

~~"Employee" means a person employed by an employer, a person who is self-employed, or a person who is eligible for~~

~~a federal health coverage tax credit under 26 U.S.C. 35. A self-employed person shall meet the criteria specified in R9-27-301.~~

~~"Employer" means a business within this state that employs at least one but not more than 50 eligible full-time employees on the effective date of the first GSA with an HCG Plan, or an eligible political subdivision of this state. An employer includes a person who is self-employed.~~

~~"Employer group" means all eligible enrolled subscribers and eligible enrolled dependents, who receive HCG coverage through a contract with the employer.~~

~~"Enrollment" means the process in which an eligible employee and any eligible dependents are qualified to receive HCG covered services by selecting HCG coverage and completing and submitting all necessary and required documentation specified by HCGA under R9-27-302, provided that HCGA receives the full required premium for the entire employer group no later than the date specified in the employer group GSA.~~

~~"Experimental services" means services that are associated with treatment or diagnostic evaluation and that are not generally and widely accepted as a standard of care in the practice of medicine in the United States unless:~~

~~The weight of evidence in peer-reviewed articles in medical journals published in the United States supports the safety and effectiveness of the service; or~~

~~In the absence of such articles, for services that are rarely used, novel, or relatively unknown in the general professional medical community, the weight of opinions from specialists who provide the service attests to the safety and effectiveness of the service.~~

~~"Full-time employee" means an employee or a self-employed person who works at least 20 hours per week.~~

~~"GSA" means Group Service Agreement, a contract between an employer and HCGA or between HCGA and a person eligible for the federal health coverage tax credit.~~

~~"HCG" means Healthcare Group of Arizona, the program within the Administration authorized by A.R.S. § 36-2912 that allows HCG Plans to provide pre-paid health care coverage to subscribers of small businesses and political subdivisions within the state of Arizona through contracts with HCGA.~~

~~"HCGA" means Healthcare Group of Arizona Administration, which directs, determines eligibility, and regulates the continuous development and operation of the HCG program.~~

~~"HCG Plan" means a health plan offered by HCGA or by an entity under contract with the HCGA that establishes networks, manages the provision of covered services, and arranges for, and pays for HCG covered services through subcontracts with providers.~~

~~"Health care coverage" means a hospital or medical service corporation policy or certificate, a health care services organization contract, a multiple-employer welfare arrangement, or any other arrangement under which health services or health benefits are provided to two or more persons. Health care coverage does not include the following:~~

~~Accident only, dental only, vision only, disability income only or long-term care only insurance, fixed or hospital indemnity coverage, limited benefit coverage, specified disease coverage, credit coverage, or Taft-Hartley trusts;~~

~~Coverage that is issued as a supplement to liability insurance;~~

~~Medicare supplemental insurance;~~

~~Workers' compensation insurance; or~~

~~Automobile medical payment insurance.~~

~~"Health care practitioner" means a person who is licensed or certified under Arizona law to deliver health care services.~~

~~"Hospital" means a health care institution licensed as a hospital by the ADHS under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is determined by AHCCCS to meet the requirements for certification under Title XVIII of the Social Security Act, as amended.~~

~~"Inpatient hospital services" means services provided to a member who is admitted to a hospital for medical care and treatment. An inpatient hospital service is provided by or under the direction of a physician or other health care practitioner upon referral from a member's primary care provider.~~

~~"Late enrollee" means a member who enrolls 31 days after the effective date of the employer's initial GSA, or 31 days after a qualifying event, or outside of the open enrollment period.~~

~~"Medically necessary" means a covered service is determined by the HCG Plan or HCGA Medical Director, and a physician or other licensed health care practitioner within the scope of the physician's or other health care practitioner's practice under state law to:~~

~~Prevent disease, disability, or other adverse health condition or its progression; or~~

~~Prolong life.~~

~~"Member" means a subscriber and the subscriber's dependents who are enrolled with an HCG Plan for health care coverage.~~

~~"Member handbook and evidence of coverage" or "member handbook" means the written description that HCGA provides to each subscriber on enrollment, of the rights and responsibilities of members, as well as a list of covered services, limitations, exclusions, coinsurance, copayments, and deductibles that apply to the member's choice of coverage.~~

~~"Network" means the affiliation of physicians, hospitals and other providers that provide health care services to members through contracts with HCGA or HCG Plans.~~
~~"Network provider" means a provider who has a subcontract with HCGA or an HCG Plan and renders covered services to the member.~~
~~"Political subdivision" means the state of Arizona or a county, city, town, or school district within the state, or an entity whose employees are eligible for hospitalization and medical care under Arizona Revised Statutes, Title 38, Chapter 4, Article 4.~~
~~"Post-stabilization services" means covered services related to an emergency medical condition provided after the condition is stabilized.~~
~~"Premium" means the entire monthly pre-payment amount due to HCGA by the employer for coverage of medical benefits for all subscribers and dependents.~~
~~"Pre-payment" means the monthly submission by the employer or any eligible employee of the full premium payment at least 30 days in advance of coverage under the GSA.~~
~~"Prior authorization" means the process by which the HCGA or the HCG Plan informs a provider that it has made a preliminary determination that a requested service is medically necessary, appropriate, and is a covered service. Prior authorization is not a guarantee of payment.~~
~~"Qualifying event" means a situation as described in the GSA that enables a person to enroll outside a designated open enrollment period without being considered a late enrollee, or to obtain continuation coverage, if applicable.~~
~~"Scope of services" means the covered, limited, and excluded services listed in Article 2 of this Chapter, the GSA, and the member handbook.~~
~~"Spouse" means a husband or a wife of an HCG subscriber who has entered into a marriage recognized as valid by the state of Arizona.~~
~~"Subcontract" means an agreement entered into by HCGA or an HCG Plan with any of the following:~~
~~A provider of health care services who agrees to furnish covered services to members,~~
~~A marketing organization, or~~
~~Any other organization to serve the needs of the HCG Plan.~~
~~"Subscriber" means an enrolled HCG employee, including a person who meets the eligibility requirements for the federal health coverage tax credit under 26 U.S.C. 35 (Section 35 of the Internal Revenue Code of 1986).~~
~~"Subscriber enrollment form" means the form that a subscriber fills out to select and enroll in an HCG Plan and to choose a deductible.~~
~~"United States" means the 50 states, the District of Columbia, and includes the territorial waters adjoining these entities. A ship or an aircraft, even of American registry, is not considered to constitute American territory when it is not within or above the land area or territorial waters of the United States.~~

ARTICLE 2. ~~SCOPE OF SERVICES~~ REPEAL

R9-27-202. ~~Covered Services~~ Repeal
~~Covered services. HCGA or an HCG Plan shall provide covered services to members as specified in the GSA.~~

R9-27-203. ~~Exclusions and Limitations~~ Repeal
~~A.~~ ~~Excluded services. An HCG Plan shall not cover the following:~~
1. ~~Excluded services as specified in the GSA and the member handbook;~~
2. ~~Services not covered in the member's choice of HCG benefit options;~~
3. ~~Services that require prior authorization for which the member does not obtain prior authorization;~~
4. ~~Care for a health condition for which a state or local law requires the member to be treated in a public facility;~~
5. ~~Care for military service disabilities treatable through governmental facilities if the member is legally entitled to treatment and the facilities are available;~~
6. ~~Pregnancy termination, except when required by law to be covered;~~
7. ~~Treatment of gender dysphoria including gender reassignment surgeries and reversal of voluntarily induced infertility (sterilization);~~
8. ~~Services that HCGA, through its Medical Director, deems not to be medically necessary;~~
9. ~~Charges for injuries incurred as the result of:~~
   a. ~~Participating in a riot,~~
   b. ~~Committing or attempting to commit a felony or assault,~~
   c. ~~Committing intentional acts of self-inflicted injury, or~~
   d. ~~Attempting suicide.~~
10. ~~Infertility testing, in-vitro fertilization, and all other fertilization treatments;~~
11. ~~Experimental services; and~~
12. ~~Medications not approved by the FDA.~~

~~B.~~ ~~Limitations. When providing covered services, the HCG Plan shall adhere to the coverage limitations in this Article and~~

~~the following:~~

~~1. Inpatient hospital accommodations are covered as specified in the GSA and the member handbook.~~
~~2. Alternative levels of care instead of hospitalization are covered if cost-effective and medically necessary.~~
~~3. Dialysis is limited to services not covered by Title XVIII, of the Social Security Act, as amended.~~

R9-27-204. ~~Emergency Medical Services~~ Repeal

~~**A.** Emergency medical services provided at a medical facility in the United States are covered when a member presents for emergency medical services regardless of whether the services are provided within or outside the network if the member or provider notifies the selected HCG Plan no later than 48 hours from the day that the member presents for the emergency service. Failure to provide timely notice constitutes cause for denial of payment unless the member or provider shows good cause. All emergency medical services are subject to review after services are received to ensure that the services are emergent and are covered, medically necessary services.~~
~~**B.** Emergency medical services provided outside the United States are not covered.~~

R9-27-210. ~~Pre-existing Conditions~~ Repeal

~~**A.** Pre-existing conditions exclusions. Except as provided in subsection (B), any health and medical services related to a pre-existing condition are not covered as specified in A.R.S. § 36-2912 and the GSA.~~
~~**B.** Pre-existing conditions coverage. Health and medical services relating to pre-existing conditions for the following individuals are covered:~~
~~1. Newborns from the time of birth, adopted children, and children placed for adoption, if enrolled within the timeframes set forth in the GSA;~~
~~2. A subscriber eligible under R9-27-302 who meets the aggregate periods of creditable coverage as calculated under A.R.S. § 36-2912 of 12 months or 18 months in the case of a late enrollee.~~
~~**C.** Credit for prior health coverage. A member shall receive a credit toward meeting the 12-month or 18-month pre-existing condition exclusion period of one month for each month of continuous coverage that a member received from HCG/HCGA or an accountable health plan under A.R.S. § 36-2912. Upon request, an HCG Plan that provided continuous coverage to a person shall disclose the coverage provided.~~

ARTICLE 3. ~~ELIGIBILITY AND ENROLLMENT~~ REPEAL

R9-27-301. ~~Eligibility Criteria for Employers~~ Repeal

~~**A.** Criteria for employers.~~
~~1. To be eligible for health care coverage through HCG, an employer shall:~~
~~a. Conduct business in the state of Arizona for at least 60 days before applying to HCGA.~~
~~b. Have a minimum of one (self-employed) and a maximum of 50 eligible full-time employees on the effective date of the first GSA with HCGA.~~
~~2. R9-27-301(A)(1)(b) does not apply to political subdivisions.~~
~~**B.** Employer's prior health care coverage. HCGA shall not enroll an employer in Healthcare Group sooner than 180 days after the date that the employer's health care coverage under an accountable health plan is discontinued. An employer's enrollment in HCG is effective on the first day of the month after the 180-day period. The 180-day enrollment restriction does not apply to an employer if the employer's accountable health plan discontinues offering the health plan of which the employer is a member.~~
~~**C.** Required initial enrollment of a minimum percentage of eligible employees. An employer other than a political subdivision shall meet the following enrollment percentages on the effective date of the first GSA with HCGA:~~
~~1. An employer with five or fewer eligible full-time employees shall enroll 100 percent of these employees in an HCG Plan, or~~
~~2. An employer with six or more eligible full-time employees shall enroll at least 80 percent of these employees in an HCG Plan.~~
~~**D.** Full-time employees with proof of other health care coverage. Full-time employees with proof of existing health care coverage who elect not to participate in HCG shall not be considered when determining the required percentage of enrollees, specified in subsection (C), if the health care coverage is one of the following:~~
~~1. Group coverage provided through a spouse, parent, legal guardian; or~~
~~2. Medical assistance provided by a government-subsidized health care program; or~~
~~3. Medical assistance provided under A.R.S. § 36-2982; or~~
~~4. Individual coverage or health care coverage through another employer.~~
~~**E.** Post-enrollment changes in employer size. Changes in employer size that occur during the term of the GSA or during any renewal periods do not affect eligibility.~~
~~**F.** Review and verification of eligibility. HCGA may conduct random reviews for continued eligibility of an employer and the members.~~

R9-27-302. ~~Eligibility and Enrollment Criteria for Employees~~ Repeal

~~**A.** Eligibility criteria for employees. An eligible employee shall:~~
~~1. Be eligible for a federal health coverage tax credit under 26 U.S.C. 35 as specified in A.R.S. § 36-2912 (AA)(4)(d); or~~
~~2. Be employed by an enrolled employer with a contract with HCG as specified in R9-27-301; and~~
~~a. Work at least 20 hours per week for the employer; and~~
~~b. Meet other requirements as specified in the GSA.~~
~~**B.** Enrollment criteria for eligible employees. An eligible employee and an eligible dependent may receive HCG coverage if all of the following occur:~~
~~1. An eligible employee selects health care coverage through HCG;~~
~~2. An eligible employee completes and submits all necessary documentation specified by HCGA, including the subscriber enrollment form and health history forms; for the eligible employee and each applying family member; and~~
~~3. HCGA receives the full required premium no later than the date specified in the GSA.~~
~~**C.** After completion of the actions in subsection (B), HCGA shall send written notification of the effective date of coverage to the subscriber and dependent.~~
~~**D.** Eligibility for government-subsidized health care programs. HCGA shall provide written information to members who may be eligible for a government-subsidized health care program.~~

R9-27-303. ~~Dependent Eligibility Criteria~~ Repeal

~~**A.** Eligible dependents. An eligible dependent of an employee member includes:~~
~~1. A legal spouse;~~
~~2. An unmarried child less than the age of 19 or less than the age of 24 if the child is a full-time student, and is:~~
~~a. A natural child,~~
~~b. An adopted child or a child who is placed for adoption,~~
~~c. A step-child, or~~
~~d. A child for whom the subscriber or enrolled spouse is a legal guardian.~~
~~3. An unmarried child, as specified in subsection (A)(2), of any age with a disability that existed before the child's 19th birthday, as determined by HCGA through the HCGA Medical Director.~~
~~**B.** For the purposes of this Section:~~
~~1. "Disability" means the inability to do any substantial gainful activity by reason of any impairment or combination of impairments that HCGA through the HCGA Medical Director expects to be permanent and continuous. The impairment must result from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques. Medical evidence consisting of signs, symptoms, and laboratory findings, not only the member's statement of symptoms, establishes an impairment.~~
~~2. "Substantial gainful activity" means work that:~~
~~a. Involves doing significant and productive physical or mental duties, and~~
~~b. Is done or intended for pay or profit.~~

R9-27-307. ~~Enrollment; Effective Date of Coverage~~ Repeal

~~**A.** Enrollment. A member who meets the eligibility requirements may select and enroll in HCG coverage under the terms of the GSA at any time. In order not to be considered a late enrollee, an eligible member shall enroll during the qualifying event periods specified in the GSA:~~
~~1. Within 31 days following the effective date of the initial GSA with the employer;~~
~~2. Within 31 days after the qualifying event occurs;~~
~~3. When the open enrollment period occurs as specified in the GSA; or~~
~~4. Within 31 days following the termination of health care coverage for an eligible subscriber or dependent.~~
~~**B.** Effective date of coverage. The HCGA shall establish the effective date of coverage for an employer group or a subscriber or dependent and shall provide written notice of the effective date of coverage to the employer as provided under this Chapter.~~

R9-27-310. ~~Termination of HCG Coverage; Denial of Enrollment; Exclusion from Eligibility and Enrollment~~ Repeal

~~**A.** Immediate termination of a member's coverage. HCGA may terminate a member's coverage effective immediately for any of the following reasons:~~
~~1. Clear and convincing evidence of fraud or misrepresentation regarding enrollment or factors listed in A.R.S. § 36-2912 when the member applies for coverage or obtains services;~~
~~2. Committing or threatening to commit violence toward an employee or an agent of HCGA, an employee or an agent of an HCG Plan, including a network provider or an out-of-network provider.~~
~~**B.** Written notice. For immediate termination of a member's coverage under subsection (A), HCGA shall mail a notice of termination of coverage to the member's last known address within one business day after HCGA terminates a member's coverage. The notice shall state the date and time coverage was terminated and the reason for termination.~~

~~**C.** Termination of a member's coverage with 30-day notice. HCGA may terminate a member's coverage 30 days from the date of the notice for any of the following reasons:~~
~~1. Repeated and unreasonable demands for unnecessary or uncovered medical services;~~
~~2. Failure to pay any copayment, coinsurance, or deductible;~~
~~3. Violation of a material provision of the member handbook;~~
~~4. Termination of employment;~~
~~5. Change in status of the member that is required for eligibility under R9-27-302; or~~
~~6. Changes to the eligibility criteria for a dependent under R9-27-303.~~
~~**D.** Written notice. For termination of a member's coverage with 30 days notice under subsection (C), HCGA shall mail a notice of proposed termination to the member's last known address. The notice shall state the reason for proposed termination and the date coverage will be terminated.~~
~~**E.** Termination of an employer group. If HCGA does not receive the full premium payment from an employer for an employer group by the premium due date specified in the GSA, HCGA shall send notice of the final due date to the employer at the employer's last known address. The notice shall advise the employer that HCGA must receive the full premium payment by the final due date contained in the notice and state the reason and date for the termination of coverage for the employer group if the full premium is not received by the final due date.~~
~~**F.** Exclusion of member from eligibility and enrollment. HCGA may exclude, as ineligible to enroll or re-enroll, any member whose prior health care coverage has been terminated by HCGA for any of the following reasons:~~
~~1. Clear and convincing evidence of fraud or misrepresentation regarding enrollment or criteria listed in R9-27-302 and R9-27-303 when the member applies for coverage or obtains services;~~
~~2. Committing or threatening to commit violence toward an employee or an agent of HCGA, an employee or an agent of an HCG Plan, including a network provider, or an out-of-network provider;~~
~~3. Repeated and unreasonable demands for unnecessary or uncovered medical services;~~
~~4. Failure to pay any copayment, coinsurance, or deductible;~~
~~5. Violation of a material provision of the member handbook.~~
~~**G.** Exclusion of an employer from eligibility and enrollment. HCGA may exclude, as ineligible to enroll or re-enroll, an employer whose prior health care coverage has been terminated by HCGA for any of the following reasons:~~
~~1. Violating a provision of the GSA;~~
~~2. Committing or threatening to commit violence toward an employee or an agent of HCGA, an employee or an agent of an HCG Plan, including a network provider, or an out-of-network provider;~~
~~3. Clear and convincing evidence of fraud or misrepresentation regarding eligibility and enrollment criteria for an employer in R9-27-301.~~

R9-27-311. ~~Effective Date of Termination of HCG Coverage~~ Repeal

~~**A.** Except as specified in subsection (B), HCG coverage for a member shall terminate on the date specified in the notice mailed to the member as provided in R9-27-310(B), (D), or (E).~~
~~**B.** HCGA shall provide and pay for health care services for a member who is an inpatient on the effective date of termination of coverage until the HCG Plan Medical Director or designee determines that care in the hospital is no longer medically necessary, provided that HCGA continues to receive timely paid premiums for the member. Coverage for all other members, except the member who is an inpatient, shall terminate as provided in subsection (A).~~

R9-27-312. ~~Continuation Coverage~~ Repeal

~~A member who is entitled to continuation coverage under A.R.S. § 36-2912(AA)(2) may retain HCG coverage until the benefit expires, the continuation coverage ends, or the premium is not paid by the member, whichever is earlier.~~

ARTICLE 5. ~~GENERAL PROVISIONS AND STANDARDS~~ REPEAL

R9-27-509. ~~Information to Subscribers~~ Repeal

~~**A.** Member handbook. HCGA shall produce and distribute a printed member handbook to each subscriber by the effective date of coverage or as otherwise stated in the GSA. The member handbook shall include the following:~~
~~1. A description of all available services and an explanation of any service limitations, exclusions from coverage, and charges for services, when applicable;~~
~~2. An explanation of the procedure for obtaining covered services, including a notice stating that the HCG Plan is only liable for services authorized by a member's primary care provider or the HCG Plan;~~
~~3. Procedures for obtaining emergency medical services;~~
~~4. An explanation of the procedure for obtaining emergency medical services outside the network of an HCG Plan;~~
~~5. Circumstances under which a member may lose coverage;~~
~~6. A description of the grievance and request for hearing procedures;~~
~~7. Copayment, coinsurance, and deductible schedules;~~
~~8. Information on obtaining health services and on the maintenance of personal and family health; and~~

9. Information regarding medically necessary emergency transportation offered by an HCG Plan.

B. Notification of changes in services. HCGA shall prepare and distribute to members a printed member handbook endorsement describing any changes, including changes to deductibles, coinsurance, and copayments that HCGA proposes to make in services provided within the HCG network. HCGA shall distribute the endorsement to all affected members and dependents at least 14 days before a planned change. HCGA shall provide notification as soon as possible when unforeseen circumstances require an immediate change in services or service locations.

ARTICLE 7. ~~STANDARDS FOR PAYMENTS~~ Repeal

R9-27-702. ~~Charges to Members~~ Repeal

If a member notifies a provider that the member is covered by HCG, the provider shall not charge, submit a claim to, or demand or otherwise collect payment from the member or a person acting on behalf of the member for any covered service, except the provider may collect from or bill the member:

1. For any copayment, coinsurance, or deductible as described in the GSA;
2. If the member requests the provision of services, other than emergency medical services, that are excluded under the GSA or have not been authorized by an HCG Plan; or
3. For the difference between any payments the provider receives from an HCG Plan and billed charges for services if the provider has obtained, prior to the delivery of the service, the written agreement of the member to accept financial responsibility for the difference.

R9-27-703. ~~Payments by an HCG Plan~~ Repeal

A. Neither HCGA nor an HCG Plan is responsible for reimbursing a provider for services that are:

1. Excluded under the GSA; or
2. In the case of non-emergency services, services not authorized by an HCG Plan or that did not result from a referral.

B. An HCG Plan shall reimburse a network provider for covered services as specified in the subcontract between the HCG Plan and the provider.

C. If a member receives emergency medical services from a provider other than a network provider, or if an HCG Plan authorizes services to be delivered by, or refers a member to a provider other than a network provider, the HCG Plan shall reimburse the provider for covered services at the lesser of billed charges or an amount negotiated with the provider less any copayment, coinsurance, or deductible as described in the GSA.

D. An HCG Plan shall adjudicate claims from providers within 60 days of receipt of a clean claim from the provider unless a different time is specified in the subcontract between the HCG Plan and the provider.

R9-27-704. ~~Liability of an HCG Plan to a Noncontracting Hospital for the Provision of Emergency and Post-stabilization Services to Members~~ Repeal

An HCG Plan shall reimburse a noncontracting hospital for the provision of emergency and post-stabilization services to a member in accordance with the terms of the HCG Plan's contract with HCGA and the GSA. Unless the GSA or contract with HCGA states otherwise, the HCG Plan shall meet the following requirements:

1. Liability to noncontracting hospitals. An HCG Plan shall reimburse a noncontracting hospital for a member's emergency medical services until the member's condition is stabilized and the member is transferable to a contracting hospital or is discharged after the member's condition is stabilized.
2. Member refusal of transfer. If a member refuses transfer from a noncontracting hospital to a contracting hospital, neither HCGA nor an HCG Plan is liable for any costs incurred after the date of refusal when:
   a. The HCG Plan consulted with the member and the member continued to refuse the transfer; and
   b. The member is provided and signs a written statement of liability on or before the date of consult by which the member indicates the member is aware of the financial consequences of refusing to transfer, or two witnesses sign a statement indicating that the member was provided the statement of liability but refused to sign.

NOTICE OF PROPOSED RULEMAKING

TITLE 19. ALCOHOL, HORSE AND DOG RACING, LOTTERY, AND GAMING

CHAPTER 3. ARIZONA STATE LOTTERY COMMISSION

Editor's Note: The following Notice of Proposed Rulemaking was reviewed per Executive Order 2012-03 as issued by Governor Brewer. (See the text of the executive order on page 3586.) The Governor's Office authorized the notice to proceed through the rulemaking process on July 18, 2013.

[R13-193]

PREAMBLE

1. Article, Part, or Section Affected (as applicable) **Rulemaking Action**

R19-3-202 Amend

2. Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):

Authorizing statute: A.R.S. § 5-554(B)

Implementing statute: A.R.S. § 5-562

3. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the proposed rules:

Notice of Rulemaking Docket Opening: 19 A.A.R. 2858, September 20, 2013

4. The agency's contact person who can answer questions about the rulemaking:

Name:	Jeff Hatch-Miller, Executive Director
Address:	Arizona State Lottery 4740 E. University Dr. Phoenix, AZ 85034
Telephone:	(480) 921-4505
Fax:	(480) 921-4488
E-mail:	jhatchmiller@azlottery.gov
or	
Name:	Pam DiNunzio
Address:	Arizona State Lottery 4740 E. University Dr. Phoenix, AZ 85034
Telephone:	(480) 921-4489
Fax:	(480) 921-4488
E-mail:	pdinunzio@azlottery.gov

5. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation of the rulemaking:

Article 2, Retailers, prescribes the requirements and procedures for Arizona retail businesses that sell Lottery game products. The rules require a license applicant to submit fingerprints in order to perform a criminal background check. The Department of Public Safety (DPS) has historically provided this service for the Lottery. However, DPS has established a new program that will make compliance difficult for both the Lottery and prospective retailers. Through a data comparison, the Lottery found that criminal background information obtained from a database service was equivalent to that received from DPS. The rules are being amended to remove fingerprint requirements from the licensing process.

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:

The Lottery utilized two different approaches for securing criminal background information to determine if results were comparable. One method continued to use the fingerprint processing services of DPS and the other involved using a public records database system to obtain relevant information. Both methods were used for employment

background checks over a period of approximately eight months, and a comparison indicated that results were equivalent. This information is available at the Lottery's Phoenix office.

7. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking 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:

1. Identification of the proposed rulemaking.

The rules for Article 2, Retailers, describe various requirements and procedures for retail businesses that sell Lottery game products. The Lottery's existing retailer rules require a license applicant to submit fingerprints in order to perform a criminal background check. The Department of Public Safety (DPS) has been performing this service for the Lottery, but recently instituted a new compliance program for agencies requesting criminal history record information for non-criminal justice purposes, such as licensing. The new standards and chain of custody requirements will make it difficult and time-consuming for the applicant and the Lottery to comply with the new policy. This rulemaking removes licensing provisions pertaining to fingerprint requirements; no new rules are necessary.

Conduct and frequency of occurrence: There is no specific conduct this rulemaking is designed to change.

2. Persons who will be directly affected by, bear the costs of, or directly benefit from the proposed rulemaking.

The Lottery anticipates this rulemaking will primarily impact the agency and prospective Lottery retailers.

3. Cost-benefit Analysis:

a. Probable costs and benefits to the implementing agency and other agencies directly affected by the implementation and enforcement of the proposed rulemaking, including the number of new full-time employees necessary to implement and enforce the proposed rules.

Costs to the Lottery related to this rulemaking include application/licensing expenses. Retailers pay a license fee that allows the Lottery to recover costs for this service. No fee changes are requested as a result of these rules. The Lottery benefits from the rulemaking by avoiding time-consuming training that would strain limited staff resources. The Lottery also benefits from eliminating delays in the licensing process.

The Lottery has historically checked criminal background information for potential retailers by submitting fingerprints to DPS for processing. DPS has recently adopted FBI practices and policies for agencies requesting criminal history information. The new standards and chain of custody (protecting against fraud as fingerprints move through the process) would require extensive training, a difficult undertaking with the Lottery's present staffing levels.

Criminal background information can also be obtained through the use of a public records database service, without the need for fingerprints. Over the past 8 months, the Lottery conducted employment background checks using a dual system of fingerprints through DPS and "Lexis Nexis Accurint," a public records database. The database gathers information from various courts, property records, and tax assessments. The Lottery's investigations division compared the results from both sources and found that Lexis Nexis Accurint provided criminal background information that was just as reliable and more complete. The dual process test ensures there is a factual basis for determining that the replacement of a fingerprint-based criminal background check with a database criminal background check will provide the same information to the Lottery.

An ancillary benefit of a database service is increased efficiency in the licensing process. It takes up to 30 days to receive information back from DPS as compared to almost immediate turnaround from the database system. This should result in a reduced time frame to process license applicants. In FY13, the average application processing time was 35 days.

The cost to use the public records database is within $1 of the cost to DPS. As a result, no increase to the license fee is warranted. In addition, the change from DPS to Lexis Nexis Accurint will eliminate the need to recoup the additional DPS fingerprint charge for applicants that resided outside Arizona within the last 10 years. In FY13, the Lottery processed 195 new retailer license applications and renewed 320 license applications. Corporate chain stores submit one application for all store locations.

Other Agencies: The only other agency impacted by the rulemaking is the Department of Public Safety. DPS will no longer receive the fee for processing Lottery fingerprint requests, but this revenue was not significant in any given year. In FY13, the Lottery paid DPS approximately $9,000 for its services. It is likely that DPS will benefit from the ability to redirect time previously spent processing Lottery fingerprint requests to a more useful purpose.

FTE Requirements: The Lottery does not anticipate the need to hire any additional full-time employees; current staff resources will be used to implement the proposed rules.

b. Probable costs and benefits to a political subdivision of this state directly affected by the implementation and enforcement of the proposed rulemaking.

Other than the impact outlined above for DPS, this rulemaking should not have any impact on political subdivisions of the state.

c. Probable costs and benefits to businesses directly affected by the proposed rulemaking, including any anticipated effect on the revenues or payroll expenditure of employers who are subject to the proposed rulemaking.

Businesses impacted by these rules are retail establishments that choose to apply for a license to sell Lottery products. Lottery retailers are also the only small businesses impacted by this rulemaking. The rules are expected to benefit retailers, both large and small.

Costs to retailers include application/licensing fees and any administrative costs associated with selling Lottery products. There are no additional costs as a result of this rulemaking. The basic license fee remains unchanged, and eliminating the fingerprint requirement means applicants will save any out-of-pocket fees paid to have this performed, in addition to the related time investment. If relevant, applicants will also no longer incur the supplemental fingerprint fee associated with residing outside Arizona within the past 10 years.

Retailer license applicants will benefit from a more efficient Lottery licensing process. A faster turnaround time for becoming a licensed retailer translates to the opportunity to earn commissions earlier. In FY13, Lottery retailers earned over $46 million in game commissions. There are currently about 2900 licensed Lottery retailers.

The Lottery has a large number of retailers and the licensing process should be as straightforward as possible while still protecting the interests of the Lottery and the state. The new compliance standards through DPS would impose an undue burden on Lottery license applicants; some applicants may choose not to proceed with the licensing process if forced to comply with the new requirements. Replacing the traditional fingerprint process with the use of a database system simplifies the application process and lessons the burden for Lottery retailers, while still maintaining the integrity of licensing procedures.

4. Probable impact on private and public employment in businesses, agencies, and political subdivisions of the state directly affected by the proposed rulemaking.

This rulemaking will not have any identifiable impact on private and public employment.

5. Probable impact of the rulemaking on small business.

a. Identification of the small businesses subject to the rulemaking.

Small businesses impacted by these rules are also retail establishments that choose to apply for a license to sell Lottery products. The impact on these businesses should be positive as well. The elimination of the fingerprint requirement benefits all potential retailers, but small retail applicants may derive a greater benefit from the associated cost and time savings since these retailers are more likely to have limited administrative and personnel resources.

b. Administrative and other costs required for compliance with the rulemaking.

Any administrative costs incurred to comply with application requirements will apply to all businesses, including small businesses. However, as described above, this rulemaking reduces administrative costs associated with the fingerprint licensing requirement.

c. A description of methods that may be used to reduce the impact on small businesses and reasons for the agency's decision to use or not use each method.

Not applicable to this rulemaking; the rules are expected to have a positive impact on small businesses.

6. Probable cost and benefit to private persons and consumers who are directly affected by the proposed rulemaking.

There are no identifiable costs to consumers or the general public associated with this rulemaking. Consumers who also enjoy playing Lottery games will continue to benefit from a variety of retail locations offering Lottery products.

7. Probable effect on state revenues.

Revenue generated from retailer license fees are deposited into the Lottery Fund. The rulemaking is expected to have a neutral impact on state revenues since license fees only allow the Lottery to recover the cost of providing the service. In FY13, the Lottery collected $53,200 in license revenue.

A percentage of Lottery game revenue is returned to the state to fund various beneficiary programs as specified in A.R.S. §§ 5-572. Although an exact amount cannot be calculated, the state will benefit financially from any incremental revenues retailers generate as a result of a reduced licensing turnaround time. The Lottery returned a record $176.5 million to state beneficiaries in FY13.

8. Less intrusive or less costly alternative methods of achieving the purpose of the proposed rulemaking.

The Lottery is unaware of any other less intrusive or less costly methods for achieving the purpose of the rulemaking. Retailers will have reduced requirements with respect to the licensing process, which minimizes the burden on applicants, while still providing the Lottery with necessary criminal background information. Similarly, the elimination of the fingerprint requirement will lessen the administrative burden for the Lottery. The Lottery does not require additional funding or personnel resources to implement the proposed rules.

9. Description of any data on which the rule is based.

The only data/information utilized with respect to the rules was a comparison of criminal background information received from DPS and a database service to ensure consistency and reliability of results.

9. The agency's contact person who can answer questions about the economic, small business and consumer impact statement:

Name: Pam DiNunzio

Address: Arizona State Lottery
4740 E. University Dr.
Phoenix, AZ 85034

Telephone: (480) 921-4489

Fax: (480) 921-4488

E-mail: pdinunzio@azlottery.gov

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

Date: December 20, 2013

Time: 10:00 a.m.

Location: Arizona State Lottery
4740 E. University Dr.
Phoenix, AZ 85034

Nature: Oral Proceeding

The close of record is 5:00 p.m. on December 20, 2013 for written comments and the end of the oral proceeding for verbal comments. Written comments should be directed to the person listed in item 9.

11. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

Not applicable

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

The implementing statutes of the Lottery require a licensing process rather than a general permit.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

There is no corresponding federal law that is applicable to the subject matter. The rules are based on state law.

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

No analysis was submitted.

12. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:

None

13. The full text of the rules follows:

TITLE 19. ALCOHOL, HORSE AND DOG RACING, LOTTERY, AND GAMING

CHAPTER 3. ARIZONA STATE LOTTERY COMMISSION

ARTICLE 2. RETAILERS

Section
R19-3-202. Retailer's Application for License

ARTICLE 2. RETAILERS

R19-3-202. Retailer's Application for License

All applicants shall provide the Director with the following to apply for a license to sell Lottery tickets:

1. A verified application on forms prescribed by the Director containing the following information:
   a. The applicant's name, and if different, the trade name of the business premise, address of the physical location of the place of business, the mailing address if different, and phone number;
   b. The applicant's current transaction privilege tax license number issued under A.R.S. § 42-5005 and federal taxpayer identification number issued by the Internal Revenue Service and recorded on Form W-9;
   c. Certification that access to the applicant's business complies with the Americans with Disabilities Act;
   d. Marketing and sales information on the forms provided by the Lottery. The information required includes the number of cash registers, hours of operation, products presently offered for sale, and the approximate daily volume of customers entering the place of business;
   e. Evidence the applicant operates a business with other products or services unrelated to lottery products or services concerning lotteries;
   f. Financial relationship and any outstanding debt owed to the state of Arizona, any of its political subdivisions, or the United States government;
   g. Evidence the applicant for a full product license is financially solvent. The evidence may include either of the following:
      i. Evidence the applicant has established business credit, has a record of meeting its business debts as they became due for the three years immediately preceding the date of application, and does not have outstanding legal actions, judgments, or tax liens; or
      ii. Personal guarantee, in writing, of applicant's Lottery account signed by a guarantor and the guarantor's spouse, if community property is being used to guarantee the account, or by the guarantor only, if guarantor provides proof that the guarantee is based on sole and separate property.
   h. An Electronic Funds Transfer Authorization agreement showing a valid bank account number for the full product applicant from which the Lottery will withdraw any amounts due.
2. If the applicant does business as a sole proprietorship or partnership:
   a. The name, home address, and home phone number of each owner or partner, including spouse if community property owner, unless applicant provides proof that the business is sole property separate from the community; and
   b. Written authorization and tax identification number for the business entity and Social Security number of each applicant in order to obtain a credit check from a credit reporting agency~~; and~~.
   ~~c. A completed, authorized fingerprint card for the applicant. If any general partner is a corporation, a fingerprint card is required under subsection (4).~~
3. If the applicant does business as a limited liability partnership ("LLP") or a limited liability company ("LLC"):
   a. The name, home address, and home phone number of each partner or member; and
   b. Written authorization and a tax identification number to perform a credit check~~; and~~.
   ~~c. A completed authorized fingerprint card for each partner or member.~~
4. If the applicant does business as a corporation:
   a. The name, corporate address, and corporate phone number of each officer and director, and the name, home address and home phone number of the responsible local premise manager who is the contact representative for the applicant's corporate location in Arizona; and
   b. Written authorization and a tax identification number to perform a credit check~~; and~~.
   ~~c. A completed authorized fingerprint card for the appropriate responsible local premise manager.~~
5. If the applicant does business as a charitable organization:
   a. A copy of the organization charter or formation, documentation of current membership status in the organization, and if applicable, the authorization of the auxiliary;
   b. The name, home address, and home phone number of each officer and local premise manager, or if an auxiliary, of each officer and local premise manager of the auxiliary;
   c. A letter of determination issued in the organization's name by the United States Internal Revenue Service verifying the organization's tax-exempt status; and
   ~~d. A completed authorized fingerprint card for each officer and local premise manager, or if an auxiliary, of each officer and local premise manager of the auxiliary; and~~
   e. Evidence the charitable organization has maintained a premise within the state of Arizona for the two years immediately preceding the date of application.
6. If the Lottery licenses an applicant under subsection (1)(g)(ii), the guarantor shall provide a written authorization to perform a credit check. If the guarantee is based on community property, the guarantor and guarantor's spouse shall provide written authorization for the Lottery to perform a credit check.
7. An application fee of $45.00 and ~~the following fees, if applicable:~~ an additional credit check fee of $22 if the applicant does business as a corporation, limited liability company, limited liability partnership, or partnership.
   ~~a. If any individual listed on the personal questionnaire has resided outside the state of Arizona within the last 10 years, a fingerprint fee per individual as set by the Department of Public Safety.~~

~~b. If the applicant does business as a corporation, limited liability company, limited liability partnership, or a partnership, a credit check fee of $22.~~

8. If the applicant is a business with more than one currently licensed location, the application fee for the new location shall be pro-rated at $1.25 per month from the application date until the date the other licenses are due for renewal under R19-3-202.04(B)(3).