NOTICES OF FINAL RULEMAKING

The Administrative Procedure Act requires the publication of the final rules of the state's agencies. Final rules are those which have appeared in the *Register* first as proposed rules and have been through the formal rulemaking process including approval by the Governor's Regulatory Review Council or the Attorney General. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the *Register* after the final rules have been submitted for filing and publication.

NOTICE OF FINAL RULEMAKING

TITLE 2. ADMINISTRATION

CHAPTER 5. DEPARTMENT OF ADMINISTRATION PERSONNEL ADMINISTRATION

[R08-107]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R2-5-101	Amend
R2-5-416	Amend
R2-5-417	Amend
R2-5-418	Amend
R2-5-419	Amend
R2-5-421	Amend
R2-5-422	Amend

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. §§ 38-653 and 41-763(2) and (6)

Implementing statutes: A.R.S. § 38-651 et seq.

3. The effective date of the rules:

May 31, 2008

4. A list of all previous notices appearing in the *Register* addressing the final rules:

Notice of Rulemaking Docket Opening: 13 A.A.R. 4219, November 30, 2007

Notice of Proposed Rulemaking: 13 A.A.R. 4182, November 30, 2007

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

Name: Christine Bronson, Rulewriter

Address: 100 N. 15th Ave., Suite 261
Phoenix, AZ 85007

Telephone: (602) 542-1423

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

Eligible state officers, employees, and retirees may enroll in the state's qualifying insurance plans. Where specified, eligible members may also enroll their eligible dependents. The Arizona Department of Administration (ADOA) Personnel Rules define "eligible dependent" as the eligible member's spouse and each qualifying child. This rulemaking will amend the rules to extend insurance coverage to include an eligible member's domestic partner and the domestic partner's child(ren).

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

"Annual Advisory Recommendation" to the Governor and the Legislature prepared by the Arizona Department of Administration, September 2007 – this report provides market comparisons between State Service salaries and those of other states and other Arizona and regional employers. The report also provides information on turnover trends and projections for future market movement.

8. 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

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

These rules affect only state agencies, employees, elected officials and retirees and do not directly impact small businesses or consumers. The anticipated economic impact is due to a projected increase in employer subsidy costs in providing benefits to domestic partners and the domestic partner's child(ren). The Department has projected these costs to be between $1.4 and $4.25 million; however, the Department believes the program can be implemented cost-neutrally due to other savings in the benefits program through cost savings in Plan Year 2009. The changes in the rules will benefit state agencies in their recruitment and retention efforts and will also benefit state employees, retirees, and elected officials who have domestic partners and elect to enroll their partners due to the enhancements contained in the rulemaking. There should be no negative effect on state revenues because any costs to the state are currently included in budgeted funds. However, employees will pay state income tax on benefits not covered by Section 125 of the Internal Revenue Code and it is anticipated these additional taxes may offset some of the costs associated with the expansion of the benefits program.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

Change 1: The Department revised R2-5-101(10) "Child," specifically, in R2-5-101(10)(a)(i) and (v) by inserting, "of the employee-member, retiree, former elected official or domestic partner" and in R2-5-101(10)(b)(i) and (v) by inserting, "of the employee-member, former elected official or domestic partner" for clarification purposes.

Change 2: The Department amended R2-5-101(23) "Eligible dependent" by striking all of the language after, "…or an unmarried child." The language repeated the definition of "child," thus, it was duplicative and unnecessary.

Change 3: One commentator noted the Department's proposed definition of "qualified life event" included "domestic partnership or death of domestic partner" and questioned if this would include termination of the domestic partnership. The Department agrees with this comment and amended R2-5-101(56) "Qualified life event" to include "termination of domestic partnership."

Additional minor, non-substantive changes were made between the publication of the notice of proposed rulemaking and this notice of final rulemaking at the suggestion of Council staff.

11. A summary of the comments made regarding the rules and the agency response to them:

The Department received more than 1,400 written comments via e-mail, letter, and/or fax, as well as approximately 35 oral comments via telephone call and/or voice mail message during the formal comment period. The Department also received 10 written comments after the close of record, as well as several oral comments. The Department wishes to express appreciation to all commentators for their participation in the rulemaking process.

It should be noted that of the 1,429 written comments received during the formal comment period, 516 were second and, in some cases, third, fourth, or more, submissions from the same commentator, the vast majority of which were the same or similar comment, most often one by e-mail and one by letter. Of the 913 commentators providing written comments, 787 expressed support, 112 expressed opposition, and 14 expressed no opinion, but requested either clarification or information regarding the process. Further, of the 787 expressing support, almost 600 of these commentators provided the same comments in the form of a four-paragraph document containing exactly the same text, as addressed in comment 1, below.

A summary of the written comments received and the Department's response to them are provided below. Unless otherwise noted, the comment was made by an individual and not on behalf of any organization or group.

General Comments Regarding the Rulemaking

Comment 1: Approximately 600 commentators expressed support of the rule change in the form of a four-paragraph document containing exactly the same text, some of which had been modified only slightly with personal experiences, if applicable. Included in this group of commentators were State Senator Amanda Aguirre, university administrators and faculty members, and one commentator who provided four submissions, one as an individual, one on behalf of the Amancio Project, and two on behalf of the Yuma County Gay Rights Meetup. These commentators acknowledged that state workers work every day in state jobs that improve the lives of Arizona residents and visitors, ensure public safety, protect the state's interests in water and land, and perform many other functions. They work to create the "One Arizona" envisioned by the Governor; however, some of these employees work under conditions that are not equitable from one employee to the next. Specifically, un-married workers, including heterosexual, lesbian, gay, bisexual and transgender people, are not afforded the same access to benefits as other state employees. Further, on June 21, 2003, Governor Napolitano issued an Executive Order prohibiting discrimination in state agencies on the basis of sexual orientation. The Arizona Department of Administration is charged with negotiating and implementing

health care plans for state employees. Offering domestic partner benefits to eligible state employees goes beyond "the right thing to do" and can be measured in terms of cost savings, employee productivity and loyalty, and employee recruitment and retention.

Department's response 1: The Department appreciates the support of these commentators and concurs that such expansion of benefits would aid in the recruitment and retention of state employees.

Comment 2: Approximately 20 commentators expressed support for the rulemaking without citing a specific reason or reasons.

Department's response 2: The Department appreciates the support of these commentators.

Comment 3: Approximately 20 commentators expressed opposition to the rulemaking to expand health benefits to domestic partners, citing one or more of the following reasons for their opposition: facilitates the breakdown of society; is contrary to all traditional American and family values; the costs (actual and administrative) of providing such benefits in the midst of a budget deficit; the potential for fraud; this is a matter that should be brought before the voters; a decision of this magnitude should go through the legislative process.

Department's response 3: The Department is neither proposing to change nor circumvent the definition of either marriage or spouse. Rather, this rulemaking will permit a state officer, employee, or retiree who is insurance-eligible and who is unmarried but has a domestic partner, to enroll the domestic partner in the state health benefit plan as an eligible dependent. The Department believes the rules provide a clear distinction between a spouse and a domestic partner. The Department also respects the position of the commentators expressing opposition due to the anticipated budget deficit; however, the Department believes the program can be implemented cost-neutrally due to other savings in the benefits program through cost savings in Plan Year 2009. Employees will pay state income tax on benefits not covered by Section 125 of the Internal Revenue Code and it is anticipated these additional taxes may offset some of the costs associated with the expansion of the benefits program. It is also possible that one or more individuals currently eligible for benefits under the Arizona Department of Economic Security (DES) or the Arizona Health Care Cost Containment System (AHCCCS), which is paid 100% by tax dollars, may become eligible under the state's health insurance plan as a domestic partner of a state officer, employee, or retiree, in which case, a portion of the cost would be paid through the employee-member's contributions/premiums.

Comment 4: Approximately 10 commentators expressed support for the rulemaking to expand health benefits to domestic partners, citing one or more of the following reasons for their support: makes Arizona a more attractive place to work, in part to compensate for lower salaries; increases accessibility to health benefits; and many states, cities, and corporations already have such benefits.

Department's response 4: The Department appreciates the support and concurs that such expansion of health benefits would aid in the recruitment and retention of state employees. In its research, the Department found that at least 15 states (Alabama, California, Illinois, Iowa, New Mexico, Nevada, Oregon, Rhode Island, Vermont, Washington, Connecticut, Maine, Minnesota, Montana, and New Jersey) offer domestic partner benefits to their employees. Of the Fortune 500 companies, more than half (253) offer domestic partner benefits, and a Mercer 2006 survey found that among employers with 20,000 or more employees, 62% included domestic partners as eligible dependents. In Arizona, Pima County, as well as the Cities of Phoenix, Tucson, and Tempe offer domestic partner coverage. Many large employers in the state also offer this coverage, including but not limited to: Allied Waste Management (effective 4-1-2008), Avnet, Gannett (owner of *The Arizona Republic*), Insight, PF Chang's, and Scottsdale Healthcare.

Comment 5: Approximately 10 commentators expressed opposition to the rulemaking without citing a specific reason or reasons.

Department's response 5: The Department appreciates the commentators' participation in the rulemaking process and respects their position.

Comment 6: State Representatives Russell Pearce, Chairman of the Joint Legislative Budget Committee (JLBC), and Steven Yarbrough, a member of the JLBC, submitted separate but similar e-mails expressing opposition to the rulemaking to add domestic partners to the state employee benefit plan. Representative Pearce wrote that he believed it is a legislative responsibility to alter any employee benefit plan that affects the budget or has a fiscal impact on Arizona taxpayers. Both expressed that they did not believe this significant change in benefits should be unilaterally implemented by the executive branch without legislative action.

Department's response 6: The Department respects the position of the commentators expressing opposition due to fiscal impact; however, the Department believes the expansion of benefits can be implemented cost-neutrally by offsetting any anticipated costs with other efficiencies associated with contracting improvements and benefit design. The Department has statutory authority to adopt rules to administer a health benefit plan for state officers and employees and to determine the eligibility of the dependents of officers and employees to participate in such plans.

Comment 7: State Representative John Kavanagh expressed opposition to the addition of domestic partners to the state employee benefit plan. Representative Kavanagh wrote that he believed it was unwise to encumber the state with additional expenses at this time, in light of the budget shortfall and this was a policy issue best decided by elected representatives as opposed to appointed administrators.

Department's response 7: See Department's response to comment 6, above.

Comment 8: State Representative Sam Crump expressed opposition to the extension of state employee benefits to domestic partners. Representative Crump wrote he believed such a change, with significant policy and fiscal implications, deserved to be submitted through the legislative process rather than administrative.

Department's response 8: See Department's response to comment 6, above.

Comment 9: State Representative Nancy Barto submitted a letter via facsimile expressing opposition to the rulemaking. Six commentators either referenced or attached Representative Barto's letter to their comments, as well as one commentator who submitted written comments after the close of record. Representative Barto expressed the rule change should be opposed because:

- The commentator claims the policy change is being proposed without input from the voting public – the voters should have a say in this issue because it concerns not only the moral distinction between married and unmarried persons, but also the issuance of tax dollars in support of specific associated behaviors;
- The commentator claims the proposal is fiscally irresponsible and most likely illegal – the Department does not indicate it relied on any study which would have provided data for the public to obtain or review in order to justify the proposed rule change; no cost estimates were submitted to the legislature prior to including additional insured dependents; it is fiscally irresponsible to increase benefits for state employees during a time that the state faces an enormous shortfall; and
- The commentator claims the proposal invites fraud and government intrusion of privacy – although the process requires a signed affidavit signifying a number of qualifiers, the enforcement of such an intrusive affidavit would be deemed unconstitutional, leaving the entire qualification process without practical oversight and rife with fraud.

Department's response 9: As previously stated, the Department is neither proposing to change nor circumvent the definition of either marriage or spouse. Rather, this rulemaking will permit a state officer, employee, or retiree who is insurance-eligible and who is unmarried but has a domestic partner, to enroll the domestic partner in the state health benefit plan as an eligible dependent. The Department believes the rules provide a clear distinction between a spouse and a domestic partner. Although the Department did not review or rely on a formal study for this rulemaking, the Department did canvas other employers' benefit programs with respect to domestic partner coverage (see Department's response to comment 4). The Department assumes the comment, "no cost estimates were submitted to the legislature…" refers to the requirements stipulated in A.R.S. § 38-654(I), which requires that the Department, "submit a report to the joint legislative budget committee detailing any changes to the type of benefits offered under the plan and associated costs at least forty-five days before making the change." Any changes to the plan will not be effective until at least the next insurance plan year, beginning October 1, 2008, or later. The Department intends to be fully compliant with the requirements of this statute by providing a report within the required time-frame, as well as all other statutory requirements associated with the health benefit plan. The Department also respects the position of the commentators expressing opposition due to the anticipated budget deficit; however, the Department believes the anticipated cost may be offset by other efficiencies associated with contracting improvements and benefit design.

Comment 10: At least nine current and former state employees, as well as domestic partners of state employees, expressed support for the expansion of health benefits to include domestic partners. An instructor at Northern Arizona University (NAU) indicated the expansion would provide more of an incentive to accept a full-time position at the University. A former department chair at Arizona State University (ASU) indicated the issue of domestic partner benefits came up many times when she was interviewing potential professor hires and the lack of domestic partner benefits made the state of Arizona a less desirable employer to potential candidates. A current NAU employee who previously worked for an employer that offered domestic partner benefits has been concerned with the lack of domestic partner benefits; however, this change in the benefits package will enable him to remain at NAU for the foreseeable future.

Department's response 10: The Department appreciates the support from these employees and reiterates the expansion of health benefits to include domestic partners will aid in the state's ability to recruit and retain top talent.

Comment 11: At least three commentators questioned if health benefits were being extended to domestic partners, if such benefits could be extended to an employee's parent, other blood relative, or adult child(ren) who reside(s) in the employee's home; or simply allow each insurance-eligible member to designate one and only one other person as a co-beneficiary on his or her health insurance.

Department's response 11: Although the Department recognizes the number of adults caring for their aging parents or other family members is on the increase, the Department is not considering expanding health benefits to an employee's parent at this time. The ADOA Personnel Rules already provide for insurance coverage for an employee's adult child under certain circumstances. Additional coverage to an employee's adult child is being considered by the Department in response to the Governor's request to expand these benefits up to age 25. The Department also obtained information from the City of Salt Lake, a public employer that utilizes the term "adult designee." Such modifications may be considered by the Department in future rulemakings.

Comment 12: At least two commentators expressed support for expanding health insurance benefits to same sex couples because they have no option to marry, but disagreed with extending these benefits to heterosexual couples because they have the option of getting married.

Department's response 12: The Department proposes to extend health benefits to any eligible member's domestic partner, regardless of gender, and does not propose to distinguish between opposite sex or same sex couples. Offering benefits to all domestic partners is anticipated to be beneficial with respect to the state's recruitment and retention efforts.

Comment 13: Two commentators, one expressing support and one in opposition, suggested there be more stringent rules regarding eligibility, such as requiring the couple to file a written expression of commitment signed by both parties and if the couple separates, a document similar to a divorce decree should be filed.

Department's response 13: The Department will require an employee enrolling a domestic partner to complete and sign an affidavit at the time of enrollment. It is the employee's responsibility to notify the employer if a dependent covered by the employee becomes ineligible for coverage. As with any other benefits election, falsification of such a document will be grounds for discipline or dismissal.

Comment 14: Unlike marriage, the proposed rule does not limit the number of individuals who can obtain benefits as the result of a relationship, such as roommates, with an insurance-eligible member.

Department's response 14: The intent of the rulemaking is to limit eligibility to either the spouse or domestic partner of the eligible member, not both, and not multiple spouses or multiple domestic partners. It is extremely unlikely that more than one individual would satisfy the criteria for domestic partnership with an eligible member. The number of spouses is limited by law, and the definition of "domestic partner" includes a requirement for financial interdependence with the employee or retiree, which would not be applicable to mere roommates.

Comment 15: Insurance benefits need to be structured on a "tier" system. An employee's co-pay should increase with the additions of spouses and the number of dependents they may add.

Department's response 15: Effective with the insurance plan year beginning October 1, 2007, the Department moved from a two-tier system (employee and employee plus family) to a three-tier system (employee, employee plus one, and employee plus family) to provide an alternative for married couples and single parents with one child.

Comment 16: A tier system should be instituted for our school tax, we need better control of our AHCSS (sic) program, and would like to see Arizona as a more union friendly state.

Department's response 16: The above comments are outside the scope of this rulemaking and beyond the Department's control.

Comment 17: One commentator requested the definition of a "domestic partner."

Department's response 17: The Department included a proposed definition for "domestic partner" in its Notice of Proposed Rulemaking.

Comment 18: Several commentators expressed concern that the Department had "quietly" filed the proposed rulemaking, with some commentators referencing articles in various news publications.

Department's response 18: The Department filed the rulemaking in the same manner as previous rulemakings and in accordance with Arizona Revised Statutes (A.R.S.) and *Arizona Administrative Code* (A.A.C.). Each state agency with rulemaking authority files rulemakings on a regular basis, and these rulemakings are published on a weekly basis by the Arizona Secretary of State in the *Arizona Administrative Register*. The Arizona rulemaking process requires a 30-day public comment period, which was afforded in this rulemaking, as evidenced by the comments the Department received.

Comment 19: If this proposal is put into effect, it seems that there would be no reason not to extend these benefits to a polygamous group of two or more brothers and/or sisters, if they are committed to each other.

Department's response 19: The proposed definition of "domestic partner" specifically excludes blood relatives any closer than would prohibit marriage. Additionally, the definition states, "does not have any other domestic partner, spouse, or spousal equivalent of the same or opposite sex."

Comment 20: The people already rejected the recognition of domestic partners last year.

Department's response 20: The Department assumes this commentator is referring to the 2006 general election, Proposition 107, which had proposed to amend the Arizona Constitution to prohibit (emphasis added) the creation or recognition of legal status similar to marriage for unmarried persons. Proposition 107 did not pass.

Comment 21: The Department did not rely on any study or propose to rely on any study with regards to the impact of this change. The estimate (as reported in *The Arizona Republic*) that 300-850 individuals would be added to the system, with an estimated cost of $1.3 to $4.2 million, seems grossly low.

Department's response 21: Although the Department did not rely on a formal study in regards to this rulemaking, the Department conducted considerable research. The Department's research yielded many public and private employers that provide domestic partner benefits, including those enumerated in the Department's response to comment 4. See also item 9, the summary of the economic, small business, and consumer impact.

Comment 22: The rulemaking will help bring some of the benefits (e.g. compensation) for state employees into compliance with the Governor's Executive Order [2003-22]. Similar rulemaking efforts should be commenced to bring

other areas of the Personnel Rules into accord with the Governor's Executive Order, including, but not limited to: donation of annual leave per A.A.C. R2-5-403(E), use of sick leave and family sick leave per A.A.C. R2-5-404, eligibility for bereavement leave per A.A.C. R2-5-410, eligibility for parental leave for the child of a domestic partner under A.A.C. R2-5-411, inclusion of a domestic partner in the definition of "family member" as it pertains to FMLA leave per A.A.C. R2-5-412.

Department's response 22: The Department appreciates the comments in support of the rulemaking. At this time, the Department is not considering expanding domestic partnership to other rules, such as the leave rules identified by the commentator. A.R.S. § 41-783(17) provides for the transfer of annual leave from one employee to another employee. Such transfers of annual leave are limited to employees within the same agency; however, transfers may occur between agencies if the employees are members of the same family, as defined in statute. The federal Family and Medical Leave Act (FMLA), with regards to granting an eligible employee leave to care for an immediate family member with a serious health condition, defines "family member" for this purpose as, "spouse, child, or parent."

Comment 23: A commentator expressed support for the rulemaking, but asked if the new benefit could be structured in such a way that the tax consequences could be handled the same as for a married worker. The commentator acknowledged that federal law may preclude this, but perhaps at least the state tax portion of the benefit could be handled the same as for a married worker.

Department's response 23: The commentator is correct in that the federal tax consequences are subject to the Internal Revenue Code. The effect of this benefit on state taxes would be determined by A.R.S. Titles 41 and 42, and would be under the purview of the Arizona Department of Revenue. The Department is unaware of any current or anticipated proposed statutory changes to provide tax relief for this purpose.

Comment 24: A commentator submitted a letter on behalf of the National Organization for Women (NOW) expressing strong support of the rulemaking. The letter states that extending insurance to domestic partners of eligible state employees will provide needed benefits to deserving individuals, which would improve the lives and working conditions of hardworking and often underpaid state employees and help them to achieve greater job satisfaction and productivity in a working environment that treats all employees fairly.

Department's response 24: The Department appreciates the support from this commentator.

Comment 25: A commentator submitted a letter from the Arizona Office of the Anti-Defamation League in support of domestic partner benefits for Arizona state employees. The letter states that many lesbian and gay Americans are in committed, long-term relationships and take on the same responsibilities associated with civil marriage, but cannot share the same benefits. More than 30 local governments throughout the country as well as the Arizona cities of Phoenix, Scottsdale, Tempe, and Tucson offer domestic partnership benefits to their employees.

Department's response 25: The Department appreciates the support from this commentator and agrees a number of employers are already offering this benefit to their employees (please see the Department's response to comment 4).

Comment 26: A commentator submitted a letter from United Families Arizona (UFA) expressing concern over the Department's proposed rule changes regarding domestic partner benefits for state employees. The letter states that the proposed rules: directly undermine marriage, re-define "dependents" without authorization from the state legislature, and would institute large additional spending. This increase in spending, especially during a horrendous budget shortfall, is irresponsible and careless. UFA urges the Department to reconsider the rule changes, and instead, use the legislative process because the executive branch of government is not empowered to make laws.

Department's response 26: As previously stated, the Department is neither proposing to change nor circumvent the definition of either marriage or spouse. Rather, this rulemaking will permit a state officer, employee, or retiree who is insurance-eligible and who is unmarried but has a domestic partner, to enroll the domestic partner in the state health benefit plan as an eligible dependent. The Department believes the rules provide a clear distinction between a spouse and a domestic partner. The term "dependent" is not defined in A.R.S. § 1-215, which provides general definitions for terms that are applicable to all statutes. Title 38, Public Officers and Employees, which provides the authority to the Arizona Department of Administration for this rulemaking, does not provide a definition of "dependent" for the purposes of Title 38. The Department also respects the position of the commentators expressing opposition due to the anticipated budget deficit; however, the Department believes the anticipated cost may be offset by other efficiencies associated with contracting improvements and benefit design. The Department asserts it has statutory authority to adopt rules to administer a health benefit plan for state officers and employees and to determine the eligibility of the dependents of officers and employees to participate in such plans.

Comment 27: A commentator submitted a letter on behalf of The Center for Arizona Policy urging the Department to terminate the rulemaking because:

- The commentator claims the rulemaking exceeds the Department's authority under the Arizona Constitution – the rule is an unconstitutional attempt to usurp the legislature's role in deciding matters of public policy. The Arizona Constitution entrusts only the legislature with the power to make laws. Expanding the definition of "dependent" to include "domestic partners" implicates the state's policy with regard to legally-recognized relationships. This type of policy decision is within the lawmaking function of the legislature; the legislature has not agreed to expand the definition of "dependent" beyond its traditional legal meaning, and ADOA's attempt to do so is a violation of the separation of powers required by Article III of the Arizona Constitution.

- The commentator claims the rulemaking exceeds the Department's authority under state statutes – ADOA has no statutory authority under A.R.S. § 38-653 to expand the definition of "dependent" beyond its traditional legal meaning. The term "dependent" has a consistent meaning in Arizona law. *See* A.R.S. §§ 12-2901, 20-1131, 20-1257, 23-1064, 33-1126, and 43-1001.
- The commentator claims the rulemaking undermines state policy in favor of marriage – the rule exceeds the subject matter of health accident insurance because it attempts to change state policy on the type of legally-recognized relationships. The proposed rule equates non-marital relationships with marriage in violation of state policy favoring marriage.
- The commentator claims the rulemaking creates new budget obligations without legislative authorization – the rule ignores the financial impact of creating significant, long-term obligations for the state without legislative approval. ADOA is not authorized by A.R.S. § 38-653 or any other statute to create a new class of obligations for the state, and this action is particularly provocative in light of the current budget shortfall.

Department's response 27: Arizona Revised Statutes (A.R.S.) provide authority for an agency to promulgate and adopt rules. The Department asserts it has statutory authority to adopt rules to administer a health benefit plan for state officers and employees and to determine the eligibility of the dependents of officers and employees to participate in such plans. The statutes identified by the commentator provide definitions for the term "dependent"; however, definitions provided in a specific Title are applicable only to that Title. Therefore, the citations listed by the commentator are not relevant to this rulemaking. The term "dependent" is not defined in A.R.S. § 1-215, which provides general definitions for terms that are applicable to all statutes. Title 38, Public Officers and Employees, which provides the authority to the Arizona Department of Administration for this rulemaking, does not provide a definition of "dependent" for the purposes of Title 38. The Department is neither proposing to change nor circumvent the definition of either marriage or spouse. Rather, this rulemaking will permit a state officer, employee, or retiree who is insurance-eligible and who is unmarried but has a domestic partner, to enroll the domestic partner in the state health benefit plan as an eligible dependent. The Department believes the rules provide a clear distinction between a spouse and a domestic partner. The Department also respects the position of the commentators expressing opposition due to the budget deficit; however, the Department believes the anticipated cost may be offset by other efficiencies associated with contracting improvements and benefit design.

The Department also received 10 written comments after the close of record. Of these 10 comments, five expressed support, four expressed opposition, and one did not express an opinion. A summary of these comments and the Department's response to them are provided below:

Comment 28: One commentator submitted a letter on behalf of the American Civil Liberties Union (ACLU) of Arizona expressing support for the rulemaking. This letter states: providing state employees with the option to enroll their domestic partners in the employee benefit plan is a matter of employment equity; the residents of Arizona recognize that providing insurance coverage to domestic partners is separate and distinct from the "legislative imprimatur" on marriage as being between a man and a woman; as of 2007, at least 13 state governments and 145 cities and counties throughout the country, as well as numerous leading private companies and institutions offer domestic partner benefits, and business publications report that the absence of such benefits negatively impacts the ability to attract and keep the best employees and administrators; and the rule is a reasonable and much needed step forward for Arizona because it will benefit not only the governmental employees, but all the citizens of the state and further the goal of a committed and stable work force.

Department's response 28: The Department appreciates the support of this commentator.

Comment 29: Four individuals submitted a letter on behalf of the Alliance Defense Fund (ADF) expressing opposition to the rulemaking. This letter states the rulemaking would treat governmental employees with domestic partners as though they were married for purposes of obtaining certain government benefits, which sends an unequivocal message that the state views the relationships as equal. The message conveyed through this rule should be carefully considered because marriage between one man and one woman remains the preferred relationship in Arizona, and the letter references A.R.S. § 25-101 (Void and prohibited marriages). ADF's letter expresses concern with the Department's consideration of only two jurisdictions in projecting anticipated new enrollees to the plan and the Department's cost estimates. The letter also states domestic partnerships are not relationships that the state should encourage because they are not as stable as marriage, cohabitation does not yield high-quality relationships, cohabitation puts women and children at risk, cohabitation is not good economic policy, and domestic partnerships are bad for both same-sex and opposite-sex couples, and provides statistics and studies to support these statements.

Department's response 29: This rulemaking will permit a state officer, employee, or retiree who is insurance-eligible and has a domestic partner, to enroll the domestic partner in the state's health benefit plan as an eligible dependent. The Department is neither proposing to change nor circumvent the definition of either marriage or spouse, and believes the rules provide a clear distinction between a spouse and a domestic partner. The Department's use of two jurisdictions, the City of Scottsdale and the City of Phoenix, for utilization projections was based in part on the Department's assumption that these employers' demographics would be similar to the state's and the availability of this type of data. The comments regarding opposition to domestic partnerships in general are outside the scope of this rulemaking.

Comment 30: One commentator, Osborn Maledon, P.A., a law firm representing the Tempe Firefighters Association, submitted a letter indicating that in their view, the Department has the legal authority for this rulemaking. The Department has authority under the Arizona Constitution and A.R.S. § 38-653 to interpret the term "dependents" as used in Title 38, Chapter 4, Article 4 of Arizona Revised Statutes, to include "domestic partners." Although the Arizona Constitution limits legislative functions to the Legislature, the Legislature may delegate its power to administrative agencies, as it has done so here, to allow the agencies to make rules and regulations. The Department not only has the power, but also the obligation, to adopt and promulgate rules necessary to administer health benefits to state employees and their dependents, and the Department is afforded great discretion in how it fulfills its obligation to interpret and administer the law. The commentator provides the following in support of the Department's authority for the rulemaking:

- The delegation of legislative power to interpret "dependents" is constitutional – the Arizona Constitution grants lawmaking authority to the State Legislature; however, the Supreme Court of Arizona ruled that the Constitution permits the Legislature to delegate a portion of its legislative authority to an administrative agency. The Legislature's grant of authority to administrative agencies may be in broad, general terms. The Department is authorized by statute to expend public monies to procure health and accident coverage for state officers, employees, and retirees. To do so, the Department is authorized to "adopt and promulgate rules and regulations necessary to administer the provisions of this Article." The Legislature has appropriately delegated especially broad rulemaking authority to the Department in the area of health and accident coverage, in light of the inherent complexity of benefit plan design and the continuously changing benefits offered by competing employers. This is true even though the Department's benefit plan design will necessarily have an impact on the cost of coverage and the state budget. Any rule adopted and promulgated by the Department interpreting the statutory language is constitutional so long as the rule is within the standard set forth in the act of the legislature. The rulemaking interprets the term "dependents" only to the extent necessary to administer health and accident coverage under Title 38, Chapter 4, Article 4. Nothing in the rulemaking affects any law or policy outside the context of providing health and accident coverage to state officers and employees and their dependents. Thus, the rulemaking is within the discretion of the Department and constitutional.
- The rulemaking is consistent with statutory authority – there is no universal or consistent definition of "dependents" in Arizona statutes. The Legislature has adopted numerous definitions of "dependents," carefully circumscribing the applicability of these definitions and has often included unrelated persons in its definitions of "dependent" [citing A.R.S. §§ 12-2901, 20-1131(D), 20-1257(D), and 33-1126(A)(6)]. In addition, the Legislature has not defined "dependents" for the purpose of administering health benefits. Therefore, the rulemaking is not inconsistent with or contrary to any statutory authority.
- The Department has great discretion to interpret the relevant law – the Supreme Court of Arizona has ruled that administrative agencies have great discretion to interpret the law the Legislature gives them to administer.
- The rulemaking is a valid interpretation of law – the commentator states that an administrative rule, not in conflict with any statute, need only be a reasonable interpretation of the law in order to be valid and cites three court cases. The commentator further provides that the fact that an agency's interpretation of a rule may increase the state's budget obligation does not affect the rule's validity, citing *Martinez v. Indus. Comm'n of Ariz.* The state competes with other public and private employers for employees and the Department may reasonably take into account evolving market conditions in designing a benefit package to make state employment a viable alternative to working for other governmental employers or in the private sector.

Department's response 30: The Department appreciates the support of this commentator and the detailed analysis provided.

Specific Comments Regarding the Text of the Rule(s)

Additionally, the Department received several written comments specific to the text of the rule(s). These comments and the Department's response to them are presented separately, below:

Comment 31: The proposed definition of R2-5-101(22) ("domestic partner") seems unfairly discriminatory in that a different standard, i.e., a 12-month waiting period, is imposed for a domestic partner. However, no such waiting period is imposed on married couples, and an employee's spouse is immediately eligible for benefits.

Department's response 31: The Department is not imposing a "waiting period." In lieu of traditional evidence of marriage (marriage license), the Department is asking for evidence that a meaningful and lasting relationship is demonstrated by the parties involved. There is no "waiting period," merely a request for evidence the parties have had a relationship for the prior 12 months.

Comment 32: The proposed definition of "qualified life event" [R2-5-101(56)] includes "domestic partnership or death of domestic partner"; does this include termination (i.e., divorce) of the domestic partnership?

Department's response 32: The Department does consider "termination of the domestic partnership" as a "qualified life event" for the purposes of this rulemaking. The final rulemaking has been corrected to include this language.

Comment 33: In R2-5-418(C), should the term "domestic partner" be added after "employee's spouse"?

Department's response 33: The term "domestic partner" was intentionally omitted from R2-5-418(C), which applies to extended health coverage in the event of an employee's death. A.R.S. § 38-651.01(A) specifies that such coverage may be continued for only the insured surviving spouse and eligible dependent children. Therefore, this coverage could not be provided to the surviving domestic partner without a statutory change.

Comment 34: In each R2-5-419(D) and (E), might the term "domestic partner" need to be added after "…spouse"?

Department's response 34: The term "domestic partner" was intentionally omitted from R2-5-419(D) and (E), which apply to extended health coverage in the event of the death of a former elected official and termination of coverage due to non-payment of premiums, respectively. A.R.S. § 38-651.01(B) specifies that such coverage may be continued for only the insured surviving spouse. Therefore, this coverage could not be provided to the surviving domestic partner of a former elected official without a statutory change.

Comment 35: One commentator questioned why R2-5-420 was excluded from the rulemaking.

Department's response 35: The term "domestic partner" does not apply to R2-5-420, Health Benefit Plan for Surviving Spouse of Elected Official. A.R.S. § 38-651.01(B) specifies that such coverage may be continued for only the insured surviving spouse. Therefore, this coverage could not be provided to the surviving domestic partner of an elected official without a statutory change.

Comment 36: Might the phrase "or domestic partner" need to be added after each instance of the word "spouse" in R2-5-421(C) and (D)?

Department's response 36: The term "domestic partner" was intentionally omitted from the referenced subsections, applying to life insurance coverage in the event of the death of an incumbent or former elected official and termination of coverage due to non-payment of premiums. A.R.S. § 38-651.02 specifies that such coverage may be continued for only the insured surviving spouse. Therefore, this coverage could not be provided to the surviving domestic partner without a statutory change.

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

None

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

None

14. Was this rule previously made as an emergency rule?

No

15. The full text of the rules follows:

TITLE 2. ADMINISTRATION

CHAPTER 5. DEPARTMENT OF ADMINISTRATION PERSONNEL ADMINISTRATION

ARTICLE 1. GENERAL

Section
R2-5-101. Definitions

ARTICLE 4. BENEFITS

Section
R2-5-416. Health Benefit Plan
R2-5-417. Life Insurance and Disability Income Insurance Plans
R2-5-418. Retiree Health Benefit Plan
R2-5-419. Health Benefit Plan for Former Elected Officials
R2-5-421. Life Insurance Plan for Former Elected Official
R2-5-422. Flexible or Cafeteria Employee Benefit Plan

ARTICLE 1. GENERAL

R2-5-101. Definitions

The following words and phrases have the defined meanings unless otherwise clearly indicated by the context.

1. "Agency" means a department, board, office, authority, commission, or other governmental budget unit of the state.
2. "Agency head" means the chief executive officer of an agency.
3. "Appeal" means a request for a review by the Personnel Board of a disciplinary action under A.R.S. § 41-782.

4. "Applicant" means a person who seeks appointment to a position in state service.
5. "Appointment" means the offer to and the acceptance by a person of a position in state service.
6. "Base salary" means an employee's salary excluding overtime pay, shift differential, bonus pay, special performance adjustment previously granted, or pay for other allowance or special incentive pay program.
7. "Business day" means the hours between 8:00 a.m. and 5:00 p.m. Monday through Friday, excluding observed state holidays.
8. "Candidate" means a person whose knowledge, skills, and abilities meet the requirements of a position and who may be considered for employment.
9. "Cause" means any of the reasons for disciplinary action provided by A.R.S. § 41-770 or these rules.
10. "Child" means:
    a. For purposes of R2-5-416(C), pertaining to the health benefit plan, R2-5-418(B), pertaining to the retiree health benefit plan, and R2-5-419(C), pertaining to the health benefit plan for former elected officials, an unmarried person who falls within one or more of the following categories:
        i. A natural child, adopted child, or stepchild of the employee-member, retiree, former elected official, or domestic partner and who is younger than age 19 or younger than age 25 if a full-time student;
        ii. A child who is younger than age 19 for whom the employee-member, retiree, or former elected official has court-ordered guardianship;
        iii. A foster child who is younger than age 19;
        iv. A child who is younger than age 19 and placed in the employee-member's, retiree's, or former elected official's home by court order pending adoption; or
        v. A natural child, adopted child, or stepchild of the employee-member, retiree, former elected official, or domestic partner and who was disabled prior to age 19 and continues to be disabled under 42 ~~USC~~ U.S.C. 1382c and for whom the employee-member, retiree, ~~or~~ former elected official or domestic partner had custody prior to age 19.
    b. For purposes of R2-5-417(C) and (D), pertaining to the life and disability income insurance plan, and R2-5-421(B), pertaining to the life insurance plan for former elected officials, an unmarried person who falls within one or more of the following categories:
        i. A natural child, adopted child, or stepchild of the employee-member, former elected official, or domestic partner and who is younger than age 19 or younger than age 25 if a full-time student;
        ii. A child who is younger than age 19 for whom the employee or former elected official has court-ordered guardianship;
        iii. A foster child who is younger than age 19;
        iv. A child who is younger than age 19 and placed in the employee's or former elected official's home by court order pending adoption; or
        v. A natural child, adopted child, or stepchild of the employee-member, former elected official, or domestic partner and who was disabled prior to age 19 and continues to be disabled under 42 ~~USC~~ U.S.C. 1382c and for whom the employee, ~~or~~ former elected official, or domestic partner had custody prior to age 19; or
    c. For purposes of R2-5-207(D), pertaining to the employment of relatives, R2-5-404, pertaining to sick leave, R2-5-410, pertaining to bereavement leave, the term includes a natural child, adopted child, foster child, or stepchild; and
    d. For purposes of R2-5-411, pertaining to parental leave, the term includes a natural child, adopted child, foster child, or stepchild.
11. "Class" means a group of positions with the same title and pay grade because each position in the group has similar duties, scope of discretion and responsibility, required knowledge, skills and abilities, or other job-related characteristics.
12. "Class series" means:
    a. For purposes of R2-5-902(B), pertaining to the administration of reduction in force, and R2-5-903(A), pertaining to a temporary reduction in force, a group of related classes that is listed in the Arizona Department of Administration, Human Resources Division, Occupational Listing of Classes as a subsection of the occupational group; and
    b. For purposes of R2-5-902(D), pertaining to the calculation of retention points for length of service, a group of related classes that is listed in the Arizona Department of Administration, Human Resources Division, Occupational Listing of Classes as a subsection of the occupational group, including a position that has been reclassified or reassigned to the class series within five years before the effective date of the reduction in force.
13. "Class specification" means a description of the type and level of duties and responsibilities of the positions assigned to a class.
14. "Clerical pool appointment" means the non-competitive, temporary placement of a qualified individual in a clerical position.
15. "Competition" means the process leading to the identification of candidates for employment or promotional consider-

ation that includes an evaluation of knowledge, skills, and abilities and the development of a hiring list in accordance with these rules.

16. "Covered employee" means an employee in state service who is subject to the provisions of these rules.
17. "Covered position" means a position in state service, as defined in A.R.S. § 41-762.
18. "Days" means calendar days.
19. "Demotion" means a change in the assignment of an employee from a position in one class to a position in another class with a lower pay grade that results from disciplinary action for cause.
20. "Department" means the Arizona Department of Administration.
21. "Director" means the Director of the Arizona Department of Administration, and the Director's designee with respect to personnel administration.
22. "Domestic partner" means a person of the same or opposite gender who:
    a. Shares the employee's or retiree's permanent residence;
    b. Has resided with the employee or retiree continuously for at least 12 consecutive months before filing an application for benefits and is expected to continue to reside with the employee or retiree indefinitely as evidenced by an affidavit filed at time of enrollment;
    c. Has not signed a declaration or affidavit of domestic partnership with any other person and has not had another domestic partner within the 12 months before filing an application for benefits;
    d. Does not have any other domestic partner or spouse of the same or opposite sex;
    e. Is not currently legally married to anyone or legally separated from anyone else;
    f. Is not a blood relative any closer than would prohibit marriage in Arizona;
    g. Was mentally competent to consent to contract when the domestic partnership began;
    h. Is not acting under fraud or duress in accepting benefits;
    i. Is at least 18 years of age; and
    j. Is financially interdependent with the employee or retiree in at least three of the following ways:
        i. Having a joint mortgage, joint property tax identification, or joint tenancy on a residential lease;
        ii. Holding one or more credit or bank accounts jointly, such as a checking account, in both names;
        iii. Assuming joint liabilities;
        iv. Having joint ownership of significant property, such as real estate, a vehicle, or a boat;
        v. Naming the partner as beneficiary on the employee's life insurance, under the employee's will, or employee's retirement annuities and being named by the partner as beneficiary of the partner's life insurance, under the partner's will, or the partner's retirement annuities; and
        vi. Each agreeing in writing to assume financial responsibility for the welfare of the other, such as durable power of attorney; or
        vii. Other proof of financial interdependence as approved by the Director.

~~22.~~23. "Eligible dependent" means the employee-member's, retiree's, or former elected official's spouse under Arizona law or domestic partner, or an unmarried child. ~~who falls within one or more of the following categories:~~

~~a. A natural child, adopted child, or stepchild who is younger than age 19 or younger than age 25 if a full-time student;~~
~~b. A child who is younger than age 19 for whom the employee-member, retiree, or former elected official has court-ordered guardianship;~~
~~c. A foster child who is younger than age 19;~~
~~d. A child who is younger than age 19 and placed in the employee-member's, retiree's, or former elected official's home by court order pending adoption; or~~
~~e. A natural child, adopted child, or stepchild who was disabled prior to age 19 and continues to be disabled under 42 USC 1382c and for whom the employee-member, retiree, or former elected official had custody prior to age 19.~~

~~23.~~24. "Emergency appointment" means an appointment made without regard to the recruitment, evaluation, referral, or selection requirements of these rules in response to a governmental emergency.
~~24.~~25. "Entrance salary" means the minimum rate of the pay grade established for a specific class.
~~25.~~26. "Essential job function" means the fundamental job duties of a position that an applicant or employee must be able to perform, with or without a reasonable accommodation.
~~26.~~27. "Evaluation" means the procedure used to determine the relative knowledge, skills, and abilities of an applicant.
~~27.~~28. "Flexible or cafeteria employee benefit plan" means a plan providing benefits to eligible employees that meets the requirements of Section 125 of the Internal Revenue Code.
~~28.~~29. "FLSA" means the federal Fair Labor Standards Act.
~~29.~~30. "FLSA exempt" means a position that is not entitled to overtime compensation under the FLSA.
~~30.~~31. "FLSA non-exempt" means a position that is entitled to overtime compensation under the FLSA.
~~31.~~32. "FMLA" means the federal Family and Medical Leave Act.
~~32.~~33. "Good standing" means the status of a former employee at the time of separation from state service for reasons

other than disciplinary action or anticipated disciplinary action.

~~33.~~34. "Grievance" means a formal complaint filed by an employee, using the procedure established in Article 7 of these rules, that alleges discrimination, noncompliance with these rules, or concerns other work-related matters that directly and personally affect the employee.

~~34.~~35. "Human Resources Employment Database" means the database that contains the resume of an applicant interested in employment within state service.

~~35.~~36. "Incumbent" means the officer or employee who currently holds an office or position.

~~36.~~37. "Institution" means a facility that provides supervision or care for residents on a 24-hour per day, 7-day per week, basis.

~~37.~~38. "Knowledge, skills, and abilities" means the qualifications and personal attributes required to perform a job that are generally demonstrated through qualifying service, education, or training.

a. Knowledge is a body of information applied directly to the performance of a function;
b. Skill is an observable competence to perform a learned psychomotor act; and
c. Ability is competence to perform an observable behavior or a behavior that results in an observable product.

~~38.~~39. "Limited appointment" means an appointment to a position that is funded for at least six months but not more than 36 months.

~~39.~~40. "Limited position" means a position in state service that is established for at least six months but not more than 36 months based on the duration of funding.

~~40.~~41. "Manifest error" means an act or failure to act that is, or clearly has caused, a mistake.

~~41.~~42. "Mobility assignment" means the assignment of a permanent status employee to an uncovered position or to a covered or uncovered position in another state agency.

~~42.~~43. "Original probation" means the specified period following initial appointment to state service in a regular or limited position for evaluation of the employee's work.

~~43.~~44. "Original probationary appointment" means the initial appointment to a regular or limited position in state service.

~~44.~~45. "Parent" means, for purposes of R2-5-403, pertaining to annual leave, R2-5-404, pertaining to sick leave, and R2-5-410, pertaining to bereavement leave, birth parent, adoptive parent, stepparent, foster parent, grandparent, parent-in-law, or anyone who can be considered "in loco parentis."

~~45.~~46. "Participant" means an employee who is enrolled in the state's insurance program.

~~46.~~47. "Part-time" means, for purposes of R2-5-402, pertaining to holidays, R2-5-403, pertaining to annual leave, R2-5-404, pertaining to sick leave, R2-5-902, pertaining to reduction in force, and R2-5-903, pertaining to temporary reduction in force, employment scheduled for less than 40 hours per week.

~~47.~~48. "Pay grade" means a salary range in a state service salary plan.

~~48.~~49. "Pay status" means an employee is eligible to receive pay for work or for a compensated absence.

~~49.~~50. "Permanent status" means the standing an employee achieves after the completion of an original probation or a promotional probation.

~~50.~~51. "Plan" means a flexible or cafeteria employee benefit plan.

~~51.~~52. "Plan administrator" means the Director of the Arizona Department of Administration.

~~52.~~53. "Promotion" means a permanent change in assignment of an employee from a position in one class to a position in another class that has a higher pay grade.

~~53.~~54. "Promotional probation" means the specified period of employment following promotion of a permanent status employee for evaluation of the employee's work.

~~54.~~55. "Qualified" means an individual possesses the knowledge, skills, and abilities required of a specific position, as described in the class specification, and any unique characteristics required for the position.

~~55.~~56."Qualified life event" means a change in an employee's family, employment status, or residence including but not limited to:

a. Changes in the employee's marital status such as marriage, divorce, legal separation, annulment, ~~or~~ death of spouse, domestic partnership, termination of domestic partnership, or death of domestic partner;
b. Changes in dependent status such as birth, adoption, placement for adoption, death, or dependent eligibility due to age, marriage, or student status;
c. Changes in employment status or work schedule that affect benefits eligibility for the employee, spouse, domestic partner, or dependent; or
d. Changes in residence that affect available plan options for the employee, spouse, domestic partner, or dependent.

~~56.~~57. "Reclassification" means changing the classification of a position if a material and permanent change in duties or responsibilities occurs.

~~57.~~ 58. "Reduction" means the non-appealable movement of an employee from one position to another in a lower pay grade as a result of a reduction in force.

~~58.~~59. "Reemployment" means the appointment of a former permanent status employee who was separated by a reduction in force.

~~59.~~60. "Regular position" means a full-time equivalent (FTE) position in state service.

~~60.~~61. 'Reinstatement" means the appointment of a former permanent status employee who resigned, was separated in good standing, or was separated without prejudice within two years from the effective date of separation.
~~61.~~62. "Repromotion" means the promotion of an employee who was reduced in pay grade due to a reduction in force to the pay grade held before the reduction in force or to an intervening pay grade.
~~62.~~63. "Reversion" means the return of an employee on promotional probation to a position in the class in which the employee held permanent status immediately before the promotion.
~~63.~~64. "Rules" means the rules contained in 2 A.A.C.~~, Title 2, Chapter~~ 5.
~~64.~~65. "Separation without prejudice" means a non-disciplinary removal from state service, without appeal rights, of an employee in good standing.
~~65.~~66. "Special detail" means the temporary assignment of a permanent status employee to a covered position in the same agency.
~~66.~~67. "State service" is defined in A.R.S. § 41-762.
~~67.~~68. "Surviving spouse" means the husband or wife, as provided by law, of a current or former elected official, or active or retired officer or employee who survives upon the death of the elected official, officer, or employee.
~~68.~~69. "Temporary appointment" means an appointment made for a maximum of 1,500 hours in any one position per agency in each calendar year.
~~69.~~70. "Transfer" means the movement of an employee from one position in state service to another position in state service in the same pay grade.
~~70.~~71."Uncovered position" means a position that is exempt under A.R.S. § 41-771 and not subject to the provisions of these rules.
~~71.~~72."Underfill" means the appointment of a person to a class with a pay grade that is lower than the pay grade for the allocated class for that position.
~~72.~~73."Voluntary pay grade decrease" means a change in assignment, at the request of an employee, to a position in a class with a lower pay grade.

ARTICLE 4. BENEFITS

R2-5-416. Health Benefit Plan

A. Eligibility.
1. A state employee, except an employee listed in subsection (A)(2), and the employee's eligible dependents may participate in the health benefit plan, if the employee complies with the contractual requirements of the selected health benefit plan. An eligible employee may enroll in a health benefit plan at any time within the first 31 days of employment or during an open enrollment period specified by the Director. To add an eligible dependent due to a qualified life event, an eligible employee shall submit an application for enrollment within 31 days of the qualified life event.
2. The following categories of employees are not eligible to participate in the health benefit plan:
   a. An employee who works fewer than 20 hours per week;
   b. An employee in a temporary, emergency, or clerical pool position;
   c. A patient or inmate employed in a state institution;
   d. A non-state employee, officer, or enlisted personnel of the National Guard of Arizona;
   e. An employee in a position established for rehabilitation purposes;
   f. An employee of any state college or university:
      i. Who works fewer than 20 hours per week;
      ii. Who is engaged to work for less than six months; or
      iii. For whom contributions are not made to a state retirement plan. This disqualification does not apply to a non-immigrant alien employee, an employee participating in a medical residency training program, a Cooperative Extension employee on federal appointment, or a retiree who returns to work under A.R.S. § 38-766.01.

B. Eligibility exception. An employee who is on leave without pay may continue to participate in the health benefit plan under the conditions in:
1. R2-5-405 for employees on leave without pay due to industrial illness or injury;
2. R2-5-413 for employees on medical leave without pay; or
3. R2-5-414 for employees on leave without pay for any other reason.

C. Dependent eligibility. Dependents eligible to participate in the health benefit plan include:
1. ~~an~~ An employee-member's spouse as provided by law or domestic partner; and
2. ~~each~~ Each ~~qualifying~~ child.

D. Enrollment of dependents. An eligible employee may enroll eligible dependents at the time of the employee's original enrollment, within 31 days of a qualified life event, or at open enrollment.

R2-5-417. Life Insurance and Disability Income Insurance Plans

A. Eligibility.
1. A state employee, except an employee listed in subsection (A)(2), may participate in the life insurance and short-term

disability income insurance plans.

2. The following categories of employees are not eligible to participate in the life insurance and short-term disability income insurance plans:
   a. An employee who works fewer than 20 hours per week;
   b. An employee in a temporary, emergency, or clerical pool position;
   c. A patient or inmate employed in a state institution;
   d. A non-state employee, officer, or enlisted personnel of the National Guard of Arizona;
   e. An employee in a position established for rehabilitation purposes;
   f. An employee of any state college or university:
      i. Who works fewer than 20 hours per week;
      ii. Who is engaged to work for less than six months; or
      iii. For whom contributions are not made to a state retirement plan. This disqualification does not apply to an employee participating in a medical residency training program, a Cooperative Extension employee on federal appointment, or a retiree who returns to work under A.R.S. § 38-766.01.

B. Supplemental insurance coverage. In addition to the basic life insurance provided at no cost to an employee, an eligible employee may elect to purchase additional group life insurance. The employee may purchase an amount of insurance that does not exceed three times the employee's annual base salary, rounded down to the nearest $5,000, or the maximum amount established by the Director, whichever is less.

C. Dependent coverage. An eligible employee may elect to purchase group life insurance for the employee's spouse or domestic partner, and each child in an amount established by the Director.

D. Long-term disability coverage. The monthly benefit paid under the disability portion of a plan provided under A.R.S. § 38-651 may be reduced by payments the employee receives or is eligible to receive in the same month as determined by the terms and conditions of the plan.

R2-5-418. Retiree Health Benefit Plan

A. Eligibility. A state employee is eligible to participate in the retiree health benefit plan if the employee is:
   1. Retired under a state-sponsored retirement plan and continues enrollment in the retiree health benefit plan;
   2. Newly retired under a state-sponsored retirement plan and within 31 days of the date of retirement enrolls in the retiree health benefit plan; or
   3. On long-term disability under a state-sponsored plan.

B. Dependent eligibility. A retired employee's spouse or domestic partner, and each ~~qualifying~~ child are eligible to participate in the retiree health benefit plan.

C. Extended coverage. If a state employee dies while retired, on long-term disability, or continuing to work when eligible for retirement, retiree health benefit plan coverage that is in effect for the employee's spouse or ~~qualifying~~ child may continue by payment of the premium and applicable administrative expense.

R2-5-419. Health Benefit Plan for Former Elected Officials

A. Definition. "Former elected official" means an elected official as defined in A.R.S. § 38-801(3) who is no longer in office.

B. Eligibility. A former elected official of this state is eligible to participate in the retiree health benefit plan if the former elected official:
   1. Has at least five years of credited service in the Elected Officials' Retirement Plan;
   2. Was covered under a group health or group health and accident plan at the time of leaving office;
   3. Served as an elected official on or after January 1, 1983; and
   4. Applies for enrollment within 31 days of leaving office or retiring.

C. Dependent eligibility. A former elected official's spouse or domestic partner, and each ~~qualifying~~ child are eligible to participate in the retiree health benefit plan.

D. Eligibility of surviving spouse. Upon the death of a former elected official, the surviving spouse is eligible for coverage under the retiree health benefit plan by paying the premium and applicable administrative expenses if:
   1. The deceased former elected official met the qualifications for eligibility listed in subsection (B); and
   2. The surviving spouse applies for coverage within 31 days of the death of the former elected official.

E. Termination of coverage. The insurance coverage of a former elected official or the surviving spouse of a former elected official who fails to pay insurance premiums when due shall terminate at 11:59 p.m. on the last day of the period covered by the last premium paid.

R2-5-421. Life Insurance Plan for Former Elected Officials

A. Definitions. "Former elected official" means an elected official as defined in A.R.S. § 38-801(3) who is no longer in office.

B. Eligibility. A former elected official of this state, spouse or domestic partner, and each ~~qualifying~~ child are eligible to participate in the group life insurance plan, if the former elected official:
   1. Has at least five years of credited service, as referenced in A.R.S. § 38-801 et seq., in the Elected Officials' Retirement Plan; and,

2. Served as an elected official on or after January 1, 1983.

C. Eligibility of surviving spouse.
1. Upon the death of a former elected official, the spouse is entitled to coverage under the group life insurance plan, if:
   a. The deceased former elected official met the qualifications for eligibility listed in subsection (B);
   b. The surviving spouse is receiving a monthly survivor's retirement check from the Elected Officials' Retirement Plan;
   c. The surviving spouse applies for the life insurance benefit within 31 days of the death of the former elected official; and,
   d. The surviving spouse pays the premium for the group life insurance coverage based upon the spouse's age and pays applicable administrative expenses.
2. Upon the death of an incumbent elected official, the surviving spouse is eligible to participate in the life insurance plan for former elected officials in accordance with the terms of the insurance contract covering the former elected official at the time of death, if:
   a. The deceased elected official met the qualifications for eligibility listed in subsection (B) or would have met the qualifications upon completion of the term of office in which the deceased elected official was serving at the time of death;
   b. The surviving spouse is receiving a monthly survivor's retirement check from the Elected Officials' Retirement Plan; and,
   c. The surviving spouse applies for the life insurance benefit within 31 days of the death of the incumbent elected official.

D. Termination of coverage. The insurance coverage of either a former elected official or the surviving spouse of a former or incumbent elected official who fails to pay insurance premiums when due shall terminate at 11:59 p.m. on the last day of the period covered by the last premium paid.

R2-5-422. Flexible or Cafeteria Employee Benefit Plan

A. Eligibility. A state employee who is eligible to participate in the state's employee insurance programs, other than the short-term disability program, is enrolled in the flexible or cafeteria employee benefit plan, in accordance with 26 U.S.C. 125, Internal Revenue Code of 1986~~.~~, as amended. Benefits provided to domestic partners shall receive pre-tax treatment under the flexible or cafeteria employee benefit plan only to the extent allowed by 26 U.S.C. 125, as amended.

B. Pre-taxing of plan premiums. The method of subtracting premiums for health and supplemental life insurance from gross salary before deducting federal and state income taxes and ~~social security~~ Social Security taxes, resulting in the pre-taxing of premiums for health and supplemental life insurance plans, shall not change or cancel until the end of the plan year.

C. Corresponding change in premiums. A family status event that results in the modification of a pre-tax premium will also result in a corresponding change in the premium amount being deducted.

D. Automatic disenrollment. A participant is automatically disenrolled from this plan if the participant ceases to be an eligible employee.

E. Plan administrator. The Arizona Department of Administration administers the plan and determines the type, structure, and components of the plan.

F. Responsibility for plan operation. The plan administrator has sole authority to amend or terminate, in whole or in part, the plan at any time. The plan administrator has sole responsibility for effecting salary reductions.

G. Scope of authority. The plan administrator has sole responsibility to administer the plan, including, but not limited to, the following:
1. To construe and interpret the plan, decide all questions of eligibility, and determine the amount, manner, and time of payment of any benefits; and
2. To prescribe procedures to be followed by eligible employees who want to enroll in the plan.

NOTICE OF FINAL RULEMAKING

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 46. BOARD OF APPRAISAL

[R08-106]

PREAMBLE

1. Sections Affected	Rulemaking Action
R4-46-101	Amend
R4-46-201	Amend

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

Authorizing statutes: A.R.S. §§ 32-3605(A), 32-3605(B)(2), 32-3605(B)(3), 32-3605(B)(4), 32-3605(B)(5), 32-3605(B)(6)

Implementing statutes: A.R.S. §§ 32-3612, 32-3613, 32-3614, 32-3615

3. The effective date of the rules:

May 31, 2008

4. A list of all previous notices appearing in the *Register* addressing the final rules:

Notice of Rulemaking Docket Opening: 13 A.A.R. 3766, November 9, 2007

Notice of Proposed Rulemaking: 13 A.A.R. 3756, November 9, 2007

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

Name:	Deborah G. Pearson, Executive Director
Address:	1400 W. Washington St., Suite 360 Phoenix, AZ 85007
Telephone:	(602) 542-1593
Fax:	(602) 542-1598
E-mail:	deborah.pearson@appraisal.state.az.us

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

The changes in the existing rules are to comply with Title XI of the Financial Institutions Reform, Recovery, and Enforcement Act of 1989, which requires state licensing boards to recognize and ensure that state licensed and certified appraisers meet the minimum criteria issued by the Appraiser Qualifications Board of The Appraisal Foundation, and to comply with A.R.S. §§ 32-3605(B)(2) and 32-3605(B)(3), which require the Board to adopt criteria for licensing and certification of appraisers that at a minimum are equal to the minimum criteria for licensing and certification adopted by the Appraiser Qualifications Board. The amendments will adopt the January 2008 version of *The Real Property Appraiser Qualification Criteria and Interpretations of the Criteria* (Real Property Appraiser Qualification Criteria Effective January 1, 2008; Appendix, Real Property Appraiser Qualification Criteria Prior to January 1, 2008; Includes All Interpretations and Supplementary Information as of February 1, 2007) (2008 Criteria). The January, 2008 version contains the following interpretations and guide notes issued by the Appraiser Qualifications Board: (1) Interpretation--Continuing Education Waivers and Deferrals; (2) Interpretation--Continuing Education Requirements for Partial Years; (3) Interpretation--Continuing Education Credit for Attendance at State Appraiser Regulatory Agency Meetings; (4) AQB Guide Note 4 (GN-4) relating to practicum courses to be used for experience credit; and (5) AQB Guide Note 5 (GN-5) relating to reciprocity, temporary practice, renewals, and applications for the same credential in another jurisdiction.

The amendments propose to establish that a minimum percentage of an applicant's quantitative experience requirements must include work product where the applicant inspected the subject property.

The amendments propose to revise the definition of "Direct Supervision" to better clarify the required supervision of trainees by supervising appraisers.

The amendments propose to require that an appraiser who wishes to become a supervising appraiser and existing supervising appraisers complete a course regarding the role of supervising appraisers.

The proposed rules propose to provide for enforcement of the requirements for a supervising appraiser.

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

None

8. 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

9. The summary of the economic, small business, and consumer impact.

For the rulemaking identified in item 6 of the Preamble, the major economic impact of the rules will be the indirect beneficial effect for the public and regulated community due to specific interpretation of the criteria for licensed and certified appraisers and the requirements for supervising appraisers. The cost, if any, to the regulated community, trainees, and course providers will be minimal. There will be no cost to the public. The Board will bear the cost of the rulemaking and the cost of enforcing the rules.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if appli-

cable):

The proposed rules were drafted to adopt Version 4 of the 2008 Criteria. Subsequent to the proposed rulemaking, the Appraiser Qualifications Board published a January 2008 version of the 2008 Criteria, reformatting and correcting a typographical error. The January 2008 version contains no substantive changes to Version 4 of the 2008 Criteria. The proposed rules requested a delayed effective date of May 1, 2008; however, this is no longer necessary because once the notice of final rulemaking is filed with the Secretary of State, the effective date will be after May 1, 2008. Minor grammatical, formatting, or clarifying changes were made at the request of G.R.R.C. staff.

11. A summary of the comments made regarding the rules and the agency response to them:

The Board held a public hearing on the proposed rule changes on December 13, 2007. No oral or written public comments were received. At that time the Board voted to close the record, adopt the proposed rule changes, and proceed with the Notice of Final Rulemaking.

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

Not applicable

13. Any material incorporated by reference and its location in the text:

The Real Property Appraiser Qualification Criteria and Interpretations of the Criteria (Real Property Appraiser Qualification Criteria Effective January 1, 2008; Appendix, Real Property Appraiser Qualification Criteria Prior to January 1, 2008; Includes All Interpretations and Supplementary Information as of February 1, 2007) (2008 Criteria). The location in the text is R4-46-201(A).

14. Were these rules previously made as emergency rules?

No

15. The full text of the rules follows:

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 46. BOARD OF APPRAISAL

ARTICLE 1. GENERAL PROVISIONS

Section
R4-46-101. Definitions

ARTICLE 2. LICENSING AND CERTIFICATION

Section
R4-46-201. Appraiser Qualification Criteria

ARTICLE 1. GENERAL PROVISIONS

R4-46-101. Definitions

In these rules, unless the context otherwise requires:

"Arizona or State Certified General Appraiser" No change

"Arizona or State Certified Residential Appraiser" No change

"Arizona or State Licensed Appraiser" No change

"Appraisal Foundation" No change

"Appraiser" No change

"Board" No change

"Board counsel" No change

"Board staff" No change

"Complaint" No change

"Consent agreement" No change

"Consulting assignment" No change

"Conviction" No change

"Course provider" No change

"Direct supervision" means that a supervising appraiser of a trainee is ~~physically present to direct and oversee~~ directing and overseeing the production of each appraisal assignment~~.~~ and is personally and physically present during the

entire inspection of each appraised property.

"Disciplinary action" No change

"Dismissal" No change

"Distance education" No change

"Due diligence" No change

"Formal complaint" No change

"Formal hearing" No change

"Informal hearing" No change

"Informational interview" No change

"Initial review" No change

"Investigation" No change

"Investigator" No change

"Jurisdictional criteria" No change

"Letter of concern" No change

"Letter of due diligence" No change

"Letter of remedial action" No change

"Mentor" No change

"Order" No change

"Party" No change

"Practicing appraiser" No change

"Probation" No change

"Property tax agent" No change

"Remedial action" No change

"Respondent" No change

"Rules" No change

"Summary suspension" No change

"Supervising appraiser" means a state certified appraiser in good standing with a minimum of four years of experience within the last four years as a practicing appraiser who engages in direct supervision of a trainee pursuing a state license or certificate and provides training for work included within the supervising appraiser's classification. ~~This definition is effective January 1, 2008.~~

"Trainee" No change

"USPAP" No change

"Workfile" No change

ARTICLE 2. LICENSING AND CERTIFICATION

R4-46-201. Appraiser Qualification Criteria

A. Except as provided in subsections (B), (C), and (D), an applicant for the applicable classification of license or certificate shall meet that classification's criteria established by the Appraiser Qualifications Board (AQB) in either ~~The Real Property Appraiser Qualification Criteria and Interpretations of the Criteria adopted February 16, 1994 effective January 1, 1998, All Interpretations and Supplementary Information as of January 1, 2002, and Appendix I, Criteria Revisions effective January 1, 2003, ("1998 Criteria"), or The Real Property Appraiser Qualification Criteria adopted January 1, 2003, All Interpretations And Supplementary Information as of November 1, 2005, and Appendix, Real Property Qualifications Effective January 1, 2008 ("2008 Criteria"),~~ *The Real Property Appraiser Qualification Criteria and Interpretations of the Criteria* (Real Property Appraiser Qualification Criteria adopted February 16, 1994, effective January 1, 1998; Includes all Interpretations and Supplementary Information as of January 1, 2002; Appendix I Criteria Revisions effective January 1, 2003) referred to as the "1998 Criteria," or *The Real Property Appraiser Qualification Criteria and Interpretations of the Criteria* (Real Property Appraiser Qualification Criteria Effective January 1, 2008; Appendix, Real Property Appraiser Qualification Criteria Prior to January 1, 2008; Includes All Interpretations and Supplementary Information as of February 1, 2007) referred to as the "2008 Criteria," as follows:

1. The requirements are divided into three components: education, experience and examination. An applicant shall meet the criteria in effect at the time the applicant completes a particular component.

2. The Board shall give credit for completion of a component if the applicant meets either the 1998 Criteria or the 2008 Criteria for any component completed prior to January 1, 2008.
3. The Board shall give credit for completion of a component only if the applicant meets the 2008 Criteria for any component completed on or after January 1, 2008.
4. On and after November 1, 2008, an applicant shall meet the 2008 Criteria for all components, regardless of when the component was completed. Both the 1998 Criteria and the 2008 Criteria are incorporated by reference and are on file with the Board. These incorporated criteria include no future ~~additions~~ editions or amendments. A copy of the incorporated criteria may be obtained from the Board or The Appraisal Foundation~~.~~, 1155 15th Street, NW, Suite 1111, Washington, DC 20005; (202) 347-7722; fax (202) 347-7727; or web site www.appraisalfoundtion.org.

B. Regardless of whether a transaction is federally related:
1. A State Licensed Residential Appraiser is limited to the scope of practice in A.R.S. § 32-3612(A)(3), and
2. A State Certified Residential Appraiser is limited to the scope of practice in A.R.S. § 32-3612(A)(2).

C. Notwithstanding the criteria incorporated by reference in subsection (A),
1. An applicant shall not obtain more than 75% of required qualifying education through distance education~~.~~;
2. An applicant shall not obtain the 15-hour National USPAP Course, or its equivalent, approved through the AQB Course Approval Program, through distance education~~.~~; ~~and~~
3. Qualifying education credit may be obtained at any time before the date of application, except the 15-hour National USPAP Course or its AQB approved equivalent ~~must~~ shall be obtained within two years preceding the date of application~~.~~; and
4. 75% of the applicant's quantitative experience requirements shall include work product where the applicant inspected the subject property.

D. Notwithstanding the criteria incorporated by reference in subsection (A), there is no Trainee Real Property Appraiser Classification.
1. A supervising appraiser shall instruct and directly supervise a trainee for any classification of license or certificate in the entire preparation of each appraisal. A supervising appraiser shall provide direct supervision, being personally and physically present during the entire inspection of each appraised property with the trainee. The supervising appraiser shall approve and sign all final appraisal documents~~.~~, certifying the appraisals are in compliance with the Uniform Standards of Professional Appraisal Practice. ~~To demonstrate responsibility for the instruction, guidance, and direct supervision of the trainee, the supervising appraiser shall:~~
   ~~a. Sign the appraisal report and certify the report is in compliance with the Uniform Standards of Professional Appraisal Practice,~~
   ~~b. Personally supervise the entire physical inspection of each appraised property with the trainee, and~~
   ~~c. Review and sign each trainee appraisal report.~~
2. A trainee may have more than one supervising appraiser, but a supervising appraiser shall not supervise more than three trainees at any one time. A trainee shall maintain an appraisal log for each supervising appraiser and, at a minimum, include the following in the log for each appraisal:
   a. Type of property,
   b. Date of report,
   c. Property description,
   d. Description of work performed by the trainee and scope of review and supervision by the supervising appraiser,
   e. Number of actual work hours by the trainee on the assignment, and
   f. The signature and state certificate number of the supervising appraiser. ~~This subsection (D)(2)(f) is effective January 1, 2008.~~
3. ~~A supervising appraiser and trainee shall work in the same geographic area, and in no event shall the supervising appraiser and trainee work in different states.~~
4~~.~~3. A supervising appraiser shall provide to the Board in writing the name and address of each trainee within 10 days of engagement, and notify the Board in writing immediately upon termination of the engagement. A state certified appraiser is not eligible to be a supervising appraiser unless the appraiser's certificate is in good standing and the appraiser has not been subject to license or certificate suspension, probation, or mentorship within the last two years. ~~This subsection (D)(4) is effective January 1, 2008.~~
4. An appraiser who wishes to act as a supervising appraiser shall submit proof of completion of a minimum of four hours of continuing education approved by the Board, regarding the role of a supervising appraiser, before supervision begins. The required course shall not be taken through distance education.
5. Each supervising appraiser shall submit to the Board proof of completion of a minimum of four hours of continuing education approved by the Board regarding the role of a supervising appraiser within 60 days of the effective date of this subsection. The required course shall not be taken through distance education. If the supervising appraiser does not take the course within 60 days of the effective date of this subsection, the supervising appraiser shall not act as a supervising appraiser until the class is taken and proof has been submitted to the Board.
4~~.~~6. In the event that an appraiser or a supervising appraiser does not comply with the applicable requirements of subsec-

tion (D):

a. The appraiser or the supervising appraiser may be subject to disciplinary action pursuant to A.R.S. § 32-3631(A)(8), and

b. A trainee shall not receive experience credit for hours logged during the period that the appraiser or supervising appraiser failed to comply with the applicable requirements of subsection (D).

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

[R08-108]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-22-705	Amend
R9-22-712	Amend
R9-22-712.35	Amend
R9-22-712.40	Amend

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

Authorizing statute: A.R.S. § 36-2903.01

Implementing statute: A.R.S. § 36-2903.01

3. The effective date of the rules:

May 31, 2008

4. A list of all previous notices appearing in the *Register* addressing the final rules:

Notice of Rulemaking Docket Opening: 13 A.A.R. 4331, December 7, 2007

Notice of Proposed Rulemaking: 13 A.A.R. 4477, December 21, 2007

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

Name: Mariaelena Ugarte

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

Telephone: (602) 417-4693

Fax: (602) 253-9115

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

The Administration intends to clarify the coverage and reimbursement requirements related to hospital services provided out-of-state.

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

No study was reviewed during this rulemaking; however, a data analysis for out of state health plan encounters was performed.

8. 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

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

The Administration anticipates minimal to no impact on small businesses or consumers with the rule changes. These changes provide clarification of how necessary medical services will be reimbursed when received out-of-state or out of the geographical service area.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

No substantive changes have been made between the proposed rules and the final rules below. The Administration made the rules more clear, concise, and understandable by making grammatical, verb tense, punctuation, and structural changes throughout the rules.

11. A summary of the comments made regarding the rule and the agency response to them:

The Administration received the following comments regarding the rules:

Date:	Commenter:	Comment:	Date of response:	Response:
01/21/08	Kimulet Winzer Compliance Officer United Healthcare	Sections R9-22-705(F) and R9-22-712(B) outline that a "contractor shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent state-wide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b)". R9-22-712.01(6)(b) references the use of the most current Medicare cost-to-charge ratios as published by CMS each year.	02/15/08	AHCCCS Administration reviewed health plan data for out-of-state services for a one year period and determined that the fiscal impact of using the proposed Cost to Charge Ratio (CCR) methodology rather than tier reimbursement would be minimal. 1 percent would be health-plan paid days, averaging a daily rate that is within 6% of the average tier rate paid. Moreover, the
		Following this reimbursement methodology, a health plan will be exposed and subject to any changes in an Out Of State hospital's customary charges (chargemaster) without limitation, and this may cause a financial burden to health plans and the Administration. United Health Care recommends that AHCCCS consider a "fixed-rate" methodology for inpatient Out Of State claims payment, such as the tiered payment methodology or a percentage of the Medicare MS-DRG reimbursement.		AHCCCS Administration is currently paying out-of-state hospital services using the CCR methodology. The cost associated with modifying the system to pay differently would be significant.

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

Not applicable

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

Not applicable

14. Was this rule previously adopted as an emergency rule?

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-22-705. Payments by Contractors
R9-22-712. Reimbursement: General
R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees

R9-22-712.40. Outpatient Hospital Reimbursement: Annual and Periodic Update

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-705. Payments by Contractors

A. General requirements. A contractor shall contract with providers to provide covered services to members enrolled with the contractor. The contractor is responsible for ~~the reimbursement and coordination of care~~ reimbursing providers and coordinating care for services provided to a member. Except as provided in subsection (A)(2), a contractor is not required to reimburse a noncontracting provider for services rendered to a member enrolled with the contractor.

1. Providers. A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904 and 42 CFR 431.107(b) as of March 6, 1992, which is incorporated by reference, ~~and~~ on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol ~~Street~~ St., NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
2. A contractor shall reimburse a noncontracting provider for services rendered to a member enrolled with the contractor ~~at the Administration's capped fee-for-service schedule rate~~ as specified in this Article if:
   a. The contractor referred the member to the provider or authorized the provider to render the services and the claim is otherwise payable under this Chapter, or
   b. The service is emergent under Article 2 of this Chapter.

B. Timely submission of claims.

1. Under A.R.S. § 36-2904, a contractor shall deem a paper or electronic claim as submitted on the date that the claim is received by the contractor. The contractor shall do one or more of the following for each claim the contractor receives:
   a. Place a date stamp on the face of the claim,
   b. Assign a system-generated claim reference number, or
   c. Assign a system-generated date-specific number.
2. Unless a shorter time period is specified in subcontract, a contractor shall not pay a claim for a covered service unless the claim is initially submitted within one of the following time limits, whichever is later:
   a. Six months from the date of service or for an inpatient hospital claim, six months from the date of discharge; or
   b. Six months from the date of eligibility posting.
3. Unless a shorter time period is specified in subcontract, a contractor shall not pay a clean claim for a covered service unless the claim is submitted within one of the following time limits, whichever is later:
   a. Twelve months from the date of service or for an inpatient hospital claim, twelve months from the date of discharge; or
   b. Twelve months from the date of eligibility posting.

~~**C.** Date of claim. A contractor's date of receipt of an inpatient or an outpatient hospital claim is the date the claim is received by the contractor as indicated by the date stamp on the claim, the system-generated claim reference number, or the system-generated date-specific number assigned by the contractor. A hospital claim is considered paid on the date indicated on the disbursement check. A denied hospital claim is considered adjudicated on the date of the claim's denial. For a claim that is pending for additional supporting documentation specified in A.R.S. §§ 36-2903.01 or 36-2904, the contractor shall assign a new date of receipt upon receipt of the additional documentation. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. §§ 36-2903.01 or 36-2904, the contractor shall not assign a new date of receipt. A contractor and a hospital may, through a contract approved as specified in R9-22-715, adopt a method for identifying, tracking, and adjudicating a claim that is different from the method described in this subsection.~~

C. Date of claim.

1. A contractor's date of receipt of an inpatient or an outpatient hospital claim is the date the claim is received by the contractor as indicated by the date stamp on the claim, the system-generated claim reference number, or the system-generated date-specific number assigned by the contractor.
2. A hospital claim is considered paid on the date indicated on the disbursement check.
3. A denied hospital claim is considered adjudicated on the date of the claim's denial.
4. For a claim that is pending for additional supporting documentation specified in A.R.S. § 36-2903.01 or 36-2904, the contractor shall assign a new date of receipt upon receipt of the additional documentation.
5. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. § 36-2903.01 or 36-2904, the contractor shall not assign a new date of receipt.
6. A contractor and a hospital may, through a contract approved as specified in R9-22-715, adopt a method for identifying, tracking, and adjudicating a claim that is different from the method described in this subsection.

D. Payment for in-state inpatient hospital services. A contractor shall reimburse an in-state provider ~~and a noncontracting provider for~~ of inpatient hospital services rendered with an admission date on or after March 1, 1993, at either a rate specified by subcontract or, in absence of the subcontract, the prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and this Article. Subcontract rates, terms, and conditions are subject to review and approval or disapproval under A.R.S. § 36-

2904 and R9-22-715. This subsection does not apply to an urban contractor as specified in R9-22-718 and A.R.S. § 36-2905.01.

E. Payment for in-state outpatient hospital services.

1. A contractor shall reimburse an in-state ~~provider and a noncontracting~~ provider ~~for~~ of outpatient hospital services rendered on or after March 1, 1993 through June 30, 2005, at either a rate specified by a subcontract that complies with R9-22-715(A) or, in absence of a subcontract, as described in R9-22-712 or under A.R.S. § 36-2903.01. Subcontract rates, terms, and conditions are subject to review~~,~~ and approval or disapproval~~,~~ under A.R.S. § 36-2904 and R9-22-715.
2. A contractor shall reimburse an in-state provider ~~and noncontracting provider for~~ of outpatient hospital services rendered on or after July 1, 2005, at either a rate specified by a subcontract or, in absence of a subcontract, as provided under R9-22-712.10, A.R.S. § 36-2903.01 and other sections of this Article. ~~Subcontract rates, terms, and conditions~~ The terms of the subcontract are subject to review~~,~~ and approval or disapproval~~,~~ under A.R.S. § 36-2904 and R9-22-715.

~~**F.** Inpatient and outpatient out-of-state hospital payments. A contractor shall reimburse out-of-state hospitals for covered inpatient and outpatient services and associated professional fees provided to an AHCCCS member at the lesser of the negotiated rate, or the rates as described under A.R.S. § 36-2903.01 and this Article.~~

F. Inpatient and outpatient out-of-state hospital payments. In the absence of a contract with an out-of-state hospital that specifies payment rates, a contractor shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent state-wide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b). In the absence of a contract with an out-of-state hospital that specifies payment rates, a contractor shall reimburse out-of-state hospitals for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the contractor shall pay the claim by multiplying the covered charges for the outpatient services by the state-wide outpatient cost-to-charge ratio.

G. Payment for observation days. A contractor shall reimburse a provider and a noncontracting provider for the provision of observation days at either a rate specified by subcontract or, in the absence of a subcontract, as prescribed under R9-22-712, R9-22-712.10, and R9-22-712.45. An "observation day" means a physician-ordered evaluation period of less than 24 hours to determine the need of treatment or the need for admission as an inpatient.

H. Review of claims and coverage for hospital supplies.

1. A contractor may conduct a review of any claims submitted and recoup any payments made in error.
2. A hospital shall obtain prior authorization from the appropriate contractor for nonemergency admissions. When issuing prior authorization, a contractor shall consider the medical necessity of the service, and the availability and cost effectiveness of an alternative treatment. Failure to obtain prior authorization when required is cause for nonpayment or denial of a claim. A contractor shall not require prior authorization for medically necessary services provided during any prior period for which the contractor is responsible. If a contractor and a hospital agree to a subcontract, the parties shall abide by the terms of the subcontract regarding utilization control activities. A hospital shall cooperate with a contractor's reasonable activities necessary to perform concurrent review and shall make the hospital's medical records pertaining to a member enrolled with a contractor available for review.
3. Regardless of prior authorization or concurrent review activities, a contractor may make prepayment or post payment review of all claims, including but not limited to a hospital claim. A contractor may recoup an erroneously paid claim. If prior authorization was given for a specific level of care, but medical review of a claim indicates that a different level of care was medically appropriate, a contractor shall adjust the claim to pay for the cost for the appropriate level of care. An adjustment in payment for a different level of care is effective on the date when the different level of care is medically appropriate.
4. A contractor and a hospital may enter into a subcontract that includes hospital claims review criteria and procedures if the subcontract meets the requirements of R9-22-715.
5. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
   a. Patient care kit,
   b. Toothbrush,
   c. Toothpaste,
   d. Petroleum jelly,
   e. Deodorant,
   f. Septi soap,
   g. Razor ~~or disposable razor~~,
   h. Shaving cream,
   i. Slippers,
   j. Mouthwash,
   k. Disposable razor,
   l. Shampoo,
   m. Powder,

n. Lotion,
o. Comb, and
p. Patient gown.

6. The following hospital supplies and equipment, if medically necessary and used by the member, are covered services:
   a. Arm board,
   b. Diaper,
   c. Underpad,
   d. Special mattress and special bed,
   e. Gloves,
   f. Wrist restraint,
   g. Limb holder,
   h. Disposable item used instead of a durable item,
   i. Universal precaution,
   j. Stat charge, and
   k. Portable charge.
7. The contractor shall determine in a hospital claims review whether services rendered were:
   a. Covered services as defined in R9-22-102;
   b. Medically necessary;
   c. Provided in the most appropriate, cost-effective, and least restrictive setting; and
   d. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2904.
8. If a contractor adjudicates a claim or recoups payment for a claim, a person may file a claim dispute challenging the adjudication or recoupment as described under 9 A.A.C. 34.

I. Non-hospital claims. A contractor shall pay claims for non-hospital services in accordance with contract, or in the absence of a contract, at a rate not less than the Administration's capped fee-for-service schedule or at a lower rate if negotiated between the two parties.

J. Payments to hospitals. A contractor shall pay for inpatient hospital admissions and outpatient hospital services rendered on or after March 1, 1993, as follows and as described in A.R.S. § 36-2904:
1. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.
2. If the hospital bill is paid between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.
3. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a ~~fee of~~ 1 percent penalty of the rate for each month or portion of the month following the 60th day of receipt of the bill until date of payment.

K. Interest payment. In addition to the requirements in subsection (J), a contractor shall pay interest for late claims as defined by contract.

R9-22-712. Reimbursement: General

A. Inpatient and outpatient discounts and penalties. If a claim is pended for additional documentation required under A.R.S. § 36-2903.01(H)(4), the period during which the claim is pended is not used in the calculation of the quick-pay discounts and slow-pay penalties under A.R.S. § 36-2903.01(H)(5).

~~**B.** Inpatient and outpatient out-of-state hospital payments. AHCCCS shall reimburse out-of-state hospitals for covered inpatient and outpatient services provided to a member at the lesser of the negotiated rate or the AHCCCS FFS rate as described in A.R.S. § 36-2903.01 and this Article.~~

B. Inpatient and outpatient out-of-state hospital payments. In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent state-wide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b). In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse an out-of-state hospital for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the Administration shall pay the claim by multiplying the covered charges for the outpatient services by the state-wide outpatient cost-to-charge ratio.

C. Access to records. Subcontracting and noncontracting providers of outpatient or inpatient hospital services shall allow the Administration access to medical records regarding eligible persons and shall in all other ways fully cooperate with the Administration or the Administration's designated representative in performance of the Administration's utilization control activities. The Administration shall deny a claim for failure to cooperate.

D. Prior authorization. The Administration shall deny a claim for failure to obtain prior authorization as required in R9-22-210.

E. Review of claims. Regardless of prior authorization or concurrent review activities, the Administration may subject all hospital claims, including outliers, to prepayment medical review or post-payment review, or both. The Administration shall conduct post-payment reviews consistent with A.R.S. § 36-2903.01 and may recoup erroneously paid claims. If prior authorization was given for a specific level of care but medical review of the claim indicates that a different level of care

was appropriate, the Administration may adjust the claim to reflect the more appropriate level of care, effective on the date when the different level of care was medically appropriate.

F. Claim receipt.

1. The Administration's date of receipt of inpatient or outpatient hospital claims is the date the claim is received by the Administration as indicated by the date stamp on the claim and the system-generated claim reference number or system-generated date-specific number.
2. Hospital claims are considered paid on the date indicated on disbursement checks.
3. ~~Denied claims are~~ A denied claim is considered adjudicated on the date ~~of their denial~~ the claim is denied.
4. Claims that are denied and are resubmitted are assigned new receipt dates.
5. For a claim that is pending for additional supporting documentation specified in A.R.S. §§ 36-2903.01 or 36-2904, the Administration shall assign a new date of receipt upon receipt of the additional documentation.
6. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. §§ 36-2903.01 or 36-2904, the Administration shall not assign a new date of receipt.

G. Outpatient hospital reimbursement. The Administration shall pay for covered outpatient hospital services provided to eligible persons with dates of service from March 1, 1993 through June 30, 2005, at the AHCCCS outpatient hospital cost-to-charge ratio, multiplied by the amount of the covered charges.

1. Computation of outpatient hospital reimbursement. The Administration shall compute the cost-to-charge ratio on a hospital-specific basis by determining the covered charges and costs associated with treating eligible persons in an outpatient setting at each hospital. Outpatient operating and capital costs are included in the computation but outpatient medical education costs that are included in the inpatient medical education component are excluded. To calculate the outpatient hospital cost-to-charge ratio annually for each hospital, the Administration shall use each hospital's Medicare Cost Reports and a database consisting of outpatient hospital claims paid and encounters processed by the Administration for each hospital, subjecting both to the data requirements specified in R9-22-712.01. The Administration shall use the following methodology to establish the outpatient hospital cost-to-charge ratios:
   a. Cost-to-charge ratios. The Administration shall calculate the costs of the claims and encounters for outpatient hospital services by multiplying the ancillary line item cost-to-charge ratios by the covered charges for corresponding revenue codes on the claims and encounters. Each hospital shall provide the Administration with information on how the revenue codes used by the hospital to categorize charges on claims and encounters correspond to the ancillary line items on the hospital's Medicare Cost Report. The Administration shall then compute the overall outpatient hospital cost-to-charge ratio for each hospital by taking the average of the ancillary line items cost-to-charge ratios for each revenue code weighted by the covered charges.
   b. Cost-to-charge limit. To comply with 42 CFR 447.325, the Administration may limit cost-to-charge ratios to 1.00 for each ancillary line item from the Medicare Cost Report. The Administration shall remove ancillary line items that are non-covered or not applicable to outpatient hospital services from the Medicare Cost Report data for purposes of computing the overall outpatient hospital cost-to-charge ratio.
2. New hospitals. The Administration shall reimburse new hospitals at the weighted statewide average outpatient hospital cost-to-charge ratio multiplied by covered charges. The Administration shall continue to use the statewide average outpatient hospital cost-to-charge ratio for a new hospital until the Administration rebases the outpatient hospital cost-to-charge ratios and the new hospital has a Medicare Cost Report for the fiscal year being used in the rebasing.
3. Specialty outpatient services. The Administration may negotiate, at any time, reimbursement rates for outpatient hospital services in a specialty facility. ~~For purposes of this subsection, "specialty facility" means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.~~
4. Reimbursement requirements. To receive payment from the Administration, a hospital shall submit claims that are legible, accurate, error free, and have a covered charge greater than 0. The Administration shall not reimburse hospitals for emergency room treatment, observation hours or days, or other outpatient hospital services performed on an outpatient basis, if the eligible person is admitted as an inpatient to the same hospital directly from the emergency room, observation area, or other outpatient department. Services provided in the emergency room, observation area, and other outpatient hospital services provided before the hospital admission are included in the tiered per diem payment.
5. Rebasing. The Administration shall rebase the outpatient hospital cost-to-charge ratios at least every four years but no more than once a year using updated Medicare Cost Reports and claim and encounter data.
6. If a hospital files an increase in its charge master for an existing outpatient service provided on or after July 1, 2004, and on or before June 30, 2005, which represents an aggregate increase in charges of more than 4.7 percent, the Administration shall adjust the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through (G)(5) by applying the following formula:

   CCR*[1.047/(1+ % increase)]

   Where "CCR" means the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through (G)(5) and "% increase" means the aggregate percentage increase in charges for outpatient services shown on the hospital charge master.

"Charge master" means the schedule of rates and charges as described under A.R.S. § 36-436 and the rules that relate to those rates and charges that are filed with the Director of the Arizona Department of Health Services.

~~"Existing outpatient services" means a service provided by the hospital prior to the hospital filing an increase in its charge master, regardless of whether the service was explicitly described in the hospital charge master before filing the increase, or how the service was described in the charge master before filing the increase.~~

R9-22-712.35. Outpatient Hospital Reimbursement: Adjustments to Fees

A. AHCCCS shall increase the ~~fees~~ outpatient capped-fee-schedule established under R9-22-712.20 (except for laboratory services and out-of-state hospital services) for the following hospitals submitting any claims:
1. By 48 percent for public hospitals on July 1, 2005, as well as hospitals that were public ~~in~~ anytime during the calendar year 2004~~.~~;
2. By 45 percent for hospitals in counties other than Maricopa and Pima with more than 100 Medicare PPS beds during the contract year in which the outpatient capped-fee-schedule rates are effective~~.~~;
3. By 50 percent for hospitals in counties other than Maricopa and Pima with 100 or less Medicare PPS beds during the contract year in which the outpatient capped-fee-schedule rates are effective~~.~~;
4. By 115 percent for hospitals designated as Critical Access Hospitals, or for hospitals that have not been designated as Critical Access Hospitals, but meet the criteria~~.~~ during the contract year in which the outpatient capped-fee-schedule rates are effective;
5. By 113 percent for a freestanding children's hospital with at least 110 pediatric beds~~.~~ during the contract year in which the outpatient capped-fee-schedule rates are effective; or
6. By 14 percent for a University Affiliated Hospital ~~defined as those hospitals that have~~, which is a hospital that has a majority of the ~~member~~ members of its board of directors appointed by the Board of Regents during the contract year in which the outpatient capped-fee-schedule rates are effective.

B. In addition to subsection (A), the following outpatient capped-fee-schedule rate increase ~~may be~~ shall be established: A 50 percent adjustment for a Level 2 and 3 emergency department procedures billed by a ~~level~~ Level 1 ~~Trauma~~ trauma center as defined by R9-22-2101.

C. Fee adjustments ~~in~~ made under subsection (A) and (B) are available with the AHCCCS Outpatient Capped Fee-For Service Schedule, which is on file ~~and online~~ with AHCCCS and posted on AHCCCS' web site.

R9-22-712.40. Outpatient Hospital Reimbursement: Annual and Periodic Update

A. Procedure ~~Codes~~ codes. When procedure codes are issued by CMS and added to the Current Procedural Terminology published by the American Medical Association, AHCCCS shall add the new procedure codes for covered outpatient services and shall either assign the default CCR, the Medicare rate, or calculate an appropriate fee ~~when procedure codes are issued by CMS or the Current Procedural Terminology published by the American Medical Association~~.

B. APC ~~Changes~~ changes. AHCCCS may reassign procedure codes to new or different APC groups when APC groups are revised by ~~Medicare~~ CMS. AHCCCS may reassign procedure codes to a different APC group than Medicare. If AHCCCS determines that utilization of ~~the~~ a procedure code within the Medicare program is substantially different from utilization of the procedure code in the AHCCCS program, AHCCCS may chose not to assign the procedure code to any APC group. For procedure codes not grouped into an APC by Medicare, AHCCCS may assign the code to an APC group when AHCCCS determines that the cost and resources associated with the non-assigned code are substantially similar to those in ~~a particular~~ the APC group.

C. Annual ~~Update~~ update for Outpatient Hospital Fee Schedule. Beginning October 1, 2006, AHCCCS shall adjust outpatient fee schedule rates:
1. ~~On an annual basis~~ Annually by multiplying the rates effective during the prior year by the Global Insight Prospective Hospital Market Basket Inflation Index; or
2. In ~~any given~~ a particular year the director may substitute the increases in subsection ~~(B)(1)~~ (C)(1) by calculating the dollar value associated with the ~~inflationary increase in (B)(1)~~ inflation index in subsection (C)(1), and applying ~~that~~ the dollar value to adjust rates at varying levels.

D. Rebase. AHCCCS shall rebase the outpatient fees every five years.

E. Statewide CCR. The statewide CCR calculated in R9-22-712.30 shall be recalculated at the time of rebasing~~.~~, ~~at which time~~ When rebasing, AHCCCS may consider recalculating the statewide CCR based on the costs and charges for ~~those~~ services excluded from the outpatient hospital fee schedule.