

# UTAH STATE BULLETIN

OFFICIAL NOTICES OF UTAH STATE GOVERNMENT  
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Kenneth A. Hansen, Director  
Nancy L. Lancaster, Editor

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Inquiries concerning administrative rules or other contents of the *Bulletin* may be addressed to the responsible agency or to: Division of Administrative Rules, 4120 State Office Building, Salt Lake City, Utah 84114, telephone (801) 538-3218, FAX (801) 538-1773. To view rules information, and on-line versions of the division's publications, visit: <http://www.rules.utah.gov/>

The information in this *Bulletin* is summarized in the *Utah State Digest (Digest)*. The *Digest* is available by E-mail or over the Internet. Visit <http://www.rules.utah.gov/publicat/digest.htm> for additional information.

Division of Administrative Rules, Salt Lake City 84114

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# SPECIAL NOTICES

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## Governor's Proclamation: Calling the Fifty-Sixth Legislature into the First Special Session

### Proclamation

**WHEREAS**, since the adjournment of the 2005 General Session of the Fifty-Sixth Legislature of the State of Utah, matters have arisen that require immediate legislative attention; and

**WHEREAS**, Article VII, Section 6 of the Constitution of the State of Utah provides that the Governor may, by proclamation, convene the Legislature into Special Session;

**NOW, THEREFORE**, I, Jon M. Huntsman, Jr., Governor of the State of Utah, by virtue of the authority vested in me by the Constitution and the Laws of the State of Utah, do by this Proclamation call the Fifty-Sixth Legislature of the State of Utah into a Special Session at the State Capitol Complex, at Salt Lake City, Utah, on the 19th day of April, 2005, at 2:00 p.m., for the following purposes:

1. To consider a provision directing public education officials regarding the administration and implementation of federal educational programs;
2. To consider a provision authorizing funding for, and the construction of, a veterans nursing home;
3. To consider a provision authorizing a substance abuse screening, assessment, and treatment study;
4. To consider a provision modifying the conditions under which a health care provider may bring an action against a health maintenance organization or preferred provider organization for payment and to require objective provider contracting provisions;
5. To consider a provision requiring the State Court Administrator, subject to legislative appropriation, to provide grants to nonprofit legal assistance providers;
6. To consider a joint resolution supporting jail expansion in Beaver, Millard, and Sanpete Counties through a contract with the Utah Department of Corrections;
7. To consider modifying provisions relating to tourism advertising, marketing, and branding;
8. To consider a provision modifying notice and hearing provisions relating to property tax increases by participants in certain interlocal cooperation entities;
9. To consider a provision modifying existing law regarding property tax levy rates, or other methods of funding services, for county service areas;
10. To consider a provision regarding funding for convention facilities in counties of the first class;
11. To consider a provision modifying membership of legislative task forces;
12. To consider a provision regarding funding for transportation;
13. To consider a provision modifying existing law concerning the process of making boundary adjustments between municipalities;
14. To consider a provision to give certain executive officials a 4.5% compensation increase; and
15. To consider a provision amending election law to require the State to obtain voting equipment capable of producing an auditable record of votes cast.

**IN TESTIMONY WHEREOF**, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Utah. Done at the State Capitol Complex in Salt Lake City, Utah, this 14th day of April, 2005.

(State Seal)

**Jon M. Huntsman, Jr.**  
**Governor**

**ATTEST:**

**Gary R. Herbert**  
**Lieutenant Governor**

---

**Governor's Proclamation: Amending the Proclamation Calling the Fifty-Sixth Legislature into the First Special Session**

**Proclamation**

**WHEREAS**, the undersigned issued a Proclamation on April 14, 2005, calling the Legislature into a Special Session beginning on the 19th day of April, 2005; and

**WHEREAS**, the undersigned has since been informed of the need to modify paragraph nine of that Proclamation;

**NOW, THEREFORE**, I, Jon M. Huntsman, Jr., Governor of the State of Utah, do by this Proclamation amend paragraph nine of the Proclamation dated April 14, 2005, to read as follows: "To consider provisions modifying existing law regarding property tax levy rates, or other methods of funding services for unincorporated or previously unincorporated areas."

**IN TESTIMONY WHEREOF**, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Utah. Done at the State Capitol Complex in Salt Lake City, Utah, this 18th day of April, 2005.

(State Seal)

**Jon M. Huntsman, Jr.**  
**Governor**

**ATTEST:**

**Gary R. Herbert**  
**Lieutenant Governor**



## NOTICES OF PROPOSED RULES

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A state agency may file a PROPOSED RULE when it determines the need for a new rule, a substantive change to an existing rule, or a repeal of an existing rule. Filings received between April 2, 2005, 12:00 a.m., and April 15, 2005, 11:59 p.m. are included in this, the May 1, 2005, issue of the *Utah State Bulletin*.

In this publication, each PROPOSED RULE is preceded by a RULE ANALYSIS. This analysis provides summary information about the PROPOSED RULE including the name of a contact person, anticipated cost impact of the rule, and legal cross-references.

Following the RULE ANALYSIS, the text of the PROPOSED RULE is usually printed. New rules or additions made to existing rules are underlined (e.g., example). Deletions made to existing rules are struck out with brackets surrounding them (e.g., [~~example~~]). Rules being repealed are completely struck out. A row of dots in the text (· · · · ·) indicates that unaffected text was removed to conserve space. If a PROPOSED RULE is too long to print, the Division of Administrative Rules will include only the RULE ANALYSIS. A copy of each rule that is too long to print is available from the filing agency or from the Division of Administrative Rules.

The law requires that an agency accept public comment on PROPOSED RULES published in this issue of the *Utah State Bulletin* until at least May 31, 2005. The agency may accept comment beyond this date and will list the last day the agency will accept comment in the RULE ANALYSIS. The agency may also hold public hearings. Additionally, citizens or organizations may request the agency to hold a hearing on a specific PROPOSED RULE. Section 63-46a-5 (1987) requires that a hearing request be received "in writing not more than 15 days after the publication date of the PROPOSED RULE."

From the end of the public comment period through August 29, 2005, the agency may notify the Division of Administrative Rules that it wants to make the PROPOSED RULE effective. The agency sets the effective date. The date may be no fewer than 31 days nor more than 120 days after the publication date of this issue of the *Utah State Bulletin*. Alternatively, the agency may file a CHANGE IN PROPOSED RULE in response to comments received. If the Division of Administrative Rules does not receive a NOTICE OF EFFECTIVE DATE or a CHANGE IN PROPOSED RULE, the PROPOSED RULE filing lapses and the agency must start the process over.

The public, interest groups, and governmental agencies are invited to review and comment on PROPOSED RULES. *Comment may be directed to the contact person identified on the RULE ANALYSIS for each rule.*

PROPOSED RULES are governed by *Utah Code* Section 63-46a-4 (2001); and *Utah Administrative Code* Rule R15-2, and Sections R15-4-3, R15-4-4, R15-4-5, R15-4-9, and R15-4-10.

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**The Proposed Rules Begin on the Following Page.**

# Environmental Quality, Air Quality

## R307-101-2

### Definitions

**NOTICE OF PROPOSED RULE**  
(Amendment)

DAR FILE No.: 27818  
FILED: 04/15/2005, 09:52

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The purpose of the change is to incorporate the new federal definition of "volatile organic compound" (VOC) into Utah rules.

**SUMMARY OF THE RULE OR CHANGE:** The definition of VOC is revised to include the exemptions from the definition that were added to the federal rule late in 2004. The substances that will no longer be classified as VOCs are 1,1,1,2,2,3,3-heptafluoro-3-methoxy-propane, known as HFE-7000; 3-ethoxy-1,1,1,2,3,4,4,5,5,6,6-dodecafluoro-2-hexane, known as HFE-7500, HFE-s702, T-7145, and L-15381; 1,1,1,2,3,3,3-heptafluoropropane, known as HFC 227ea; methyl formate; and t-butyl acetate, known as TBAC or TBAC. Excluding these compounds from the VOC classification allows them to be used in place of more volatile, ozone-causing substances. At a later date, the Air Quality Board will consider whether to incorporate by reference 40 CFR 51.100(s)(5), which requires sources of VOCs to report TBAC as a separate item when they submit emission inventories to the Division of Air Quality.

**STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Section 19-2-104 and 40 CFR 51.100(s)

**THIS RULE OR CHANGE INCORPORATES BY REFERENCE THE FOLLOWING MATERIAL:** 40 CFR 51.100(s)(1), effective December 29, 2004

**ANTICIPATED COST OR SAVINGS TO:**

- ❖ **THE STATE BUDGET:** This change will not affect costs or benefits to state government. The staff of the Division of Air Quality collects inventories of the total of all VOCs that are emitted to the atmosphere; adding or subtracting one substance from the list does not affect state costs.
- ❖ **LOCAL GOVERNMENTS:** The few local governments that operate sources that emit VOCs may be able to use exempt substances in place of products currently in use. This may not change their costs, but will be a benefit in reducing their emissions of VOCs.
- ❖ **OTHER PERSONS:** Those sources that emit VOCs may be able to use exempt substances in place of products currently in use. Certain sources whose emissions of volatile organic compounds are limited to avoid formation of unhealthy levels of ozone may be able to use the de-listed compounds instead; this may allow increases in production. No costs are imposed by this change.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** Those sources that emit VOCs may be able to use exempt substances in place of products currently in use. Certain sources whose emissions of VOCs are limited to avoid formation of unhealthy levels of ozone may be able to use the de-listed compounds instead; this may allow increases in production. No costs are imposed by this change.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** No additional costs are imposed. This change may bring savings or increased production possibilities for some businesses. Dianne R. Nielson, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

ENVIRONMENTAL QUALITY  
AIR QUALITY  
150 N 1950 W  
SALT LAKE CITY UT 84116-3085, or  
at the Division of Administrative Rules.

**DIRECT QUESTIONS REGARDING THIS RULE TO:**  
Jan Miller at the above address, by phone at 801-536-4042, by FAX at 801-536-4099, or by Internet E-mail at janmiller@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 05/31/2005

INTERESTED PERSONS MAY ATTEND A PUBLIC HEARING REGARDING THIS RULE: 5/24/2005 at 1:30 PM, DEQ Building, 168 N 1950 W, Room 201, Salt Lake City, UT.

THIS RULE MAY BECOME EFFECTIVE ON: 07/06/2005

AUTHORIZED BY: M. Cheryl Heying, Planning Branch Manager

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**R307. Environmental Quality, Air Quality.**  
**R307-101. General Requirements.**  
**R307-101-2. Definitions.**

Except where specified in individual rules, definitions in R307-101-2 are applicable to all rules adopted by the Air Quality Board.

.....

"Vertically Restricted Emissions Release" means the release of an air contaminant through a stack or opening whose flow is directed in a downward or horizontal direction due to the alignment of the opening or a physical obstruction placed beyond the opening, or at a height which is less than 1.3 times the height of an adjacent building or structure, as measured from ground level.

"Vertically Unrestricted Emissions Release" means the release of an air contaminant through a stack or opening whose flow is directed upward without any physical obstruction placed beyond the opening, and at a height which is at least 1.3 times the height of an adjacent building or structure, as measured from ground level.

"Volatile Organic Compound (VOC)" as defined in 40 CFR [Subsection] 51.100(s)(1), as [published on July 1, 1998] effective on July 1, 2004, and amended on November 29, 2004, by 69 FR 69290 and 69 FR 69298, is hereby adopted and incorporated by reference.

"Waste" means all solid, liquid or gaseous material, including, but not limited to, garbage, trash, household refuse, construction or demolition debris, or other refuse including that resulting from the prosecution of any business, trade or industry.

"Zero Drift" means the change in the instrument meter readout over a stated period of time of normal continuous operation when the VOC concentration at the time of measurement is zero.

**KEY: air pollution, definitions**  
**[December 31, 2003] 2005**  
**Notice of Continuation June 5, 2003**  
**19-2-104**

## Environmental Quality, Water Quality

### R317-1-7

#### TMDLs

#### NOTICE OF PROPOSED RULE

(Amendment)

DAR FILE NO.: 27817

FILED: 04/14/2005, 17:20

#### RULE ANALYSIS

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The purpose of this amendment is to incorporate by reference eight completed and approved Total Maximum Daily Loads (TMDLs) into the rule.

**SUMMARY OF THE RULE OR CHANGE:** This section incorporates by reference eight completed and approved TMDLs into the rule. Each TMDL document has gone through an individual public review process, have been approved by EPA, and adopted by the Utah Water Quality Board.

**STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Section 19-5-104

**THIS RULE OR CHANGE INCORPORATES BY REFERENCE THE FOLLOWING MATERIAL:** San Pitch River TMDL, November 18, 2003; Newton Creek TMDL, June 24, 2004; Panguitch Lake TMDL, June 24, 2004; West Colorado TMDL, August 4, 2004; Silver Creek TMDL, August 4, 2004; Upper Sevier River TMDL, August 4, 2004; Lower and Middle Sevier River TMDL, August 17, 2004; and Lower Colorado River TMDL, September 20, 2004

#### ANTICIPATED COST OR SAVINGS TO:

❖ **THE STATE BUDGET:** There are no anticipated impacts to the state budget. The proposed amendments will be addressed using existing resources.

❖ **LOCAL GOVERNMENTS:** No cost impacts to local governments are anticipated. However, individual TMDLs may or may not result in capital construction costs or costs associated with changes in management strategies to address point sources

and nonpoint source pollution problems. If increased compliance costs to local governments are identified as a result of a TMDL they are presented to the public for comment and discussion prior to the adoption of the TMDL.

❖ **OTHER PERSONS:** No anticipated cost to other persons are anticipated. However, individual TMDLs may or may not result in capital construction costs or costs associated with changes in management strategies to address point sources and nonpoint source pollution problems. If increased compliance costs to other persons are identified as a result of a TMDL, they are presented to the public for comment and discussion prior to the adoption of the TMDL.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** TMDLs may or may not result in capital construction costs or costs associated with changes in management strategies to address point sources and nonpoint source pollution problems. If increased compliance costs to individuals or local governments are identified as a result of a TMDL, they are presented to the public for comment and discussion prior to the adoption of the TMDL.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** Each state is required under Section 303 of the federal Clean Water Act to establish TMDLs for waters identified as impaired, i.e., those waters included on the 303(d) list. States must complete and implement TMDLs. Fiscal impacts to businesses that may result from TMDL implementation, if any, will be declared and discussed in public forums during the development of individual TMDLs. Dianne Nielson, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

ENVIRONMENTAL QUALITY  
 WATER QUALITY  
 CANNON HEALTH BLDG  
 288 N 1460 W  
 SALT LAKE CITY UT 84116-3231, or  
 at the Division of Administrative Rules.

#### DIRECT QUESTIONS REGARDING THIS RULE TO:

Dave Wham at the above address, by phone at 801-538-6052, by FAX at 801-538-6016, or by Internet E-mail at [dwham@utah.gov](mailto:dwham@utah.gov)

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 05/31/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/01/2005

AUTHORIZED BY: Dianne R. Nielson, Executive Director

#### **R317. Environmental Quality, Water Quality.** **R317-1. Definitions and General Requirements.** **R317-1-7. TMDLs.**

The following TMDLs are approved by the Board and hereby incorporated by reference into these rules:

- 7.1 Bear River -- December 23, 1997
- 7.2 Chalk Creek -- December 23, 1997
- 7.3 Otter Creek -- December 23, 1997
- 7.4 Little Bear River -- May 23, 2000
- 7.5 Mantua Reservoir -- May 23, 2000
- 7.6 East Canyon Creek -- September 1, 2000
- 7.7 East Canyon Reservoir -- September 1, 2000
- 7.8 Kents Lake -- September 1, 2000
- 7.9 LaBaron Reservoir -- September 1, 2000
- 7.10 Minersville Reservoir -- September 1, 2000
- 7.11 Puffer Lake -- September 1, 2000
- 7.12 Scofield Reservoir -- September 1, 2000
- 7.13 Onion Creek (near Moab) -- July 25, 2002
- 7.14 Cottonwood Wash -- September 9, 2002
- 7.15 Deer Creek Reservoir -- September 9, 2002
- 7.16 Hyrum Reservoir -- September 9, 2002
- 7.17 Little Cottonwood Creek -- September 9, 2002
- 7.18 Lower Bear River -- September 9, 2002
- 7.19 Malad River -- September 9, 2002
- 7.20 Mill Creek (near Moab) -- September 9, 2002
- 7.21 Spring Creek -- September 9, 2002
- 7.22 Forsyth Reservoir -- September 27, 2002
- 7.23 Johnson Valley Reservoir -- September 27, 2002
- 7.24 Lower Fremont River -- September 27, 2002
- 7.25 Mill Meadow Reservoir -- September 27, 2002
- 7.26 UM Creek -- September 27, 2002
- 7.27 Upper Fremont River -- September 27, 2002
- 7.28 Deep Creek -- October 9, 2002
- 7.29 Uinta River -- October 9, 2002
- 7.30 Pineview Reservoir -- December 9, 2002
- 7.31 Browne Lake -- February 19, 2003
- 7.32 San Pitch River -- November 18, 2003
- 7.33 Newton Creek -- June 24, 2004
- 7.34 Panguitch Lake -- June 24, 2004
- 7.35 West Colorado -- August 4, 2004
- 7.36 Silver Creek -- August 4, 2004
- 7.37 Upper Sevier River -- August 4, 2004
- 7.38 Lower and Middle Sevier River -- August 17, 2004
- 7.39 Lower Colorado River -- September 20, 2004

**KEY: water pollution, waste disposal, industrial waste, effluent standards**

**[~~March 29, 2004~~2005**

**Notice of Continuation October 7, 2002  
19-5**

## Health, Health Care Financing, Coverage and Reimbursement Policy

# R414-1

## Utah Medicaid Program

### NOTICE OF PROPOSED RULE

(Amendment)

DAR FILE NO.: 27805

FILED: 04/07/2005, 14:49

### RULE ANALYSIS

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** Subsection 26-18-3(2)(b) requires the Utah Medicaid Program use rulemaking to implement policy. Therefore, the Utah Medicaid program regularly goes through rulemaking to incorporate the most current Medicaid State Plan by reference. In addition, this rulemaking adds the definition of Centers for Medicaid and Medicare Services, deletes subsections on the Intermediate Care Facilities for the Mentally Retarded (ICF-MR) Transition Project, adds a section on billing codes, and updates the medical necessity and appropriateness standard of the utilization control section.

**SUMMARY OF THE RULE OR CHANGE:** Subsection R414-1-2(6) is added defining Centers for Medicaid and Medicare Services. Subsection R414-1-5(2) is changed to update the incorporation of the State Plan by reference to September 1, 2004. Subsections R414-1-6(2)(a)(i) and R414-1-6(2)(a)(ii) have been deleted because a new rule has superseded these subsections on the ICF-MR Transition Project. Subsection R414-1-12(3) deletes the 1998 version of the InterQual criteria in favor of language that says the state will use the criteria in effect on the date of hospital admission. Section R414-1-22 changes from 3 months to 90 days the amount of time individuals are entitled to Medicaid services under the plan preceding the month of application if they were, or would have been, eligible at that time. Section R414-1-25 is a new section that describes billing codes to be used by providers.

**STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Title 26, Chapter 18

**THIS RULE OR CHANGE INCORPORATES BY REFERENCE THE FOLLOWING MATERIAL:** Utah Medicaid State Plan, September 1, 2004

**ANTICIPATED COST OR SAVINGS TO:**

❖ **THE STATE BUDGET:** There have been ten State Plan Amendments approved since this rule was last amended. All but one were technical amendments or changes that otherwise have no budget impacts. State Plan Amendment 04-002-UT Chiropractic Copayment, has an estimated annual federal savings of \$21,600 and annual state savings of \$8,400.

❖ **LOCAL GOVERNMENTS:** For State Plan Amendment 03-014-UT Disproportionate Share Hospitals, local government operated hospitals will pay \$609,352 in FY 2005, \$881,145 in FY 2006, and \$1,196,425 in FY 2007 and FY 2008. All of these funds will be matched with federal funds and paid back to them through Medicaid reimbursements. It is estimated that the local government hospitals will be benefited approximately \$1,800,000 in FY 2005, \$2,600,000 in FY 2006, and \$3,600,000 in each of FY 2007 and FY 2008.

❖ **OTHER PERSONS:** State Plan Amendment 04-002-UT Chiropractic Copayment, will require Medicaid recipients to pay a \$1 copayment for chiropractic visits. It is anticipated that most chiropractors will not collect these copayments. The impact shared by chiropractors and their patients for this amendment is \$8,400. State Plan Amendment 04-001-UT Optometrist Services allows optometrists to be reimbursed for some services that heretofore were reimbursed only if performed by an ophthalmologist. Thus, optometrists will

benefit and ophthalmologists will perform fewer Medicaid reimbursed services. However, the impact to each group will vary over time and is difficult to quantify.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Impacts to chiropractors are variable depending on the number of Medicaid patients treated, the number of Medicaid patient visits, and whether they collect the copayment. Costs to chiropractic patients are variable by the number of visits and whether the chiropractor collects the copayment. Disproportionate share hospitals will experience an initial cost that will be more than offset by increased reimbursement rates.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This rule facilitates the smooth operation of the Medicaid program and should have an overall positive impact on business. A. Richard Melton, Acting Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HEALTH  
HEALTH CARE FINANCING,  
COVERAGE AND REIMBURSEMENT POLICY  
CANNON HEALTH BLDG  
288 N 1460 W  
SALT LAKE CITY UT 84116-3231, or  
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Ross Martin at the above address, by phone at 801-538-6592, by FAX at 801-538-6099, or by Internet E-mail at [rmartin@utah.gov](mailto:rmartin@utah.gov)

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 05/31/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/01/2005

AUTHORIZED BY: Richard Melton, Deputy Director

#### **R414. Health, Health Care Financing, Coverage and Reimbursement Policy.**

##### **R414-1. Utah Medicaid Program.**

##### **R414-1-2. Definitions.**

The following definitions are used throughout the rules of the Division:

- (1) "Act" means the federal Social Security Act.
- (2) "Applicant" means any person who requests assistance under the medical programs available through the Division.
- (3) "Categorically needy" means aged, blind or disabled individuals or families and children:
  - (a) who are otherwise eligible for Medicaid; and
  - (i) who meet the financial eligibility requirements for AFDC as in effect in the Utah State Plan on July 16, 1996; or

(ii) who meet the financial eligibility requirements for SSI or an optional State supplement, or are considered under section 1619(b) of the federal Social Security Act to be SSI recipients; or  
(iii) who is a pregnant woman whose household income does not exceed 133% of the federal poverty guideline; or

(iv) is under age six and whose household income does not exceed 133% of the federal poverty guideline; or

(v) who is a child under age one born to a woman who was receiving Medicaid on the date of the child's birth and the child remains with the mother; or

(vi) who is least age six but not yet age 18, or is at least age six but not yet age 19 and was born after September 30, 1983, and whose household income does not exceed 100% of the federal poverty guideline; or

(vii) who is aged or disabled and whose household income does not exceed 100% of the federal poverty guideline; or

(viii) who is a child for whom an adoption assistance agreement with the state is in effect.

(b) whose categorical eligibility is protected by statute.

(4) "Code of Federal Regulations" (CFR) means the publication by the Office of the Federal Register, specifically Title 42, used to govern the administration of the Medicaid Program.

(5) "Client" means a person the Division or its duly constituted agent has determined to be eligible for assistance under the Medicaid program.

(6) "CMS" means The Centers for Medicare and Medicaid Services, a Federal agency within the U.S. Department of Health and Human Services. Programs for which CMS is responsible include Medicare, Medicaid, and the State Children's Health Insurance Program.

(~~6~~7) "Department" means the Department of Health.

(~~7~~8) "Director" means the director of the Division.

(~~8~~9) "Division" means the Division of Health Care Financing within the Department.

(~~9~~10) "Emergency medical condition" means a medical condition showing acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:

- (a) placing the patient's health in serious jeopardy;
- (b) serious impairment to bodily functions;
- (c) serious dysfunction of any bodily organ or part; or
- (d) death.

(~~11~~0) "Emergency service" means immediate medical attention and service performed to treat an emergency medical condition. Immediate medical attention is treatment rendered within 24 hours of the onset of symptoms or within 24 hours of diagnosis.

(~~12~~1) "Emergency Services Only Program" means a health program designed to cover a specific range of emergency services.

(~~13~~2) "Executive Director" means the executive director of the Department.

(~~14~~3) "InterQual" means the McKesson InterQual~~[-Medical Review] Criteria[-and System]~~, a comprehensive, clinically based, patient focused medical review criteria and system developed by ~~InterQual Inc.]~~McKesson Corporation.

(~~15~~4) "Medicaid agency" means the Department of Health.

(~~16~~5) "Medical assistance program" or "Medicaid program" means the state program for medical assistance for persons who are eligible under the state plan adopted pursuant to Title XIX of the federal Social Security Act; as implemented by Title 26, Chapter 18, UCA.

(17[6]) "Medical or hospital assistance" means services furnished or payments made to or on behalf of recipients under medical programs available through the Division.

(18[7]) "Medically necessary service" means that:

(a) it is reasonably calculated to prevent, diagnose, or cure conditions in the recipient that endanger life, cause suffering or pain, cause physical deformity or malfunction, or threaten to cause a handicap; and

(b) there is no other equally effective course of treatment available or suitable for the recipient requesting the service that is more conservative or substantially less costly.

(19[8]) "Medically needy" means aged, blind, or disabled individuals or families and children who are otherwise eligible for Medicaid, who are not categorically needy, and whose income and resources are within limits set under the Medicaid State Plan.

(19[20]) "Provider" means any person, individual or corporation, institution or organization, qualified to perform services available under the Medicaid program and who has entered into a written contract with the Medicaid program.

(21[9]) "Recipient" means a person who has received medical or hospital assistance under the Medicaid program, or has had a premium paid to a managed care entity.

(22[+]) "Undocumented alien" means an alien who is not recognized by Immigration and Naturalization Services as being lawfully present in the United States.

#### R414-1-5. State Plan.

(1) As a condition for receipt of federal funds under title XIX of the Act, the Utah Department of Health must submit a State Plan contract to the federal government for the medical assistance program, and agree to administer the program in accordance with the provisions of the State Plan, the requirements of Titles XI and XIX of the Act, and all applicable federal regulations and other official issuances of the United States Department of Health and Human Services. A copy of the State Plan is available for public inspection at the Division's offices during regular business hours.

(2) The department adopts the Utah State Plan Under Title XIX of the Social Security Act Medical Assistance Program, in effect [December]September 1, 200[3]4, which is incorporated by reference.

#### R414-1-6. Services Available.

(1) Medical or hospital services available under the Medical Assistance Program are generally limited by federal guidelines as set forth under Title XIX of the federal Social Security Act and Title 42 of the Code of Federal Regulations (CFR).

(2) The following services provided in the State Plan are available to both the categorically needy and medically needy:

(a) inpatient hospital services, with the exception of those services provided in an institution for mental diseases;[

~~(i) A Medicaid recipient residing in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) may at any time apply for enrollment to the Medicaid 1915c Home and Community Based Waiver for individuals with developmental disabilities or mental retardation through the application process established in the federally approved waiver implementation plan. ICF/MR resident applications are processed consistent with all waiver applications.~~

~~(ii) The Department, through an ICF/MR Portability Project established in rule, will make the Medicaid 1915c Home and Community Based Waiver for Individuals with Developmental Disabilities or Mental Retardation available to Medicaid recipients~~

~~who have resided for 12 or more continuous months in a Medicaid certified ICF/MR. The Department will make the ICF/MR Portability Project available to eligible individuals during a specified time period up to the number of individuals authorized for the project by the Utah Legislature through appropriation for that time period.]~~

(b) outpatient hospital services and rural health clinic services;

(c) other laboratory and x-ray services;

(d) skilled nursing facility services, other than services in an institution for mental diseases, for individuals 21 years of age or older;

(e) early and periodic screening and diagnoses of individuals under 21 years of age, and treatment of conditions found, are provided in accordance with federal requirements;

(f) family planning services and supplies for individuals of child-bearing age;

(g) physician's services, whether furnished in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere;

(h) podiatrist's services;

(i) optometrist's services;

(j) psychologist's services;

(k) interpreter's services;

(l) home health services:

(i) intermittent or part-time nursing services provided by a home health agency;

(ii) home health aide services by a home health agency; and

(iii) medical supplies, equipment, and appliances suitable for use in the home;

(m) private duty nursing services for children under age 21;

(n) clinic services;

(o) dental services;

(p) physical therapy and related services;

(q) services for individuals with speech, hearing, and language disorders furnished by or under the supervision of a speech pathologist or audiologist;

(r) prescribed drugs, dentures, and prosthetic devices and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist;

(s) other diagnostic, screening, preventive, and rehabilitative services other than those provided elsewhere in the State Plan;

(t) services for individuals age 65 or older in institutions for mental diseases:

(i) inpatient hospital services for individuals age 65 or older in institutions for mental diseases;

(ii) skilled nursing services for individuals age 65 or older in institutions for mental diseases; and

(iii) intermediate care facility services for individuals age 65 or older in institutions for mental diseases;

(u) intermediate care facility services, other than services in an institution for mental diseases. These services are for individuals determined, in accordance with section 1902(a)(31)(A) of the Social Security Act, to be in need of this care, including those services furnished in a public institution for the mentally retarded or for individuals with related conditions;

(v) inpatient psychiatric facility services for individuals under 22 years of age;

(w) nurse-midwife services;

(x) family or pediatric nurse practitioner services;

(y) hospice care in accordance with section 1905(o) of the Social Security Act;

(z) case management services in accordance with section 1905(a)(19) or section 1915(g) of the Social Security Act;

(aa) extended services to pregnant women, pregnancy-related services, postpartum services for 60 days, and additional services for any other medical conditions that may complicate pregnancy;

(bb) ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider in accordance with section 1920 of the Social Security Act; and

(cc) other medical care and other types of remedial care recognized under state law, specified by the Secretary of the United States Department of Health and Human Services, pursuant to 42 CFR 440.60 and 440.170, including:

(i) medical or remedial services provided by licensed practitioners, other than physician's services, within the scope of practice as defined by state law;

(ii) transportation services;

(iii) skilled nursing facility services for patients under 21 years of age;

(iv) emergency hospital services; and

(v) personal care services in the recipient's home, prescribed in a plan of treatment and provided by a qualified person, under the supervision of a registered nurse.

(dd) other medical care, medical supplies, and medical equipment not otherwise a Medicaid service if the Division determines that it meets both of the following criteria:

(i) it is medically necessary and more appropriate than any Medicaid covered service; and

(ii) it is more cost effective than any Medicaid covered service.

#### **R414-1-12. Utilization Review.**

(1) Utilization review provides for review and evaluation of the utilization of Medicaid services provided in acute care general hospitals, and by members of the medical staff to patients entitled to benefits under the Medicaid plan.

(2) The Department shall conduct hospital utilization review as outlined in the Superior Utilization Waiver state implementation plan, November 1997 edition, which is incorporated by reference in this rule.

(3) The Department shall determine medical necessity and appropriateness of inpatient admissions during utilization review by use of InterQual [~~Medical Review~~] Criteria [~~and System~~], published by McKesson Corporation, 2004 edition [~~InterQual, Inc., January 1998 edition, 293 Boston Post Road West, Suite 180, Marlborough, MA, 07152~~], McKesson Health Solutions LLC, 275 Grove Street, Suite 1-110, Newton, MA 02466-2273, which is incorporated by reference in this rule, or by following other criteria and protocols outlined in ATTACHMENT 4.19-A, Section 180, of the Medicaid State Implementation Plan. Level of Care and Care Planning Criteria in effect at the time the service was rendered. This criteria is incorporated by reference in this rule. Other criteria and protocols outlined in ATTACHMENT 4.19-A, Section 180 of the State Plan, are also used to determine medical necessity and appropriateness of inpatient admissions.

(4) The standards in the InterQual [~~Medical Review~~] Criteria [~~and System~~] shall not apply to services that are:

(a) excluded as a Medicaid benefit by rule or contract;

(b) provided in an intensive physical rehabilitation center as described in R414-2B; or

(c) organ transplant services as described in R414-10A.

In these three exceptions, or where InterQual is silent, the Medicaid agency shall approve or deny claims based upon

appropriate administrative rules or its own criteria as incorporated in provider contracts that incorporate the Medicaid Provider Manuals.

(5) The Department may take remedial action as outlined in ATTACHMENT 4.19-A, Section 180, of the Medicaid State Implementation Plan for inappropriate services identified through utilization review.

(6) In accordance with 42 CFR 431, Subpart E, the Utilization Review Committee shall send written notification of remedial action to the provider.

#### **R414-1-22. Retroactive Coverage.**

Individuals are entitled to Medicaid services under the plan during the [~~three months~~] 90 days preceding the month of application if they were, or would have been, eligible at that time.

#### **R414-1-25. Billing Codes.**

In submitting claims to the Department, every provider shall use billing codes compliant with Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements as found in 45 CFR Part 162.

#### **R414-1-26. General Rule Format.**

The following format is used generally throughout the rules of the Division. Section headings as indicated and the following general definitions are for guidance only. The section headings are not part of the rule content itself. In certain instances, this format may not be appropriate and will not be implemented due to the nature of the subject matter of a specific rule.

(1) Introduction and Authority. A concise statement as to what Medicaid service is covered by the rule, and a listing of specific federal statutes and regulations and state statutes that authorize or require the rule.

(2) Definitions. Definitions that have special meaning to the particular rule.

(3) Client Eligibility. Categories of Medicaid clients eligible for the service covered by the rule: Categorically Needy or Medically Needy or both. Conditions precedent to the client's obtaining coverage such as age limitations or otherwise.

(4) Program Access Requirements. Conditions precedent external to the client's obtaining service, such as type of certification needed from attending physician, whether available only in an inpatient setting or otherwise.

(5) Service Coverage. Detail of specific services available under the rule, including limitations, such as number of procedures in a given period of time or otherwise.

(6) Prior Authorization. As necessary, a description of the procedures for obtaining prior authorization for services available under the particular rule. However, prior authorization must not be used as a substitute for regulatory practice that should be in rule.

(7) Other Sections. As necessary under the particular rule, additional sections may be indicated. Other sections include regulatory language that does not fit into sections (1) through (5).

#### **KEY: Medicaid**

**[July 19, 2004]2005**

**Notice of Continuation April 30, 2002**

**26-1-5**

**26-18-1**



**Health, Health Care Financing,  
Coverage and Reimbursement Policy**  
**R414-7A**  
**Medicaid Certification of New Nursing  
Facilities**

**NOTICE OF PROPOSED RULE**

(Amendment)

DAR FILE NO.: 27806

FILED: 04/07/2005, 15:14

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** This rulemaking is necessary to comply with the requirements of Subsection 26-18-504(2). This rule establishes the administrative hearing process to review decisions by the director of the Division of Health Care Financing to deny additional bed capacity for an existing Medicaid nursing facility or to deny a new Medicaid nursing facility's participation in the program.

**SUMMARY OF THE RULE OR CHANGE:** The old rule language is eliminated because it was made obsolete by Title 26, Chapter 18, Part 5. The new language establishes that administrative proceedings under this part are informal.

**STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Section 26-18-504

**ANTICIPATED COST OR SAVINGS TO:**

- ❖ **THE STATE BUDGET:** There are no new costs to the state because the administrative hearing process mentioned in this rulemaking is already in place.
- ❖ **LOCAL GOVERNMENTS:** There are no new costs to local governments because they are not responsible for the administrative hearing process mentioned in this rulemaking. If local governments operate nursing facilities, they are already using the hearing process mentioned in this rulemaking.
- ❖ **OTHER PERSONS:** No new costs will be incurred and there are no savings because the administrative hearing process contained in this rulemaking is already in place.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** No new costs will be incurred and there are no savings because the administrative hearing process contained in this rulemaking is already in place.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** Designating the administrative process for this type of hearing as informal should have a neutral impact on businesses affected by this process. A. Richard Melton, Acting Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HEALTH  
HEALTH CARE FINANCING,  
COVERAGE AND REIMBURSEMENT POLICY  
CANNON HEALTH BLDG  
288 N 1460 W  
SALT LAKE CITY UT 84116-3231, or  
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Ross Martin at the above address, by phone at 801-538-6592, by FAX at 801-538-6099, or by Internet E-mail at rmartin@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 05/31/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/01/2005

AUTHORIZED BY: Richard Melton, Deputy Director

**R414. Health, Health Care Financing, Coverage and Reimbursement Policy.**

**R414-7A. Medicaid Certification of New Nursing Facilities.**

**R414-7A-1. ~~[Introduction and Authority]~~ Administrative Proceedings.**

~~[(1) The purpose of this rule is to control the supply of Medicaid nursing facility programs. The oversupply of nursing facility programs in the state has adversely affected the Utah Medicaid program and the health of the people within the state. This rule continues the prohibition against certification of new nursing facility programs that has been in place since January 13, 1989. This rule clarifies that prohibition and sets up policy to deal with the possible future need for additional Medicaid nursing facility programs in a service area. The July 1990 Report of the Governor's Task Force on Long Term Care recommended continuation of this prohibition. The Task Force concluded that "Market entry into the nursing home industry should be regulated to allow supply to come more in line with demand". This rule also supports the policy of the department to direct new resources into community based alternatives.~~

~~— (2) Authority for this rule is found in Sections 26-18-2.3, 26-1-5, 26-1-30(2)(a), (b), and (w), and 26-18-3.] Adjudicative proceedings for decisions by the Division of Health Care Financing made pursuant to Section 26-18-504 are informal and conducted accordance with R410-14.~~

**~~[R414-7A-2. Definitions.~~**

~~— For purposes of this rule the definitions in R414-1-1 apply. In addition:~~

~~— (1) "Certified program" means a nursing facility program with Medicaid certification.~~



— (2) "Critical Care Access Hospital" means a hospital that meets the criteria set forth in 42 U.S.C. 1395i-4(c)(2)(1998).

— (3) "Medicaid certification" means the right to Medicaid reimbursement as a provider of a nursing facility program shown by a valid federal Health Care Financing Administration (HCFA) Form 1539 (7-84).

— (4) "Nursing facility" means any Medicaid-participating NF, SNF, ICF, ICF/MR, or a combination thereof, as defined in 42 USC 1396r(a) (1988), 42 CFR 440.150 and 442.12 (1993), and UCA 26-21-2(15).

— (5) "Nursing facility program" means the personnel, licenses, services, contracts, and all other requirements that must be present for a nursing facility to be eligible for Medicaid certification as detailed in 42 CFR 442.1 through .119, 483.1 through .480, and 488.1 through .64 (1993), which are adopted and incorporated by reference.

— (6) "Physical facility" means the building(s) or other physical structure(s) where a nursing facility program is operated.

— (7) "Service area" means the boundaries of the distinct geographical area served by a type of certified program, the department to determine the exact area, based on fostering price competition and maintaining economy and efficiency in the Medicaid program.

#### **R414-7A-3. Prohibition Against Medicaid Certification of Nursing Facility Programs.**

— The department finds that it is in the best interests of the state to prohibit Medicaid certification of nursing facility programs, except as authorized by this rule.

— (1) Medicaid reimbursement of nursing facility programs is limited to certified programs as of January 13, 1989.

— (2) The department shall not process initial applications for Medicaid certification or execute initial provider agreements with nursing facility programs, except as authorized by R414-7A-4 or R414-7A-5.

— (3) The department shall not reinstate Medicaid certification for a previously certified provider whose Medicaid certification expires, or is terminated by action of the federal or state government, except as authorized by R414-7A-4 or R414-7A-5.

— (4) The department shall not execute a Medicaid provider agreement with a certified program that moves its nursing facility program to a different physical facility, except as authorized by R414-7A-4 or R414-7A-5.

#### **R414-7A-4. Authorization to Renew, Assign, or Transfer Medicaid Certification.**

— (1) The department may renew Medicaid certification of a certified program if the program, without any lapse in service to Medicaid recipients, has its nursing facility program certified by the department at the same physical facility.

— (2) The department may certify a new nursing facility program if a certified program transfers all of its right to Medicaid certification to the new nursing facility program, and the new program meets all of the following conditions:

— (a) The new nursing facility program operates at the same physical facility as the previous certified program.

— (b) The new nursing facility program complies with 42 CFR 442.14 (1993).

— (c) The new nursing facility program receives Medicaid certification within one year of the date the previously certified program ceased to provide medical assistance to a Medicaid recipient.

— (3) The department may certify a previously certified program that moves to a different physical facility and meets all of the following conditions:

— (a) On the last day that the certified program provided medical assistance to a Medicaid recipient in the original physical facility, it meets all applicable requirements to be a certified program.

— (b) The different physical facility is in the same service area.

— (c) The time between which the certified program ceases to operate in the original physical facility and begins to operate in the different physical facility is not more than three years.

— (d) The provider operating the certified program gives written assurances satisfactory to the executive director or his designee that:

— (i) no third party has a legitimate claim to operate a certified program at the previous physical facility;

— (ii) the certified program agrees to defend and indemnify the department against any claims made by third parties who may assert a right to operate a certified program at the previous physical facility; and

— (iii) if a third party is found, by a final agency action of the department after exhaustion of all administrative and judicial appeal rights, to be entitled to operate a certified program at the original physical facility, the certified program shall voluntarily comply with R414-7A-4(4).

— (4) Upon a finding being made as set forth in R414-7A-4(3)(d)(iii), the certified program shall immediately surrender its Medicaid certification, cease billing Medicaid for all services to Medicaid recipients, and arrange for the orderly discharge of Medicaid recipients to a facility satisfactory to the department. If the third party found to be entitled to operate a certified program at the original physical facility requests Medicaid certification, and the previously certified program has surrendered its Medicaid certification, the department shall treat the request as a transfer of all its rights under R414-7A-4(2).

#### **R414-7A-5. Certification of Additional Nursing Facility Programs.**

— The department may certify additional nursing facility programs if the executive director or his designee determines that there is insufficient capacity at certified programs in a service area to meet the public need.

— (1) The department may certify an additional nursing facility program only if:

— (a) after 30-day notice to the Department of Human Services of the department's finding that there is insufficient capacity at certified programs in a service area to meet the public need, the Department of Human Services cannot demonstrate that community-based services can meet the public need; and

— (b) after the close of the 30-day notice to the Department of Human Services and a separate 30-day notice to all certified programs operating in the service area, the certified programs operating in the service area cannot demonstrate that they have tangible plans to add additional capacity to their nursing facility programs to meet the public need.

~~—(2) If community based services and existing certified programs operating in the service area cannot demonstrate that they can meet the public need, the department may select an additional nursing facility program through a request for proposal process.~~

~~—(a) Each proposal must include sufficient information to allow the department to evaluate and rank it among all proposals according to the criteria in R414-7A-5(2)(b), as well as other information that the department solicits in its request for proposals. The department shall reject all proposals that offer to operate for a reimbursement rate higher than that paid to similar certified programs.~~

~~—(b) The department shall evaluate and select from among the proposals based on maintaining price competition, economy, and efficiency in the Medicaid program; the ability of the proposed nursing facility program to deliver quality care; and how quickly the proposed nursing facility program can begin to operate.~~

~~—(3) If a nursing facility program that the department selected under the request for proposal process fails to undertake the necessary steps to become Medicaid certified or fails to begin to provide medical assistance to Medicaid recipients as represented in its proposal, the department may reject that nursing facility program, and either select the next ranked nursing facility program or solicit new proposals without again complying with the requirements of R414-7A-5(1).~~

~~—(4) If, after certifying an additional nursing facility program, the executive director or his designee determines that there is sufficient capacity at certified programs in a service area to meet the public need, the limitations set out in R414-7A-5(1) through (3) control the certification of nursing facility programs.~~

~~—(5) The department hereby determines that there is insufficient capacity to meet the public need wherever a critical care access hospital is located and may certify a new nursing facility program that is directly related to the operation of a critical care access hospital, without the need to meet the requirements of subsections (1) to (4) above.~~

~~—(6) The department hereby determines that there is insufficient capacity to meet the public need for those eligible for placement at the Utah State Veterans Nursing Home and may certify the Utah State Veterans Nursing Home, without the need to meet the requirements of subsections (1) to (4) above.~~

**]KEY: Medicaid**

**]July 14, 2003]2005**

**Notice of Continuation November 8, 2004**

**26-1-5**

**~~26-18-1~~**

**~~26-18-2.3~~**

**~~26-1-30(2)(a), (b), (w)~~**

**~~26-18-3]26-18-504(2)~~**



**Insurance, Administration**

**R590-93**

**Replacement of Life Insurance and Annuities**

## **NOTICE OF PROPOSED RULE**

(Repeal and Reenact)

DAR FILE No.: 27829

FILED: 04/15/2005, 16:03

### **RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** As a result of H.B. 374 which was passed in 2003, the terms "agent" and "agency" were changed to "producer." This rule is being updated to comply with the new language and also to adopt the new National Association of Insurance Commissioner's Model Regulation #613, Life Insurance and Annuities Replacement Model. (DAR NOTE: H.B. 374 is found at UT L 2003 Ch 298, and was effective 05/05/2003.)

**SUMMARY OF THE RULE OR CHANGE:** The reenacted text contains the substantive language from the repealed text plus the following new language is added: 1) new trigger involved for completing replacement notice; 2) the notice has been revised to contain consumer education and protection which can now be completed electronically; 3) expanded the time period from 3-5 days for the replacing insurer to notify the existing insurer of the replacement; 4) requires existing insurers to keep record of the replacement notifications; and 5) for direct response business the replacing insurer does not need to delay processing the application if the notice is not completed, but does require a good faith effort.

**STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** 31A-2-201, 31A-23a-402

**THIS RULE OR CHANGE INCORPORATES BY REFERENCE THE FOLLOWING MATERIAL:** Appendix A and Appendix C, Important Notice: Replacement of Life Insurance or Annuities; and Appendix B, Notice Regarding Replacement, from the National Association of Insurance Commissioners, dated 2000

**ANTICIPATED COST OR SAVINGS TO:**

❖ **THE STATE BUDGET:** The changes to this rule will have no fiscal impact on the department's or the state's budget. Neither will the changes impact the department's work load significantly. Most of the 500 plus life insurance companies selling insurance in Utah have already changed their filings to comply with this rule.

❖ **LOCAL GOVERNMENTS:** Since the rule deals with the relationship between the Insurance Department and life insurers they regulate, this rule will have no fiscal impact on local government.

❖ **OTHER PERSONS:** There are approximately 374 life insurers who will be required to revise their applications and replacement notices. Many have already made these changes. The only expense will be the loss of preprinted forms for those using paper forms verses electronic. Consumers will not be impacted financially by these changes. The educational information in the notice may help consumers make the best choice for their needs.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are approximately 374 life insurers who will be required to revise their applications and replacement notices. Many have already made these changes. The only expense will be the loss of preprinted forms for those using paper forms verses electronic. Consumers will not be impacted financially by these changes. The educational information in the notice may help consumers make the best choice for their needs.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The changes in this rule will have no substantive fiscal impact on Utah businesses. D. Kent Michie, Commissioner

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

INSURANCE  
ADMINISTRATION  
Room 3110 STATE OFFICE BLDG  
450 N MAIN ST  
SALT LAKE CITY UT 84114-1201, or  
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Jilene Whitby at the above address, by phone at 801-538-3803, by FAX at 801-538-3829, or by Internet E-mail at [jwhitby@utah.gov](mailto:jwhitby@utah.gov)

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 05/31/2005

INTERESTED PERSONS MAY ATTEND A PUBLIC HEARING REGARDING THIS RULE: 5/24/2005 at 11:00 AM, State Office Building (behind the Capitol), 450 N Main, Room 1112, Salt Lake City, UT.

THIS RULE MAY BECOME EFFECTIVE ON: 06/01/2005

AUTHORIZED BY: Jilene Whitby, Information Specialist

## **R590. Insurance, Administration.**

### **~~R590-93. Replacement of Life Insurance and Annuities.~~**

#### **~~R590-93-1. Authority.~~**

~~— This rule is adopted and promulgated by the Insurance Commissioner pursuant to Subsection 31A-2-201(3), Utah Code, which empowers the Commissioner of Insurance to make reasonable rules necessary for, or as an aid to, the effectuation of any provision of the Insurance Code, and to define acts and practices reasonably found to be unfair or deceptive.~~

~~— The issuance or offer to issue any insurance, as defined herein, which is a replacement of existing insurance, as defined herein, shall, if not done in compliance with the terms of this rule, be deemed a misrepresentation in violation of Subsection 31A-23-302(1)(a)(i), Utah Code, and provide unfair inducement which is prohibited by Subsection 31A-23-302(8), Utah Code.~~

~~— It is hereby recognized and ordered that insurance purchasers have inherent interests and rights in the continuance of existing insurance coverage which may be compromised if purchasers are not allowed sufficient time and provided with sufficient information to enable them to make an informed choice regarding their desire to continue existing insurance or replace it with alternative coverage. This rule is adopted to assure that sufficient time and information shall be provided to all persons so situated and failure to meet the requirements set forth herein shall be deemed to be an unfair and deceptive trade practice by any insurer or any representative of an insurer.~~

#### **~~R590-93-2. Purpose.~~**

~~— The purpose of this rule is to protect the interests of life insurance and annuity purchasers during a replacement transaction by establishing minimum standards to be observed by insurers and agents in providing adequate and timely information concerning the existing and proposed policies or contracts so that the purchasers may make a better informed decision.~~

#### **~~R590-93-3. Definition of Replacement.~~**

~~— "Replacement" means any transaction in which new life insurance or a new annuity contract is to be purchased, and it is known or should be known to the proposing agent, or to the proposing insurer if there is no agent, that by reason of such transaction, an existing life insurance policy(ies) or an annuity contract(s) has been or is to be:~~

~~— A. Lapsed, forfeited, surrendered, exchanged or otherwise terminated;~~

~~— B. Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;~~

~~— C. Amended so as to effect a reduction either in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;~~

~~— D. Reissued with any reduction in cash value; or~~

~~— E. Pledged as collateral or subjected to borrowing, whether in a single loan or under a schedule of borrowing over a period of time.~~

#### **~~R590-93-4. Other Definitions.~~**

~~— A. "Conservation" means any attempt by the existing insurer or its agent to dissuade a policyholder from the replacement of existing insurance. A conservation effort does not include such routine administrative procedures as late payment reminders, late payment offers or reinstatement offers.~~

~~— B. "Direct Response Sales" means any sale of insurance where the insurer does not utilize an agent or company representative in the sale or delivery of the policy. Normally the entire transaction is handled by way of correspondence.~~

~~— C. "Existing Insurance" means any insurance in force including insurance under a binding or conditional receipt, an insurance policy or contract that is within an unconditional refund period or an insurance policy while in the premium grace period.~~

~~— D. "Existing Insurer" means the insurance company whose policy is or will be changed or terminated in such a manner as described within Section 3, "Definition of Replacement," of this rule.~~

~~— E. "Insurance" means any life insurance policy or annuity contract issued by an insurance company except as provided within Section 5, "Exemptions," of this rule.~~

— F. "Notice" means the required one-page three-part format which includes the "Explanation", the statement of "Existing Insurance Which May Be Replaced or Changed," and the list of "Items to Consider" followed by signatures and identifying information. A sample "Notice" is incorporated herein by reference (see addendum) and is to be made available by the replacing insurance company. The "Notice" must have imprinted the name, address and telephone number of the replacing insurer.

— G. "Replacing Insurer" means the insurance company to which application is made for a new policy or contract which is a replacement of existing insurance.

#### **R590-93-5. Exemptions.**

— Unless otherwise specifically included, this rule shall not apply to:

- A. Credit life insurance;
- B. Group life insurance or group annuities;
- C. Proposed insurance that is to replace insurance applied for under a binding or conditional receipt issued by the same company;
- D. Proposed insurance to be provided by the insurer that issued existing insurance where a contractual change or conversion privilege is being exercised; and
- E. Proposed insurance offered on a direct response basis to a class or classes of existing policyholders by the same insurer, for the principal purpose of upgrading existing insurance. The rationale and proposed process and related policyholder information must be filed with the Department and approved to qualify for this exemption and the cost benefit to policyholders must be reasonable.

#### **R590-93-6. Duties of Agents.**

— A. In connection with or as part of each application for insurance, an agent must complete and submit to the insurer the required statement from the applicant as well as the agent's own statement as to whether or not replacement may be involved in the transaction.

— B. Where a replacement is involved, the agent shall:

- 1. Present to and leave with the applicant, not later than at the time of taking the application, a properly completed and signed copy of the three-part Notice which includes a list of all existing insurance to be replaced;
- 2. Submit to the replacing insurer with the application a copy of the properly completed and signed Notice; and
- 3. Leave with the applicant the original or a copy of written or printed communications used in connection with the presentation.

— C. Each agent who uses written or printed communications in a conservation effort shall leave with the policyholder the original or a copy of such materials used. Each agent should explain optional modifications or changes within the existing insurance.

— D. The current Utah Insurance Department rule(s) regarding the solicitation of life insurance and annuities also apply in replacement and conservation situations. If applicable, Security and Exchange Commission disclosure requirements must also be followed.

#### **R590-93-7. Duties of Insurers Represented by Agents.**

— Each insurer shall:

- A. Inform its agents, field representatives or other personnel responsible for compliance with this rule concerning the requirements of this rule.
- B. Require with or as a part of each completed application for insurance:
  - 1. A statement in connection with the application signed by the applicant as to whether such proposed insurance will replace existing insurance; and

- 2. A statement signed by the agent as to whether or not he or she knows replacement is or may be involved in the transaction.

— C. Where a replacement is involved, the replacing insurer shall:

- 1. Require from the agent with the application for insurance a copy of the three-part Notice properly completed and signed;
- 2. Send to the existing insurer at its home office within three (3) working days of the date the Notice is received, a copy of the Notice advising of the replacement or proposed replacement of existing insurance. Forwarding of the Notice is not required if the replacing insurer and existing insurer are one and the same in name and direct management control;
- 3. Maintain copies of the Notice, all written communications with respect to replacement, and a replacement register, cross-indexed by replacing agent and existing insurer to be replaced, for at least three years or until the conclusion of the next regular examination by the Insurance Department of its state of domicile, whichever is later;
- 4. Furnish to the applicant a Policy Summary and/or disclosure material in accordance with the provisions of the current rules concerning the solicitation of insurance. In connection with registered contracts, applicants shall be furnished premium or contract contribution amounts and identification of the appropriate prospectus or offering circular; and
- 5. Provide the applicant with a right to an unconditional refund of all premiums paid, which right may be exercised within a period of at least twenty (20) days commencing from the date of delivery of the policy or contract.

#### **R590-93-8. Duties of Insurers with Respect to Direct Response Sales.**

— Each insurer shall:

- A. Inform its personnel responsible for compliance with this rule of the requirements of this rule;
- B. Require with or as a part of each completed application for insurance a statement signed by the applicant as to whether such proposed insurance will replace existing insurance;
- C. Where a replacement is proposed by an insurer in the solicitation of a direct response sale or it is known by the insurer on the date of application that a replacement will occur:
  - 1. Provide the applicant or prospective applicant with or as part of the application the three-part Notice with the request that the applicant properly complete, sign and return a copy of the Notice with the application;
  - 2. Send to the existing insurer at its home office within three (3) working days of the date of the Notice is received, a copy of the Notice advising of the replacement or proposed replacement of existing insurance. Forwarding the Notice is not required if the replacing insurer and existing insurer are one and the same in name and direct management control;
  - 3. Maintain copies of the Notice, all written communications with respect to replacement, and a replacement register, cross-indexed by existing insurer to be replaced, for at least three years or until the conclusion of the next regular examination by the insurance department of its state of domicile, whichever is later;
  - 4. Furnish to the applicant a Policy Summary and/or disclosure material in accordance with the provisions of current rules concerning the solicitation of insurance. In connection with registered contracts, applicants shall be furnished premium or contract contribution amounts and identification of the appropriate prospectus or offering circular; and
  - 5. Provide the applicant with a right to an unconditional refund of all premiums paid, which right may be exercised at least twenty (20) days commencing from the date of delivery of the policy or contract.

— D. Where no replacement is proposed by an insurer in the solicitation of a direct response sale and the three part Notice was not included with or as part of the application and returned to the insurer, but it is indicated on the application that a replacement might occur and the insurer plans to issue a policy:

— 1. Suspend the application process for no longer than ten (10) days;

— 2. Provide the applicant with the Notice within three (3) days after receipt of the application;

— 3. Request that the applicant properly complete, sign and return a copy of the Notice within five (5) days; and

— 4. Continue the process as outlined in Sections 8(C)(2) through 8(C)(5). The insurer may continue the application process after ten (10) days from receipt of application even if a copy of the Notice has not been received.

#### **R590-93-9. Duties of Existing Insurer.**

— Each existing insurer in connection with a voluntary conservation effort, may, or upon request from the policyholder shall, furnish current, complete and detailed summary or ledger statements pertaining to the existing insurance and in accordance with the provisions of current rules concerning the solicitation of insurance. The existing insurer should explain optional modifications or changes within the existing insurance.

#### **R590-93-10. Penalties.**

— A. Pursuant to the provisions of Sections 31A-2-308, 31A-23-216 and 31A-23-217, Utah Code, violations of this rule shall subject licensees to the following penalties:

— 1. Any insurer found in violation of this rule may be charged an administrative forfeiture of not more than \$1,000 for each separate violation. Additionally, willful violation of this rule could subject the insurer to censorship against its certificate of authority.

— 2. Any individual or organizational licensee found in violation of this rule may be charged an administrative forfeiture of not more than \$1,000 for each separate violation. Additionally, willful violation of this rule could subject the individual or organizational licensee to be placed on probation, license suspension or revocation.

— B. Any action on the part of an agent, insurer, or representative to discourage the policyholder from reading, completing or signing the three part Notice shall be deemed a violation of this rule.

— C. Policyholders have the right to replace existing insurance after indicating in or as part of the application for insurance that such is not their intention; however, patterns of such action by policyholders who purchase replacing policies from the same insurer or agent shall be deemed prima facie evidence of the insurer's or agent's knowledge that replacement was intended in connection with the sale of those policies, and such patterns or action shall be deemed prima facie evidence of the insurer's or agent's violation of this rule.

— D. This rule does not prohibit the use of additional material other than that which is required that is not in violation of this rule or any other Utah statute or rule.

#### **R590-93-11. Relationship to Other Statutes and Rules.**

— If any portion of this rule is inconsistent with any provision of any statute or other rule dealing with life insurance or annuity marketing practices or disclosure, said inconsistent portion shall be interpreted so as to provide the greatest information or protection to the policyholder.

#### **R590-93-12. Severability.**

— If any section, term, or provision of this rule shall be adjudged invalid for any reason, such judgment shall not affect, impair or invalidate any other section, term, or provision of this rule and the remaining sections, terms, and provisions shall be and remain in full force.

#### **R590-93-13. Effective Date.**

— This rule shall be effective May 26, 1989.

#### **KEY: insurance law**

**1989**

**Notice of Continuation April 28, 2004**

**31A-2-201]**

#### **R590-93. Replacement of Life Insurance and Annuities.**

##### **R590-93-1. Authority.**

This rule is promulgated pursuant to Subsection 31A-2-201(3)(a) wherein the commissioner may make rules to implement the provisions of Title 31A and pursuant to Subsection 31A-23a-402(8), which allows the commissioner to define methods of competition and acts and practices found to be unfair or deceptive.

##### **R590-93-2. Purpose and Scope.**

(1) The purpose of this rule is:

(a) to regulate the activities of insurers and producers with respect to the replacement of existing life insurance and annuities; and

(b) to protect the interests of life insurance and annuity purchasers by establishing minimum standards of conduct to be observed in replacement or financed purchase transactions. It will:

(i) assure that purchasers receive information with which a decision can be made in the purchaser's own best interest;

(ii) reduce the opportunity for misrepresentation and incomplete disclosure; and

(iii) establish penalties for failure to comply with requirements of this rule.

(2) Unless otherwise specifically included, this rule shall not apply to transactions involving:

(a) credit life insurance;

(b) group life insurance or group annuities where there is no direct solicitation of individuals by an insurance producer. Direct solicitation shall not include any group meeting held by an insurance producer solely for the purpose of educating or enrolling individuals or, when initiated by an individual member of the group, assisting with the selection of investment options offered by a single insurer in connection with enrolling that individual. Group life insurance or group annuity certificates marketed through direct response solicitation shall be subject to the provisions of Section R590-93-8;

(c) group life insurance and annuities used to fund prearranged funeral contracts;

(d) an application to the existing insurer that issued the existing policy or contract when a contractual change or a conversion privilege is being exercised; or, when the existing policy or contract is being replaced by the same insurer pursuant to a program filed with and approved by the commissioner;

(e) proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same company;

(f)(i) policies or contracts used to fund;

(A) an employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);

(B) a plan described by Sections 401(a), 401(k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer;

(C) a governmental or church plan defined in Section 414, a governmental or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under Section 457 of the Internal Revenue Code; or

(D) a nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

(i) Notwithstanding Subsection (i), this rule shall apply to policies or contracts used to fund any plan or arrangement that is funded solely by contributions an employee elects to make, whether on a pre-tax or after-tax basis, and where the insurer has been notified that plan participants may choose from among two or more insurers and there is a direct solicitation of an individual employee by an insurance producer for the purchase of a contract or policy. As used in this subsection, direct solicitation shall not include any group meeting held by an insurance producer solely for the purpose of educating individuals about the plan or arrangement or enrolling individuals in the plan or arrangement or, when initiated by an individual employee, assisting with the selection of investment options offered by a single insurer in connection with enrolling that individual employee;

(g) where new coverage is provided under a life insurance policy or contract and the cost is borne wholly by the insured's employer or by an association of which the insured is a member;

(h) existing life insurance that is a non-convertible term life insurance policy that will expire in five years or less and cannot be renewed;

(i) immediate annuities that are purchased with proceeds from an existing contract. Immediate annuities purchased with proceeds from an existing policy are not exempted from the requirements of this rule; or

(j) structured settlements.

(3) Registered contracts shall be exempt from the requirements of Subsections R590-93-6(1)(c) and R590-93-7(2) with respect to the provision of illustrations or policy summaries; however, premium or contract contribution amounts and identification of the appropriate prospectus or offering circular shall be required instead.

### **R590-93-3. Definitions.**

In addition to the definitions of Section 31A-1-301, the following definitions shall apply for the purposes of this rule.

(1) "Direct-response solicitation" means a solicitation through a sponsoring or endorsing entity or individually solely through mails, telephone, the Internet or other mass communication media.

(2) "Existing insurer" means the insurance company whose policy or contract is or will be changed or affected in a manner described within the definition of "replacement."

(3) "Existing policy or contract" means an individual life insurance policy, hereinafter referred to as policy, or annuity contract, hereinafter referred to as contract, in force, including a policy under a binding or conditional receipt or a policy or contract that is within an unconditional refund period.

(4) "Financed purchase" means the purchase of a new policy involving the actual or intended use of funds obtained by the withdrawal or surrender of, or by borrowing from values of an existing policy to pay all or part of any premium due on the new policy. For purposes of a regulatory review of an individual transaction only, if a withdrawal, surrender or borrowing involving the policy values of an existing policy is used to pay premiums on a new policy owned by the same policyholder and issued by the same company within four months before or 13 months after the effective date of the new policy, it will be deemed prima facie evidence of the policyholder's intent to finance the purchase of the new policy with existing policy values. This prima facie standard is not intended to increase or decrease the monitoring obligations contained in Subsection R590-93-5(1)(d).

(5) "Illustration" means a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years as defined in R590-177, Life Insurance Illustrations Rule.

(6) "Notice" means Appendix A and Appendix C, Important Notice: Replacement of Life Insurance or Annuities, and Appendix B, Notice Regarding Replacement, from the National Association of Insurance Commissioners, dated 2000 and which are incorporated herein by reference. The notice is to be made available by the replacing insurer and must be imprinted with the name, address, and telephone number of the replacing insurer.

(7)(a) "Policy summary" for policies or contracts other than universal life policies, means a written statement regarding a policy or contract which shall contain to the extent applicable, but need not be limited to, the following information:

- (i) current death benefit;
- (ii) annual contract premium;
- (iii) current cash surrender value;
- (iv) current dividend;
- (v) application of current dividend; and
- (vi) amount of outstanding loan.

(b) "Policy summary" for universal life policies, means a written statement that shall contain at least the following information:

- (i) the beginning and end date of the current report period;
- (ii) the policy value at the end of the previous report period and at the end of the current report period;
- (iii) the total amounts that have been credited or debited to the policy value during the current report period, identifying each by type, e.g., interest, mortality, expense and riders;
- (iv) the current death benefit at the end of the current report period on each life covered by the policy;
- (v) the net cash surrender value of the policy as of the end of the current report period; and
- (vi) the amount of outstanding loans, if any, as of the end of the current report period.

(8) "Replacing insurer" means the insurance company that issues or proposes to issue a new policy or contract that replaces an existing policy or contract or is a financed purchase.

(9) "Registered contract" means a variable annuity contract or variable life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933.

(10) "Replacement" means a transaction in which a new policy or contract is to be purchased, and it is known or should be known to the proposing producer, or to the proposing insurer if there is no producer, that by reason of the transaction, an existing policy or contract has been or is to be:

(a) lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated;

(b) converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(c) amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

(d) reissued with any reduction in cash value; or

(e) used in a financed purchase.

(11) "Sales material" means a sales illustration and any other written, printed or electronically presented information created, or completed or provided by the company or producer and used in the presentation to the policy or contract holder related to the policy or contract purchased.

#### **R590-93-4. Duties of Producers.**

(1) A producer who initiates an application shall submit to the insurer, with or as part of the application, a statement signed by both the applicant and the producer as to whether the applicant has existing policies or contracts. If the answer is "no," the producer's duties with respect to replacement are complete.

(2) If the applicant answered "yes" to the question regarding existing coverage referred to in Subsection (1), the producer shall present and read to the applicant, not later than at the time of taking the application, the Notice regarding replacements in the form as described in Appendix A or other substantially similar form approved by the commissioner. However, no approval shall be required when amendments to the Notice are limited to the omission of references not applicable to the product being sold or replaced. The Notice shall be signed by both the applicant and the producer attesting that the Notice has been read aloud by the producer or that the applicant did not wish the Notice to be read aloud, in which case the producer need not have read the Notice aloud, and left with the applicant. With respect to an electronically completed application and Notice, the producer is not required to leave a copy of the electronically completed Notice with the applicant.

(3) The Notice shall list each existing policy or contract contemplated to be replaced, properly identified by name of insurer, the insured or annuitant, and policy or contract number if available; and shall include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for the new policy or contract. If a policy or contract number has not been issued by the existing insurer, alternative identification, such as an application or receipt number, shall be listed.

(4) In connection with a replacement transaction the producer shall leave with the applicant at the time an application for a new policy or contract is completed the original or a copy of all sales material. With respect to electronically presented sales material, it shall be provided to the policy or contract holder in printed form no later than at the time of policy or contract delivery.

(5) Except as provided in Subsection R590-93-6(3), in connection with a replacement transaction the producer shall submit to the insurer to which an application for a policy or contract is presented, a copy of each document required by this section, a

statement identifying any preprinted or electronically presented company approved sales materials used, and copies of any individualized sales materials, including any illustrations related to the specific policy or contract purchased.

#### **R590-93-5. Duties of Insurers that Use Producers.**

Each insurer shall:

(1) maintain a system of supervision and control to insure compliance with the requirements of this rule that shall include at least the following:

(a) inform its producers of the requirements of this rule and incorporate the requirements of this rule into all relevant producer training manuals prepared by the insurer;

(b) provide to each producer a written statement of the company's position with respect to the acceptability of replacements providing guidance to its producer as to the appropriateness of these transactions;

(c) a system to review the appropriateness of each replacement transaction that the producer does not indicate is in accord with Subsection (b) above;

(d) procedures to confirm that the requirements of this rule have been met;

(e) procedures to detect transactions that are replacements of existing policies or contracts by the existing insurer, but that have not been reported as such by the applicant or producer. Compliance with this rule may include, but shall not be limited to, systematic customer surveys, interviews, confirmation letters, or programs of internal monitoring;

(2) have the capacity to monitor each producer's life insurance policy and annuity contract replacements for that insurer, and shall produce, upon request, and make such records available to the department. The capacity to monitor shall include the ability to produce records for each producer's:

(a) life replacements, including financed purchases, as a percentage of the producer's total annual sales for life insurance;

(b) number of lapses of policies by the producer as a percentage of the producer's total annual sales for life insurance;

(c) annuity contract replacements as a percentage of the producer's total annual annuity contract sales;

(d) number of transactions that are unreported replacements of existing policies or contracts by the existing insurer detected by the company's monitoring system as required by Subsection R590-93-5(1)(e); and

(e) replacements, indexed by replacing producer and existing insurer;

(3) require with or as a part of each application for life insurance or an annuity a signed statement by both the applicant and the producer as to whether the applicant has existing policies or contracts;

(4) require with each application for life insurance or annuity that indicates an existing policy or contract, a completed Notice regarding replacements as contained in Appendix A;

(5) when the applicant has existing policies or contracts, each insurer shall be able to produce copies of any sales material required by Subsection R590-93-4(5), the basic illustration and any supplemental illustrations related to the specific policy or contract that is purchased, and the producer's and applicant's signed statements with respect to financing and replacement for at least five years after the termination or expiration of the proposed policy or contract;

(6) ascertain that the sales material and illustrations required by Subsection R590-93-4(5) of this rule meet the requirements of this rule and are complete and accurate for the proposed policy or contract;

(7) if an application does not meet the requirements of this rule, notify the producer and applicant and fulfill the outstanding requirements; and

(8) maintain records in any media or by any process that accurately reproduces the actual document.

**R590-93-6. Duties of Replacing Insurers that Use Producers.**

(1) Where a replacement is involved in the transaction, the replacing insurer shall:

(a) verify that the required forms are received and are in compliance with this rule;

(b) with respect to an electronically completed Notice, the replacing insurer shall send a printed copy of the electronically executed Notice to the applicant within five working days of the date the Notice is received by the company;

(c) Notify any other existing insurer that may be affected by the proposed replacement within five business days of receipt of a completed application indicating replacement or when the replacement is identified if not indicated on the application, and mail a copy of the available illustration or the policy summary for the proposed policy or disclosure document for the proposed contract within five business days of a request from an existing insurer;

(d) be able to produce copies of the notification regarding replacement required in Subsection R590-93-4(2), indexed by producer, for at least five years or until the next regular examination by the insurance department of a company's state of domicile, whichever is later; and

(e) provide to the policy or contract holder notice of the right to return the policy or contract within 20 days of the delivery of the contract and receive an unconditional full refund of all premiums or considerations paid on it; such notice may be included in Appendix A or C. This subsection does not preempt the requirements of 31A-22-423.

(2) In transactions where the replacing insurer and the existing insurer are the same or subsidiaries or affiliates under common ownership or control, allow credit for the period of time that has elapsed under the replaced policy's or contract's incontestability and suicide periods up to the face amount of the existing policy or contract. With regard to financed purchases the credit may be limited to the amount the face amount of the existing policy is reduced by the use of existing policy values to fund the new policy or contract.

(3) If an insurer prohibits the use of sales material other than that approved by the company, as an alternative to the requirements made of an insurer pursuant to Subsection R590-93-4(5) with regard to sales materials, the insurer may:

(a) require with each application a statement signed by the producer that:

(i) represents that the producer used only company-approved sales material; and

(ii) states that copies of all sales material were left with the applicant in accordance with Subsection R590-93-4(4); and

(b) within ten days of the issuance of the policy or contract:

(i) notify the applicant by sending a letter or by verbal communication with the applicant by a person whose duties are separate from the marketing area of the insurer, that the producer has

represented that copies of all sales material have been left with the applicant in accordance with Subsection R590-93-4(4);

(ii) provide the applicant with a toll free number to contact company personnel involved in the compliance function if such is not the case; and

(iii) stress the importance of retaining copies of the sales material for future reference; and

(c) be able to produce a copy of the letter or other verification in the policy file for at least five years after the termination or expiration of the policy or contract.

**R590-93-7. Duties of the Existing Insurer.**

Where a replacement is involved in the transaction, the existing insurer shall:

(1) retain and be able to produce all replacement notifications received, indexed by replacing insurer, for at least five years or until the conclusion of the next regular examination conducted by the insurance department of its state of domicile, whichever is later;

(2) send a letter to the policy or contract holder of the right to receive information regarding the existing policy or contract values including, if available, an in force illustration or policy summary if an in force illustration cannot be produced. The information shall be provided within five business days of receipt of the request from the policy or contract holder; and

(3) upon receipt of a request to borrow, surrender or withdraw any policy values, send a notice, advising the policy holder that the release of policy values may affect the guaranteed elements, non-guaranteed elements, face amount or surrender value of the policy from which the values are released. The notice shall be sent separate from the check if the check is sent to anyone other than the policyholder. In the case of consecutive automatic premium loans, the insurer is only required to send the notice at the time of the first loan.

**R590-93-8. Duties of Insurers with Respect to Direct Response Solicitations.**

(1) In the case of an application that is initiated as a result of a direct response solicitation, the insurer shall require, with or as part of each completed application for a policy or contract, a statement asking whether the applicant, by applying for the proposed policy or contract, intends to replace, discontinue or change an existing policy or contract. If the applicant indicates a replacement or change is not intended or if the applicant fails to respond to the statement, the insurer shall send the applicant, with the policy or contract, the Notice regarding replacement in Appendix B, or other substantially similar form approved by the commissioner.

(2) If the insurer has proposed the replacement or if the applicant indicates a replacement is intended and the insurer continues with the replacement, the insurer shall:

(a) provide to applicants or prospective applicants with the policy or contract a Notice, as described in Appendix C, or other substantially similar form approved by the commissioner. In these instances the insurer may delete the references to the producer, including the producer's signature, and references not applicable to the product being sold or replaced, without having to obtain approval of the form from the commissioner. The insurer's obligation to obtain the applicant's signature shall be satisfied if it can demonstrate that it has made a diligent effort to secure a signed copy of the Notice referred to in this subsection. The requirement to make a diligent effort shall be deemed satisfied if the insurer



includes in the mailing a self-addressed postage prepaid envelope with instructions for the return of the signed Notice referred to in this section; and

(b) comply with the requirements of Subsection R590-93-6(1)(c), if the applicant furnishes the names of the existing insurers, and the requirements of Subsections R590-93-6(1)(d), R590-93-6(1)(e), and R590-93-6(2).

**R590-93-9. Violations and Penalties.**

(1) Any failure to comply with this rule shall be considered a violation of 31A-23a-402. Examples of violations include:

(a) any deceptive or misleading information set forth in sales material;

(b) failing to ask the applicant in completing the application the pertinent questions regarding the possibility of financing or replacement;

(c) the intentional incorrect recording of an answer;

(d) advising an applicant to respond negatively to any question regarding replacement in order to prevent notice to the existing insurer; or

(e) advising a policy or contract holder to write directly to the company in such a way as to attempt to obscure the identity of the replacing producer or company.

(2) Policy and contract holders have the right to replace existing life insurance policies or annuity contracts after indicating in or as a part of applications for new coverage that replacement is not their intention; however, patterns of such action by policy or contract holders of the same producer shall be deemed prima facie evidence of the producer's knowledge that replacement was intended in connection with the identified transactions, and these patterns of action shall be deemed prima facie evidence of the producer's intent to violate this rule.

(3) Where it is determined that the requirements of this rule have not been met, the replacing insurer shall provide to the policy holder an in force illustration if available or a policy summary for the replacement policy or disclosure document for the replacement contract and the appropriate Notice regarding replacements in Appendix A or C.

(4) Violations of this rule shall subject the violators to penalties that may include the revocation or suspension of a producer's or company's license, monetary fines and the forfeiture of any commissions or compensation paid to a producer as a result of the transaction in connection with which the violations occurred. In addition, where the commissioner has determined that the violations were material to the sale, the insurer may be required to make restitution, restore policy or contract values and pay interest at the legal rate as provided in Title 15 of the Utah Code on the amount refunded in cash.

**R590-93-10. Relationship to Other Statutes and Rules.**

If any portion of this rule is inconsistent with any provision of any statute or other rule dealing with life insurance or annuity marketing practices or disclosure, said inconsistent portion shall be interpreted so as to provide the greatest information or protection to the policyholder.

**R590-93-11. Severability.**

If any section, term, or provision of this rule shall be adjudged invalid for any reason, such judgment shall not affect, impair or invalidate any other section, term, or provision of this rule and the

remaining sections, terms, and provision shall be and remain in full force.

**R590-93-12. Enforcement Date.**

The commissioner will begin enforcing this rule September 1, 2005.

**KEY: life insurance, annuity replacement**

**2005**

**31A-2-201**

**31A-23a-402**



Insurance, Administration  
**R590-146**  
Medicare Supplement Insurance  
Minimum Standards

**NOTICE OF PROPOSED RULE**

(Amendment)

DAR FILE NO.: 27810

FILED: 04/12/2005, 14:13

**RULE ANALYSIS**

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The changes being made to this rule are being made to comply with the Federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The department has patterned the changes to this rule after the National Association of Insurance Commissioners' Model Regulation #651 entitled, Medicare Supplements, in complying with the new federal MAA requirements.

SUMMARY OF THE RULE OR CHANGE: Due to the new prescription drug benefit, Medicare Part D, Medicare Supplement Plans H, I and J will no longer be newly issued with prescription benefits. As part of the MMA, the Medicare Supplement Plans have been expanded to include Plans K and L. Both K and L are high deductible, high cost sharing plans. This rule provides the federal requirements for these new products.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 31A-22-620

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: The changes to this rule will create no fiscal impact to the department's or the state's budget. Health insurers selling Medicare Supplement coverage will need to refile their policy forms with the department but this will not change the amount of money coming into the budget or require a change in personnel.

❖ LOCAL GOVERNMENTS: This rule and its changes will have no effect on local government since it deals only with the regulatory requirements of state law on health insurers and the Medicare Supplement insurance products they offer to the public.

❖ OTHER PERSONS: Health insurers selling Medicare Supplement policies will experience additional cost to print the new and changed policy forms. Centers for Medicaid and Medicare Services require the Medicare Supplement insurer send approved notices to all Medicare Supplement recipients regarding their new options. At least 34 if not 350 health insurers could be affected by the changes in this rule. The department does not yet have a complete list of insurers selling Medicare Supplement insurance. Consumers will have the option to stay with their Medicare Supplement's drug coverage or replace it with Medicare's Part D drug program, which in some cases may be less expensive. The consumer will need to study which programs cover their particular prescriptions to keep the consumer costs lower.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Consumers will have the option to stay with their Medicare Supplement's drug coverage or replace it with Medicare's Part D drug program, which in some cases may be less expensive. The consumer will need to study which programs cover their particular prescriptions to keep the consumer costs lower.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: These Medicare Supplement changes will have little effect on local businesses. Insurers selling Medicare Supplement products will experience some expense in printing new forms for their supplement policies. D. Kent Michie, Utah Insurance Commissioner

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

INSURANCE  
ADMINISTRATION  
Room 3110 STATE OFFICE BLDG  
450 N MAIN ST  
SALT LAKE CITY UT 84114-1201, or  
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Jilene Whitby at the above address, by phone at 801-538-3803, by FAX at 801-538-3829, or by Internet E-mail at [jwhitby@utah.gov](mailto:jwhitby@utah.gov)

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 05/31/2005

INTERESTED PERSONS MAY ATTEND A PUBLIC HEARING REGARDING THIS RULE: 5/24/2005 at 9:00 AM, State Office Building (behind the Capitol), Room 1112, Salt Lake City, UT.

THIS RULE MAY BECOME EFFECTIVE ON: 06/01/2005

AUTHORIZED BY: Jilene Whitby, Information Specialist

## **R590. Insurance, Administration.**

### **R590-146. Medicare Supplement Insurance ~~[Minimum]~~ Standards.**

#### **R590-146-1. Authority.**

This rule is issued pursuant to the authority vested in the commissioner under Subsection 31A-22-620(3)(c), (d) and (e) requiring the commissioner to adopt rules to establish minimum standards for Individual and Group Medicare Supplement Insurance.

#### **R590-146-2. Purpose.**

The purpose of this rule is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; ~~[and]~~ to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare; and to establish rating and reporting requirements.

#### **R590-146-3. Applicability and Scope.**

A. Except as otherwise specifically provided in Sections 7, 13, 14, 17 and 22, this rule shall apply to:

(1) all Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this rule; and

(2) all certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this state.

B. This rule shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination, of the labor organizations.

#### **R590-146-4. Definitions.**

For purposes of this rule:

A. "Applicant" means:

(1) in the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and

(2) in the case of a group Medicare supplement policy, the proposed certificateholder.

B. "Bankruptcy" means when a Medicare Advantage~~[+Choice]~~ organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

C. "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

D. "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

E. "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

F.(1) "Creditable coverage" ~~[means, with respect to an individual, coverage of the individual provided under any of the following: ]has the same meaning as provided in federal regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936.~~

- (a) a group health plan;
- (b) health insurance coverage;
- (c) Part A or Part B of Title XVIII of the Social Security Act, Medicare;
- (d) Title XIX of the Social Security Act, Medicaid, other than coverage consisting solely of benefits under section 1928;
- (e) Chapter 55 of Title 10 United States Code, ~~[{CHAMPUS}]~~;
- (f) a medical care program of the Indian Health Service or of a tribal organization;
- (g) a State health benefits risk pool;
- (h) a health plan offered under chapter 89 of Title 5 United States Code, Federal Employees Health Benefits Program;
- (i) a public health plan as defined in federal regulation; and
- (j) a health benefit plan under Section 5(e) of the Peace Corps Act, 22 United States Code 2504(e).

(2) "Creditable coverage" shall not include one or more, or any combination of, the following:

- (a) coverage only for accident or disability income insurance, or any combination thereof;
- (b) coverage issued as a supplement to liability insurance;
- (c) liability insurance, including general liability insurance and automobile liability insurance;
- (d) workers' compensation or similar insurance;
- (e) automobile medical payment insurance;
- (f) credit-only insurance;
- (g) coverage for on-site medical clinics; and
- (h) other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) "Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

- (a) limited scope dental or vision benefits;
- (b) benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and
- (c) such other similar, limited benefits as are specified in federal regulations.

(4) "Creditable coverage" shall not include the following benefits if offered as independent, noncoordinated benefits:

- (a) coverage only for a specified disease or illness; and
- (b) hospital indemnity or other fixed indemnity insurance.

(5) "Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

- (a) medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;
- (b) coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code; and
- (c) similar supplemental coverage provided to coverage under a group health plan.

G. "Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002, Employee Retirement Income Security Act.

H. "Insolvency" means ~~that~~when an issuer, licensed to transact the business of insurance in this state, has ad a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.~~[-]~~

~~[—(a) an insurer is unable to pay its debts or meet its obligations as they mature;~~

~~—(b) an insurer's total adjusted capital is less than the insurer's mandatory control level RBC under Subsection 31A-17-601(7)(c); or~~

~~—(c) an insurer is determined to be hazardous under this title.~~

] I. "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

J. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

K. "Medicare Advantage~~Medicare+Choice~~ plan" means a plan of coverage for health benefits under Medicare Part C as defined in U.S.C. 1395w-28(b)(1), and includes:

(1) coordinated care plans which provide health care services, including but not limited to health maintenance organization plans, with or without a point-of-service option, plans offered by provider-sponsored organizations, and preferred provider organization plans;

(2) medical savings account plans coupled with a contribution into a Medicare Advantage~~Medicare+Choice~~ medical savings account; and

(3) Medicare Advantage~~Medicare+Choice~~ private fee-for-service plans.

L. "Medicare supplement policy" means a group or individual policy of disability insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act, 42 U.S.C. Section 1395 et seq., or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. "Medicare supplement policy" does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan, HCPP, that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act.

M. "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

N. "Secretary" means the Secretary of the United States Department of Health and Human Services.

#### **R590-146-5. Policy Definitions and Terms.**

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms, which conform to the requirements of this section.

A. "Accident," "accidental injury," or "accidental means" shall be defined to employ "result" language and shall not include words, which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(1) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(2) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers'

compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

B. "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.

C. "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.

D. "Health care expenses" means, for purposes of Section 14, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. [

~~Expenses shall not include:~~

~~(1) home office and overhead costs;~~

~~(2) advertising costs;~~

~~(3) commissions and other acquisition costs;~~

~~(4) taxes;~~

~~(5) capital costs;~~

~~(6) administrative costs; and~~

~~(7) claims processing costs.]~~

E. "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

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

G. "Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

H. "Physician" shall not be defined more restrictively than as defined in the Medicare program.

I. "Sickness" shall not be defined to be more restrictive than the following:

"Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force."

The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

#### **R590-146-6. Policy Provisions.**

A. Except for permitted preexisting condition clauses as described in Subsections 7A(1) and 8A(1) of this rule, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

B. No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

C. No Medicare supplement policy or certificate in force in the state shall contain benefits, which duplicate benefits provided by Medicare.

D.(1) Subject to sections 7(A)(4),(5) and (7) and 8(A)(4) and (5), a Medicare supplement policy with benefits for outpatient drugs in existence prior to January 1, 2006 shall be renewed for current

policyholders who do not enroll in Part D at the option of the policyholder.

(2) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

(3) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

(a) The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan, and;

(b) Premiums are adjusted to reflect the elimination of outpatient prescription coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

#### **R590-146-7. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to July 30, 1992.**

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

A. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this rule.

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

(4) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:

(a) provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(b) be canceled or non-renewed by the issuer solely on the grounds of deterioration of health.

(5)(a) Except as authorized by the commissioner of this state, an issuer shall neither cancel nor non-renew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(b) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in Subsection (5)(d), the issuer shall offer certificateholders an individual Medicare supplement policy. The issuer shall offer the certificateholder at least the following choices:

(i) an individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(ii) an individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Subsection 8B of this rule.

(c) If membership in a group is terminated, the issuer shall:

(i) offer the certificateholder the conversion opportunities described in Subsection (b); or

(ii) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group.

(d) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(7) If a Medicare supplement policy eliminates a outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection.

#### B. Minimum Benefit Standards.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

(3) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

(4) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

(5) Coverage under Medicare Part A for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations or already paid for under Part B;

(6) Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible, \$100;

(7) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

#### **R590-146-8. Benefit Standards for Policies or Certificates Issued or Delivered on or After July 30, 1992.**

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 30, 1992. No policy or certificate may be advertised,

solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

A. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this rule.

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

(4) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Each Medicare supplement policy shall be guaranteed renewable.

(a) The issuer shall not cancel or non-renew the policy solely on the ground of health status of the individual.

(b) The issuer shall not cancel or non-renew the policy for any reason other than nonpayment of premium or material misrepresentation.

(c) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Subsection 8A(5)(e), the issuer shall offer certificateholders an individual Medicare supplement policy which, at the option of the certificateholder:

(i) provides for continuation of the benefits contained in the group policy; or

(ii) provides for benefits that otherwise meet the requirements of this subsection.

(d) if an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(i) offer the certificateholder the conversion opportunity described in Subsection 8A(5)(c); or

(ii) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(e) if a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(f) if a Medicare supplement policy eliminate an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this Subsection.

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced

while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(7)(a) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period, not to exceed 24 months, in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to assistance.

(b) If suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstated, effective as of the date of termination of entitlement, as of the termination of entitlement if the policyholder or certificateholder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(c) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended, for the period provided by federal regulation, at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan, as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstated, effective as of the date of loss of coverage, if the policyholder provides notice of loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(d) Reinstitution of coverages:

(i) shall not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) shall provide for resumption of coverage [which] that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstatement of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

(iii) shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

B. Standards for Basic, Core, Benefits Common to All Benefit Plans A - J.

Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period.

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

(3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the [diagnostic related group (DRG) day-outlier per diem] applicable prospective payment system, PPS, rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations.

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services under a prospective payment system, the co-payment amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by Section 9 of this rule.

(1) Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.

(3) Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(4) 80% of the Medicare Part B Excess Charges: Coverage for 80% of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(5) 100% of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) Basic Outpatient Prescription Drug Benefit: Coverage for 50% of outpatient prescription drug charges, after a \$250 calendar year deductible, to a maximum of \$1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(7) Extended Outpatient Prescription Drug Benefit: Coverage for 50% of outpatient prescription drug charges, after a \$250 calendar year deductible to a maximum of \$3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(8) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(9) Preventive Medical Care Benefit: Coverage for the following preventive health services not covered by Medicare:

(a) An annual clinical preventive medical history and physical examination that may include tests and services from Subsection (b) and patient education to address preventive health care measures.

(b) ~~[Any one or a combination of the following p]~~Preventive screening tests or preventive services, the selection and frequency of which is determined to be [considered] medically appropriate by the attending physician.[-]

~~— (1) digital rectal examination;~~

~~— (2) dipstick urinalysis for hematuria, bacteriuria and proteinuria;~~

~~— (3) pure tone, air only, hearing screening test, administered or ordered by a physician;~~

~~— (4) serum cholesterol screening, every five years;~~

~~— (5) thyroid function test;~~

~~— (6) diabetes screening;~~

~~— (c) Tetanus and diphtheria booster, every ten years.~~

~~]~~ ~~(c)(d) Any other tests or preventive measures determined appropriate by the attending physician.~~ Reimbursement shall be for the actual charges up to 100% of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology, AMA CPT, codes, to a maximum of \$120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(10) At-Home Recovery Benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(a) For purposes of this benefit, the following definitions shall apply:

(i) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(ii) "Care provider" means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(iii) "Home" shall mean any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(iv) "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.

(b) Coverage Requirements and Limitations

(i) At-home recovery services provided shall be primarily services, which assist in activities of daily living.

(ii) The insured's attending physician shall certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to:

(I) no more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(II) the actual charges for each visit up to a maximum reimbursement of \$40 per visit;

(III) \$1,600 per calendar year;

(IV) seven visits in any one week;

(V) care furnished on a visiting basis in the insured's home;

(VI) services provided by a care provider as defined in this section;

(VII) at-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(VIII) at-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit.

(c) Coverage is excluded for:

(i) home care visits paid for by Medicare or other government programs; and

(ii) care provided by family members, unpaid volunteers or providers who are not care providers.

~~[(11) New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies.]D. Standards for Plans K and L~~

(1) Standardized Medicare supplement benefit plan "K" shall consist of the following:

(a) Coverage of 100% of the part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(b) Coverage of 100% of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(c) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system, PPS, rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Medicare Part A Deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subsection (j);

(e) Skilled Nursing Facility Care: Coverage for 50% of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subsection (j);

(f) Hospice Care: Coverage for 50% of the cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Subsection (j);

(g) Coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subsection (j);

(h) Except for coverage provided in Subsection (i) below, coverage for 50% of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subsection (j) below;

(i) Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(j) Coverage of 100% of all cost sharing under Medicare Part A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Part A and B of \$4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(2) Standardized Medicare supplement benefit plan "L" shall consist of the following:

(a) The benefits described in Subsections 146-8(D)(1)(a), (b), (c) and (i);

(b) The benefits described in Subsections 146-8 (D)(1) (d), (e), (f), (g) and (h), but substituting 75% for 50%; and

(c) The benefit described in Subsection 146-8 (D)(1)(j), but substituting \$2000 for \$4000.

#### **R590-146-9. Standard Medicare Supplement Benefit Plans.**

A. An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic core benefits, as defined in Subsection 8B of this rule.

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this section may be offered for sale in this state, except as may be permitted in Subsection ~~8C(14)~~9(G) and in Section 10 of this rule.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "J" listed in this section and conform to the definitions in Section 4 of this rule. Each benefit shall be structured in accordance with the format provided in Subsections 8B and 8C, or 8D and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

D. An issuer may use, in addition to the benefit plan designations required in Subsection C, other designations to the extent permitted by law. Make-up of benefit plans:

(1) Standardized Medicare supplement benefit plan "A" shall be limited to the basic, core, benefits common to all benefit plans, as defined in Subsection 8B of this rule.

(2) Standardized Medicare supplement benefit plan "B" shall include only the following: The core benefit as defined in Subsection 8B of this rule, plus the Medicare Part A deductible as defined in Subsection 8C(1).

(3) Standardized Medicare supplement benefit plan "C" shall include only the following: The core benefit as defined in Subsection 8B of this rule, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in Subsections 8C(1), (2), (3) and (8) respectively.

(4) Standardized Medicare supplement benefit plan "D" shall include only the following: The core benefit, as defined in Subsection 8B of this rule, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in Subsections 8C(1), (2), (8) and (10) respectively.

(5) Standardized Medicare supplement benefit plan "E" shall include only the following: The core benefit as defined in Subsection 8B of this rule, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country

and preventive medical care as defined in Subsections 8C(1), (2), (8) and (9) respectively.

(6) Standardized Medicare supplement benefit plan "F" shall include only the following: The core benefit as defined in Subsection 8B of this rule, plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Subsections 8C(1), (2), (3), (5) and (8) respectively.

(7) Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in Subsection 8B of this rule, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Subsections 8C(1), (2), (3), (5) and (8) respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be \$1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.

(8) Standardized Medicare supplement benefit plan "G" shall include only the following: The core benefit as defined in Subsection 8B of this rule, plus the Medicare Part A deductible, skilled nursing facility care, 80% of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in Subsections 8C(1), (2), (4), (8) and (10) respectively.

(9) Standardized Medicare supplement benefit plan "H" shall consist of only the following: The core benefit as defined in Subsection 8B of this rule, plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as defined in Subsections 8C(1), (2), (6) and (8) respectively. The prescription drug benefit shall not be included in a new Medicare supplement policy sold after December 31, 2005.

(10) Standardized Medicare supplement benefit plan "I" shall consist of only the following: The core benefit as defined in Subsection 8B of this rule, plus the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in Subsections 8C(1), (2), (5), (6), (8) and (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(11) Standardized Medicare supplement benefit plan "J" shall consist of only the following: The core benefit as defined in Subsection 8B of this rule, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100% of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in Subsections 8C(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.



(12) Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in Subsection 8B of this rule, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100% of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in Subsections 8C(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be \$1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(E) Make-up of two Medicare supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, MMA;

(1) Standardized Medicare supplement benefit plan "K" shall consist of only those benefits described in Section 8 D(1).

(2) Standardized Medicare supplement benefit plan "L" shall consist of only those benefits described in Section 8D(2).

#### **R590-146-10. Medicare Select Policies and Certificates.**

A.(1) This section shall apply to Medicare Select policies and certificates, as defined in this section.

(2) No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

B. For the purposes of this section:

(1) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

(2) "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

(3) "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

(4) "Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.

(5) "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

(6) "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) "Service area" means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare Select policy.

C. The commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and Section 4358 of the Omnibus Budget Reconciliation Act, OBRA, of 1990 if the

commissioner finds that the issuer has satisfied all of the requirements of this rule.

D. A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until ~~[its plan of operation has been approved by]~~ the commissioner has approved its plan of operation.

E. A Medicare Select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(a) Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(b) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(i) to deliver adequately all services that are subject to a restricted network provision; or

(ii) to make appropriate referrals.

(c) There are written agreements with network providers describing specific responsibilities.

(d) Emergency care is available 24 hours per day and seven days per week.

(e) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This subsection shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

(2) A statement or map providing a clear description of the service area.

(3) A description of the grievance procedure to be utilized.

(4) A description of the quality assurance program, including:

(a) the formal organizational structure;

(b) the written criteria for selection, retention and removal of network providers; and

(c) the procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(5) A list and description, by specialty, of the network providers.

(6) Copies of the written information proposed to be used by the issuer to comply with Subsection I.

(7) Any other information requested by the commissioner.

F.(1) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing the changes. Changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

(2) An updated list of network providers shall be filed with the commissioner at least quarterly.

G. A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

(1) the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

(2) it is not reasonable to obtain services through a network provider.

H. A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

I. A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

(1) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

(a) other Medicare supplement policies or certificates offered by the issuer; and

(b) other Medicare Select policies or certificates.

(2) A description, including address, phone number and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.

(3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network do not count toward the out-of-pocket annual limit contained in plans K and L.

(4) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

(5) A description of limitations on referrals to restricted network providers and to other providers.

(6) A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

(7) A description of the Medicare Select issuer's quality assurance program and grievance procedure.

J. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection I of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

K. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

(1) The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(3) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action shall be taken promptly.

(5) All concerned parties shall be notified about the results of a grievance.

(6) The issuer shall report no later than each March 31st to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

L. At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or

certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

M.(1) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six months.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this subsection, a significant benefit means coverage for the Medicare Part A deductible, coverage for ~~[prescription drugs, coverage for]~~ at-home recovery services or coverage for Part B excess charges.

N. Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this subsection, a significant benefit means coverage for the Medicare Part A deductible, coverage for ~~[prescription drugs, coverage for]~~ at-home recovery services or coverage for Part B excess charges.

O. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

#### **R590-146-11. Open Enrollment.**

A. An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this section without regard to age.

B. ~~[Except as provided in Section 22, Subsection A shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six months before the coverage became effective.]~~ (1) If an applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and,

as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall exclude benefits based on a preexisting condition.

(2) If the applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subsection.

C. Except as provided in Subsection B and Sections 12 and 23, Subsection A shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six months before the coverage became effective.

### **R590-146-12. Guaranteed Issue for Eligible Persons.**

#### A. Guaranteed Issue

(1) Eligible persons are those individuals described in subsection B who ~~subject to Subsection B(2)(b), apply~~ seek to enroll under the policy ~~not later than 63 days after the date of the termination of enrollment described in subsection B~~ during the period specified in Subsection C, and who submit evidence of the date of termination, ~~or disenrollment, or Medicare Part D enrollment~~ with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in ~~subsection~~ Subsection ~~C~~E that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

(3) In case of the individual described in Subsection A, the guaranteed issue period begins on the later of:

(i) the date the individual receives a notice of termination or cessation of all supplemental health benefits, or if a notice is not received, notice that a claim has been denied because of such a termination or cessation; or

(ii) the date that the applicable coverage terminates or ceases; and ends sixty-three days thereafter.

#### B. Eligible Persons

An eligible person is an individual described in any of the following ~~paragraphs~~ subsections:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;

(2) ~~(a)~~ The individual is enrolled with a ~~Medicare+Choice~~ Medicare Advantage organization under a ~~Medicare+Choice~~ Medicare Advantage plan under part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a program of All-Inclusive Care for the Elderly, ~~(PACE)~~, provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a ~~Medicare+Choice~~ Medicare Advantage plan:

(~~i~~)a) the certification of the organization, or plan under this part, has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or

(~~ii~~)b) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuance of such plan;

(~~iii~~)c) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act, ~~[(where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856)]~~, or the plan is terminated for all individuals within a residence area;

(~~iv~~)d) the individual demonstrates, in accordance with guidelines established by the Secretary, that:

(~~i~~)i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(~~ii~~)ii) the organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(~~v~~)e) the individual meets such other exceptional conditions as the Secretary may provide."]

~~(b)(i) An individual described in Subparagraph (2)(a) may elect to apply Subsection R590-146-12.A. by substituting, for the date of termination of enrollment, the date on which the individual was notified by the Medicare+Choice organization of the impending termination or discontinuance of the Medicare+Choice plan it offers in the area in which the individual resides, but only if the individual disenrolls from the plan as a result of such notification.~~

~~(ii) In the case of an individual making the election in Subparagraph (b)(i) the issuer involved shall accept the application of the individual submitted before the date of termination of enrollment, but the coverage under Subsection R590-146-12.A. shall only become effective upon termination of coverage under the Medicare+Choice plan involved.]~~

(3)(a) The individual is enrolled with:

(i) an eligible organization under a contract under Section 1876~~(2)~~ of the Social Security act, Medicare cost; ~~Medicare risk or cost;~~

(ii) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(iii) an organization under an agreement under Section 1833(a)(1)(A)~~(2)~~ of the Social Security Act, health care prepayment plan; or

(iv) an organization under a Medicare Select policy; and

(b) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage in Section 12B(2).

(4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(a)(i) of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(ii) of other involuntary termination of coverage or enrollment under the policy;

(b) the issuer of the policy substantially violated a material provision of the policy; or

(c) the issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

(5)(a) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any ~~[Medicare+Choice]~~ Medicare Advantage organization under a ~~[Medicare+Choice]~~ Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act, Medicare ~~[risk or]~~ cost, any similar organization operating under demonstration project authority, any PACE program under Section 1894 of the Social Security Act ~~an organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan);~~ or a Medicare Select policy; and

(b) The subsequent enrollment under ~~[subparagraph]~~ Subsection (a) is terminated by the enrollee during any period within the first 12 months of such subsequent enrollment, during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act; or

(6) The individual, upon first becoming eligible for benefits under part A of Medicare, enrolls in a ~~[Medicare+Choice]~~ Medicare Advantage plan under part C of Medicare, or in a PACE program under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than 12 months after the effective date of enrollment.

(7) The individual enrolls in a Medicare Part D plan during the initial enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Subsection E(4).

(8) The individual is enrolled under medical assistance under Title XIX of the Social Security Act, Medicaid, and is involuntarily terminated outside of requirements of Subsection 8(A)(7)(a) and (b).

#### C. Guaranteed Issue Time Periods

(1) In the case of an individual described in Subsection B(1), the guaranteed issue period begins on the later of:

(i) the date the individual receives a notice of termination or cessation of all supplemental health benefits or, if a notice is not received, noticed that a claim has been denied because of a termination or cessation; or

(ii) the date that the applicable coverage terminates or ceases; and ends sixty-three days thereafter;

(2) In case of an individual described in Subsection B(2), B(3), B(5) or B(6), whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three days after the date applicable coverage is terminated;

(3) In the case of an individual described in Subsection B(4)(a), the guaranteed issue period begins on the earlier of:

(i) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and

(ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three days after the date the coverage is terminated;

(4) In case of an individual described in Subsection B(2), B(4)(b), B(4)(c), B(5) or B(6) who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty days before the effective date of

the disenrollment and ends on the day that is sixty-three days after the effective date;

(5) In the case of an individual described in Subsection B(7), the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty-day period immediately preceding the initial Part D enrollment period ends on the date that is sixty-three days after the effective date of the individual's coverage under Medicare Part D; and

(6) In case of an individual described in Subsection B but not described in the preceding provisions of this Subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on that date that is sixty-three days after the effective date.

#### D. Extended Medigap Access for Interrupted Trail Periods

(1) In the case of an individual described in Subsection B(5), or deemed to be so described, pursuant to this Subsection, whose enrollment with a plan or in a program described in Subsection B(6) is involuntarily terminated within the first twelve months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 12B(5);

(2) In the case of an individual described in Subsection B(6), or deemed to be so described, pursuant to this Subsection, whose enrollment with a plan or in a program described in Subsection B(6) is involuntarily terminated within the first twelve months of enrollment, and who, without an intervening enrollments, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 12B(6); and

(3) For the purposes of Subsections B(5) and B(6), no enrollment of an individual with an organization or provider described in Subsection B(5)(a), or with a plan or in a program described in Subsection B(6), may be deemed to be an initial enrollment under this Subsection after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

#### [C]E. Products to Which Eligible Persons are Entitled

The Medicare supplement policy to which eligible persons are entitled under:

(1) Subsection 12B(1), (2), (3) and (4) is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F, including F with a high deductible, K or L, offered by any issuer.

(2) ~~-(a)~~ Subject to Subsection (b), Subsection 12B(5) is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Subsection [C](1) ~~[-]~~;

(b) After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with a outpatient drug benefit, a Medicare supplement policy described in this Subsection is:

(i) The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(ii) At the election of the policyholder, an A, B, C, F, including F with a high deductible, K or L policy that is offered by any issuer;

(3) Subsection 12B(6) shall include any Medicare supplement policy offered by any issuer.

(4) Section 12B(7) is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F, including F with a high deductible, K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

#### D. Notification provisions

(1) At the time of an event described in Subsection B of this section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Subsection A. Such notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in Subsection B of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Subsection 12A. Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

#### **R590-146-13. Standards for Claims Payment.**

A. An issuer shall comply with section 1882(c)(3) of the Social Security Act, as enacted by section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987, OBRA, 1987, Pub. L. No. 100-203, by:

(1) accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(2) notifying the participating physician or supplier and the beneficiary of the payment determination;

(3) paying the participating physician or supplier directly;

(4) furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

(5) paying user fees for claim notices that are transmitted electronically or otherwise; and

(6) providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

B. Compliance with the requirements set forth in Subsection A above shall be certified on the Medicare supplement insurance experience reporting form.

#### **R590-146-14. Loss Ratio Standards and Refund or Credit of Premium.**

##### A. Loss Ratio Standards.

(1)(a) A Medicare Supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy form or certificate form:

(i) at least 75% of the aggregate amount of premiums earned in the case of group policies; or

(ii) at least 65% of the aggregate amount of premiums earned in the case of individual policies;

(b) calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

(i) Home office and overhead costs;

(ii) Advertising costs;

(iii) Commissions and other acquisition costs;

(iv) Taxes;

(v) Capital costs;

(vi) Administration costs; and

(vii) Claims processing costs.

(2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(3) For policies issued prior to July 30, 1992, expected claims in relation to premiums shall meet:

(a) the originally filed anticipated loss ratio when combined with the actual experience since inception;

(b) the appropriate loss ratio requirement from Subsection A(1)(a)(i) and (ii) when combined with actual experience beginning with the effective date of October 31, 1994 as set forth in Bulletin 94-8; and

(c) the appropriate loss ratio requirement from Subsection A(1)(a)(i) and (ii) over the entire future period for which the rates are computed to provide coverage.

##### B. Refund or Credit Calculation

(1) An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.

(2) If on the basis of the experience as reported the benchmark ratio since inception, ratio 1, exceeds the adjusted experience ratio since inception, ratio 3, then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(3) For the purposes of this section, policies or certificates issued prior to July 30, 1992, the issuer shall make the refund or credit calculation separately for all individual policies, including all group policies subject to an individual loss ratio standard when issued, combined and all other group policies combined for experience after the effective date of this rule. The first report shall be due by May 31, 1998.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Annual ~~[filing]~~Filing of Premium Rates.

An issuer of Medicare supplement policies and certificates issued before or after the effective date of July 30, 1992 in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration ~~[for approval by the commissioner]~~in accordance with the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio, which is greater than or equal to the applicable percentage, shall be demonstrated for policies or certificates in force less than three years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state:

(1)(a) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing.

(b) An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(c) If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this section.

(d) The Annual Filing of Premium Rates shall be filed no later than May 31 each year.

(2) Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

D. Public Hearings.

The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of July 30, 1996 if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the commissioner.

**R590-146-15. Filing ~~[and Approval]~~of Policies, ~~[and]~~Certificates, and Premium Rates.**

A. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed ~~[with and approved by the commissioner]~~for use in

accordance with filing requirements and procedures prescribed by the commissioner.

B. An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the commissioner in the state in which the policy or certificate was issued.

~~[B]~~C. An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed ~~[with and approved by the commissioner]~~for acceptance in accordance with the filing requirements and procedures prescribed by the commissioner.

~~[C]~~D. (1) Except as provided in ~~[Paragraph]~~Subsection (2) of this subsection, an issuer shall not file ~~[for approval]~~more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(2) An issuer may offer, with the approval of the commissioner, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

- (a) the inclusion of new or innovative benefits;
- (b) the addition of either direct response or agent marketing methods;
- (c) the addition of either guaranteed issue or underwritten coverage;
- (d) the offering of coverage to individuals eligible for Medicare by reason of disability.

(3) For the purposes of this section, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

~~[D]~~E. (1) Except as provided in Subsection (1)(a), an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this rule that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

(a) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer may no longer offer for sale the policy form or certificate form in this state.

(b) An issuer that discontinues the availability of a policy form or certificate form pursuant to Subsection (a) shall not file ~~[for approval]~~a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this section.

(3) A change in the rating structure or methodology shall be considered a discontinuance under Subsection (1) unless the issuer complies with the following requirements:

(a) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

(b) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential, which is in the public interest.

[E]E. (1) Except as provided in Subsection (2), the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Rule R590-146-14.

(2) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

#### **R590-146-16. Permitted Compensation Arrangements.**

A. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than 200% of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

B. The commission or other compensation provided in subsequent renewal years shall be the same as that provided in the second year or period and shall be provided for no fewer than five renewal years.

C. No issuer or other entity may provide compensation to its agents or other producers and no agent or producer may receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

D. For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

#### **R590-146-17. Required Disclosure Provisions.**

##### **A. General Rules.**

(1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(2) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

(3) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

(4) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate ~~paragraph~~ Subsection of the policy and be labeled as "Preexisting Condition Limitations."

(5) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(6)(a) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the ~~Health Care Financing Administration~~ CMS, Centers for Medicare and Medicaid Services and in a type size no smaller than 12 point type. Delivery of the Guide shall be made whether or not the policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this rule. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.

(b) For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

##### **B. Notice Requirements**

(1) As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the commissioner. The notice shall:

(a) include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate; and

(b) inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare.

(2) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(3) The notices shall not contain or be accompanied by any solicitation.

##### **C. MMA Notice Requirements.**

Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

##### **D. Outline of Coverage Requirements for Medicare Supplement Policies.**

(1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of the outline from the applicant; and

(2) if an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than 12 point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(3) The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than 12-point type. All plans A-[3] shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(4) The Outline of Medicare Supplement Coverage, from the National Association of Insurance Commissioners, dated 1998, as incorporated by reference herein, is available for public inspection at the Insurance Department.

**[D]E.** Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

(1) Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act, 42 U.S.C. 1395 et seq., disability income policy; or other policy identified in Subsection 3B of this rule, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than 12 point type and shall contain the following language:

"THIS (POLICY OR CERTIFICATE) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CONTRACT). If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

(2) Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Subsection D(1) shall disclose, using the applicable statement in Appendix C, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

**R590-146-18. Requirements for Application Forms and Replacement Coverage.**

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has ~~another~~ Medicare supplement Medicare Advantage, Medicaid coverage, or another ~~or other~~ health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A

supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

TABLE I

(Statements)  
(Boldface Type)

- (1) You do not need more than one Medicare supplement policy.
- (2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- (3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, [F]the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy or, if that is no longer available, a substantially equivalent policy, will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy or, if that is no longer available, a substantially equivalent policy, will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

([5]G) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Questions  
(Boldface Type)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with the application. PLEASE ANSWER ALL QUESTIONS.  
(Please mark Yes or No below with an "X")

To the best of your knowledge,  
(1)(a) Did you turn age 65 in the last 6 months?

Yes No

(b) Did you enroll in Medicare Part B in the last 6 months?

Yes No

(c) If yes, what is the effective date?

(2) Are you covered for medical assistance through the state Medicaid program?

(NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost", please answer NO to this question.)

YES NO

(a) Will Medicaid pay your premiums for this Medicare supplement policy?

YES NO



(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?  
 YES NO

(3)(a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days, for example, a Medicare Advantage plan, or a Medicare HMO or PPO, fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.  
 START / / END / /

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?  
 YES NO

(c) Was this your first time in this type of Medicare plan?  
 YES NO

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?  
 YES NO

(4)(a) Do you have another Medicare supplement policy in force?  
 YES NO

(b) If so, with what company, and what plan do you have (optional for Direct Mailers)?  
 .....

(c) If so, do you intend to replace your current Medicare supplement policy with this policy?  
 YES NO

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)  
 YES NO

(a) If so, with what company and what kind of policy?  
 .....  
 .....  
 .....

(b) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank.  
 START / / END / /

~~[- (1) Do you have another Medicare supplement policy or certificate in force?  
 (a) If so, with which company?  
 (b) If so, do you intend to replace your current Medicare supplement policy with this policy (certificate)?  
 (2) Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?  
 (a) If so, with which company?  
 (b) What kind of policy?  
 (3) Are you covered for medical assistance through the state Medicaid program?  
 (a) As a Specified Low Income Medicare Beneficiary (SLMB)?  
 (b) As a Qualified Medicare Beneficiary (QMB)?  
 (c) For other Medicaid medical benefits?]~~

B. Agents shall list any other health insurance policies they have sold to the applicant.

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

C. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

D. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance

of the policy the notice regarding replacement of Medicare supplement coverage.

E. The notice required by Subsection D above for an issuer shall be provided in substantially the following form in no less than twelve point type:

TABLE II

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

(Boldface Type)  
(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.  
(Boldface Type)

According to (your application) (information you have furnished), you intend to terminate existing Medicare supplement insurance or Medicare Advantage and replace it with a policy to be issued by (Company Name) Insurance Company. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement or Medicare Advantage coverage is a wise decision, you should terminate your present Medicare supplement coverage.

You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.  
STATEMENT TO APPLICANT BY ISSUER, AGENT (BROKER OR OTHER REPRESENTATIVE):

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

- ..... Additional benefits.
- ..... No change in benefits, but lower premiums.
- ..... Fewer benefits and lower premiums.
- ..... My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- ..... Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. (optional only for Direct Mailer.)
- ..... Other. (please specify)

1. Note: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

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

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

properly recorded. (If the policy or certificate is guaranteed issue, this ~~[paragraph]~~ Subsection need not appear.)

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

.....  
(Signature of Agent, Broker or Other Representative)

(Typed Name and Address of Issuer, Agent or Broker)

.....  
(Applicant's Signature)

.....  
(Date)

Signature not required for direct response sales.

F. ~~[Paragraph]~~ Subsections 1 and 2 of the replacement notice, applicable to preexisting conditions, may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

**R590-146-19. Filing Requirements for Advertising.**

An issuer shall, upon specific request from the commissioner, provide file for use a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio, electronic, or television medium, to the Commissioner of Insurance of this state for review or approval by the commissioner to the extent it may be required under state law.

**R590-146-20. Standards for Marketing.**

A. An issuer, directly or through its producers, shall:

(1) establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate;

(2) establish marketing procedures to assure excessive insurance is not sold or issued.

(3) display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

"Notice to buyer: This policy may not cover all of your medical expenses"

(4) inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance; and

(5) establish auditable procedures for verifying compliance with this Subsection A.

B. In addition to the practices prohibited in Section 31A-23-302, the following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy or to take out a policy of insurance with another insurer.

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

C. The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this rule.

**R590-146-21. Appropriateness of Recommended Purchase and Excessive Insurance.**

A. In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

B. Any sale of Medicare supplement ~~[coverage]~~ policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

C. An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

**R590-146-22. Reporting of Multiple Policies.**

A. On or before May 31 ~~[March 1]~~ of each year, an issuer shall report the following information on the applicable reporting form contained in Appendix B for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate:

- (1) policy and certificate number; and
- (2) date of issuance.

B. The items set forth above shall be grouped by individual policyholder.

**R590-146-23. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates.**

A. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

B. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods for benefits similar to those contained in the original policy or certificate.

**R590-146-24. Documents Incorporated by Reference.**

The following filing documents are hereby incorporated by reference from the NAIC Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, September 2004:

- (1) "Appendix A: Reporting Form for Calculation of Loss Ratios";
- (2) "Appendix B: Form for Reporting Duplicate Policies"; and
- (3) "Appendix C: Disclosure Statements".

**R590-146-25. Enforcement Date.**

The commissioner will begin enforcing the new provisions of this rule January 1, 2006.

**R590-146-[24]26. Separability.**

If any provision of this rule or the application to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected.

**KEY: insurance**~~May 23, 2001~~ 2005

Notice of Continuation April 23, 2002

31A-22-620



Judicial Conduct Commission,  
Administration  
**R595-4-2**  
Sanctions Guidelines

**NOTICE OF PROPOSED RULE**  
(Amendment)

DAR FILE No.: 27807  
FILED: 04/08/2005, 11:17

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The existing rule requires the Judicial Conduct Commission (JCC) to disregard, when determining an appropriate sanction for judicial misconduct, any publicity generated by the complainant or someone acting in concert with the complainant. The proposed change allows the JCC to consider any such publicity, but to also consider the source of the publicity.

**SUMMARY OF THE RULE OR CHANGE:** This amendment eliminates a proviso in the existing rule that requires the JCC to disregard, when determining an appropriate sanction for judicial misconduct, any publicity generated by the complainant or someone acting in concert with the complainant.

**STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Art. VIII, Sec 13; and Sections 78-8-101 through 78-1-108

**ANTICIPATED COST OR SAVINGS TO:**

- ❖ **THE STATE BUDGET:** None--These revisions do not alter the basic operations or functions of the JCC, and therefore, do not result in either costs or savings to the State.
- ❖ **LOCAL GOVERNMENTS:** None--The JCC operations do not affect local governments, therefore, there are no costs or savings.
- ❖ **OTHER PERSONS:** None--These revisions do not alter the basic operations or functions of the JCC, and therefore, do not result in either costs or savings to other persons.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** None--These revisions do not alter the basic operations or functions of the JCC, and therefore, do not result in either compliance costs or compliance savings to affected persons.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** None--The Judicial Conduct Commission operations do not affect businesses. Colin R. Winchester, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

JUDICIAL CONDUCT COMMISSION  
ADMINISTRATION  
Room 104  
645 S 200 E  
SALT LAKE CITY UT 84111-3837, or  
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Colin Winchester at the above address, by phone at 801-533-3200, by FAX at 801-533-3208, or by Internet E-mail at colin.winchester@utahbar.org

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 05/31/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/01/2005

AUTHORIZED BY: Colin Winchester, Executive Director

**R595. Judicial Conduct Commission, Administration.****R595-4. Sanctions.****R595-4-2. Sanctions Guidelines.**

In determining an appropriate sanction for misconduct, the Commission shall consider the following non-exclusive factors:

- A. the nature of the misconduct;
- B. the gravity of the misconduct;
- C. the extent to which the misconduct has been reported or is known among court employees, participants in the judicial system or the public, ~~provided that the complainant or someone acting in concert with the complainant is not~~ and the source of the dissemination of information;
- D. the extent to which the judge has accepted responsibility for the misconduct;
- E. the extent to which the judge has made efforts to avoid repeating the same or similar misconduct;
- F. the length of the judge's service on the bench;
- G. the effect the misconduct has had upon the confidence of court employees, participants in the judicial system or the public in the integrity or impartiality of the judiciary;
- H. the extent to which the judge profited or satisfied his or her personal desires as a result of the misconduct; and
- I. the number and type of previous sanctions imposed against the judge.

**KEY: judicial conduct commission**~~February 1,~~ 2005

Art. VIII, Sec. 13

78-8-101 through 78-8-108



Natural Resources, Wildlife Resources  
**R657-55**  
 Wildlife Convention Permits

**NOTICE OF PROPOSED RULE**

(New Rule)

DAR FILE No.: 27827

FILED: 04/15/2005, 14:16

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** This new rule is proposed to provide standards and requirements for issuing one series of wildlife conservation permits per year to a qualified conservation organization.

**SUMMARY OF THE RULE OR CHANGE:** This rule provides the standards and requirements for issuing wildlife convention permits. Wildlife convention permits and the corresponding wildlife convention permit vouchers are authorized by the Wildlife Board and issued by the division to a qualified conservation organization for purposes of generating revenue to fund wildlife conservation activities. The selected conservation organization shall distribute the wildlife convention permit vouchers through a drawing at a convention held in Utah. This rule is intended as authorization to issue one series of wildlife convention permits per year beginning in 2007 through 2011 to one qualified conservation organization.

**STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Sections 23-14-18 and 23-14-19

**ANTICIPATED COST OR SAVINGS TO:**

❖ **THE STATE BUDGET:** This rule is intended as authorization to issue one series of wildlife convention permits per year beginning in 2007 through 2011 to one qualified conservation organization. The Division of Wildlife Resources (DWR) determines that this rule does not create a cost or savings impact to the state budget or DWR's budget.

❖ **LOCAL GOVERNMENTS:** None--This filing does not create any direct cost or saving impact to local governments because they are not directly affected by the rule. Nor are local governments indirectly impacted because the rule does not create a situation requiring services from local governments.

❖ **OTHER PERSONS:** This rule is intended as authorization to issue one series of wildlife convention permits per year beginning in 2007 through 2011 to one qualified conservation organization. Therefore, this rule does not impose any compliance costs for affected persons.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** This rule is intended as authorization to issue one series of wildlife convention permits per year beginning in 2007 through 2011 to one qualified conservation organization. Therefore, this rule does not impose any compliance costs for affected persons.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** There are several non-profit (501C-3) wildlife-related businesses that would use these

permits to assist in the drawing of a major convention in Salt Lake City. This rule would positively impact many hotels and other tourism-related businesses in the Salt Lake City area. Otherwise, this rule does not create an impact on businesses. Michael R. Styler, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

NATURAL RESOURCES  
 WILDLIFE RESOURCES  
 1594 W NORTH TEMPLE  
 SALT LAKE CITY UT 84116-3154, or  
 at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Debbie Merrill at the above address, by phone at 801-538-4707, by FAX at 801-538-4745, or by Internet E-mail at [debbiemerrill@utah.gov](mailto:debbiemerrill@utah.gov)

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 05/31/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/01/2005

AUTHORIZED BY: Miles Moretti, Acting Director

**R657. Department of Natural Resources, Wildlife Resources.  
 R657-55. Wildlife Convention Permits.**

**R657-55-1. Purpose and Authority.**

(1) Under the authority of Sections 23-14-18 and 23-14-19 of the Utah Code, this rule provides the standards and requirements for issuing wildlife convention permits.

(2) Wildlife convention permits and the corresponding wildlife convention permit vouchers are authorized by the Wildlife Board and issued by the division to a qualified conservation organization for purposes of generating revenue to fund wildlife conservation activities.

(3) The selected conservation organization shall distribute the wildlife convention permit vouchers through a drawing at a convention held in Utah.

(4) This rule is intended as authorization to issue one series of wildlife convention permits per year beginning in 2007 through 2011 to one qualified conservation organization.

**R657-55-2. Definitions.**

(1) Terms used in this rule are defined in Section 23-13-2.

(2) In addition:

(a) "Conservation organization" means a nonprofit chartered institution, corporation, foundation, or association founded for the purpose of promoting wildlife conservation.

(b) "Wildlife Convention" means a multi-day event held within the state of Utah that is sponsored by multiple wildlife conservation organizations as their national or regional convention or event that is open to the general public and designed to draw nationwide attendance of more than 10,000 individuals. The wildlife convention may include wildlife conservation fund raising activities, outdoor exhibits, retail marketing of outdoor products and services, public awareness programs, and other similar activities.

(c) "Wildlife Convention Permit" means a permit which:  
(i) is authorized by the Wildlife Board to be issued to successful applicants through a drawing or random selection process conducted at a Utah wildlife convention; and  
(ii) allows the permittee to hunt for the designated species on the designated unit during the respective season for each species as authorized by the Wildlife Board.  
(d) "Wildlife Convention Permit series" means a single package of permits to be determined by the Wildlife Board for:  
(i) deer;  
(ii) elk;  
(iii) pronghorn;  
(iv) moose;  
(v) bison;  
(vi) rocky mountain goat;  
(vii) desert bighorn sheep;  
(viii) rocky mountain bighorn sheep;  
(ix) wild turkey;  
(x) cougar; or  
(xi) black bear.  
(e) "Wildlife convention permit voucher" means the official document awarded to a successful wildlife convention permit applicant, which authorizes that person to receive from the division the permit designated thereon upon receipt of the applicable permit fee and verifying the person's eligibility to legally hunt the specified species in Utah.

**R657-55-3. Wildlife Convention Permit Allocation.**

(1) The Wildlife Board may allocate wildlife convention permits by May 1 of the year preceding the wildlife convention.  
(2) Wildlife convention permit vouchers shall be issued as a single series to one conservation organization.  
(3) The number of wildlife convention permits authorized by the Wildlife Board shall be based on:  
(a) the species population trend, size, and distribution to protect the long-term health of the population;  
(b) the hunting and viewing opportunity for the general public, both short and long term; and  
(c) a percentage of the permits available to nonresidents in the annual big game drawings matched by an equal number of resident permits.  
(4) Wildlife convention permits shall not exceed 200 total permits.  
(5) Wildlife convention permits designated for the convention each year shall be deducted from the number of public drawing permits.

**R657-55-4. Obtaining Authority to Distribute Wildlife Convention Permit Series.**

(1) The wildlife convention permit series is issued for a period of five years as provided in Section R657-55-1(4).  
(2) The wildlife convention permit series is available to eligible conservation organizations for distribution through a drawing or other random selection process held at a wildlife convention in Utah open to the public.  
(3) Conservation organizations may apply for the wildlife convention permit series by sending an application to the division July 1 through August 1, 2005.  
(4) Each application must include:  
(a) the name, address and telephone number of the conservation organization;

(b) a description of the conservation organization's mission statement;  
(c) the name of the president or other individual responsible for the administrative operations of the conservation organization; and  
(d) a detailed business plan describing how the wildlife convention will take place and how the wildlife convention permit voucher drawing procedures will be carried out.  
(5) An incomplete or incorrect application may be rejected.  
(6) The division shall recommend to the Wildlife Board which conservation organization may receive the wildlife convention permit series based on:  
(a) the business plan for the convention and drawing procedures contained in the application; and  
(b) the conservation organization's, including its constituent entities, ability, including past performance in marketing conservation permits under Rule R657-41, to effectively plan and complete the wildlife convention.  
(7) The Wildlife Board shall make the final assignment of the wildlife convention permit series based on the:  
(a) division's recommendation;  
(b) benefit to protected wildlife;  
(c) historical contribution of the organization, including its constituent entities, to the conservation of wildlife; and  
(d) previous performance of the conservation organization, including its constituent entities.  
(8) The conservation organization receiving the wildlife convention permit series must:  
(a) distribute the wildlife convention permit vouchers by drawing or other random selection process in accordance with law, provisions of this rule, proclamation, and order of the Wildlife Board;  
(b) allow applicants to apply for the wildlife convention permit vouchers without purchasing admission to the wildlife convention;  
(c) notify the division of the recipient of each wildlife convention permit voucher within 10 days of the recipient's selection;  
(d) maintain records demonstrating that the drawing was conducted fairly; and  
(e) submit to wildlife convention permit series audits by a division-appointed auditor upon division request.  
(9) The division shall issue the appropriate wildlife convention permit to the designated recipient of the wildlife convention permit voucher upon the recipient being found eligible for the permit and the payment of the appropriate permit fee.  
(10) The division and the conservation organization receiving the wildlife convention permit series shall enter into a contract, including the provisions outlined in this rule.  
(11) The division may suspend or terminate the conservation organization's authority to distribute wildlife convention permit vouchers at any time during the five year award term for:  
(a) violating any of the requirements set forth in this rule or the contract; or  
(b) failing to bring or organize a wildlife convention in Utah, as described in the business plan under R657-55-4(4)(d), in any given year.

**R657-55-5. Hunter Application Procedures.**

(1) Any hunter legally eligible to hunt in Utah may apply for a permit.

(2) Any handling fee assessed by the conservation organization to process applications shall not exceed \$5 per application submitted at the convention.

(3) Applicants must be present in person at the wildlife convention to apply for wildlife convention permits, and no person may submit an application in behalf of another.

(4) Applicants may apply for each individual hunt.

(5) Applicants may apply only once for each hunt, regardless of the number of permits for that hunt.

(6) Applicants must submit an application for each desired hunt.

#### **R657-55-6. Drawing Procedures.**

(1) A random drawing or selection process must be conducted for each wildlife convention permit voucher.

(2) No preference or bonus points shall apply or be awarded in the drawings.

(3) Waiting periods do not apply, except any person who obtains a wildlife convention permit for a once-in-a-lifetime species is subject to the once-in-a-lifetime restrictions applicable to obtaining a subsequent permit for the same species through a division application and drawing process, as provided in Rule R657-5 and the proclamation of the Wildlife Board for taking big game.

(4) No predetermined quotas or restrictions shall be imposed in the application or selection process for wildlife convention permit vouchers between resident and nonresident applicants.

(5) Drawings will be conducted at the close of the convention.

(6) Applicants do not have to be present at the drawing to be awarded the wildlife convention permit voucher.

(7) The conservation organization shall draw ten alternates for each wildlife convention permit and maintain the list of alternates until all permits are issued and then provide the list to the division.

(8) The conservation organization shall contact successful applicants by phone or mail, and the results posted on a designated website.

#### **R657-55-7. Issuance of Permits.**

(1) The division shall provide a wildlife convention permit voucher to the conservation organization for each wildlife convention permit to be issued.

(2) The conservation organization must provide a wildlife convention permit voucher to each successful applicant, except as otherwise provided in this rule.

(3) Successful applicants must provide the wildlife convention permit voucher to the division and, if legally eligible to hunt in Utah, will be issued the designated wildlife convention permit upon payment of the appropriate permit fee.

(4) Residents will pay resident permit fees and nonresidents will pay nonresident permit fees.

(5) Applicants are eligible to obtain only one permit per species, except as provided in Rule R657-5, but no restrictions apply on obtaining permits for multiple species.

(6)(a) Any successful applicant who fails to redeem their wildlife convention permit voucher by the dates provided in Subsection (b) annually, will be ineligible to receive the wildlife convention permit and the next drawing alternate for that permit will be selected.

(b) A wildlife convention permit voucher must be redeemed by:

(i) November 15 for cougar;

(ii) February 1 for wild turkey and bear; and

(iii) August 1 for deer, elk, pronghorn, moose, bison, rocky mountain goat, desert bighorn sheep, and rocky mountain bighorn sheep.

#### **R657-55-8. Surrender or Transfer of Wildlife Convention Permits and Vouchers.**

(1)(a) If a person selected to receive a wildlife convention permit is also successful in obtaining a Utah limited entry permit for the same species in the same year or obtaining a general permit for a male animal of the same species in the same year, that person cannot possess both permits and must select the permit of choice.

(b) In the event the wildlife convention permit voucher is surrendered, the next applicant on the alternate drawing list for that wildlife convention permit will be selected to receive the wildlife convention permit voucher.

(c) In the event the wildlife convention permit voucher is redeemed for a wildlife convention permit and the permit is thereafter surrendered, the next applicant on the alternate drawing list for that permit will be selected to receive the permit, and the permit fee will not be refunded, except as provided in Sections 23-19-38 and 23-19-38.2.

(d) In the event the limited entry or general permit is surrendered, the permit may be reallocated pursuant to Rule R657-42, and the permit fee will not be refunded, except as provided in Sections 23-19-38 and 23-19-38.2.

(2) If a person is successful in obtaining more than one wildlife convention permit for the same species, the applicant must select the permit of choice and the remaining permit will go to the applicant on the alternate drawing list.

(3) A person selected by a conservation organization to receive a wildlife convention voucher or permit, may not sell or transfer the voucher, permit, or any rights thereunder to another person in accordance with Section 23-19-1.

(4) If a person is successful in obtaining a wildlife convention permit but is legally ineligible to hunt in Utah the next applicant on the alternate drawing list for that permit will be selected to receive the permit.

#### **R657-55-9. Using a Wildlife Convention Permit.**

(1) A wildlife convention permit allows the recipient to:

(a) take only the species for which the permit is issued;

(b) take only the species and sex printed on the permit; and

(c) take the species only in the area and during the season specified on the permit.

(2) The recipient of a wildlife convention permit is subject to all of the provisions of Title 23, Wildlife Resources Code, and the rules and proclamations of the Wildlife Board for taking and pursuing wildlife.

#### **KEY: wildlife, wildlife permits**

**2005**

**23-14-18**

**23-14-19**



**Public Safety, Driver License  
R708-41  
Requirements for Acceptable  
Documentation**

**NOTICE OF PROPOSED RULE**

(New Rule)  
DAR FILE NO.: 27809  
FILED: 04/11/2005, 17:11

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The purpose of the rule is to establish standards for acceptable documentation of an applicant's identity, Utah resident status, Utah residence address, proof of legal presence, proof of citizenship, and other proof or documentation required under Title 53, Chapter 3.

**SUMMARY OF THE RULE OR CHANGE:** The new law requires the Driver License Division to determine if an applicant is a Utah resident and have an applicant establish proof of a Utah residence address as part of the requirement to get a Utah Driving Privilege Card, a Driver License, a Commercial Driver License, or an Identification Card. Effective July 1, 2005, documentation is required by the division to verify that the applicant is a citizen of a country other than the United States, is legally present in the United States, and does not qualify for a Social Security Number. Additionally, a Utah Driving Privilege Card cannot be used by a governmental entity as proof of personal identification and it cannot be renewed through the mail or on the Internet. (DAR NOTE: A corresponding 120-day (emergency) Rule R708-41 that was effective as of 04/11/2005 is under DAR No. 27808 in this issue.)

**STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Section 53-3-104

**ANTICIPATED COST OR SAVINGS TO:**

❖ **THE STATE BUDGET:** There is no cost to state government because this rule only clarifies what documentation is acceptable for getting a Utah Driving Privilege Card, a Driver License, a Commercial Driver License, and an Identification Card.

❖ **LOCAL GOVERNMENTS:** There will be no cost to local governments because the issuance of a Driving Privilege Card, a Driver License, a Commercial Driver License, and an Identification Card is exclusively a state responsibility.

❖ **OTHER PERSONS:** There is a potential for an individual to incur a cost for obtaining authorized copies of documents necessary to provide acceptable documentation, if the individual does not have the required documents in his or her possession.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** There is a potential for an individual to incur a cost for obtaining authorized copies of documents necessary to provide acceptable documentation, if the individual does not have the required documents in his or her possession.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** There is no fiscal impact on businesses because of this rule. Robert Flowers, Commissioner

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

PUBLIC SAFETY  
DRIVER LICENSE  
CALVIN L RAMPTON COMPLEX  
4501 S 2700 W 3RD FL  
SALT LAKE CITY UT 84119-5595, or  
at the Division of Administrative Rules.

**DIRECT QUESTIONS REGARDING THIS RULE TO:**

Vinn Roos at the above address, by phone at 801-965-4456, by FAX at 801-964-4482, or by Internet E-mail at vroos@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 05/31/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/01/2005

AUTHORIZED BY: Nannette Rolfe, Director

**R708. Public Safety, Driver License.**

**R708-41. Requirements for Acceptable Documentation.**

**R708-41-1. Purpose.**

The purpose of this rule is to define acceptable documentation pursuant to Title 53, Chapter 3.

**R708-41-2. Authority.**

This rule is authorized by Section 53-3-104.

**R708-41-3. Definitions.**

(1) "Utah Residence address" means the place where an individual has a fixed permanent home and principal establishment in Utah and in which the individual voluntarily resides, that is not for a special or temporary purpose.

(2) "Legal Presence" means that an individual's presence in the United States does not violate state or federal law.

**R708-41-4. Obtaining a Utah Driving Privilege Card, Driver License, Commercial Driver License or an Identification Card.**

(1) An applicant seeking to obtain a Utah Driving Privilege Card, Driver license, Commercial Driver License or an Identification Card must:

(a) provide two different forms of identification from the following list to verify full legal name, date of birth, and gender pursuant to Section 53-3-205(9)(a) and 53-3-804 (2):

(i) Certificate of Naturalization;

(ii) Certificate of Citizenship;

(iii) driver license issued in the United States;

(iv) foreign birth certificate with certified translation;

(v) I-94 card or INS I-551 card;

(vi) Indian Blood Certificate;

(vii) Matricular Consular ID Card (Issued in Utah);

- (viii) Resident Alien Card;  
(ix) U.S. Birth Certificate (from Vital Records);  
(x) U.S. Certificate of Birth Abroad;  
(xi) U.S. Military Identification Card or DD-214;  
(xii) U.S. Passport; and  
(xiii) other documentation furnished by the individual if it can be determined that the documentation unequivocally demonstrates proof of identity.  
(b) provide the applicant's Utah residence address. PO Boxes and business addresses are not accepted; and  
(c) provide two different types of original (current and valid) documents from the following list as proof of a Utah resident address.  
(i) property tax notice, statement or receipt, within one year;  
(ii) utility bill, billing date within 60 days, (no cell phone bills);  
(iii) Utah vehicle registration or title;  
(iv) bank statement, within 60 days;  
(v) recent mortgage papers;  
(vi) current residential rental contract;  
(vii) major credit card bill, within 60 days;  
(viii) court order of probation, order of parole or order of mandatory release, must display residential address;  
(ix) transcripts from an accredited college, university, or high school; or  
(x) other documentation furnished by the individual if it can be determined that the documentation unequivocally demonstrates proof of residency or domicile.  
(2) An applicant for a Utah Driving Privilege Card must also provide:  
(a) a valid Individual Tax Identification Number (ITIN) card issued by the Internal Revenue Service; or  
(b) effective July 1, 2005, documentation from the following list, as requested by the division, to verify that the applicant is a citizen of a country other than the United States, is legally present in the United States, and does not qualify for a Social Security Number:  
(i) valid foreign passport with appropriate immigration document(s);  
(ii) INS-I-551 Resident Alien Card issued since 1997 (cards issued prior to this date need to be screened for appropriate security features);  
(iii) INS I-688 Temporary Resident Identification Card;  
(iv) INS I-688B, I-766 Employment Authorization Card;  
(v) U.S. Department of Receptions and Placement Program Assurance Form (Refugee); or  
(vi) other documentation furnished by the individual if it can be determined that the documentation unequivocally demonstrates that the applicant is a citizen of a country other than the United States, is legally present in the United States, and does not qualify for a Social Security Number.

**KEY: acceptable documentation****2005****53-3-104**

Public Service Commission,  
 Administration  
**R746-341**  
 Lifeline Rule

**NOTICE OF PROPOSED RULE**

(Amendment)

DAR FILE NO.: 27821

FILED: 04/15/2005, 13:40

**RULE ANALYSIS**

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this amendment is to comply with changes to federal rules and to clarify the responsibilities of telecommunications carriers and recipients of Lifeline.

SUMMARY OF THE RULE OR CHANGE: Changes are made to provide updated guidelines for carriers and individuals to participate in the state Lifeline program. In addition to previous eligibility based on participation in specified assistance programs (and updating the current names for such programs), the rule is amended to reorganize the existing rule dealing with the Commission practice of eligibility based on income levels and specifically tracts the Federal Communications Commission income eligibility criteria and documentation standards. The change also places in the rule past practice and policy of steps to carry over eligibility from year to year and clarifies the steps necessary to establish qualification and how to challenge program disqualifications.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 54-8b-15 and 54-8b-10

**ANTICIPATED COST OR SAVINGS TO:**

❖ THE STATE BUDGET: There is no anticipated cost or saving impacts upon state agency budgets, but for a possible impact on the Universal Service Fund (USF), which is not a state agency budget, if some additional individuals participate in the Lifeline program and generate some additional subsidy payments. The subsidy amounts for participants remain the same, but the number of participants may change. The Commission has no information to estimate the number of additional individuals who may participate beyond those already participating. As the Commission already permits income-based qualification beyond assistance program participation qualification for Lifeline service, additional participation likely will come from continuing outreach programs (which are not affected by the rule change other than including in the rule the current practice of telecommunications carriers informing the Commission of their outreach efforts and coordination attempts) rather than from any proposed change in the existing rule. The Commission administers the USF for telecommunications carrier expenses and its own associated costs and those of other state



agencies who are impacted (the agency verifying participation in specified assistance programs). The Commission believes that any changes in state agency operations can be accommodated without any change in costs or savings for these agencies or any impact on the level of funds currently budgeted in the USF.

❖ LOCAL GOVERNMENTS: No effect--This rule does not affect local government. Therefore, there are no costs or savings.

❖ OTHER PERSONS: Costs for telecommunications carriers may decrease as they may standardize current practices for eligibility determinations, but no significant change is anticipated as the changes to the rule follow current practices used in administering the Lifeline program. Cost to participants may increase as they may have to obtain different or additional documents, and retain them for a specified period, but no significant changes are anticipated as the rule change follows current income based qualification process. Indeed, some (small) savings may be realized as the rule change specifies the specific documentation which will be accepted, possibly reducing participants document acquisition and retention efforts of documents which may no longer be needed in eligibility determinations.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Individuals discounted telephone service will be the same as currently provided; the number of participants may change, but this will not have an affect at the individual level. Individuals will receive the same discount/price reduction for Lifeline telephone service as was provided prior to the proposed rule change.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The state participation in the Lifeline program has attempted to mirror the federal program and maximize as much as possible the benefits that can be obtained for telecommunication services customers in the State of Utah. Eligibility criteria and verifications methods have changed at the federal level, so this rule change is generally driven to reflect these changes, rather than make changes on the financial or fiscal aspects of the existing rule. While the rule change can result in additional individuals participating in the program, the current funding mechanism is sufficient to accommodate that potential change without changing the surcharge. Ric Campbell, Chairman

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

PUBLIC SERVICE COMMISSION  
ADMINISTRATION  
HEBER M WELLS BLDG  
160 E 300 S  
SALT LAKE CITY UT 84111-2316, or  
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Barbara Stroud or Sandy Mooy at the above address, by phone at 801-530-6714 or 801-530-6708, by FAX at 801-530-6796 or 801-530-6796, or by Internet E-mail at bstroud@utah.gov or smooy@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 05/31/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/01/2005

AUTHORIZED BY: Barbara Stroud, Paralegal

#### **R746. Public Service Commission, Administration.**

##### **R746-341. Lifeline/Link-up Rule.**

##### **R746-341-1. Applicability.**

Telecommunications corporations that have been designated as eligible telecommunications carriers by the Commission, pursuant to Section 214 of the Federal Communications Act, shall establish a lifeline telephone service pursuant to the requirements of Sections 2 through [8]10.

##### **R746-341-2. Definitions.**

A. "Applicant" -- means ~~[a head of a household or person in whose name the property or rental agreement resides]~~the eligible telecommunications customer who owns and resides in a residential property or rents and resides in a residential property.

B. "~~Appropriate State]~~Responsible Agency" -- means ~~[the agency administering the public assistance programs listed in R746-341-3(A)]~~the agency that administers the certification, verification, and continued verification of Lifeline enrollment.

C. "ETC" -- means the eligible telecommunications carrier.

D. "Federal Poverty Guidelines" -- means the poverty guidelines issued each year by the Department of Health and Human Services and published in the Federal Register.

E. "Income" -- means gross income, whether earned or unearned, received by all members of the household including, but not limited to, salary before deductions. Income shall not include student financial aid, military housing and cost-of-living allowances, or irregular income from occasional small jobs.

##### **R746-341-3. Eligibility Requirements.**

A. ~~Program-Based Criteria~~ -- The [eligible telecommunications carriers]ETCs shall provide lifeline telephone service to any applicant who self-certifies, under the penalty of perjury, the household members' eligibility for public assistance under one of the following or its successor programs:

1. Temporary Assistance to Needy Families (TANF);
2. ~~[Emergency Work Programs]~~Work Toward Employment;
3. Food Stamps;
4. General Assistance;
5. Home Energy Assistance Target Programs/Help Program;
6. Medicaid~~[Assistance]~~;
7. Refugee Assistance;
8. Supplemental Security Income.
9. Federal Public Housing Assistance, including Section 8 Housing;
10. National School Lunch Free Lunch Program; or
11. Head Start Program (income qualifying standard only).

B. Income-Based Criteria -- The ETCs shall provide lifeline telephone service to any applicant who certifies via supporting documentation, under the penalty of perjury, income to be at or below 135 percent of the then applicable Federal Poverty Guidelines.

1. Income-based eligibility is based on family size and actual income, therefore, the Lifeline customer must certify, under the penalty of perjury, the number of individuals residing in their household.

2. A Lifeline customer must certify, under the penalty of perjury, that the documentation presented accurately represents the applicant's annual household income. The following documents, or any combination of these documents, are acceptable for Lifeline certification:

- a. Prior year's state, federal, or tribal tax return;
- b. Current year-to-date earnings statement from an employer or three consecutive months of paycheck stubs;
- c. Social Security statement of benefits;
- d. Veterans Administration statement of benefits;
- e. Retirement/pension statement of benefits;
- f. Unemployment/Worker's Compensation statement of benefits;
- g. Federal or tribal notice letter of participation in Bureau of Indian Affairs General Assistance; or
- h. Divorce decree, or child support wage assignment statement.

[B.]C. [Self-e]Certification -- [will be upon a form]The application form for participation will be supplied by the [eligible telecommunications—carrier]ETC or the [appropriate state]responsible agency and contain the following:

- 1. applicant's name, current telephone number, and social security number;
- 2. a request for lifeline service;
- 3. an affirmative statement that the applicant qualifies for lifeline service.
- 4. a statement, under the penalty of perjury, as to whether the person is participating in one of the programs [set out]listed in Subsection R746-341-3.A[ above or would be eligible for one or more of those programs, without respect to any time limitation for participation in those programs]; or a statement, under the penalty of perjury, as to whether the person's income is at or below 135 percent of the Federal Poverty Guidelines.

a. If qualified by income-based criteria, certification must be supported by acceptable documentation listed in R746-341-3.B.

5. a statement that if the applicant is later shown to have submitted a false self-certification for the Lifeline program, the applicant will be responsible to pay the difference between the lifeline service rate and the otherwise applicable service rate;

6. a statement whether this is a connection or a reconnection[ or not]; and

7. the applicant's signature.

D. Documentation Retention -- The responsible agency will retain income and program eligibility certification for as long as the eligible customer receives Lifeline service from an ETC.

E. Tribal Land Lifeline Discounts -- Customers who live on tribal lands and who qualify for the state Lifeline service rate based on the program qualifications and income qualifications set forth in R746-341-3.B, are eligible to receive a larger federal discount. Those federal discounts are not within the scope of, nor governed by, these rules.

#### **R746-341-4. [Verification Procedures]Continuing Eligibility.**

A. Annual Verification -- The continuing eligibility of all customers on the Lifeline service rate shall be verified annually[At least a]

B. ETC Verification Responsibilities -- Annually, the [eligible telecommunications—carriers]ETCs offering Lifeline telephone

service shall provide the [appropriate state]responsible agency with computer tapes, written lists, or personal computer disks, listing their Lifeline service customers' names, telephone numbers, addresses and social security numbers. [Eligible telecommunications—carriers]ETCs with more than 300 Lifeline telephone customers shall provide the information in an electronic format useable by the [appropriate state]responsible agency. ETC's with less than 300 customers shall provide the information in a format designated by the responsible agency.

C. Verification Criteria -- The responsible agency will verify the continued eligibility of Lifeline customers under the program-based and income-based eligibility criteria.

1. The responsible agency shall identify a method by which income eligibility will be verified on an annual basis including, but not limited to, annual self-certification, random beneficiary audits, a periodic submission of income documents, or the continued eligibility of a statistically valid sample of Lifeline customers.

2. The responsible agency will use the records provided in Subsection R746-341-3.A. to match, using the state computer system, against program participation.

3. If a Lifeline customer does not appear as a participant in a program on the state computer system, the responsible agency will send a letter to the Lifeline customer requesting:

a. proof of participation in any of the programs listed in R746-341-3.A; or

b. documentation of eligibility under the income-based criteria set forth in R746-341-3.B.

4. The responsible agency shall notify any Lifeline customer who fails to supply proof of participation in one of the programs listed in R746-341-3.A or documentation of income eligibility as listed in R746-341-3.B of an intent to discontinue the customer's eligibility for the Lifeline service discount. The letter will explain the appeals process as set forth in Subsection R746-341-4.D.

a. The notice must allow the customer at least 60 days to demonstrate continued eligibility consistent with this rule.

5. If the customer fails to file an appeal within the prescribed appeal period, or if the customer does not prevail on appeal, the responsible agency will notify each ETC, using a format designated by the responsible agency, that the customer is no longer eligible for the Lifeline service rate.

[B.]Lifeline telephone customers who do not participate in any of the programs listed in Section 3, but who are qualified to participate in those programs, shall be certified by the appropriate state agency as being eligible for any of the qualifying programs, and shall thereafter be included on a Lifeline Only verification list maintained by the agency. Lifeline customers on Lifeline Only lists will be required to annually recertify with the appropriate state agency to verify their continued eligibility for Lifeline telephone service.

C. Eligible telecommunications carriers shall notify any Lifeline telephone service customer who fails to appear on the appropriate state agency's listing of public assistance program participants, or Lifeline Only list, that the customer is now ineligible and is no longer entitled to the Lifeline service rate.

D. A subscriber denied Lifeline telephone service under Subsection C above shall be entitled to resubscribe to Lifeline service only after the eligible telecommunications carrier providing telephone service to that subscriber has received confirmation from the appropriate state agency that the discontinued Lifeline telephone services subscriber is currently a participant in a state public assistance program or is qualified to participate in those programs,

~~or would be able to participate in those programs but for any time limitation related to participation in those programs.]D. Termination Notices and Dispute Resolution --~~

~~1. Should the ETC or the responsible agency have a reasonable basis to believe that a Lifeline telephone service customer no longer qualifies for Lifeline service in accordance with this rule, the ETC or the responsible agency shall notify the customer of its intent to discontinue the customer's eligibility and the basis for that decision. The notice shall be in writing and shall be delivered to the customer in a mailing separate from the customer's monthly bill.~~

~~a. The notice must allow the customer at least 60 days to demonstrate continued eligibility consistent with this rule. The customer's participation in Lifeline may not be discontinued during the 60-day period.~~

~~b. The notice shall also alert the customer of the option to continue local telephone service after termination of Lifeline benefits at the non-discounted rate.~~

~~2. If the customer fails to provide proof of continued eligibility as required, or if the ETC or the responsible agency does not accept the customer's proof of continued eligibility, the ETC or the responsible agency shall notify the customer in writing of its determination and intent to discontinue the customer's participation in the program. The notice shall also include instructions for filing an appeal of the determination.~~

~~a. The customer may appeal this decision within ten days of the notification by filing a written notice of appeal with the agency assigned responsibility for administering the Lifeline program.~~

~~b. Lifeline benefits will continue pending an appeal of a non-eligibility decision.~~

~~3. The appeal shall be addressed consistent in time and manner with the dispute resolution procedures set forth in R746-240-7 and 8 that provide for review and resolution of disputes between telecommunications carriers and consumers.~~

~~E. False Certification Penalties -- A Lifeline telephone service customer who does not qualify and has falsely self-certified and participated in the Lifeline program will be responsible to pay the difference between the Lifeline service rate and the otherwise applicable service rate for the length of time the customer subscribed to Lifeline telephone service for which the customer was not eligible.~~

#### **R746-341-5. Lifeline Telephone Service Features.**

A. ~~Discounts -- Lifeline telephone service provided by [eligible telecommunications carriers]ETCs shall consist of dial tone line, usage charges or their equivalent, and any Extended Area Service (EAS) charges, less a discount [equal to the end user common line charge]of \$3.50 and any other matching funds established by the Federal Communication Commission.~~

B. ~~Deposits -- When customer security deposits are otherwise required, they will be waived for Lifeline telephone service [subscribers]customers if the [subscriber]customer voluntarily elects to receive toll blocking.~~

C. ~~Link-Up America Plan Participation -- Companies providing Lifeline service shall apply for the Link-Up America Plan provided by the Federal Communications Commission.~~

D. ~~Link-Up America Plan Discounts -- In addition to the Link-Up America reduction, Lifeline qualifying customers are entitled to a 50 percent reduction of the remaining connection charges.~~

E. ~~Nonrecurring Charge Waiver -- Lifeline telephone service [subscribers]customers will receive a waiver of the nonrecurring service charge for changing the type of local exchange usage service~~

to Lifeline service, or changing from flat rate service to message rate service, or vice versa, but only ~~[one]one~~ such waiver shall be allowed during any 12-month period.

F. ~~Disconnection -- Lifeline service shall not be disconnected for nonpayment of toll service.~~

G. ~~Restrictions -- Lifeline telephone service will be subject to the following restrictions:~~

1. Lifeline telephone service will only be provided to the applicant's principal residence.

2. A Lifeline telephone service ~~[subscriber]customer~~ will only receive a Lifeline discount on one single residential access line.

H. ~~Other Services -- A Lifeline telephone service customer will not be prohibited from purchasing vertical services.~~

#### **R746-341-6. Link-up America Plan Telephone Service.**

A. ~~Link-Up -- An ETC shall provide the initial installation for telephone service to any applicant who qualifies for Lifeline service in accordance with the eligibility criteria listed under R746-341-3.~~

1. ~~Link-up telephone service provided by ETCs is a federal program that provides a 50 percent discount of the initial hook-up fee, up to \$30.00, for eligible customers.~~

B. ~~Enhanced Link-UP -- Customers who live on tribal lands and qualify for the state Lifeline service rate under R746-341-3, are eligible to receive a larger federal discount. Those federal discounts are not within the scope of, nor governed by, these rules.~~

#### **R746-341-[6]7. Reporting Requirements.**

A. ~~[Eligible telecommunications carriers]Reporting Requirements -- ETCs shall submit, to the Division of Public Utilities, a semi-annual report, by June 30 and December 31, of each year, containing a description of the [eligible telecommunication carriers]ETC's Lifeline program. The reports shall also contain monthly information on:~~

1. the forgone revenue resulting from the discounts provided to Lifeline customers;

2. the amounts of administrative, advertising, voucher and other program expenses;

3. interest accrual amounts on Lifeline and Link up funds; and

4. the number of Lifeline telephone service ~~[subscribers]customers~~ by exchange area; and

5. a detailed report of outreach efforts.

#### **R746-341-[7]8. Funding of Lifeline.**

A. ~~Cost Recovery -- The t[F]otal cost of providing Lifeline telephone service, including the administrative costs of the [eligible telecommunications carriers]ETCs and the costs incurred by the responsible[ of the appropriate state] agency, shall be recovered and funded as provided in 54-8b-15.~~

#### **R746-341-[8]9. Collection and disbursement of Lifeline Funds.**

A. ~~ETC Payment -- Within 30 days after review and audit of an [eligible telecommunications carrier's]ETC's semi-annual report, the Public Service Commission shall disburse an amount equal to the [eligible telecommunications carrier's]ETC's semi-annual Lifeline program expenses and Lifeline discounts granted.~~

#### **R746-341-10. Outreach Guidelines.**

A. ~~Reporting and Coordination -- ETC's shall report their outreach efforts to the Public Service Commission, as well as coordinate with agencies that administer any of the relevant~~

government assistance programs to maximize public awareness and participation in the Lifeline Program.

**KEY: telephone, telecommunications, rules and procedures, lifeline rates**

**[~~March 1, 2004~~2005**

**Notice of Continuation November 15, 2000**

**54-4-1**

**54-4-4**

▼ ————— ▼

**School and Institutional Trust Lands,  
Administration  
R850-21  
Oil, Gas and Hydrocarbon Resources**

**NOTICE OF PROPOSED RULE**

(Amendment)

DAR FILE NO.: 27813

FILED: 04/14/2005, 11:21

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The amendments being made to this rule will correct three references that were unintentionally carried over from the previously repealed rule, R850-20, at the time this new rule was written.

**SUMMARY OF THE RULE OR CHANGE:** The amendments to this rule delete a reference to a form dated prior to February 1, 2005, which is no longer applicable to the oil, gas and hydrocarbon lease process; and a provision for the end-of-year recoupment of rentals if certain criteria have been met. The amendments also change a reference to the amount of minimum royalty to be paid from "not less than twice the annual minimum royalty," to "not less than the current annual minimum royalty."

**STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Subsection 53C-2-20(1)(a)(ii), and Title 53C, Chapter 2

**ANTICIPATED COST OR SAVINGS TO:**

❖ **THE STATE BUDGET:** There is a potential savings to the state due to the elimination of the accounting procedures required by the monthly submission of royalty reports and payments by the lessees and operators. Any loss from the reduction in annual minimum royalty paid on shut-in gas wells will be offset by other provisions outlined in the new oil, gas, and hydrocarbon rules that became effective on April 1, 2005.

❖ **LOCAL GOVERNMENTS:** Local government is not affected by these changes because they do not have any oversight responsibilities or receive any revenue from oil and gas leases. Also, because local government does not engage in producing oil and gas, they would never be in the position of being a lessee or operator of a lease.

❖ **OTHER PERSONS:** There is a potential savings to other persons because of the elimination of the requirement to file monthly royalty reports and payments. This will reduce the

amount of time spent in accounting procedures from a monthly basis to a once-a-year basis. The reduction in the annual minimum royalty that must be paid on shut-in gas wells could provide some savings to other persons, or it could be offset by provisions that were placed into rule effective April 1, 2005.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** Compliance costs for affected persons as a result of these changes should be very minimal, if any. They will experience a reduction in costs related to the amount of time required to file a year-end report instead of a monthly report. There is also the potential that the amount they are required to pay on the anniversary date of the lease could be less than what they might have previously paid in rentals. There would also be a reduction in the amount of annual minimum royalties that would be paid in connection with a shut-in gas well.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** The provision being removed from the definition in Subsection R850-21-175(21) is provided for in Subsection R850-21-500(1)(f), and therefore, will likely have no impact on businesses. The amendment in Subsection R850-21-500(6)(a) will likely provide a savings to businesses since the minimum royalty floor is being lowered from twice the annual minimum royalty to the current minimum royalty. Kevin S. Carter, Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

SCHOOL AND INSTITUTIONAL TRUST LANDS  
ADMINISTRATION  
Room 500  
675 E 500 S  
SALT LAKE CITY UT 84102-2818, or  
at the Division of Administrative Rules.

**DIRECT QUESTIONS REGARDING THIS RULE TO:**

LaVonne Garrison at the above address, by phone at 801-538-5100, by FAX at 801-355-0922, or by Internet E-mail at [lavonnegarrison@utah.gov](mailto:lavonnegarrison@utah.gov)

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 05/31/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/01/2005

AUTHORIZED BY: Kevin S. Carter, Director

**R850. School and Institutional Trust Lands, Administration.**

**R850-21. Oil, Gas and Hydrocarbon Resources.**

**R850-21-175. Definitions.**

The following words and terms, when used in Section R850-21 shall have the following meanings, unless otherwise indicated:

1. Act: Utah Code 53C-1 et seq.
2. Agency: School and Institutional Trust Lands Administration or its predecessor agency.

3. **Anniversary Date:** the same day and month in succeeding years as the effective date of the lease.

4. **Assignment(s):** a conveyance of all or a portion of the lessee's record title, non-working interest, or working interest in a lease.

(a) **Certification of Net Revenue Interest:** the certification by oath of an assignor to the agency that the total net working revenue interest (NRI) in the lease which the assignment affects has not been reduced to less than 80 per cent of 100 per cent NRI. Certification shall only be required for leases issued after April 1, 2005.

(b) **Mass Assignment:** an assignment that affects more than one lease, including assignments which affect record title, working or non-working interests.

(c) **Non-Working Interest Assignment:** an assignment of interest in production from a lease other than the agency's royalty, the record title, or the working interest including but not limited to overriding royalties, production payments, net profits interests, and carried interests assignments but excluding liens and security interests.

(d) **Record Title Assignment:** an assignment of the lessee's interest in a lease which includes the obligation to pay rent, the rights to assign/or relinquish the lease, and the ultimate responsibility to the agency for obligations under the lease.

(e) **Working Interest Assignment:** a transfer of a non-record title interest in a lease, including but not limited to wellbore assignments, but excepting overriding royalty, oil payment, net-profit, or carried interests or other non-working interests.

5. **Board of Trustees:** the School and Institutional Trust Lands Board of Trustees created under Section 53C-1-202.

6. **Bonus Bid:** a payment reflecting an amount to be paid by an applicant in addition to the delay rentals and royalties set forth in a lease in an application as consideration for the issuance of such lease.

7. **Committed Lands:** a consolidation of all or a portion of lands subject to a lease approved by the director for pooling or unitization which form a logical unit for exploration, development or drilling operations.

8. **Delay Rental:** a sum of money as prescribed in the lease payable to the agency for the privilege of deferring the commencement of drilling operations or the commencement of production during the term of the lease.

9. **Designated Operator:** the person or entity that has been granted authority by the record title interest owner(s) in a lease and has been approved by the agency to conduct operations on the lease or a portion thereof.

10. **Director:** the person designated within the agency who manages the agency in fulfillment of its purposes as set forth in the Act.

11. **Effective Date:** unless otherwise defined in the lease, the effective date shall be the first day of the month following the date a lease is executed by the agency. An amended, extended or segregated lease will retain the effective date of the original lease.

12. **Gas Well:** a well capable of producing volumes exceeding 100,000 cubic feet of gas to each barrel of oil from the same producing horizon where both oil and gas are produced; or, a well producing gas only from a formation or producing horizon.

13. **Lease:** an oil, gas and hydrocarbon lease covering the commodities defined in R850-21-200(1) issued by the agency.

14. **Lease Year:** the twelve-month period commencing at 12:01 a.m. on the month and day of the effective date of the lease and ending on the last day of the twelfth month at 12 midnight.

15. **Leasing Unit:** a parcel of trust land lying within one or more sections that is offered for lease as an indivisible unit through a competitive oil and gas lease application process which would constitute one lease when issued.

16. **Lessee:** a person or entity holding a record title interest in a lease.

17. **NGL:** natural gas liquids.

18. **Other Business Arrangement ("OBA"):** an agreement entered into between the agency and a person or entity consistent with the purposes of the Act and approved by the Board of Trustees. By way of example, but not of limitation, OBAs may be for farmout agreements or joint venture agreements. An agreement for an OBA may be initiated by the agency or by a proponent of an agreement by filing a proposal for an OBA with the agency.

19. **Paying Quantities:** the gross income from the leased substances produced and sold (after deduction for taxes and lessor's royalty) that exceeds the cost of operation.

20. **Qualified Interest Owner:** a person or legal entity who meets the requirements of R850-3-200 of these rules.

21. **Rental:** the amount due and payable on the anniversary of the effective date of a lease [~~in a form dated prior to February 1, 2005~~] to maintain the lease in full force and effect for the following lease year. [~~This payment may be recouped at the end of a lease year for which production in paying quantities was obtained and payment of royalties in excess of minimum royalties was made.~~]

22. **Shut-in Gas Well:** a gas well which is physically capable of producing gas in paying quantities, but, for which the producible gas cannot be marketed at a reasonable price due to existing marketing or transportation conditions.

23. **Shut-In or Minimum Royalty:** the amount of money accruing and payable to the agency in lieu of rental or delay rental beginning from the first anniversary date of the lease on or after the initial discovery of oil or gas in paying quantities on the leasehold or the allocation of production to the leasehold. Minimum royalty accrues beginning from the anniversary date of a lease but is not payable until the end of the year. Actual royalty accruing from a lease or allocated to a unitized or communitized lease during the lease year is credited against the minimum royalty obligation for the lease year. If the royalty from production does not equal or exceed the required minimum royalty for the lease year, the lessee is obligated to pay the difference.

24. **Surveyed Lot:** an irregular part of a section identified by cadastral survey and maintained in the official records of the agency.

25. **Trust Lands:** those lands and mineral resources granted by the United States in the Utah Enabling Act to the State of Utah in trust, and other lands and mineral resources acquired by the trust, which must be managed for the benefit of the state's public education system or the institutions designated as beneficiaries.

26. **UDOGM:** the Division of Oil, Gas and Mining of the Utah State Department of Natural Resources.

27. Except as specifically defined above, the definitions set forth at R850-1-200 shall also be applicable.

#### **R850-21-500. Lease Provisions.**

The following provisions, terms and conditions shall apply to all leases granted by the agency:

1. **Delay Rentals and Rental Credits.**

(a) The delay rental rate shall not be for less than \$1 per acre, or fractional acre thereof, per year at the time the lease is offered.

(b) The minimum annual delay rental on any lease, regardless of the amount of acreage, shall in no case be less than \$40.

(c) Delay rental payments shall be paid each year on or before the lease anniversary date, unless otherwise stated in the lease.

(d) Any overpayment of delay rental occurring from the lease applicant's incorrect calculation of acreage of lands described in the lease may, at the option of the agency, be credited toward the applicant's rental account.

(e) The agency may accept lease payments made by any party provided, however, that the acceptance of such payment(s) shall not be deemed to be recognition by the agency of any interest of the payee in the lease. Ultimate responsibility for such payments remains with the record title interest owner.

(f) Rental credits, if any, shall be governed by the terms of the lease which provide for such credits.

2. Royalty Provisions: the production royalty rate shall not be less than 12.5% of gross proceeds minus costs of transportation off lease, at the time the lease is offered.

3. Primary Lease Term: no lease shall establish a primary term in excess of ten (10) years.

4. Continuance of a Lease after Expiration of the Primary Term.

(a) A lease shall be continued after the primary term has expired so long as:

(i) the leased substance is being produced in paying quantities from the leased premises or from other lands pooled, communitized or unitized with committed lands; or

(ii) the agency determines that the lessee or designated operator:

(A) is engaged in diligent operations which are determined by the director to be reasonably calculated to advance or restore production of the leased substance from the leased premises or from other lands pooled, communitized, or unitized with committed lands; and

(B) pays the annual minimum royalty set forth in the lease.

(b) Diligent operations may include cessation of operations not to exceed 90 days in duration or a cumulative period of 180 days in one calendar year.

5. Pooling, Communitization or Unitization of Leases.

(a) Lessees, upon prior written authorization of the director, may commit leased trust lands or portions of such lands to unit, cooperative or other plans of development with other lands.

(b) The director may, with the consent of the lessee, modify any term of a lease for lands that are committed to a unit, cooperative, or other plan of development.

(c) Production allocated to leased trust lands under the terms of a unit, cooperative, or other plan of development shall be considered produced from the leased lands whether or not the point of production is located on the leased trust lands.

(d) The term of all leases included in any cooperative or unit plan of oil and gas development or operation in which the agency has joined, or shall hereafter join, shall be extended automatically for the term of the unit or cooperative agreement. Rentals on leases so extended shall be at the rate specified in the lease, subject to change in rates at the discretion of the director or as may be prescribed in the terms of the lease.

(e) Any lease eliminated from any cooperative or unit plan of development or operation, or any lease which is in effect at the termination of a cooperative or unit plan of development or operation, unless relinquished, shall continue in effect for the fixed term of the lease, or for two (2) years after its elimination from the plan or agreement or the termination thereof, whichever is longer, and so long thereafter as the leased substances are produced in

paying quantities. Rentals under such leases shall continue at the rate specified in the lease.

6. Shut-in Gas Wells Producing Gas in Paying Quantities: to qualify as a shut-in gas well capable of producing gas in paying quantities:

(a) a minimum royalty shall be paid in an amount not less than ~~twice~~ the current annual minimum royalty provided for in the lease;

(b) the terms of the lease shall provide the basis upon which the minimum royalty is to be paid by the lessee for a shut-in gas well; and

(c) the director may, at any time, require written justification from the lessee that a well qualifies as a shut-in gas well. A shut-in gas well will not extend a lease more than five years beyond the original primary term of the lease.

7. Oil/Condensate/Gas/NGL Reporting and Records Retention.

(a) Notwithstanding the terms of the lease agreements, gas and NGL report payments are required to be received by the agency on or before the last day of the second month succeeding the month of production.

(b) The extension of payment and reporting time for gas and NGL's does not alter the payment and reporting time for oil and condensate royalty which must be received by the agency on or before the last day of the calendar month succeeding the month of production as currently provided in the lease form.

(c) A lessee, operator, or other person directly involved in developing, producing or disposing of oil or gas under a lease through the point of first sale or point of royalty computation, whichever is later, shall establish and maintain records of such activities and make any reports requested by the director to implement or require compliance with these rules. Upon request by the director or the director's designee, appropriate reports, records or other information shall be made available for inspection and duplication.

(d) Records of production, transportation and sales shall be maintained for six (6) years after the records are generated unless the director notifies the record holder that an audit has been initiated or an investigation begun, involving such records. When so notified, records shall be maintained until the director releases the record holder of the obligation to maintain such records.

8. When the agency approves the amendment of an existing lease by substituting a new lease form for the existing form(s), the amended lease will retain the effective date of the original lease.

9. Other lease provisions.

The agency may require, in addition to the lease provisions required by these rules, any other reasonable provisions to be included in the lease as it deems necessary, but which does not substantially impair the lessees' rights under the lease.

**KEY: oil, gas and hydrocarbons, administrative procedures, lease provisions, operations**

**~~April 1, 2005~~ June 1, 2005**

**53C-1-302(1)(a)(ii)**

**53C-2 et seq.**



**School and Institutional Trust Lands,  
Administration  
R850-24-200  
Insurance Requirements**

**NOTICE OF PROPOSED RULE**

(Amendment)  
DAR FILE NO.: 27814  
FILED: 04/14/2005, 11:22

**RULE ANALYSIS**

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this amendment is to include coal and geothermal steam to the types of resources requiring insurance under the general provisions.

SUMMARY OF THE RULE OR CHANGE: The amendment to this rule expands the insurance requirements under the general provisions to cover all mineral and material resources that may be permitted or leased rather than just for "sand, gravel and cinders" as stated in Section R850-24-200.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsections 53C-1-302(1)(a)(ii), 53C-2-201(1)(a), and 53C-2-402(1)

ANTICIPATED COST OR SAVINGS TO:

- ❖ THE STATE BUDGET: It is not anticipated that there will be any cost or savings to the state as a result of this rule amendment. Insurance and bonding requirements have always been in place for all mineral and material resources and this amendment simply clarifies the resources covered under the general provisions.
- ❖ LOCAL GOVERNMENTS: There are no anticipated costs or savings to local government as this amendment does not change any requirements, but simply clarifies the resources the provision pertains to.
- ❖ OTHER PERSONS: There are no anticipated costs or savings to other persons as a result of this amendment. Insurance and bonding requirements have always been in place and this just clarifies the resources this provision applies to.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no additional compliance costs for affected persons. Insurance and bonding have always been requirements for holding a lease and this amendment will not add any additional costs for holding a lease.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Since businesses subject to this rule have already anticipated that the application of the rule would be consistent with the proposed modification, we do not expect that they will experience any additional costs. Kevin S. Carter, Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

SCHOOL AND INSTITUTIONAL TRUST LANDS  
ADMINISTRATION  
Room 500  
675 E 500 S  
SALT LAKE CITY UT 84102-2818, or  
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Thomas B. Faddies at the above address, by phone at 801-538-5150, by FAX at 801-355-0922, or by Internet E-mail at tomfaddies@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 05/31/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/01/2005

AUTHORIZED BY: Kevin S. Carter, Director

**R850. School and Institutional Trust Lands, Administration.  
R850-24. General Provisions: Mineral and Material Resources,  
Mineral Leases and Material Permits.  
R850-24-200. Insurance Requirements.**

Prior to the issuance of a permit [~~for sand, gravel and cinders, or lease for mineral and material resources~~, the applicant may be required to obtain insurance of a type and in an amount acceptable to the agency. Proof of insurance shall be in the form of a certificate of insurance containing sufficient information to satisfy the agency that insurance provisions of the permit have been complied with.

1. Such insurance, if required, shall be placed with an insurer with a financial rating assigned by the Best Insurance Guide of A:X or higher, unless this requirement is waived in writing by the agency.
2. The agency shall retain the right to review the coverage, form, and amount of the insurance required at any time and to require the permittee to obtain insurance sufficient in coverage, form, and amount to provide adequate protection upon 30 days written notice.

**KEY: mineral leases, material permits, mineral resources, lease operations**

~~April 1, 2005~~ June 1, 2005

53C-1-302(1)(a)(ii)

53C-2-201(1)(a)

53C-2-402(1)

▼ ————— ▼  
**School and Institutional Trust Lands,  
Administration  
R850-50  
Range Management**

**NOTICE OF PROPOSED RULE**

(Amendment)

DAR FILE NO.: 27811

FILED: 04/14/2005, 11:19

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The agency believes that these amendments will facilitate a more positive outcome for industry and the respective trust beneficiaries by enhancing more equitable returns to the Trust and providing incentives for permittees to improve stewardship practices.

**SUMMARY OF THE RULE OR CHANGE:** The change to Section R850-50-600 provides for the agency to assess 50% of the difference between the base grazing fee assessed the permittee by the agency and the fee received by the permittee for a sublease on their permit. The change to Section R850-50-1000 allows the agency to extend the period of time for grazing permits beyond 15 years if substantial investments for range improvement projects are made by the permittee on the allotment.

**STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Subsections 53C-1-302(1)(a)(ii) and 53C-2-201(1)(a), and Section 53C-5-102

**ANTICIPATED COST OR SAVINGS TO:**

❖ **THE STATE BUDGET:** It is anticipated that there will be a savings to the State through the assessment of 50% of the difference between the grazing fee charged by the agency to the permittee and the amount the permittee receives from their sublessee under a sublease. The actual amount the State receives will vary according to the amount our permittee charges their sublessee. The extension of a permit beyond the term of 15 years will not cost the agency additional money, but the improvements required to extend the permit could potentially improve the land so that it would support a greater number of Animal Unit Month (AUMs) and thus increase the amount the State would receive from the grazing permit.

❖ **LOCAL GOVERNMENTS:** Local government will not be affected by these changes since they do not regulate grazing activities or receive any revenue from grazing. Because local government doesn't participate in grazing operations, they would never become a permittee, thus subject to the grazing rules.

❖ **OTHER PERSONS:** It is anticipated that there will be an increased cost to the permittee because of the agency's assessment of 50% of the difference between what the permittee would pay us per AUM for the grazing permit and what he would in turn receive from his sublessee. Previously, the agency assessed a flat fee for approving a sublease. The permittee could potentially receive less of the sublease fees or the sublessee could pay higher sublease fees to compensate for the amount that would have to be paid to the agency for the sublease. The extension of the permit period beyond 15 years could potentially save the permittee the application fee required to apply for the permit again, in addition to the value added to his operation due to the improvements made to the range.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** There are no compliance costs per se, however, the agency's approval of a sublease and the subsequent assessment of the 50% difference in the amount received by the agency and the amount the permittee receives for the sublease will most likely lower the amount the permittee will be able to keep from the sublease. The costs involved to have the permit extended beyond the 15 year term would be for the required improvements to the range. However, those improvements could potentially increase the value of the range for the permittee.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** Two changes are addressed in this rule modification. The first will allow the Trust Lands Administration to share in the revenues currently received solely by our grazing permittees. The current practice allows grazing permittees to further sublease forage resources on trust lands for \$1/AUM, regardless of the fee that the permittee charges to the sublessee. The rule change will require the permittee to share this subleasing fee on a 50/50 ratio with Trust Lands Administration. We anticipate that this will continue to encourage the permittee to negotiate for the best price possible while still allowing a fair market return to the Trust Lands Administration for its forage resources. The second modification should not have any financial impacts on the permittee except positive benefits associated with retaining the right to maintain a permit beyond the normal expiration date if the permittee has practiced good stewardship measures and created additional forage values through range improvements. Kevin S. Carter, Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

SCHOOL AND INSTITUTIONAL TRUST LANDS  
ADMINISTRATION  
Room 500  
675 E 500 S  
SALT LAKE CITY UT 84102-2818, or  
at the Division of Administrative Rules.

**DIRECT QUESTIONS REGARDING THIS RULE TO:**

Kim S. Christy at the above address, by phone at 801-538-5183, by FAX at 801-355-0922, or by Internet E-mail at kimchristy@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 05/31/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/01/2005

AUTHORIZED BY: Kevin S. Carter, Director



**R850. School and Institutional Trust Lands, Administration.****R850-50. Range Management.****R850-50-600. Grazing Permit Terms.**

No grazing permit shall be issued for a period of time exceeding 15 years. The agency may at its discretion, however, extend the period of time beyond 15 years if it determines that substantial range improvements approved pursuant to R850-50-1100 warrant such an extension. Every grazing permit executed under these rules shall include the following terms and conditions:

1. Terms, conditions, and provisions that shall protect the interests of the trust beneficiaries with reference to securing the payment to the agency of all amounts owed.

2. Terms, conditions, and provisions that shall protect the range resources from improper and unauthorized grazing uses.

3. Other terms, conditions, and provisions that may be deemed necessary by the agency or board in effecting the purpose of these rules and not inconsistent with any of its provisions.

4. The agency may cancel or suspend grazing permits, in whole or in part, after 30 days notice by certified mail to the permittee for a violation of the terms of the permit, or of these rules, or upon the issuance of a lease or permit, the purpose of which the agency has determined to be a higher and better use, or disposal of the trust land. Failure to pay the required rental within the time prescribed shall automatically work a forfeiture and cancellation of the permits and all rights thereunder.

5. Locked gates on trust land without written approval are prohibited. If such approval is granted, keys shall be supplied to the agency and other appropriate parties requiring access to the area as approved by the agency, including those with fire and regulatory responsibilities.

6. Supplemental livestock feeding on trust grazing lease lands may be permitted subject to written authorization by the agency with the designation of a specific area, length of time, number and class of livestock, and subject to a determination that this shall not inflict long term damage upon the land. The agency may assess an additional fee for authorized supplemental feeding. Emergency supplemental feeding shall be allowed for ten days prior to notification.

**R850-50-1000. Assignment and Subleasing of Grazing Permits.**

1. Permittee shall not assign, partially assign, sublease, mortgage, pledge, or otherwise transfer, dispose or encumber any interest in the permit without the written consent of the agency. To do so shall automatically, and without notice, work a forfeiture and cancellation of the permit. ~~Consent for subleasing shall only be given if the sublease is compatible with the best interests of the beneficiaries and long-term management of the land and will not unreasonably conflict with the interests of other permittees in the area.~~

~~2. The agency may assess an additional fee based upon either the fair market value of the permit or a flat fee per AUM for its approval of any assignment, partial assignment, or sublease which shall be based on the following criteria:~~

2. The agency shall assess a fee equal to 50% of the difference between the base grazing fee per AUM assessed by the agency and the AUM fee received by the permittee through the sublease multiplied by the number of AUMs subleased, or a \$1.00 per AUM minimum fee, whichever is greater, for its approval of any sublease. The approval of any sublease shall be subject to the following restrictions:

(a) Consent for subleasing shall only be given if the sublease is compatible with the best interests of the beneficiaries and long-term management of the land and will not unreasonably conflict with the interests of other permittees in the area.

~~(b)~~ (b) Subleases in-lieu of a collateral assignment shall not be approved.

~~(b) An approved sublease shall be valid only for the remaining term of the permit.~~ (c) Any subleases shall not be effective for more than five years.

3. The agency may assess an additional fee based upon either the fair market value of the permit or a flat fee per AUM for its approval of any assignment or partial assignment.

~~3-4.~~ Mortgage agreements or collateral assignments are for the convenience of the permittee. The term of a mortgage agreement or collateral assignment shall not exceed the remaining term of the permit. If the grazing permit is renewed, the permittee may also renew the mortgage agreement or collateral assignment of the permit pursuant to these rules.

**KEY: administrative procedures, range management**

**[June 3, 2003] June 1, 2005**

**Notice of Continuation June 27, 2002**

**53C-1-302(1)(a)(ii)**

**53C-2-201(1)(a)**

**53C-5-102**



## Tax Commission, Auditing

### R865-91-21

## Return By Partnership Pursuant to Utah Code Ann. Section 59-10-507

### NOTICE OF PROPOSED RULE

(Amendment)

DAR FILE NO.: 27804

FILED: 04/05/2005, 16:57

### RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: Section 59-10-514, amended by S.B. 133 (2005), allows the Commission rulemaking authority to define what constitutes "filing a return with the Commission".

This change will ease the filing requirements of some partnerships. (DAR NOTE: S.B. 133 is found at UT L 2005 Ch 267, and was effective 05/02/2005.)

SUMMARY OF THE RULE OR CHANGE: The proposed amendment provides that a partnership, all of whose members are resident individuals, satisfies the requirement to file a partnership return with the Commission by maintaining records of each partner's share of distributive items, and making those records available for audit.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 59-10-507 and 59-10-514

## ANTICIPATED COST OR SAVINGS TO:

- ❖ THE STATE BUDGET: None--Any costs would have been considered in S.B. 133 (2005).
- ❖ LOCAL GOVERNMENTS: None--Any costs would have been considered in S.B. 133 (2005).
- ❖ OTHER PERSONS: None--Any costs would have been considered in S.B. 133 (2005).

COMPLIANCE COSTS FOR AFFECTED PERSONS: None--In the instance specified in the rule, a partnership is not required to file a return with the Commission, but simply retain the required records for audit purposes.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There will be no fiscal impact on businesses, however, some partnerships will no longer be required to file a return, however they must retain the records. Pam Hendrickson, Commission Chair

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

TAX COMMISSION  
AUDITING  
210 N 1950 W  
SALT LAKE CITY UT 84134, or  
at the Division of Administrative Rules.

## DIRECT QUESTIONS REGARDING THIS RULE TO:

Cheryl Lee at the above address, by phone at 801-297-3900, by FAX at 801-297-3919, or by Internet E-mail at clee@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 05/31/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/01/2005

AUTHORIZED BY: Pam Hendrickson, Commissioner

**R865. Tax Commission, Auditing.****R865-9I. Income Tax.****R865-9I-21. Return By Partnership Pursuant to Utah Code Ann.****[Section] Sections 59-10-507 and 59-10-514.**

[A-](1) Every partnership having a [resident]nonresident partner [or having any]and income derived from sources in this state [(determined in accordance with Utah Code Ann. Section 59-10-303 and Rule R865-9I-13)] shall file a return in accordance with forms and instructions provided by the Tax Commission.

[B-](2) If the partnership has income derived from or connected with sources both inside and outside Utah and if any partner was not a resident of Utah, the portion derived from or connected with sources in this state must be determined and shown.

[+](a) [They]The Utah portion must be determined and shown for each item of the partnership's, and each nonresident partner's, distributive shares of income, credits, deductions, etc., shown on Schedules K and K-1 of the federal return.

[2-](b) The Utah portion may be shown;

(i) alongside the total for each item on the federal schedules K and K-1[-]; or

(ii) [they may be shown]on an attachment to the Utah return.

(3) A partnership, all of whose partners are resident individuals, shall satisfy the requirement to file a return with the commission by:

(a) maintaining records that show each partner's share of income, losses, credits, and other distributive items; and

(b) making those records available for audit.

**KEY: historic preservation, income tax, tax returns, enterprise zones**

[June 29, 2004]2005

Notice of Continuation April 22, 2002

59-10-507

59-10-514



**Tax Commission, Auditing**  
**R865-19S-20**  
**Basis for Reporting Tax Pursuant to**  
**Utah Code Ann. Section 59-12-107**

**NOTICE OF PROPOSED RULE**

(Amendment)

DAR FILE NO.: 27819

FILED: 04/15/2005, 13:12

**RULE ANALYSIS**

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: Section 59-12-107, amended by S.B. 147 (2003), and Section 59-12-104.3, amended by S.B. 127 (2005), indicate when a taxpayer may obtain a sales tax credit or refund for bad debt. These statutory provisions cover all issues relating to bad debt, so no rule language is needed. (DAR NOTE: S.B. 147 is found at UT L 2003 Ch 312, and was effective 07/01/2004. S.B. 127 is found at UT L 2005 Ch 158, and will be effective 07/01/2005.)

SUMMARY OF THE RULE OR CHANGE: The proposed amendment deletes provisions relating to sales tax credit for repossessions since those provisions were codified by S.B. 127 (2005).

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 59-12-107

## ANTICIPATED COST OR SAVINGS TO:

- ❖ THE STATE BUDGET: None--Any fiscal impacts were taken into account by S.B. 147 (2003) and S.B. 127 (2005).
- ❖ LOCAL GOVERNMENTS: None--Any fiscal impacts were taken into account by S.B. 147 (2003) and S.B. 127 (2005).
- ❖ OTHER PERSONS: None--Any fiscal impacts were taken into account by S.B. 147 (2003) and S.B. 127 (2005).

COMPLIANCE COSTS FOR AFFECTED PERSONS: None--Automobile dealers continue to be entitled to a credit or refund for a bad debt on repossessed vehicles.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Auto dealers will continue to take a bad debt sales tax credit for vehicles they repossess. Pam Hendrickson, Commission Chair

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

TAX COMMISSION  
AUDITING  
210 N 1950 W  
SALT LAKE CITY UT 84134, or  
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Sheri McFall at the above address, by phone at 801-297-3901, by FAX at 801-297-3919, or by Internet E-mail at sherimcfall@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 06/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/02/2005

AUTHORIZED BY: Pam Hendrickson, Commissioner

**R865. Tax Commission, Auditing.**

**R865-19S. Sales and Use Tax.**

**R865-19S-20. Basis for Reporting Tax Pursuant to Utah Code Ann. Section 59-12-107.**

A. "Total sales" means the total amount of all cash, credit, installment, and conditional sales made during the period covered by the return.

B. Amounts shown on returns must include the total sales made during the period of the returns, and the tax must be reported and paid upon that basis.

C. ~~Justified adjustments~~ Adjustments may be made and credit allowed for cash discounts, returned goods, ~~and bad debts~~ ~~and repossessions~~ that result from sales upon which the tax has been reported and paid in full by ~~retailers~~ a seller to the Tax Commission.

1. Adjustments and credits will be allowed only if the ~~retailer~~ seller has not been reimbursed ~~himself~~ in the full amount of the tax except as noted in C.6.a) and can establish that fact by records, receipts or other means.

2. In no case shall the credit be greater than the sales tax on that portion of the purchase price remaining unpaid at the time the goods are returned, the account is charged off, ~~or the repossession occurs~~.

3. Any refund or credit given to the purchaser must include the related sales tax.

~~4. Sales tax credits for bad debts are allowable only on accounts determined to be worthless and actually charged off for income tax purposes. Recoveries made on bad debts and repossessions for which credit has been claimed must be reported and the tax paid.~~

~~5. Sales tax credit for repossessions is allowable on the basis of the original amount subject to tax, less down payment. This amount is multiplied by the ratio of the number of monthly payments not made, divided by the total number of monthly payments required by the contract.~~

~~a) For example: the credit allowed on a taxable \$30,000 car sale with a \$5,000 down payment financed on a 60 month contract and repossessed after 20 full payments were made would be \$16,667 as computed and shown below. The number of unpaid full payments is determined by dividing the total received on the contract by the monthly payment amount.~~

TABLE

<del>Example:</del>	
<del>(1) Original amount subject to tax</del>	<del>\$30,000</del>
<del>(2) Down payment</del>	<del>(5,000)</del>
<del>(3) Balance of taxable base financed</del>	<del>25,000</del>
<del>(4) Number of full payments unpaid at the time of repossession</del>	<del>40</del>
<del>(5) Total contract period (no. of months)</del>	<del>60</del>

~~Line 4 divided by line 5 times taxable base financed equals repossession credit~~

~~(40/60) x \$25,000 = \$16,667~~

~~b) In cases where a contract assignment creates a partial (part of the loan amount) recourse obligation to the seller, any repossession credit must be calculated in the same manner as shown above.~~

~~c) The credit for repossession shall be reported on the dealer's or vendor's sales tax return with an attached schedule showing computations and appropriate adjustments for any tax rate changes between the date of sale and the date of repossession.~~

~~6. Credit for tax on repossessions is allowed only to the selling dealer or vendor.~~

~~a) This does not preclude arrangements between the dealer or vendor and third party financial institutions wherein sales tax credits for repossessions by financial institutions may be taken by the dealer or vendor who will in turn reimburse the financial institution.~~

~~b) In the event the applicable vehicle dealer is no longer in business, and there are no outstanding delinquent taxes, the third party financial institution may apply directly to the Tax Commission for a refund of the tax in the amount that would have been credited to the dealer.~~

~~D. Adjustments in sales price, such as allowable discounts or rebates, cannot be anticipated. The tax must be D. Tax is based upon the original price unless adjustments were made prior to the close of the reporting period in which the tax upon the sale is due. If the price upon which the tax is computed and paid is subsequently adjusted, credit may be taken against the tax due on a subsequent return.~~

~~E. If a sales tax rate change takes place prior to the reporting period when the seller claims the credit [is claimed], the [tax credit must be determined and deducted rather than deducting the sales price adjustments] seller must adjust the taxable amount so that the amount of tax credited corresponds proportionally to the amount of tax originally collected.~~

~~F. Commissions to agents are not deductible under any conditions for purposes of tax computation.~~

**KEY: charities, tax exemptions, religious activities, sales tax [December 21, 2004]2005 Notice of Continuation April 5, 2002 59-12-107**



**Tax Commission, Auditing**  
**R865-19S-32**  
**Leases and Rentals Pursuant to Utah**  
**Code Ann. Section 59-12-103**

**NOTICE OF PROPOSED RULE**

(Amendment)  
 DAR FILE NO.: 27820  
 FILED: 04/15/2005, 13:29

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The conditional lease option is removed because S.B. 147 (2003) and S.B. 127 (2005) codify that option. (DAR NOTE: S.B. 147 is found at UT L 2003 Ch 312, and was effective 07/01/2004. S.B. 127 is found at UT L 2005 Ch 158, and will be effective 07/01/2005.)

**SUMMARY OF THE RULE OR CHANGE:** The proposed amendment removes language that allowed a lease to be treated as a conditional sale because that language has been codified by S.B. 147 (2003) and S.B. 127 (2005).

**STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Section 59-12-103

**ANTICIPATED COST OR SAVINGS TO:**

- ❖ **THE STATE BUDGET:** None--Any fiscal impacts were taken into account by S.B. 147 (2003) and S.B. 127 (2005).
- ❖ **LOCAL GOVERNMENTS:** None--Any fiscal impacts were taken into account by S.B. 147 (2003) and S.B. 127 (2005).
- ❖ **OTHER PERSONS:** None--Any fiscal impacts were taken into account by S.B. 147 (2003) and S.B. 127 (2005).

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** None--The codified language from the bills is substantially similar to the removed rule language.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** None--There are no changes in the treatment of leases with the removal of this language. Pam Hendrickson, Commission Chair

**THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:**

TAX COMMISSION  
 AUDITING  
 210 N 1950 W  
 SALT LAKE CITY UT 84134, or  
 at the Division of Administrative Rules.

**DIRECT QUESTIONS REGARDING THIS RULE TO:**

Sheri McFall at the above address, by phone at 801-297-3901, by FAX at 801-297-3919, or by Internet E-mail at sherimcfall@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 06/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/02/2005

AUTHORIZED BY: Pam Hendrickson, Commissioner

**R865. Tax Commission, Auditing.**

**R865-19S. Sales and Use Tax.**

**R865-19S-32. Leases and Rentals Pursuant to Utah Code Ann. Section 59-12-103.**

A. The lessor shall compute sales or use tax on all amounts received or charged in connection with a lease or rental.

B. When a lessee has the right to possession, operation, or use of tangible personal property, the tax applies to the amount paid pursuant to the lease agreement, regardless of the duration of the agreement. ~~The tax applies when situs of the property is in Utah or if the lessee takes possession in Utah. However, if the leased property is used exclusively outside Utah and an affidavit is furnished to the lessor to this effect, the tax does not apply. Examples of taxable leases include neon signs and custom made signs on the premises of the lessee, automobiles, and construction equipment leased for use in Utah.~~

C. Lessors of tangible personal property shall furnish an exemption certificate when purchasing tangible personal property subject to the sales or use tax on rental receipts. Costs of repairs and renovations to tangible personal property are exempt if paid for by the lessor since it is assumed that those costs are recovered by the lessor in his rental receipts.

D. Persons who furnish an operator with the rental equipment and charge for the use of the equipment and personnel are regarded as the consumers of the property leased or rented. An example of this type of rental is the furnishing of a crane and its operating personnel to a building erector. Sales or use tax then applies to the purchase of the equipment by the lessor rather than to the rental revenue.

E. Rentals to be applied on a future sale or purchase are subject to sales or use tax. ]

~~F. A lessee may, at its option, treat a conditional sale lease as either a sale or lease for sales or use tax purposes.~~

~~A conditional sale lease is a lease in which:~~

~~1. the consideration the lessee is to pay the lessor for the right to possession and use of the property is an obligation for the term of the lease not subject to termination by the lessee, and~~

~~2. the total consideration to be paid by the lessee is fixed at the time the lease is executed and cannot be modified by use, condition, or market value, and either:~~

~~a. the lessee is bound to become the owner of the property; or~~

~~b. the lessee has an option to become the owner of the property for no additional consideration or nominal additional consideration upon compliance with the lease agreement. Nominal consideration in this sense means ten percent or less of the original lease amount.~~

~~G. If the lessee treats a conditional sale lease as a sale, and if the lessor is also the vendor of the property, the sales price for sales tax purposes must be at least equal to the average sales price of similar property.~~

~~—H. If the lessee treats a conditional sale lease as a sale, the sales tax must be collected by the lessor on the full purchase price of the property at the time of the purchase.]~~

**KEY: charities, tax exemptions, religious activities, sales tax**  
~~[December 21, 2004]~~**2005**  
**Notice of Continuation April 5, 2002**  
**59-12-103**



**Tax Commission, Auditing**  
**R865-19S-51**  
**Fabrication and Installation Labor in**  
**Connection With Retail Sales of**  
**Tangible Personal Property Pursuant to**  
**Utah Code Ann. Section 59-12-103**

**NOTICE OF PROPOSED RULE**

(Amendment)  
DAR FILE NO.: 27822  
FILED: 04/15/2005, 13:46

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The section is amended as a result of recent legislation that amends the provisions for imposing tax on labor charges.

**SUMMARY OF THE RULE OR CHANGE:** The proposed amendment deletes language that is found in statute subsequent to amendments made by H.B. 51 (2002) and S.B. 127 (2005). (DAR NOTE: H.B. 51 is found at UT L 2002 Ch 117, and was effective 07/01/2002. S.B. 127 is found at UT L 2005 Ch 158, and will be effective 07/01/2005.)

**STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Section 59-12-103

**ANTICIPATED COST OR SAVINGS TO:**

- ❖ **THE STATE BUDGET:** The current statutory treatment for taxation of labor charges is a result of H.B. 51 (2002) and S.B. 127 (2005).
- ❖ **LOCAL GOVERNMENTS:** The current statutory treatment for taxation of labor charges is a result of H.B. 51 (2002) and S.B. 127 (2005).
- ❖ **OTHER PERSONS:** The current statutory treatment for taxation of labor charges is a result of H.B. 51 (2002) and S.B. 127 (2005).

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** Generally, if the underlying property is exempt from sales tax, charges for repairs to the property are tax exempt.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** None--The rule language removed is unnecessary because sales tax statutes indicate when repairs are taxable. Pam Hendrickson, Commission Chair

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

**TAX COMMISSION**  
**AUDITING**  
210 N 1950 W  
SALT LAKE CITY UT 84134, or  
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Sheri McFall at the above address, by phone at 801-297-3901, by FAX at 801-297-3919, or by Internet E-mail at sherimcfall@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 06/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/02/2005

AUTHORIZED BY: Pam Hendrickson, Commissioner

**R865. Tax Commission, Auditing.**

**R865-19S. Sales and Use Tax.**

**R865-19S-51. Fabrication ~~[and Installation]~~ Labor in Connection With Retail Sales of Tangible Personal Property Pursuant to Utah Code Ann. Section 59-12-103.**

A. The amount charged for fabrication ~~[or installation which]~~ that is part of the process of creating a finished article of tangible personal property must be included in the amount upon which tax is collected. This type of labor and service charge may not be deducted from the selling price used for taxation purposes even though billed separately to the consumer and regardless of whether the articles are commonly carried in stock or made up on special order.

B. Casting, forging, cutting, drilling, heat treating, surfacing, machining, constructing, and assembling are examples of steps in the process resulting in the creation or production of a finished article.

~~[C. Charges for labor to install personal property in connection with other personal property are taxable (see Rule R865-19S-78) whether material is furnished by seller or not.~~

~~—D. Labor to install tangible personal property to real property is exempt, whether the personal property becomes part of the realty or not. See Rule R865-19S-58, dealing with improvements to or construction of real property, to determine the applicable tax on personal property which becomes a part of real property.~~

~~—E.]C. [Tangible] Sale of tangible personal property [which] that is attached to real property, but remains personal property, is subject to sales tax on the retail selling price of the personal property, ~~[and installation charges are exempt if separately stated. If the retailer does not segregate the selling price and installation charges, the sales tax applies to the entire sales price, including installation charges] unless the tangible personal property attached to the real property is exempt from sales and use tax under Section 59-12-104.~~~~

~~[F.]D.~~ This rule primarily covers manufacturing and assembling labor. Other rules deal with other types of labor and should be referred to whenever necessary.

**KEY: charities, tax exemptions, religious activities, sales tax**  
**~~December 21, 2004~~2005**  
**Notice of Continuation April 5, 2002**  
**59-12-103**

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY  
 SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER  
 THAN 5:00 PM on 06/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/02/2005

AUTHORIZED BY: Pam Hendrickson, Commissioner

▼ ————— ▼

**Tax Commission, Auditing**  
**R865-19S-52**  
**Federal, State and Local Taxes**  
**Pursuant to Utah Code Ann. Section**  
**59-12-102**

**NOTICE OF PROPOSED RULE**

(Amendment)  
 DAR FILE NO.: 27825  
 FILED: 04/15/2005, 13:59

**RULE ANALYSIS**

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: As a result of S.B. 147 (2003), the definition of purchase price in Section 59-12-102 now indicates that a tax imposed on the seller is subject to sales tax. Thus, this section is no longer necessary. (DAR NOTE: S.B. 147 is found at UT L 2003 Ch 312, and was effective 07/01/2004.)

SUMMARY OF THE RULE OR CHANGE: The section is removed.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 59-12-102

ANTICIPATED COST OR SAVINGS TO:

- ❖ THE STATE BUDGET: None--Any impact would have been taken into account in S.B. 147 (2003).
- ❖ LOCAL GOVERNMENTS: None--Any impact would have been taken into account in S.B. 147 (2003).
- ❖ OTHER PERSONS: None--Any impact would have been taken into account in S.B. 147 (2003).

COMPLIANCE COSTS FOR AFFECTED PERSONS: None--The substance of the rule has been codified in statute.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: None--The substance of the rule has been codified. Pam Hendrickson, Commission Chair

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

TAX COMMISSION  
 AUDITING  
 210 N 1950 W  
 SALT LAKE CITY UT 84134, or  
 at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Sheri McFall at the above address, by phone at 801-297-3901, by FAX at 801-297-3919, or by Internet E-mail at sherimcfall@utah.gov

**R865. Tax Commission, Auditing.**  
**R865-19S. Sales and Use Tax.**  
**~~R865-19S-52. Federal, State and Local Taxes Pursuant to Utah~~**  
**~~Code Ann. Section 59-12-102.~~**

— A. Federal excise tax involved in a transaction which is subject to sales or use tax is exempt from sales and use tax provided the federal tax is separately stated on the invoice or sales ticket and collected from the purchaser.

— B. State and local taxes are taxable as a part of the sales price of an article if the tax is levied on the manufacturer or the seller.

**KEY: charities, tax exemptions, religious activities, sales tax**  
**~~December 21, 2004~~2005**  
**Notice of Continuation April 5, 2002**  
**59-12-102**

▼ ————— ▼

**Tax Commission, Auditing**  
**R865-19S-60**  
**Sales of Machinery, Fixtures and**  
**Supplies to Manufacturers,**  
**Businessmen and Others Pursuant to**  
**Utah Code Ann. Section 59-12-103**

**NOTICE OF PROPOSED RULE**

(Amendment)  
 DAR FILE NO.: 27826  
 FILED: 04/15/2005, 14:12

**RULE ANALYSIS**

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: Recent amendments to Section 59-12-102 provide that the installation of tangible personal property is not part of the item's purchase price if the installation is separately identified on the invoice. Section R865-19S-78 provided guidance on the tax consequences of installation.

SUMMARY OF THE RULE OR CHANGE: The proposed amendment removes the reference to Section R865-19S-78 since that section no longer contains the language referred to.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 59-12-103

## ANTICIPATED COST OR SAVINGS TO:

- ❖ THE STATE BUDGET: None--Any fiscal impacts were taken into account by H.B. 51 (2002) and S.B. 127 (2005). (DAR NOTE: H.B. 51 is found at UT L 2002 Ch 117, and was effective 07/01/2002. S.B. 127 is found at UT L 2005 Ch 158, and will be effective 07/01/2005.)
- ❖ LOCAL GOVERNMENTS: None--Any fiscal impacts were taken into account by H.B. 51 (2002) and S.B. 127 (2005).
- ❖ OTHER PERSONS: None--Any fiscal impacts were taken into account by H.B. 51 (2002) and S.B. 127 (2005).

COMPLIANCE COSTS FOR AFFECTED PERSONS: None--The language is removed since it now appears in statute.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: None--Language is removed because the statute, not the referred section, indicates the sales tax treatment for installations. Pam Hendrickson, Commission Chair

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

TAX COMMISSION  
AUDITING  
210 N 1950 W  
SALT LAKE CITY UT 84134, or  
at the Division of Administrative Rules.

## DIRECT QUESTIONS REGARDING THIS RULE TO:

Sheri McFall at the above address, by phone at 801-297-3901, by FAX at 801-297-3919, or by Internet E-mail at sherimcfall@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 06/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/02/2005

AUTHORIZED BY: Pam Hendrickson, Commissioner

**R865. Tax Commission, Auditing.****R865-19S. Sales and Use Tax.****R865-19S-60. Sales of Machinery, Fixtures and Supplies to Manufacturers, Businessmen and Others Pursuant to Utah Code Ann. Section 59-12-103.**

A. Unless specifically exempted by statute, sales of machinery, tools, equipment, and supplies to a manufacturer or producer are taxable.

B. Sales of furniture, supplies, stationery, equipment, appliances, tools, and instruments to stores, shops, businesses, establishments, offices, and professional people for use in carrying on their business and professional activities are taxable.

C. Sales of trade fixtures to a business owner are taxable as sales of tangible personal property even if the fixtures are temporarily attached to real property.

1. Trade fixtures are items of tangible personal property used for the benefit of the business conducted on the property.

2. Trade fixtures tend to be transient in nature in that the fixtures installed in a commercial building may vary from one tenant to the next without substantial alteration of the building, and the building itself is readily adaptable to multiple uses.

3. Examples of trade fixtures include cases, shelves and racks used to store or display merchandise.

~~[D. Sales tax treatment or charges for installing trade fixtures to real property are dealt with in R865-19S-78.~~

~~—E.]D. Sales described in A. through C. of this rule are sales to final buyers or ultimate consumers and therefore not sales for resale.~~

**KEY: charities, tax exemptions, religious activities, sales tax**  
~~[December 21, 2004]2005~~

Notice of Continuation April 5, 2002  
59-12-103



Tax Commission, Auditing  
**R865-19S-68**  
Premiums, Gifts, Rebates, and  
Coupons Pursuant to Utah Code Ann.  
Sections 59-12-102 and 59-12-103

**NOTICE OF PROPOSED RULE**

(Amendment)

DAR FILE NO.: 27828

FILED: 04/15/2005, 14:33

**RULE ANALYSIS**

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: S.B. 147 (2003) and S.B. 127 (2005) amended Section 59-12-102 to provide that most manufacturer rebates are included in the purchase price and, accordingly, included in the tax base of a taxable transaction; and Section 59-12-104 to exempt manufacturer rebates on the purchase of a new motor vehicle. (DAR NOTE: S.B. 147 is found at UT L 2003 Ch 312, and was effective 07/01/2004. S.B. 127 is found at UT L 2005 Ch 158, and will be effective 07/01/2005.)

SUMMARY OF THE RULE OR CHANGE: The proposed amendment removes language that is in conflict with language codified by S.B. 147 (2003) and S.B. 127 (2005); and makes technical changes.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 59-12-102 and 59-12-103

## ANTICIPATED COST OR SAVINGS TO:

- ❖ THE STATE BUDGET: None--Any impacts would have been taken into account in S.B. 147 (2003) and S.B. 127 (2005).
- ❖ LOCAL GOVERNMENTS: None--Any impacts would have been taken into account in S.B. 147 (2003) and S.B. 127 (2005).
- ❖ OTHER PERSONS: None--Any impacts would have been taken into account in S.B. 147 (2003) and S.B. 127 (2005).

COMPLIANCE COSTS FOR AFFECTED PERSONS: None--The statutory changes mirror the current practice.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: None--The language placed in statute matches current practices. Pam Hendrickson, Commission Chair

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

TAX COMMISSION  
AUDITING  
210 N 1950 W  
SALT LAKE CITY UT 84134, or  
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

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THIS RULE MAY BECOME EFFECTIVE ON: 06/02/2005

AUTHORIZED BY: Pam Hendrickson, Commissioner

#### **R865. Tax Commission, Auditing.**

##### **R865-19S. Sales and Use Tax.**

##### **R865-19S-68. Premiums, Gifts, Rebates, and Coupons Pursuant to Utah Code Ann. Sections 59-12-102 and 59-12-103.**

A. Donors ~~[of articles] that give away items~~ of tangible personal property ~~[, which are given away]~~ as premiums or otherwise~~[-]~~ are regarded as the users or consumers ~~[thereof]~~ of those items and the sale to ~~[them]~~ the donor is a taxable sale. Exceptions to this treatment are items of tangible personal property donated to or provided for use by exempt organizations ~~[who] that~~ would qualify for exemption under R865-19S-43 or R865-19S-54 if a sale of such items were made to them. An item given away as a sales incentive is exempt to the donor if the sale of that item would have been exempt. An example is prescribed medicine given away by a drug manufacturer.

B. When a retailer making a retail sale of tangible personal property ~~[which] that~~ is subject to tax gives a premium together with the tangible personal property sold, the transaction is regarded as a sale of both articles to the purchaser, provided the delivery of ~~[such] the~~ premium is certain and does not depend upon chance.

C. Where a retailer is engaged in selling tangible personal property ~~[which] that~~ is not subject to tax and furnishes a premium with the property sold, the retailer is the consumer of the premium furnished.

D. If a retailer accepts a coupon for part or total payment for a taxable product and is reimbursed by a manufacturer or another party, the total sales value, including the coupon amount, is subject to sales tax.

E. A coupon for which no reimbursement is received is considered to be a discount and the taxable amount is the net amount paid by the customer after deducting the value of the coupon.

~~[F. Manufacturer rebates on sales of tangible personal property are considered as a discount and the taxable amount is the net amount paid by the customer after deducting the rebate. If the manufacturer's rebate is certain at the time of sale, tax should be charged only on the~~

~~net amount of the sale; otherwise, tax is charged on the total before the rebate credit, and then later refunded to the customer when proof of rebate is given to the dealer for his file.~~

~~—1. If the rebate is applied as part of the down payment, it must be segregated on the buyer's order, invoice, or other sales document from any cash down payment. Since the tax base for collection is reduced by the amount of the rebate, the rebate must be shown separately and identified for sales tax computation and subsequent audit verification. Care must be taken to avoid a double deduction if the gross sales price on the sales document has already been reduced by the rebate amount.~~

~~—G.]E. If a retailer agrees to furnish a free item in conjunction with the sale of an item, the sales tax applies only to the net amount due. If sales tax is computed on both items and only the sales value of the free item is deducted from the bill, excess collection of sales tax results. The vendor is then required to follow the procedure outlined in R865-19S-16 and remit any excess sales tax collected.~~

~~[H.]G. Any coupon with a fixed price limit must be deducted from the total bill and sales tax computed on the difference. For example, if a coupon is redeemed for two \$6 meals, but the value of the free meal is limited to \$5, the \$12 is rung up and the \$5 deducted, resulting in a taxable sale of \$7.~~

**KEY: charities, tax exemptions, religious activities, sales tax**  
**~~[December 21, 2004]2005~~**

**Notice of Continuation April 5, 2002**

**59-12-102**

**59-12-103**



## Tax Commission, Auditing **R865-19S-71**

### Transportation Charges in Connection With the Sale of Tangible Personal Property Pursuant to Utah Code Ann. Sections 59-12-103 and 59-12-104

#### **NOTICE OF PROPOSED RULE**

(Amendment)

DAR FILE NO.: 27831

FILED: 04/15/2005, 19:32

#### **RULE ANALYSIS**

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: S.B. 127 (2005) amended Section 59-12-102 to provide that delivery charges are not included in the purchase price, and accordingly, not subject to sales tax, if those charges are separately identified on the invoice. This new language is in conflict with the rule language, therefore, the section must be removed. (DAR NOTE: S.B. 127 is found at UT L 2005 Ch 158, and will be effective 07/01/2005.)

SUMMARY OF THE RULE OR CHANGE: This section is being removed.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 59-12-103 and 59-12-104



## ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: None--Any impacts should have been taken into account in S.B. 147 (2003) and S.B. 127 (2005). (DAR NOTE: S.B. 147 is found at UT L 2003 Ch 312, and was effective 07/01/2004.)

❖ LOCAL GOVERNMENTS: None--Any impacts should have been taken into account in S.B. 147 (2003) and S.B. 127 (2005).

❖ OTHER PERSONS: None--Any impacts should have been taken into account in S.B. 147 (2003) and S.B. 127 (2005).

COMPLIANCE COSTS FOR AFFECTED PERSONS: Individuals will not pay sales tax on the delivery of items that they purchase.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Individuals will not pay sales tax on the delivery of items that they purchase. Pam Hendrickson, Commission Chair

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

TAX COMMISSION  
AUDITING  
210 N 1950 W  
SALT LAKE CITY UT 84134, or  
at the Division of Administrative Rules.

## DIRECT QUESTIONS REGARDING THIS RULE TO:

Sheri McFall at the above address, by phone at 801-297-3901, by FAX at 801-297-3919, or by Internet E-mail at sherimcfall@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 06/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/02/2005

AUTHORIZED BY: Pam Hendrickson, Commissioner

**R865. Tax Commission, Auditing.  
R865-19S. Sales and Use Tax.**

~~**[R865-19S-71. Transportation Charges in Connection With the Sale of Tangible Personal Property Pursuant to Utah Code Ann. Sections 59-12-103 and 59-12-104.**~~

~~— A. To qualify for the sales tax exemption for movements of freight by common carrier, transportation charges must satisfy all of the following conditions:~~

- ~~— 1. Shipment must take place by means of common carrier.~~
- ~~— 2. Charges must be segregated and listed separately.~~
- ~~— 3. Charges must reflect the actual cost of shipping the particular tangible personal property by common carrier.~~
- ~~— 4. Shipment of the tangible personal property must take place after passage of title.~~
  - ~~— a) Shipment of the tangible personal property takes place after passage of title if the terms of the sale or lease are F.O.B. origin or F.O.B. shipping point.~~
  - ~~— b) If the invoice does not indicate an F.O.B. point, and a common carrier is used, it is assumed the terms are F.O.B. origin.~~

~~— e) In all other cases, the shipment of tangible personal property takes place before passage of title.~~

~~— B. If shipment of the tangible personal property occurs before the passage of title, shipping costs, to the extent included in the sales price of the item, and regardless of whether they are segregated on the invoice, shall be included in the sales and use tax base.~~

**]KEY: charities, tax exemptions, religious activities, sales tax  
[December 21, 2004]2005**

**Notice of Continuation April 5, 2002**

**59-12-103**

**59-12-104**

▼ ————— ▼

**Tax Commission, Auditing  
R865-19S-85**

**Sales and Use Tax Exemptions for New  
or Expanding Operations and Normal  
Operating Replacements Pursuant to  
Utah Code Ann. Section 59-12-104**

**NOTICE OF PROPOSED RULE**

(Amendment)  
DAR FILE No.: 27832  
FILED: 04/15/2005, 19:48

**RULE ANALYSIS**

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: Section 59-12-103 indicates the sales tax treatment for charges for repair of tangible personal property. Section R865-19S-78 provided guidance on the tax consequences of repairs. Section 59-12-106 provides requirements for the sales tax exemption certificate. Language in Section R865-19S-78 that is redundant in this section is removed.

SUMMARY OF THE RULE OR CHANGE: The proposed amendment deletes reference to Section R865-19S-78 since that section no longer contains the language referred to and deletes language that is replaced by statute in a recent statutory amendment.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 59-12-104

## ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: None--Any fiscal impacts were taken into account by H.B. 51 (2002), S.B. 147 (2003), and S.B. 127 (2005). (DAR NOTE: H.B. 51 is found at UT L 2002 Ch 117, and was effective 07/01/2002. S.B. 147 is found at UT L 2003 Ch 312, and was effective 07/01/2004. S.B. 127 is found at UT L 2005 Ch 158, and will be effective 07/01/2005.)

❖ LOCAL GOVERNMENTS: None--Any fiscal impacts were taken into account by H.B. 51 (2002), S.B. 147 (2003), and S.B. 127 (2005).

❖ OTHER PERSONS: None--Any fiscal impacts were taken into account by H.B. 51 (2002), S.B. 147 (2003), and S.B. 127 (2005).

COMPLIANCE COSTS FOR AFFECTED PERSONS: None--Language is removed since it now appears in statute.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: None--Language is removed since it appears in statute. Pam Hendrickson, Commission Chair

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

TAX COMMISSION  
AUDITING  
210 N 1950 W  
SALT LAKE CITY UT 84134, or  
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Sheri McFall at the above address, by phone at 801-297-3901, by FAX at 801-297-3919, or by Internet E-mail at sherimcfall@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 06/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/02/2005

AUTHORIZED BY: Pam Hendrickson, Commissioner

**R865. Tax Commission, Auditing.**

**R865-19S. Sales and Use Tax.**

**R865-19S-85. Sales and Use Tax Exemptions for New or Expanding Operations and Normal Operating Replacements Pursuant to Utah Code Ann. Section 59-12-104.**

A. Definitions:

1. "Establishment" means an economic unit of operations, that is generally at a single physical location in Utah, where qualifying manufacturing processes are performed. If a business operates in more than one location (e.g., branch or satellite offices), each physical location is considered separately from any other locations operated by the same business.

2. "Machinery and equipment" means:

a) electronic or mechanical devices incorporated into a manufacturing process from the initial stage where actual processing begins, through the completion of the finished end product, and including final processing, finishing, or packaging of articles sold as tangible personal property. This definition includes automated material handling and storage devices when those devices are part of the integrated continuous production cycle; and

b) any accessory that is essential to a continuous manufacturing process. Accessories essential to a continuous manufacturing process include:

(i) bits, jigs, molds, or devices that control the operation of machinery and equipment; and

(ii) gas, water, electricity, or other similar supply lines installed for the operation of the manufacturing equipment, but only if the primary use of the supply line is for the operation of the manufacturing equipment.

3. "Manufacturer" means a person who functions within a manufacturing facility.

4a) "New or expanding operations" means:

(i) the creation of a new manufacturing operation in this state; or

(ii) the expansion of an existing Utah manufacturing operation if the expanded operation increases production capacity or is substantially different in nature, character, or purpose from that manufacturer's existing Utah manufacturing operation.

b) The definition of new or expanding operations is subject to limitations on normal operating replacements.

c) A manufacturer who closes operations at one location in this state and reopens the same operation at a new location does not qualify for the new or expanding operations sales and use tax exemption without demonstrating that the move meets the conditions set forth in A.4.a). Acquisitions of machinery and equipment for the new location may qualify for the normal operating replacements sales and use tax exemption if they meet the definition of normal operating replacements in A.5.

5. "Normal operating replacements" includes:

a) new machinery and equipment or parts, whether purchased or leased, that have the same or similar purpose as machinery or equipment retired from service due to wear, damage, destruction, or any other cause within 12 months before or after the purchase date, even if they improve efficiency or increase capacity.

b) if existing machinery and equipment or parts are kept for backup or infrequent use, any new, similar machinery and equipment or parts purchased and used for the same or similar function.

B. The sales and use tax exemptions for new or expanding operations and normal operating replacements apply only to purchases or leases of tangible personal property used in the actual manufacturing process.

1. The exemptions do not apply to purchases of real property or items of tangible personal property that become part of the real property in which the manufacturing operation is conducted.

2. Purchases of qualifying machinery and equipment or normal operating replacements are treated as purchases of tangible personal property under R865-19S-58, even if the item is affixed to real property upon installation.

C. Machinery and equipment or normal operating replacements used for a nonmanufacturing activity qualify for the exemption if the machinery and equipment or normal operating replacements are primarily used in manufacturing activities. Examples of nonmanufacturing activities include:

1. research and development;

2. refrigerated or other storage of raw materials, component parts, or finished product; or

3. shipment of the finished product.

D. Where manufacturing activities and nonmanufacturing activities are performed at a single physical location, machinery and equipment or normal operating replacements purchased for use in the manufacturing operation are eligible for the sales and use tax exemption for new or expanding operations or for normal operating replacements if the manufacturing operation constitutes a separate and distinct manufacturing establishment.

1. Each activity is treated as a separate and distinct establishment if:

- a) no single SIC code includes those activities combined; or
- b) each activity comprises a separate legal entity.

2. Machinery and equipment or normal operating replacements used in both manufacturing activities and nonmanufacturing activities qualify for the exemption for new or expanding operations or for normal operating replacements only if the machinery and equipment or normal operating replacements are primarily used in manufacturing activities.

~~[E. Charges for labor to repair, renovate, or install tangible personal property shall be taxable or tax exempt as provided in R865-19S-78.~~

~~—F.]E.~~ The manufacturer shall retain records to support the claim that the machinery and equipment or normal operating replacements are qualified for exemption from sales and use tax under the provisions of this rule and Section 59-12-104.

~~[G. Vendors are required to obtain a tax exemption certificate upon which the purchaser certifies that the use of the machinery and equipment or normal operating replacements qualifies for exemption under Title 59, Chapter 12. Vendors must obtain a separate tax exemption certificate, or a purchase order that incorporates the appropriate language, including authorized signature, date and title, of the tax exemption certificate, from the purchaser for each purchase of exempt machinery and equipment, at the time of purchase.~~

~~—H.]E.~~ If a purchase consists of items that are exempt from sales and use tax under this rule and Section 59-12-104, and items that are subject to tax, the tax exempt items must be separately stated on the invoice or the entire purchase will be subject to tax.

**KEY: charities, tax exemptions, religious activities, sales tax**  
~~December 21, 2004~~**2005**  
**Notice of Continuation April 5, 2002**  
**59-12-104**



**Tax Commission, Auditing**  
**R865-19S-90**  
**Telephone Service Pursuant to Utah**  
**Code Ann. Section 59-12-103**

**NOTICE OF PROPOSED RULE**  
 (Amendment)

DAR FILE NO.: 27833  
 FILED: 04/15/2005, 20:01

**RULE ANALYSIS**

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: Section 59-12-103 indicates the sales tax treatment for charges for repair of tangible personal property. Section R865-19S-78 provided guidance on the tax consequences of repairs. Also, S.B. 127 (2005) amended Section 59-12-104 so that installation charges are not part of the sales price. All of which requires changes to this section. (DAR NOTE: S.B. 127 is found at UT L 2005 Ch 158, and will be effective 07/01/2005.)

SUMMARY OF THE RULE OR CHANGE: The proposed amendment deletes reference to two sections since those sections no

longer contain the language referred to, and deletes language that is replaced by statute in a recent statutory amendment.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 59-12-103

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: None--Any fiscal impacts were taken into account by H.B. 51 (2002) and S.B. 127 (2005). (DAR NOTE: H.B. 51 is found at UT L 2002 Ch 117, and was effective 07/01/2002.)

❖ LOCAL GOVERNMENTS: None--Any fiscal impacts were taken into account by H.B. 51 (2002) and S.B. 127 (2005).

❖ OTHER PERSONS: None--Any fiscal impacts were taken into account by H.B. 51 (2002) and S.B. 127 (2005).

COMPLIANCE COSTS FOR AFFECTED PERSONS: None--Language is removed since it now appears in statute.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: None--Language is removed since it now appears in statute. Pam Hendrickson, Commission Chair

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

**TAX COMMISSION**  
**AUDITING**  
 210 N 1950 W  
 SALT LAKE CITY UT 84134, or  
 at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Sheri McFall at the above address, by phone at 801-297-3901, by FAX at 801-297-3919, or by Internet E-mail at sherimcfall@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 06/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/02/2005

AUTHORIZED BY: Pam Hendrickson, Commissioner

**R865. Tax Commission, Auditing.**

**R865-19S. Sales and Use Tax.**

**R865-19S-90. Telephone Service Pursuant to Utah Code Ann. Section 59-12-103.**

A. Definitions.

1. "Interstate" means a transmission that originates in this state but terminates in another state, or a transmission that originates in another state but terminates in this state.

2. "Intrastate" means a transmission that originates and terminates in this state, even if the route of the transmission signal itself leaves and reenters the state. Prepaid telephone services or service contracts are presumed to be used for intrastate telephone services unless the service contract is sold exclusively for use in interstate communications.

- 3. "Two-way transmission" includes any services provided over a public switched network.
  - B. Taxable telephone service charges include:
    - 1. subscriber access fees;
    - 2. charges for optional telephone features, such as call waiting, caller ID, and call forwarding; and
    - 3. nonrecurring charges that are ordinarily charged to subscribers only once or only under exceptional circumstances, including charges to:
      - a) establish, change, or disconnect telephone service or optional features; and
      - b) install or repair telephone equipment that retains its character as tangible personal property[ ~~under R865-19S-58 and R865-19S-78~~].
  - C. Nontaxable charges include:
    - 1. refundable subscriber deposits, interest, and late payment penalties;
    - 2. charges for interstate long distance or toll calls;
    - 3. telephone answering services received or relayed by a human operator;
    - 4. charges to install or repair subscriber equipment that is regarded as real property[ ~~under R865-19S-58 and R865-19S-78~~];
    - 5. charges levied on subscribers to fund or subsidize special telephone services, including 911 service, special communications services for the deaf, and special telephone service for low income subscribers;
    - 6. contributions in aid of construction, land development fees, payments in lieu of land development fees, and special plant construction and relocation charges; and
    - 7. charges for one-way pager services.

**KEY: charities, tax exemptions, religious activities, sales tax**  
~~December 21, 2004~~**2005**  
**Notice of Continuation April 5, 2002**  
**59-12-103**



**Tax Commission, Auditing**  
**R865-19S-101**  
**Application of Sales Tax to Fees**  
**Assessed in Conjunction with the Retail**  
**Sale of a Motor Vehicle Pursuant to**  
**Utah Code Ann. Section 59-12-103**

**NOTICE OF PROPOSED RULE**  
 (Amendment)  
 DAR FILE NO.: 27834  
 FILED: 04/15/2005, 20:12

**RULE ANALYSIS**

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: S.B. 147 (2003) amended the Section 59-12-102 definition of purchase price to include all charges by the seller for services necessary to complete the sale. The language being proposed to be removed is contradictory to the new statutory language. (DAR NOTE: S.B. 147 is found at UT L 2003 Ch 312, and was effective 07/01/2004.)

SUMMARY OF THE RULE OR CHANGE: The proposed amendment removes language that contradicts S.B. 147 (2003) and S.B. 127 (2005). (DAR NOTE: S.B. 127 is found at UT L 2005 Ch 158, and will be effective 07/01/2005.)

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 59-12-103

ANTICIPATED COST OR SAVINGS TO:

- ❖ THE STATE BUDGET: None--Any fiscal impacts were taken into account by S.B. 147 (2003) and S.B. 127 (2005).
- ❖ LOCAL GOVERNMENTS: None--Any fiscal impacts were taken into account by S.B. 147 (2003) and S.B. 127 (2005).
- ❖ OTHER PERSONS: None--Any fiscal impacts were taken into account by S.B. 147 (2003) and S.B. 127 (2005).

COMPLIANCE COSTS FOR AFFECTED PERSONS: A purchaser of a motor vehicle will now be subject to sales tax on dealer imposed document preparation fees.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: An automobile purchaser will pay sales tax on dealer imposed document preparation fees pursuant to Streamlined Sales Tax. Pam Hendrickson, Commission Chair

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

TAX COMMISSION  
 AUDITING  
 210 N 1950 W  
 SALT LAKE CITY UT 84134, or  
 at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Sheri McFall at the above address, by phone at 801-297-3901, by FAX at 801-297-3919, or by Internet E-mail at sherimcfall@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 06/01/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/02/2005

AUTHORIZED BY: Pam Hendrickson, Commissioner

**R865. Tax Commission, Auditing.**  
**R865-19S. Sales and Use Tax.**  
**R865-19S-101. Application of Sales Tax to Fees Assessed in Conjunction with the Retail Sale of a Motor Vehicle Pursuant to Utah Code Ann. Section 59-12-103.**

~~[A. Document preparation fees assessed in conjunction with the retail sale of a motor vehicle are not subject to the sales tax if they satisfy both of the following conditions:~~

- ~~1. Fees must be separately identified and segregated.~~
- ~~2. Fees may not be included in the total sale price upon which sales tax is calculated and collected.~~

~~B.]~~ State-mandated fees and taxes assessed in conjunction with the retail sale of a motor vehicle are not subject to the sales tax and must be separately identified and segregated on the invoice as required by Tax Commission rule R877-23V-14.

**KEY: charities, tax exemptions, religious activities, sales tax**  
**~~December 21, 2004~~2005**  
**Notice of Continuation April 5, 2002**  
**59-12-103**



Tax Commission, Motor Vehicle  
**R873-22M-27**  
 Issuance of Special Group License  
 Plates Pursuant to Utah Code Ann.  
 Sections 41-1a-408, 41-1a-409 and 41-  
 1a-414

**NOTICE OF PROPOSED RULE**  
 (Amendment)  
 DAR FILE NO.: 27803  
 FILED: 04/05/2005, 15:07

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The purpose of the amendment is to remove outdated provisions of the rule, and to establish criteria for persons to surrender certain special group license plates.

**SUMMARY OF THE RULE OR CHANGE:** The proposed amendment deletes language that is contained in statute or has been changed by statute; and provides a mechanism for revoking firefighter special group license plates for an individual who no longer qualifies for those plates.

**STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Sections 41-1a-418, 41-1a-419, 41-1a-420, and 41-1a-421

**ANTICIPATED COST OR SAVINGS TO:**

- ❖ **THE STATE BUDGET:** Immaterial increase in revenue--a person who is no longer eligible to have firefighter plates will pay \$5 to replace those plates.
- ❖ **LOCAL GOVERNMENTS:** None--The fees involved are state fees.
- ❖ **OTHER PERSONS:** Immaterial cost--a person who is no longer eligible for a firefighter plate will pay \$5 to replace those plates.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** The statutory fee for new license plates has always applied to a person who is no longer eligible to have a special group license plate. Firefighting entities, however, want to actively enforce revoking the plate from a person who is not eligible. As a result, there may be some, but not many revocations. Those persons would pay a \$5 new license fee.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** There will be no fiscal impact on businesses. Pam Hendrickson, Commission Chair

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

TAX COMMISSION  
 MOTOR VEHICLE  
 210 N 1950 W  
 SALT LAKE CITY UT 84134, or  
 at the Division of Administrative Rules.

**DIRECT QUESTIONS REGARDING THIS RULE TO:**

Cheryl Lee at the above address, by phone at 801-297-3900, by FAX at 801-297-3919, or by Internet E-mail at clee@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 05/31/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/01/2005

AUTHORIZED BY: Pam Hendrickson, Commissioner

**R873. Tax Commission, Motor Vehicle.**

**R873-22M. Motor Vehicle.**

**R873-22M-27. Issuance of Special Group License Plates Pursuant to Utah Code Ann. Sections ~~41-1a-408, 41-1a-409 and 41-1a-414~~41-1a-418, 41-1a-419, 41-1a-420, and 41-1a-421.**

(1) Except as otherwise provided, a special group license plate shall consist of a symbol affixed to the left-hand side of the plate, followed by five characters. The first four characters shall be numbers and the fifth shall be a letter.

~~[A-](2)(a) Legislature special group license plates shall be issued to current members of the Utah Legislature upon application and payment of the applicable fees.~~

~~1. These special group license plates shall carry the letter combination SEN or REP with the number of the district from which the legislator was elected or appointed.~~

~~[2-](b) [State legislators] A state legislator may, upon payment of the requisite registration fees, register a maximum of two vehicles with [legislature] Legislature special group license plates.~~

~~[3-](c) Upon leaving office, a legislator may not display the Legislature special group license plates on any motor vehicle. Legislators not reelected to office may not display the Legislature special group license plates after December 31 of the election year. [Legislators leaving office or not reelected to office shall be issued regular license plates at no charge.]~~

~~[B-](3)(a) United States Congress special group license plates shall be issued to current members of the United States Congress upon application and payment of the applicable fees.~~

~~1. These special group license plates shall carry, in the case of representatives, the letter combination HR, followed by the number of the district from which the representative was elected or appointed, or, in the case of senators, USS 1 or USS 2, signifying the senior and junior senators.~~

~~[2-](b)~~ Upon leaving office, ~~[members]~~a member of Congress may not display United States Congress special group license plates on any motor vehicle. ~~[Members]~~A member of Congress not reelected to office may not display United States Congress special group license plates after December 31 of the election year. ~~[Members of Congress leaving office or not reelected to office shall be issued regular license plates at no charge.]~~

~~[C-](4)~~ Survivor of the Japanese attack on Pearl Harbor special group license plates ~~[shall]~~may be issued to qualified U.S. military veterans who.~~[upon application and payment of the applicable fees.]~~

~~[4-](a)~~ ~~[Only those U.S. military veterans who]~~ provide a copy of their discharge papers, notice of separation, or other government issued document acceptable to the division verifying dates and locations of active service~~];~~ or ~~[who]~~

~~\_\_\_\_\_~~ (b) present evidence of membership in the Pearl Harbor Survivors Association~~];~~ ~~[qualify for issuance of this special group license plate].~~

~~\_\_\_\_\_~~ 2. Motor vehicles displaying these plates shall be registered and titled in, or registered and leased in, the name of the veteran or the veteran and the spouse. Upon the death of the veteran, the surviving spouse may, upon application to the division, retain the special license plates so long as the surviving spouse remains unmarried.]

~~[D-](5)~~ Former prisoner of war special group license plates shall be issued to qualified U.S. military veterans~~[upon application and payment of the applicable fees].~~

~~\_\_\_\_\_~~ 1. Only those U.S. military veterans who provide a copy of their discharge papers, notice of separation, or other government issued document acceptable to the division indicating that the veteran was classified as a prisoner of war qualify for issuance of this special group license plate.

~~\_\_\_\_\_~~ 2. Motor vehicles displaying these plates shall be registered and titled in, or registered and leased in, the name of the veteran or the veteran and the spouse. Upon the death of the veteran, the surviving spouse may, upon application to the division, retain the special license plates so long as the surviving spouse remains unmarried.]

~~[E-](6)~~ Recipient of a purple heart special group license plates shall be issued to qualified U.S. military veterans~~[upon application and payment of the applicable fees.~~

~~\_\_\_\_\_~~ 1. Only those U.S. military veterans] who:

~~\_\_\_\_\_~~ (a) provide a copy of their discharge papers, notice of separation, or other government issued document acceptable to the division indicating the veteran was awarded the purple heart~~];~~ or ~~[who]~~

~~\_\_\_\_\_~~ (b) present evidence of current membership in the Military Order of the Purple Heart~~];~~ ~~[qualify for issuance of this special group license plate].~~

~~\_\_\_\_\_~~ 2. Motor vehicles displaying these plates shall be registered and titled in, or registered and leased in, the name of the veteran or the veteran and the spouse. Upon the death of the veteran, the surviving spouse may, upon application to the division, retain the special license plates so long as the surviving spouse remains unmarried.]

~~[F-](7)~~ ~~An applicant for a National Guard special group license [plates shall be issued to active members of the Utah National Guard upon application and payment of the applicable fees.~~

~~\_\_\_\_\_~~ 1. To qualify for this special group license]plate~~];~~ applicants] must present a current military identification card ~~[which]~~that shows active membership in the Utah National Guard.

~~[G-]~~ Disabled special group license plates shall be issued to persons with disabilities which limit or impair their ability to walk and for vehicles that are used by an organization primarily to transport persons with disabilities that limit or impair their ability to walk, upon application and payment of the applicable fees.

~~\_\_\_\_\_~~ 1. Persons with disabilities which limit or impair the ability to walk as defined in Uniform System for Handicapped Parking, 58 Fed. Reg. 10328, 10329 (1991), which is adopted and incorporated by reference.

~~\_\_\_\_\_~~ 2. An applicant for this special group license plate shall present a licensed physician's certification upon initial application, stating that the applicant has a permanent disability which limits or impairs ability to walk, or sign an affidavit attesting that the vehicle is used by an organization primarily for the transportation of persons with disabilities that limit or impair their ability to walk.

~~\_\_\_\_\_~~ 3. The Tax Commission may, on a case by case basis, issue disabled special group license plates to persons with disabilities other than disabilities which limit or impair the ability to walk.

~~\_\_\_\_\_~~ 4. The fee for the issuance of a handicapped person special group license plate shall not exceed the fee charged for a similar license plate for the same class vehicle.

~~\_\_\_\_\_~~ 5. A physician's certification is not required for renewal of the special group license plate.~~](8)~~ The issuance, renewal, surrender, and design of disability special group license plates and windshield placards shall be subject to the provisions of the federal Uniform System for Parking for Persons with Disabilities, 23 C.F.R. Ch. 11, Subch. B, Pt. 1235.2 (1991), which is adopted and incorporated by reference.

~~[H-]~~ Collegiate special group license plates shall be issued in accordance with Section 41-1a-408 upon application and payment of the applicable fees.

~~\_\_\_\_\_~~ I. Wildlife special group license plates shall be issued in accordance with Section 41-1a-408 upon application and payment of the applicable fees.

~~\_\_\_\_\_~~ J. Special interest vehicle special group license plates shall be issued to owners of qualified vehicles upon application and payment of the applicable fees.

~~\_\_\_\_\_~~ 1. To qualify for this special group license plate, a vehicle must meet the definition of special interest vehicle as that term is defined in Section 41-1a-102.

~~\_\_\_\_\_~~ K. Vintage vehicle special group license plates shall be issued to owners of qualified vehicles upon application and payment of the applicable fees.

~~\_\_\_\_\_~~ 1. To qualify for this special group license plate, a vehicle must meet the definition of vintage vehicle as that term is defined in Section 41-21-1.

~~[L-](9)(a)~~ ~~[Licensed]~~An applicant for a licensed amateur radio operator special group license~~[plates shall be issued to qualified individuals upon application and payment of the applicable fees.~~

~~\_\_\_\_\_~~ 1. To qualify for this special group license plate, applications must] plate shall present a current Federal Communication Commission (FCC) license.

~~[2-](b)~~ ~~[The alpha and numeric sequence of these plates]~~The license plate number for a licensed amateur radio operator special group license plate shall be the same combination of alpha and numeric characters that comprise the FCC assigned radio call ~~[sign]~~ letters of the licensed operator. ~~[The first letter shall be either A, K, N, or W. The next characters shall be the combination of letters or figures assigned by the FCC to the licensed operator as indicated upon the licensed operator's FCC license.]~~

~~[3-](c)~~ ~~[A maximum of one vehicle may be registered]~~Only one set of licensed amateur radio operator special group license plates may be issued per FCC license.

~~[M-]~~ Farm vehicle special group license plates shall be issued to owners of qualified vehicles upon application and payment of the applicable fees.

—1. To qualify for this special group license plate, vehicles with a gross vehicle weight rating of 12,001 pounds or more must meet the criteria for farm truck, as that term is defined in Section 41-1a-102, and furnish a completed Farm Truck Affidavit, Form TC-838, at the time of application.

—2. To qualify for this special group license plate, vehicles with a gross vehicle weight rating of 12,000 pounds or less must provide an emission test certificate or a county-issued certificate of exemption from emission inspection requirements at the time of application. ~~(10)~~ A farm truck special group license plate may be issued for a vehicle that is qualified to register as a farm truck under Section 41-1a-1206.

~~(N)-(11)(a)~~ Firefighter special group license plates shall be issued to qualified individuals upon application and payment of the applicable fees.

—1.—To qualify for ~~this~~ a firefighter special group license plate, ~~applicants~~ an applicant must present one of the following:

~~(a)~~ (i) evidence indicating the applicant has a current membership in the Utah Firefighters' Association;

~~(b)~~ (ii) an official identification card issued by the firefighting entity identifying the applicant as an employee or volunteer of that firefighting entity;

~~(c)~~ (iii) a letter on letterhead of the firefighting entity, or the municipality or county in which the firefighting entity is located, identifying the applicant as an employee or volunteer of that firefighting entity; or

~~(d)~~ (iv) a letter on letterhead from a firefighting entity, or the municipality or county in which the firefighting entity is located, identifying the applicant as a retired firefighter, whether employed or volunteer, of that firefighting entity.

(b) The division shall revoke a firefighter special group license plate issued under Section 41-1a-418 upon receipt of written notification from the head of a firefighting entity indicating:

(i) the name of the individual whose license plate is revoked;

(ii) the license plate number that is revoked;

(iii) the reason the license plate is revoked; and

(iv) that the firefighting entity has notified the individual described in Subsection (11)(b)(i) that the license plate will be revoked.

~~(O. In addition to the special group license plates listed above, any organization that makes a significant contribution promoting the education, economy, or social image of this state may request the Tax Commission to authorize a special group license plate for the organization.~~

—1. The contribution must be the result of the organization's primary purpose.

—2. Organizations may apply to the Tax Commission in letter form for preliminary approval of their request for a special group license plate. Each such application must be accompanied by an artist's color rendering of the proposed symbol and the group's identifying slogan. Final approval of the symbol and slogan rests with the Tax Commission.

—3. Organizations whose requests for special group license plates are approved by the Tax Commission shall acquire the applications and fees prescribed in Sections 41-1a-408 and 41-1a-1211 and submit those applications and fees to the division for processing.

—4. At the discretion of the requesting organization, special group license plates issued under this paragraph may be restricted to individuals meeting requirements formulated by that organization.

—5. Once a restricted special group license plate has been issued by the division, all requests to the division for that license plate must be accompanied by a letter of authorization from the organization requesting that restricted special group license plate.

—P. ~~(12)~~ An individual who no longer qualifies for the particular special group license plate may not display that special group license plate on any motor vehicle and must reregister the vehicle and obtain new license plates. ~~Unless otherwise provided in this rule, the division shall collect a replacement fee prior to issuing regular issue license plates to the disqualified individual.~~

—Q. Except as otherwise provided, all special group license plates, including personalized special group license plates, shall consist of a symbol, affixed to the left hand side of the plate, followed by five characters. The first four characters shall be numbers and the fifth shall be a letter. Plates shall be distributed consecutively.

—R. Unless otherwise prohibited by statute, the division may enact procedures to recall all special license plates currently in use. The division shall replace the recalled plates with the special group license plates enumerated in this rule, free of charge.]

**KEY: taxation, motor vehicles, aircraft, license plates**

~~November 1, 2002~~ 2005

Notice of Continuation April 5, 2002

41-1a-418

41-1a-419

41-1a-420

41-1a-421

▼ ————— ▼

**Workforce Services, Employment  
Development  
R986-200-214  
Assistance for Specified Relatives**

**NOTICE OF PROPOSED RULE**

(Amendment)

DAR FILE NO.: 27824

FILED: 04/15/2005, 13:56

**RULE ANALYSIS**

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this amendment is to change eligibility requirements for specified relatives.

SUMMARY OF THE RULE OR CHANGE: Stepparents will now be required to qualify as a household under family employment program rules and will not be eligible as specified relatives. Also, the amendment requires that the dependent children in the household be related by blood to the specified relative.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 35A-1-104 and Subsection 35A-3-302(5)(b)

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: This is a federally-funded program so there are no costs or savings to the state budget.

❖ LOCAL GOVERNMENTS: This rule does not apply to local government so therefore there are no costs or savings to local governments. Local governments do not contribute to the costs of this program.

❖ OTHER PERSONS: There are no costs or savings to any other persons as there are no fees associated with this program and it is federally funded. Some individuals currently receiving assistance as a specified relative may no longer be eligible for assistance but in those cases they will be ineligible because their income is too high.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no costs or savings to any affected persons as there are no fees associated with this program and it is federally funded. Stepparents caring for dependent children will now have to meet the income and asset eligibility requirements and will no longer qualify as specified relatives. All specified relatives will also be required to be related by blood to the dependent children receiving financial assistance. It is believed that very few cases will be affected by this change but a few will become ineligible for financial assistance which means there will be a small savings in federal dollars.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There are no compliance costs associated with this change. There are no fees associated with this change. It will not cost anyone any sum to comply with these changes. Tani Downing, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

WORKFORCE SERVICES  
EMPLOYMENT DEVELOPMENT  
140 E 300 S  
SALT LAKE CITY UT 84111-2333, or  
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Suzan Pixton at the above address, by phone at 801-526-9645, by FAX at 801-526-9211, or by Internet E-mail at spixton@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 05/31/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/01/2005

AUTHORIZED BY: Tani Downing, Executive Director

**R986. Workforce Services, Employment Development.**

**R986-200. Family Employment Program.**

**R986-200-214. Assistance for Specified Relatives.**

(1) Specified relatives include:

(a) grandparents;

(b) brothers and sisters;

~~(c) stepparents;~~

(~~d~~) stepbrothers and stepsisters;

(~~e~~) aunts and uncles;

(~~f~~) first cousins;

(~~g~~) first cousins once removed;

(~~h~~) nephews and nieces;

(~~i~~) people of prior generations as designated by the prefix grand, great, great-great, or great- great-great;

(~~j~~) a natural parent whose parental rights were terminated by court order;

(~~k~~) brothers and sisters by legal adoption;

(~~l~~) the spouse of any person listed above;

(~~m~~) the former spouse of any person listed above; and

~~(n) persons who meet any of the above relationships by means of a step relationship even if the marriage has been terminated; and~~

(~~o~~) individuals who can prove they met one of the above mentioned relationships via a blood relationship even though the legal relationship has been terminated.

(2) The Department shall require compliance with Section 30-1-4.5

(3) A specified relative may apply for financial assistance for the child. If the child is otherwise eligible, the FEP rules apply with the following exceptions:

(a) The child must have a blood or a legal relationship to the specified relative even if the legal relationship has been terminated.

(~~a~~) Both parents must be absent from the home where the child lives; and

(~~b~~) The child must be currently living with, and not just visiting, the specified relative; and

(~~c~~) The parents' obligation to financially support their child will be enforced and the specified relative must cooperate with child support enforcement; and

(~~d~~) If the parent(s) state they are willing to support the child if the child would return to live with the parent(s), the child is ineligible unless there is a court order removing the child from the parent(s)' home.

(4) If the specified relative is currently receiving FEP or FEPTP, the child must be included in that household assistance unit.

(5) The income and resources of the specified relative are not counted unless the specified relative requests inclusion in the household assistance unit.

(6) If the specified relative is not currently receiving FEP or FEPTP, and the specified relative does not want to be included in the financial assistance payment, the specified relative shall be paid, on behalf of the child, the full standard financial assistance payment for one person. The size of the financial assistance payment shall be increased accordingly for each additional eligible child in the household assistance unit excluding the dependent child(ren) of the specified relative. Since the specified relative is not included in the household assistance unit, the income and assets of the specified relative, or the relative's spouse, are not counted.

(7) The specified relative may request to be included in the household assistance unit. If the specified relative is included in the household assistance unit, the household must meet all FEP eligibility requirements including participation requirements and asset limits.

(8) Income eligibility for a specified relative who wants to be included in the household assistance unit is calculated according to R986-200-241.

**KEY: family employment program**

**[April 1, 2004]2005**

**35A-3-301 et seq.**





**Workforce Services, Employment  
Development  
R986-700  
Child Care Assistance**

**NOTICE OF PROPOSED RULE**

(Amendment)  
DAR FILE NO.: 27830  
FILED: 04/15/2005, 17:18

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The purpose of this change is to clarify when increased payments are available for child care.

**SUMMARY OF THE RULE OR CHANGE:** The proposed amendment sets eligibility requirements for increased child care for children with disabilities or special needs. Federal regulations allow the department to provide child care subsidies at a higher rate for these children if needed.

**STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Section 35A-1-104 and Subsection 35A-3-310(3)

**ANTICIPATED COST OR SAVINGS TO:**

- ❖ **THE STATE BUDGET:** This is a federally-funded program so there are no costs or savings to the state budget. The department has always allowed increased payment. This proposed amendment merely establishes the eligibility criteria for those payments.
- ❖ **LOCAL GOVERNMENTS:** This rule does not apply to local government and therefore there are no costs or savings to local governments. Local governments do not administer or consume services under this program.
- ❖ **OTHER PERSONS:** There are no costs or savings to any other persons as there are no fees associated with this program and it is federally funded. The only persons affected by this rule are parents of disabled and special needs children. There are no costs to those parents for participation. A parent just needs to make application for additional funding with the Department and if eligible, funding will be made available.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** There are no costs or savings to any affected persons as there are no fees associated with this program and it is federally funded. This rule change only affect parents of children who are disabled or have special needs. It will not cost those parents any money to comply with this amendment. A parent just needs to apply and if eligible, the Department will provide the subsidy. There is no fee or cost for applying.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** There are no compliance costs associated with this change. There are no fees associated with this change. It will not cost anyone any sum to comply with these changes. This is a federally-funded program and the money is within current Department budgets to pay any costs associated with this change. Tani Downing, Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

WORKFORCE SERVICES  
EMPLOYMENT DEVELOPMENT  
140 E 300 S  
SALT LAKE CITY UT 84111-2333, or  
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Suzan Pixton at the above address, by phone at 801-526-9645, by FAX at 801-526-9211, or by Internet E-mail at spixton@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 05/31/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/01/2005

AUTHORIZED BY: Tani Downing, Executive Director

**R986. Workforce Services, Employment Development.**

**R986-700. Child Care Assistance.**

**R986-700-702. General Provisions.**

- (1) CC is provided to support employment.
- (2) CC is available, as funding permits, to the following clients who are employed or are participating in activities that lead to employment:
  - (a) parents;
  - (b) specified relatives; or
  - (c) clients who have been awarded custody or appointed guardian of the child.
- (3) Child care is provided only for children living in the home and only during hours when neither parent is available to provide care for the children.
- (4) If a client is eligible to receive CC, the following children, living in the household unit, are eligible:
  - (a) children under the age of 13; and
  - (b) children [age 13] up to the age of 18 years if the child [is];
    - (i) [physically or mentally incapable of self care as determined by a medical doctor, doctor of osteopathy or licensed or certified psychologist;] meets the requirements of rule R986-700-717, and/or
    - (ii) is under court supervision.
- (5) Clients who qualify for child care services will be paid if and as funding is available. When the child care needs of eligible applicants exceed available funding, applicants will be placed on a waiting list. Eligible applicants on the list will be served as funding becomes available. Special needs children, homeless children and FEP or FEPTP eligible children will be prioritized at the top of the list and will be served first. "Special needs child" means a child identified by the Department of Human Services, Division of Services to People with Disabilities or other entity as determined by the Department, as having a physical or mental disability requiring special child care services.
- (6) The amount of CC might not cover the entire cost of care.
- (7) A client is only eligible for CC if the client has no other options available for child care. The client is encouraged to obtain child care at no cost from a parent, sibling, relative, or other suitable

provider. If suitable child care is available to the client at no cost from another source, CC cannot be provided.

(8) CC can only be provided for an eligible provider and will not be provided for illegal or unsafe child care. Illegal child care is care provided by any person or facility required to be licensed or certified but where the provider has not fulfilled the requirements necessary to obtain the license or certification.

(9) Neither the Department nor the state of Utah are liable for injuries that may occur when a child is placed in child care even if the parent receives a subsidy from the Department.

(10) Foster care parents receiving payment from the Department of Human Services are not eligible to receive CC for the foster children.

(11) Once eligibility for CC has been established, eligibility must be reviewed at least once every six months. The review is not complete until the re-certification forms are signed and returned to the local office. All requested verifications must be provided at the time of the review. If the Department has reason to believe the client's circumstances have changed, affecting either eligibility or payment amount, the Department will reduce or terminate CC even if the certification period has not expired.

#### **R986-700-715. Overpayments.**

(1) An overpayment occurs when a client or provider received CC for which they were not eligible. If the Department fails to establish one or more of the eligibility criteria and through no fault of the client, payments are made, it will not be considered to have been an overpayment if the client would have been eligible and the amount of the subsidy would not have been affected.

(2) If the overpayment was because the client committed fraud, including forging a provider's name on a two party CC check, the client will be responsible for repayment of the resulting overpayment and will be disqualified from further receipt of CC:

- (a) for a period of one year for the first occurrence of fraud;
- (b) for a period of two years for the second occurrence of fraud; and
- (c) for life for the third occurrence of fraud.

(3) If the client was at fault in the creation of an overpayment for any reason other than fraud in paragraph (2) above, the client will be responsible for repayment of the overpayment. There is no disqualification or ineligibility period for a fault overpayment.

(4) All child care overpayments must be repaid to the Department.

Overpayments may be deducted from ongoing child care payments for clients who are receiving child care. If the Department is at fault in the creation of an overpayment, the Department will deduct \$10 from each month's child care payment unless the client requests a larger amount.

(5) CC will be terminated if a client fails to cooperate with the Department's efforts to investigate and collect alleged overpayments.

(6) If the Department has reason to believe an overpayment has occurred and it is likely that the client will be determined to be disqualified or ineligible as a result of the overpayment, payment of future CC may be withheld, at the discretion of the Department, to offset any overpayment which may be determined.

#### **R986-700-716. CC in Unusual Circumstances.**

(1) CC may be provided for study time, to support clients in education or training activities if the parent has classes scheduled in such a way that it is not feasible or practical to pick up the child between classes. For example, if a client has one class from 8:00

a.m. to 9:00 a.m. and a second class from 11:00 a.m. to noon it might not be practical to remove the child from care between 9:00 a.m. and 11:00 a.m.

(2) An away-from-home study hall or lab may be required as part of the class course. A client who takes courses with this requirement must verify study hall or lab class attendance. The Department will not approve more study hall hours or lab hours in this setting than hours for which the client is enrolled. For example: A client enrolled for 10 hours of classes each week may not receive more than 10 hours of this type of study hall or lab.

(3) CC will not be provided for private kindergarten or preschool activities when a publicly funded education program is available.

(4) CC may be authorized to support employment for clients who work graveyard shifts and need child care services during the day. If no other child care options are available, child care services may be authorized for the graveyard shift or during the day, but not for both.

(5) CC may be authorized to support employment for clients who work at home, provided the client makes at least minimum wage from the at home work, and the client has a need for child care services. The client must choose a provider setting outside the home. [

~~(6) On a case by case basis, the Department may fund child care for children with disabilities at a higher rate if the needs of the child and provider necessitate. To qualify for the higher rate DSPD or another Department approved entity must first determine that the child care provider has additional ongoing costs in caring for the child. The Department may set different income eligibility criteria for clients with children determined to need consideration under this paragraph. The income eligibility rate is available at all Employment Centers.]~~

#### **R986-700-717. Child Care for Children With Disabilities or Special Needs.**

(1) The Department will fund child care for children with disabilities or special needs at a higher rate if the child has a physical, social, or mental condition or special health care need that requires:

- (a) an increase in the amount of care or supervision and/or
- (b) special care, which includes but is not limited to the use of special equipment, assistance with movement, feeding, toileting or the administration of medications that require specialized procedures.

(2) To be eligible under this section, the client must submit a statement from one of the following professionals or agencies documenting the child's disability or special child care needs:

- (a) medical doctor, doctor of osteopathy, licensed or certified psychologist, or mental health professional,
- (b) Social Security Administration showing that the child is a SSI recipient,
- (c) Division of Services for People with Disabilities,
- (d) Division of Mental Health,
- (e) State Office of Education, or
- (f) Baby Watch, Early Intervention Program.

(3) Verification to support that the child is disabled or has a special need must be dated and signed by the preparer and include the following:

- (a) the child's name,
- (b) a description of the child's disability, and
- (c) the special provisions that justify a higher payment rate.

(4) The Department may require additional information and may deny requests if adequate or complete information or justification is not provided.

(5) The higher rate is available through the month the child turns 18 years of age.

(6) Clients qualify for child care under this section if the household is at or below 85% of the state median income.

(7) The higher rate in effect for each child care category is available at any Department office.

**KEY: child care**  
~~April 7,~~ 2005  
 35A-3-310



**Workforce Services, Workforce  
 Information and Payment Services**  
**R994-304**  
**Special Provisions Regarding Transfers  
 of Unemployment Experience and  
 Assigning Rates**

**NOTICE OF PROPOSED RULE**

(New Rule)

DAR FILE NO.: 27823

FILED: 04/15/2005, 13:49

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The purpose of this new rule is to assist and explain enforcement of H.B. 10 passed in the 2005 General Session of the Utah State Legislature. (DAR NOTE: H.B. 10 is found at UT L 2005 Ch 12, and was effective 03/01/2005.)

**SUMMARY OF THE RULE OR CHANGE:** H.B. 10 as passed in the 2005 General Session of the Utah State Legislature, prohibits employers from transferring ownership, management, and/or control of a company to another company to obtain a lower experience rate calculation. This rule defines terms used in the legislation for determining when a controlling interest is transferred which would trigger the prohibited conduct. The rule also describes the procedure used by the department in making the determination that an illegal transfer has occurred but giving notice to the suspect entity and allowing the business the opportunity to respond.

**STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Section 35A-1-104 and Subsection 35A-4-502(1)(b)

**ANTICIPATED COST OR SAVINGS TO:**

❖ **THE STATE BUDGET:** This is a federally-funded program and there will be no cost or savings to the state budget. Even though the state pays unemployment benefits, since the state has never been able to change "ownership" to achieve a lower experience rating, this rule change will not represent a cost or savings to the state.

❖ **LOCAL GOVERNMENTS:** This is a federally-funded state-run program and there will be no cost or savings to any local governmental entity. Even though local governments pay unemployment benefits, since local governments have never been able to change "ownership" to avoid a higher experience rating, this rule change will represent no cost or savings to local governmental entities.

❖ **OTHER PERSONS:** There will be no cost or savings to other persons not anticipated by the legislation. Only those employers attempting to transfer interest in a company to another company in an effort to avoid unemployment liability will be affected. The legislation provides that the "higher" experience rating will "follow" the transfer to the new company.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** There are no compliance costs for any persons. An employer that transferred ownership in a business to avoid a higher experience rating prior to passage of H.B. 10 will be unable to illegally avoid that experience rating now but the change was made by the legislation, not this rule. This rule merely defines the procedure for effectuating the legislative change and carries no compliance costs independent of that legislation.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** There will be no impact on businesses as a result of this rule. Employers will no longer be able to avoid an experience rating by transferring ownership to a new employer as a result of the legislation. This new rule simply follows the legislation. Tani Downing, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

**WORKFORCE SERVICES  
 WORKFORCE INFORMATION  
 AND PAYMENT SERVICES  
 140 E 300 S  
 SALT LAKE CITY UT 84111-2333, or  
 at the Division of Administrative Rules.**

**DIRECT QUESTIONS REGARDING THIS RULE TO:**  
 Suzan Pixton at the above address, by phone at 801-526-9645, by FAX at 801-526-9211, or by Internet E-mail at spixton@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 05/31/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/01/2005

AUTHORIZED BY: Tani Downing, Executive Director

**R994. Workforce Services, Workforce Information and Payment Services.****R994-304. Special Provisions Regarding Transfers of Unemployment Experience and Assigning Rates.****R994-304-101. Transfer of a Trade or Business, or Portion Thereof, with Common Ownership, Management, or Control.**

(1) The term "person" includes an individual, trust, estate, partnership, association, limited liability company, corporation, government entity, or Indian tribe. The "predecessor employer" is the employer that transfers its trade or business, or a portion of its trade or business, to another employer. The "successor employer" is the employer that acquires the trade or business, or a portion of the trade or business.

(2) Common ownership exists if an employer transfers a trade or business, or a portion of a trade or business, to another employer and at the time of the transfer:

(a) the predecessor employer owns 50% or more of the of the trade or business of the successor employer. For entities that issue shares of stock ownership, 50% or more of the "voting shares" of stock interest must be common to both; or

(b) an individual with a controlling interest in the predecessor trade or business, transfers that controlling interest to an individual in the successor trade or business and the parties are related in one of the following ways:

- (i) spouse;
- (ii) parent;
- (iii) step parent;
- (iv) child;
- (v) step child;
- (vi) sibling; or
- (vii) step sibling.

(3) The Department will determine common management or control using the best available evidence.

(a) Common management will be found if the predecessor and successor employers have the same or similar:

- (i) managers, officers, board of directors;
- (ii) personnel and human resource policies;
- (iii) operating procedures;
- (iv) sales and pricing policies;
- (v) collection procedures;
- (vi) financing policies;
- (vii) accounting practices; or
- (viii) purchasing practices.

(b) common control will be found where the predecessor and successor employers have the same or similar:

- (i) control of the assets used to conduct the business enterprise;
- (ii) financing and/or leasing arrangements;
- (iii) contracts; or
- (iv) business, professional, and regulatory licenses of the business enterprise.

(4) The factors listed in subsections 3(a) and (3)(b) of this section are not exclusive and are intended as aids for analyzing the facts of each case. The degree of importance of each factor in those

subsections varies depending on the nature of the trade or business transferred. Some do not apply to certain trades or businesses and, therefore, should not be given any weight. The Department will scrutinize the facts in each case to assure that the form of the transfer does not obscure the substance of the transfer.

**R994-304-102. Notification Requirements.**

(1) All parties to a transfer described in Section 35A-4-304(3)(a) must provide the following information to the Department within 30 days of the transfer date:

- (a) the effective date of the transfer;
- (b) the percentage of the assets, trade or business, and workforce transferred;
- (c) the reason for the transfer;
- (d) the following information for both the predecessor and the successor employers:
  - (i) name;
  - (ii) street address;
  - (iii) Utah Unemployment Insurance Registration Numbers, if one has been assigned; and
  - (iv) Federal Employer Identification Numbers (FEIN), if one has been assigned.
- (e) the name and Social Security number (SSN) or FEIN of any successor employer who was also a predecessor employer, or any individual who is related to the predecessor. Related means to have a family relationship as described in Section R994-304-101(2)(b).
- (f) Common management and control practices that were retained from the predecessor employer.
- (g) Any other information requested by the Department.

**R994-304-103. Recalculation and Effective Date of Contribution Rates.**

Any employer that is a party to a transfer of an employer's trade or business described in Section 35A-4-304(3)(a) shall have its contribution rate recalculated. The effective date of the recalculation shall be the first day of the calendar quarter following the actual date of the transfer, unless the actual transfer occurred on the first day of a calendar quarter, in which case the recalculation takes effect on that day.

**R994-304-104. Identification of the Transfer or Acquisition of an Employer's Workforce.**

The Department will develop and implement programs to aid in the detection and identification of employers that transfer or acquire all or a portion of another employer's workforce.

**KEY: unemployment experience rating****2005****35-A-4-304**

## NOTICES OF CHANGES IN PROPOSED RULES

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After an agency has published a PROPOSED RULE in the *Utah State Bulletin*, it may receive public comment that requires the PROPOSED RULE to be altered before it goes into effect. A CHANGE IN PROPOSED RULE allows an agency to respond to comments it receives.

As with a PROPOSED RULE, a CHANGE IN PROPOSED RULE is preceded by a RULE ANALYSIS. This analysis provides summary information about the CHANGE IN PROPOSED RULE including the name of a contact person, anticipated cost impact of the rule, and legal cross-references.

Following the RULE ANALYSIS, the text of the CHANGE IN PROPOSED RULE is usually printed. The text shows only those changes made since the PROPOSED RULE was published in an earlier edition of the *Utah State Bulletin*. Additions made to the rule appear underlined (e.g., example). Deletions made to the rule appear struck out with brackets surrounding them (e.g., [example]). A row of dots in the text (. . . . .) indicates that unaffected text was removed to conserve space. If a CHANGE IN PROPOSED RULE is too long to print, the Division of Administrative Rules will include only the RULE ANALYSIS. A copy of rules that are too long to print is available from the agency or from the Division of Administrative Rules.

While a CHANGE IN PROPOSED RULE does not have a formal comment period, there is a 30-day waiting period during which interested parties may submit comments. The 30-day waiting period for CHANGES IN PROPOSED RULES published in this issue of the *Utah State Bulletin* ends May 31, 2005. At its option, the agency may hold public hearings.

From the end of the waiting period through August 29, 2005, the agency may notify the Division of Administrative Rules that it wants to make the CHANGE IN PROPOSED RULE effective. When an agency submits a NOTICE OF EFFECTIVE DATE for a CHANGE IN PROPOSED RULE, the PROPOSED RULE as amended by the CHANGE IN PROPOSED RULE becomes the effective rule. The agency sets the effective date. The date may be no fewer than 30 days nor more than 120 days after the publication date of this issue of the *Utah State Bulletin*. Alternatively, the agency may file another CHANGE IN PROPOSED RULE in response to additional comments received. If the Division of Administrative Rules does not receive a NOTICE OF EFFECTIVE DATE or another CHANGE IN PROPOSED RULE, the CHANGE IN PROPOSED RULE filing, along with its associated PROPOSED RULE, lapses and the agency must start the process over.

CHANGES IN PROPOSED RULES are governed by *Utah Code* Section 63-46a-6 (2001); and *Utah Administrative Code* Rule R15-2, and Sections R15-4-3, R15-4-5, R15-4-7, and R15-4-9.

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**The Changes in Proposed Rules Begin on the Following Page.**

# Environmental Quality, Water Quality R317-2 Standards of Quality for Waters of the State

## NOTICE OF CHANGE IN PROPOSED RULE

DAR File No.: 27593  
Filed: 04/14/2005, 17:19

### RULE ANALYSIS

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The proposed change is made as a result of comments received during the public notice period of the rule.

**SUMMARY OF THE RULE OR CHANGE:** A comment received from the Environmental Protection Agency (EPA) Region VIII recommended the proposed change in the Arsenic criterion for Class 1C waters (Section R317-2-14, Table 2.14.1) not have a listing of the valence state. Staff concurs with the recommendation and is proposing removal of the valence state language. (DAR NOTE: This change in proposed rule has been filed to make additional changes to a proposed amendment that was published in the January 1, 2005, issue of the Utah State Bulletin, on page 13. Underlining in the rule below indicates text that has been added since the publication of the proposed rule mentioned above; strike-out indicates text that has been deleted. You must view the change in proposed rule and the proposed amendment together to understand all of the changes that will be enforceable should the agency make this rule effective.)

**STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Section 19-5-104

**ANTICIPATED COST OR SAVINGS TO:**

- ❖ **THE STATE BUDGET:** None--The proposed change is technical in nature and will not result in a cost or saving to the state budget.
- ❖ **LOCAL GOVERNMENTS:** None--The proposed change is a technical clarification and will not result in a cost or savings to local government.
- ❖ **OTHER PERSONS:** None--The proposed change is a technical clarification and will not result in a cost or savings to other persons.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** None--The proposed change is a technical clarification and will not result in increased compliance costs for affected persons.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** The proposed change is being made in response to comments received during the public notice period for the rule. The proposed change is a technical clarification and is not anticipated to result in additional fiscal impacts to businesses. Dianne Nielson, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:  
**ENVIRONMENTAL QUALITY  
 WATER QUALITY  
 CANNON HEALTH BLDG  
 288 N 1460 W  
 SALT LAKE CITY UT 84116-3231, or  
 at the Division of Administrative Rules.**

**DIRECT QUESTIONS REGARDING THIS RULE TO:**  
 Dave Wham at the above address, by phone at 801-538-6052, by FAX at 801-538-6016, or by Internet E-mail at [dwham@utah.gov](mailto:dwham@utah.gov)

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 05/31/2005.

THIS RULE MAY BECOME EFFECTIVE ON: 06/01/2005

AUTHORIZED BY: Dianne R. Nielson, Executive Director

### **R317. Environmental Quality, Water Quality. R317-2. Standards of Quality for Waters of the State.**

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#### **R317-2-14. Numeric Criteria.**

TABLE 2.14.1  
 NUMERIC CRITERIA FOR DOMESTIC,  
 RECREATION, AND AGRICULTURAL USES

Parameter	Domestic Source	Recreation and Aesthetics		Agri-culture
	1C	2A	2B	4
<b>BACTERIOLOGICAL (30-DAY GEOMETRIC MEAN) (NO.)/100 ML (7)</b>				
E. coli	206	126	206	
<b>MAXIMUM (NO.)/100 ML (7)</b>				
E. coli	940	576	940	
<b>PHYSICAL</b>				
pH (RANGE)	6.5-9.0	6.5-9.0	6.5-9.0	6.5-9.0
Turbidity Increase (NTU)		10	10	
<b>METALS (DISSOLVED, MAXIMUM MG/L) (2)</b>				
Arsenic [ <del>Trivalent</del> ]	0.01			0.1
Barium	1.0			
Beryllium	<0.004			
Cadmium	0.01			0.01
Chromium	0.05			0.10
Copper				0.2
Lead	0.015			0.1
Mercury	0.002			
Selenium	0.05			0.05
Silver	0.05			

<p>INORGANICS (MAXIMUM MG/L)</p> <p>Bromate 0.01</p> <p>Boron 0.75</p> <p>Chlorite &lt;1.0</p> <p>Fluoride (3) 1.4-2.4</p> <p>Nitrates as N 10</p> <p>Total Dissolved Solids (4)</p> <p style="padding-left: 20px;">Irrigation 1200</p> <p style="padding-left: 20px;">Stock Watering 2000</p> <p>RADIOLOGICAL (MAXIMUM pCi/L)</p> <p>Gross Alpha 15 15</p> <p>Gross Beta 4 mrem/yr</p> <p>Radium 226, 228 (Combined) 5</p> <p>Strontium 90 8</p> <p>Tritium 20000</p> <p>Uranium 30</p> <p>ORGANICS (MAXIMUM UG/L)</p> <p>Chlorophenoxy Herbicides</p> <p>2,4-D 70</p> <p>2,4,5-TP 10</p> <p>Methoxychlor 40</p> <p>POLLUTION INDICATORS (5)</p> <p>BOD (MG/L) 5 5 5</p> <p>Nitrate as N (MG/L) 4 4</p> <p>Total Phosphorus as P (MG/L)(6) 0.05 0.05</p> <p>FOOTNOTES: (1) Reserved (2) The dissolved metals method involves filtration of the sample in the field, acidification of the sample in the field, no digestion process in the laboratory, and analysis by atomic absorption or inductively coupled plasma (ICP) spectrophotometry. (3) Maximum concentration varies according to the daily maximum mean air temperature.</p> <p>TEMP (C) MG/L</p> <p>12.0 2.4</p> <p>12.1-14.6 2.2</p> <p>14.7-17.6 2.0</p> <p>17.7-21.4 1.8</p> <p>21.5-26.2 1.6</p> <p>26.3-32.5 1.4</p> <p>(4) Total dissolved solids (TDS) limits may be adjusted if such adjustment does not impair the designated beneficial use of the receiving water. The total dissolved solids (TDS) standards shall be at background where it can be shown that natural or un-alterable conditions prevent its attainment. In such cases rulemaking will be undertaken to modify the standard accordingly.</p> <p>Site Specific Standards for Total Dissolved Solids (TDS)</p> <p>Castle Creek from confluence with the Colorado River to Seventh Day Adventist Diversion: 1,800 mg/l;</p> <p>Cottonwood Creek from the confluence with Huntington Creek to I-57: 3,500 mg/l;</p> <p>Ferron Creek from the confluence with San Rafael River to Highway 10: 3,500 mg/l;</p> <p>Gordon Creek from the confluence with Price River to headwaters: 3,800 mg/l;</p>	<p>Huntington Creek and tributaries from the confluence with Cottonwood Creek to U-10: 4,800 mg/l;</p> <p>Ivie Creek and its tributaries from the confluence with Muddy Creek to U-10: 2,600 mg/l;</p> <p>Lost Creek from the confluence with Sevier River to U.S. Forest Service Boundary: 4,600 mg/l;</p> <p>Muddy Creek and tributaries from the confluence with Quitchupah Creek to U-10: 2,600 mg/l;</p> <p>Muddy Creek from confluence with Fremont River to confluence with Quitchupah Creek: 5,800 mg/l;</p> <p>North Creek from the confluence with Virgin River to headwaters: 2,035 mg/l;</p> <p>Onion Creek from the confluence with Colorado River to road crossing above Stinking Springs: 3000 mg/l;</p> <p>Brine Creek-Petersen Creek, from the confluence with the Sevier River to U-119 Crossing: 9,700 mg/l;</p> <p>Pinnacle Creek from the confluence with Price River to headwaters: 3,800 mg/l;</p> <p>Price River and tributaries from the confluence with Coal Creek to Carbon Canal Diversion: 1,700 mg/l;</p> <p>Price River and tributaries from the confluence with Green River to confluence with Soldier Creek: 3,000 mg/l;</p> <p>Quitchupah Creek from the confluence with Ivie Creek to U-10: 2,600 mg/l;</p> <p>Rock Canyon Creek from the confluence with Cottonwood Creek to headwaters: 3,500 mg/l;</p> <p>San Pitch River from below Gunnison Reservoir to the Sevier River: 2,400 mg/l;</p> <p>San Rafael River from the confluence with the Green River to Buckhorn Crossing: 4,100 mg/l;</p> <p>San Rafael River from the Buckhorn Crossing to the confluence with Huntington Creek and Cottonwood Creek: 3,500 mg/l;</p> <p>Sevier River between Gunnison Bend Reservoir and DMAD Reservoir: 1,725 mg/l;</p> <p>Sevier River from Gunnison Bend Reservoir to Clear Lake: 3,370 mg/l;</p> <p>Virgin River from the Utah/Arizona border to Pah Tempe Springs: 2,360 mg/l</p> <p>(5) Investigations should be conducted to develop more information where these pollution indicator levels are exceeded. (6) Total Phosphorus as P (mg/l) indicator for lakes and reservoirs shall be 0.025. (7) Where the criteria are exceeded and there is a reasonable basis for concluding that the indicator bacteria are primarily from natural sources (wildlife), e.g., in National Wildlife Refuges and State Waterfowl Management Areas, the criteria may be considered attained. Exceedences of bacteriological numeric criteria from nonhuman nonpoint sources will generally be addressed through appropriate Federal, State, and local nonpoint source programs.</p> <p style="text-align: center;">*****</p> <p><b>KEY: water pollution, water quality standards 2005 Notice of Continuation October 7, 2002 19-5</b></p>
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## NOTICES OF 120-DAY (EMERGENCY) RULES

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An agency may file a 120-DAY (EMERGENCY) RULE when it finds that the regular rulemaking procedures would:

- (a) cause an imminent peril to the public health, safety, or welfare;
- (b) cause an imminent budget reduction because of budget restraints or federal requirements; or
- (c) place the agency in violation of federal or state law (*Utah Code* Subsection 63-46a-7(1) (2001)).

As with a PROPOSED RULE, a 120-DAY RULE is preceded by a RULE ANALYSIS. This analysis provides summary information about the 120-DAY RULE including the name of a contact person, justification for filing a 120-DAY RULE, anticipated cost impact of the rule, and legal cross-references. A row of dots in the text (. . . .) indicates that unaffected text was removed to conserve space.

A 120-DAY RULE is effective at the moment the Division of Administrative Rules receives the filing, or on a later date designated by the agency. A 120-DAY RULE is effective for 120 days or until it is superseded by a permanent rule.

Because 120-DAY RULES are effective immediately, the law does not require a public comment period. However, when an agency files a 120-DAY RULE, it usually files a PROPOSED RULE at the same time, to make the requirements permanent. Comment may be made on the proposed rule. Emergency or 120-DAY RULES are governed by *Utah Code* Section 63-46a-7 (2001); and *Utah Administrative Code* Section R15-4-8.

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### Public Safety, Driver License **R708-41** Requirements for Acceptable Documentation

#### NOTICE OF 120-DAY (EMERGENCY) RULE

DAR FILE NO.: 27808  
FILED: 04/11/2005, 17:10

#### RULE ANALYSIS

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The purpose of the rule is to establish standards for acceptable documentation of an applicant's identity, Utah resident status, Utah residence address, proof of legal presence, proof of citizenship, and other proof or documentation required under Title 53, Chapter 3.

**SUMMARY OF THE RULE OR CHANGE:** The new law, Title 53, Chapter 3, requires the Driver License Division to determine if an applicant is a Utah resident and have the applicant establish proof of a Utah residence address as part of the requirement to get a Utah Driving Privilege Card, a Driver License, a Commercial Driver License, or an Identification Card. Effective July 1, 2005, documentation is required by the division to verify that the applicant is a citizen of a country other than the United States, is legally present in the United States, and does not qualify for a Social Security Number. Additionally, a Utah Driving Privilege Card cannot be used by a governmental entity as proof of personal identification and it cannot be renewed through the mail or on the Internet. (DAR NOTE: A corresponding proposed new Rule R708-41 is under DAR No. 27809 in this issue.)

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 53-3-104

#### ANTICIPATED COST OR SAVINGS TO:

❖ **THE STATE BUDGET:** There is no cost to state government because this rule only clarifies what documentation is acceptable for getting a Utah Driving Privilege Card, a Driver License, a Commercial Driver License, and an Identification Card.

❖ **LOCAL GOVERNMENTS:** There will be no cost to local governments because the issuance of a Driving Privilege Card, a Driver License, a Commercial Driver License, and an Identification Card is exclusively a state responsibility.

❖ **OTHER PERSONS:** There is a potential for an individual to incur a cost for obtaining authorized copies of documents necessary to provide acceptable documentation, if the individual does not have the required documents in his or her possession.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** There is a potential for an individual to incur a cost for obtaining authorized copies of documents necessary to provide acceptable documentation, if the individual does not have the required documents in his or her possession.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** There is no fiscal impact on businesses because of this rule. Robert Flowers, Commissioner

**EMERGENCY RULE REASON AND JUSTIFICATION:** REGULAR RULEMAKING PROCEDURES WOULD place the agency in violation of federal or state law.



We need an emergency rule because the Governor signed into law S.B. 227 and H.B. 223 which required the public to immediately provide required documents necessary to establish Utah residency and a Utah resident address in order for them to get a Utah Driving Privilege Card, a Driver License, a Commercial Driver License, and an Identification card. S.B. 227 required the division to make a rule defining what is acceptable documentation. (DAR NOTE: S.B. 227 is found at UT L 2005 Ch 20, and was effective 03/08/2005. H.B. 223 is found at UT L 2005 Ch 34, and will be effective 07/01/2005.)

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

PUBLIC SAFETY  
DRIVER LICENSE  
CALVIN L RAMPTON COMPLEX  
4501 S 2700 W 3RD FL  
SALT LAKE CITY UT 84119-5595, or  
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:  
Vinn Roos at the above address, by phone at 801-965-4456, by FAX at 801-964-4482, or by Internet E-mail at vroos@utah.gov

THIS RULE IS EFFECTIVE ON: 04/11/2005

AUTHORIZED BY: Nannette Rolfe, Director

**R708. Public Safety, Driver License.**

**R708-41. Requirements for Acceptable Documentation.**

**R708-41-1. Purpose.**

The purpose of this rule is to define acceptable documentation pursuant to Title 53, Chapter 3.

**R708-41-2. Authority.**

This rule is authorized by Section 53-3-104.

**R708-41-3. Definitions.**

(1) "Utah Residence address" means the place where an individual has a fixed permanent home and principal establishment in Utah and in which the individual voluntarily resides, that is not for a special or temporary purpose.

(2) "Legal Presence" means that an individual's presence in the United States does not violate state or federal law.

**R708-41-4. Obtaining a Utah Driving Privilege Card, Driver License, Commercial Driver License or an Identification Card.**

(1) An applicant seeking to obtain a Utah Driving Privilege Card, Driver license, Commercial Driver License or an Identification Card must:

(a) provide two different forms of identification from the following list to verify full legal name, date of birth, and gender pursuant to Section 53-3-205(9)(a) and 53-3-804 (2):

- (i) Certificate of Naturalization;
- (ii) Certificate of Citizenship;
- (iii) driver license issued in the United States;
- (iv) foreign birth certificate with certified translation;

- (v) I-94 card or INS I-551 card;
- (vi) Indian Blood Certificate;
- (vii) Matricular Consular ID Card (Issued in Utah);
- (viii) Resident Alien Card;
- (ix) U.S. Birth Certificate (from Vital Records);
- (x) U.S. Certificate of Birth Abroad;
- (xi) U.S. Military Identification Card or DD-214;
- (xii) U.S. Passport; and
- (xiii) other documentation furnished by the individual if it can be determined that the documentation unequivocally demonstrates proof of identity.

(b) provide the applicant's Utah residence address. PO Boxes and business addresses are not accepted; and

(c) provide two different types of original (current and valid) documents from the following list as proof of a Utah resident address.

- (i) property tax notice, statement or receipt, within one year;
- (ii) utility bill, billing date within 60 days, (no cell phone bills);

(iii) Utah vehicle registration or title;

(iv) bank statement, within 60 days;

(v) recent mortgage papers;

(vi) current residential rental contract;

(vii) major credit card bill, within 60 days;

(viii) court order of probation, order of parole or order of mandatory release, must display residential address;

(ix) transcripts from an accredited college, university, or high school; or

(x) other documentation furnished by the individual if it can be determined that the documentation unequivocally demonstrates proof of residency or domicile.

(2) An applicant for a Utah Driving Privilege Card must also provide:

(a) a valid Individual Tax Identification Number (ITIN) card issued by the Internal Revenue Service; or

(b) effective July 1, 2005, documentation from the following list, as requested by the division, to verify that the applicant is a citizen of a country other than the United States, is legally present in the United States, and does not qualify for a Social Security Number:

(i) valid foreign passport with appropriate immigration document(s);

(ii) INS-I-551 Resident Alien Card issued since 1997 (cards issued prior to this date need to be screened for appropriate security features);

(iii) INS I-688 Temporary Resident Identification Card;

(iv) INS I-688B, I-766 Employment Authorization Card;

(v) U.S. Department of Receptions and Placement Program Assurance Form (Refugee); or

(vi) other documentation furnished by the individual if it can be determined that the documentation unequivocally demonstrates that the applicant is a citizen of a country other than the United States, is legally present in the United States, and does not qualify for a Social Security Number.

**KEY: acceptable documentation**

**April 11, 2005**

**53-3-104**



# FIVE-YEAR NOTICES OF REVIEW AND STATEMENTS OF CONTINUATION

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Within five years of an administrative rule's original enactment or last five-year review, the responsible agency is required to review the rule. This review is designed to remove obsolete rules from the *Utah Administrative Code*.

Upon reviewing a rule, an agency may: repeal the rule by filing a PROPOSED RULE; continue the rule as it is by filing a NOTICE OF REVIEW AND STATEMENT OF CONTINUATION (NOTICE); or amend the rule by filing a PROPOSED RULE and by filing a NOTICE. By filing a NOTICE, the agency indicates that the rule is still necessary.

NOTICES are not followed by the rule text. The rule text that is being continued may be found in the most recent edition of the *Utah Administrative Code*. The rule text may also be inspected at the agency or the Division of Administrative Rules. NOTICES are effective when filed. NOTICES are governed by *Utah Code* Section 63-46a-9 (1998).

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## Environmental Quality, Drinking Water **R309-600** Drinking Water Source Protection for Groundwater Sources

### FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

DAR FILE NO.: 27816  
FILED: 04/14/2005, 14:34

### NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Subsection 19-4-104(1)(a)(iv) authorizes the Drinking Water Board to adopt this rule which governs the protection of ground-water sources of drinking water.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received either supporting or opposing this rule

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: The continuation of this rule is needed because it sets forth minimum requirements deemed necessary by the Drinking Water Board to establish a uniform, statewide program for public water systems to protect their ground-water sources of drinking water from contamination.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

ENVIRONMENTAL QUALITY  
DRINKING WATER  
150 N 1950 W  
SALT LAKE CITY UT 84116-3085, or  
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Kate Johnson at the above address, by phone at 801-536-4206, by FAX at 801-536-4211, or by Internet E-mail at katej@utah.gov

AUTHORIZED BY: Kevin Brown, Director

EFFECTIVE: 04/14/2005



## Environmental Quality, Drinking Water **R309-605** Source Protection: Drinking Water Source Protection for Surface Water Sources

### FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

DAR FILE NO.: 27815  
FILED: 04/14/2005, 14:33

### NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Subsection 19-4-104(1)(a)(iv) authorizes the Drinking Water Board to adopt this rule which governs the protection of surface water sources of drinking water.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received that either oppose or support this rule.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: The continuation of this rule is needed because it establishes practices deemed necessary by the Drinking Water Board to protect developed surface

water sources of drinking water from pollution or the potential for pollution.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

ENVIRONMENTAL QUALITY  
DRINKING WATER  
150 N 1950 W  
SALT LAKE CITY UT 84116-3085, or  
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:  
Kate Johnson at the above address, by phone at 801-536-4206, by FAX at 801-536-4211, or by Internet E-mail at [katej@utah.gov](mailto:katej@utah.gov)

AUTHORIZED BY: Kevin Brown, Director

EFFECTIVE: 04/14/2005



**End of the Five-Year Notices of Review and Statements of Continuation Section**

## NOTICES OF RULE EFFECTIVE DATES

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These are the effective dates of PROPOSED RULES or CHANGES IN PROPOSED RULES published in earlier editions of the *Utah State Bulletin*. These effective dates are at least 31 days and not more than 120 days after the date the following rules were published.

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### Abbreviations

AMD = Amendment  
CPR = Change in Proposed Rule  
NEW = New Rule  
R&R = Repeal and Reenact  
REP = Repeal

### Commerce

Occupational and Professional Licensing  
No. 27698 (AMD): R156-22. Professional Engineers and Professional Land Surveyors Licensing Act Rules.  
Published: March 1, 2005  
Effective: April 4, 2005

### Health

Health Care Financing, Coverage and Reimbursement Policy  
No. 27703 (NEW): R414-33C. Targeted Case Management for the Homeless.  
Published: March 1, 2005  
Effective: April 7, 2005

### Natural Resources

Wildlife Resources  
No. 27721 (AMD): R657-12. Hunting and Fishing Accommodations for Disabled People.  
Published: March 15, 2005  
Effective: April 15, 2005

### Workforce Services

Employment Development  
No. 27661 (AMD): R986-100. Employment Support Programs.  
Published: February 15, 2005  
Effective: April 7, 2005  
  
No. 27660 (AMD): R986-700. Child Care Assistance.  
Published: February 15, 2005  
Effective: April 7, 2005

**End of the Notices of Rule Effective Dates Section**

# RULES INDEX BY AGENCY (CODE NUMBER) AND BY KEYWORD (SUBJECT)

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The *Rules Index* is a cumulative index that reflects all effective changes to Utah's administrative rules. The current *Index* lists changes made effective from January 1, 2005, including notices of effective date received through April 15, 2005, the effective dates of which are no later than May 1, 2005. The *Rules Index* is published in the *Utah State Bulletin* and in the annual *Index of Changes*. Nonsubstantive changes, while not published in the *Bulletin*, do become part of the *Utah Administrative Code (Code)* and are included in this *Index*, as well as 120-Day (Emergency) rules that do not become part of the *Code*. The rules are indexed by Agency (Code Number) and Keyword (Subject).

DAR NOTE: The index may contain inaccurate page number references. Also the index is incomplete in the sense that index entries for Changes in Proposed Rules (CPRs) are not preceded by entries for their parent Proposed Rules. Bulletin issue information and effective date information presented in the index are, to the best of our knowledge, complete and accurate. If you have any questions regarding the index and the information it contains, please contact Nancy Lancaster (801 538-3218), Mike Broschinsky (801 538-3003), or Kenneth A. Hansen (801 538-3777).

A copy of the *Rules Index* is available for public inspection at the Division of Administrative Rules (4120 State Office Building, Salt Lake City, UT), or may be viewed online at the Division's web site (<http://www.rules.utah.gov/>).

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## RULES INDEX - BY AGENCY (CODE NUMBER)

### ABBREVIATIONS

AMD = Amendment	NSC = Nonsubstantive rule change
CPR = Change in proposed rule	REP = Repeal
EMR = Emergency rule (120 day)	R&R = Repeal and reenact
NEW = New rule	5YR = Five-Year Review
EXD = Expired	

CODE REFERENCE	TITLE	FILE NUMBER	ACTION	EFFECTIVE DATE	BULLETIN ISSUE/PAGE
<b>Administrative Services</b>					
<u>Facilities Construction and Management</u>					
R23-1	Procurement of Construction	27603	AMD	03/15/2005	2005-2/2
R23-2	Procurement of Architect-Engineer Services	27605	AMD	03/15/2005	2005-2/7
R23-3	Planning and Programming for Capital Projects	27615	AMD	03/15/2005	2005-2/9
R23-4	Suspension/Debarment and Contract Performance Review Committee	27610	AMD	03/15/2005	2005-2/10
R23-26	Dispute Resolution	27614	NEW	03/15/2005	2005-2/12
<u>Fleet Operations</u>					
R27-1-2	Definitions	27546	AMD	01/10/2005	2004-23/3
R27-3-6	Application for Commute or Take Home Use	27599	NSC	02/01/2005	Not Printed
R27-4	Vehicle Replacement and Expansion of State Fleet	27543	AMD	01/10/2005	2004-23/5
R27-4-1	Authority	27594	NSC	02/01/2005	Not Printed
R27-6	Fuel Dispensing Program	27544	AMD	01/10/2005	2004-23/7

RULES INDEX

CODE REFERENCE	TITLE	FILE NUMBER	ACTION	EFFECTIVE DATE	BULLETIN ISSUE/PAGE
<u>Records Committee</u>					
R35-1a	State Records Committee Definitions	27621	NEW	03/08/2005	2005-2/17
R35-2	Declining Appeal Hearings	27625	AMD	03/04/2005	2005-2/18
R35-3	Prehearing Conferences	27622	AMD	03/04/2005	2005-2/19
R35-4	Compliance with State Records Committee Decisions and Orders	27624	AMD	03/04/2005	2005-2/20
R35-5	Subpoenas Issued by the Records Committee	27623	AMD	03/04/2005	2005-2/21
R35-6	Expedited Hearing	27620	AMD	03/04/2005	2005-2/22
<b>Agriculture and Food</b>					
<u>Animal Industry</u>					
R58-1	Admission and Inspection of Livestock, Poultry, and Other Animals	27570	AMD	01/18/2005	2004-24/5
R58-1-7	Swine	27687	AMD	03/18/2005	2005-4/8
R58-2	Diseases, Inspections and Quarantines	27581	AMD	02/01/2005	2005-1/9
R58-7	Livestock Markets, Satellite Video Livestock Auction Market, Livestock Sales, Dealers, and Livestock Market Weighpersons	27688	5YR	02/01/2005	2005-4/47
R58-10	Meat and Poultry Inspection	27693	5YR	02/03/2005	2005-5/28
R58-17	Aquaculture and Aquatic Animal Health	27696	5YR	02/03/2005	2005-5/28
R58-21	Trichomoniasis	27694	5YR	02/03/2005	2005-5/29
R58-22	Equine Infectious Anemia (EIA)	27695	5YR	02/03/2005	2005-5/29
<u>Marketing and Conservation</u>					
R65-10	Agriculture Resource Development Loans (ARDL)	27787	5YR	03/31/2005	2005-8/56
<u>Plant Industry</u>					
R68-3	Utah Fertilizer Act Governing Fertilizers and Soil Amendments	27645	5YR	01/07/2005	2005-3/58
R68-20	Utah Organic Standards	27697	5YR	02/04/2005	2005-5/30
<u>Regulatory Services</u>					
R70-440	Egg Products Inspection	27514	NSC	01/01/2005	Not Printed
R70-440-2	Adopt by Reference	27628	AMD	02/15/2005	2005-2/23
R70-440-2	Adopt by Reference	27667	NSC	03/01/2005	Not Printed
R70-540-14	Exemptions	27569	AMD	03/18/2005	2004-24/7
R70-960-7	Registration Certificate Displayed	27523	NSC	01/01/2005	Not Printed
<b>Capitol Preservation Board (State)</b>					
<u>Administration</u>					
R131-1	Procurement of Architectural and Engineering Services	27711	5YR	02/16/2005	2005-6/33
R131-2	Capitol Hill Facility Use	27712	5YR	02/16/2005	2005-6/33
R131-7	State Capitol Preservation Board Master Planning Policy	27713	5YR	02/16/2005	2005-6/34
R131-8	CPB Facilities and Grounds: Maintenance of Aesthetics	27631	NEW	03/03/2005	2005-2/24
R131-9	State Capitol Preservation Board Art Program and Policy	27632	NEW	03/03/2005	2005-2/26
<b>Commerce</b>					
<u>Administration</u>					
R151-1	Department of Commerce General Provisions	27633	NEW	02/15/2005	2005-2/29
R151-46b	Department of Commerce Administrative Procedures Act Rules	27636	AMD	02/15/2005	2005-2/32

CODE REFERENCE	TITLE	FILE NUMBER	ACTION	EFFECTIVE DATE	BULLETIN ISSUE/PAGE
<u>Occupational and Professional Licensing</u>					
R156-1	General Rules of the Division of Occupational and Professional Licensing	27499	NSC	01/01/2005	Not Printed
R156-22	Professional Engineers and Professional Land Surveyors Licensing Act Rules	27698	AMD	04/04/2005	2005-5/2
R156-31b	Nurse Practice Act Rules	27600	AMD	02/17/2005	2005-2/36
R156-38	Residence Lien Restriction and Lien Recovery Fund Rules	27752	5YR	03/15/2005	2005-7/75
R156-38b	State Construction Registry Rules	27734	NEW	04/18/2005	2005-6/6
R156-47b	Massage Therapy Practice Act Rules	27548	AMD	03/07/2005	2004-24/7
R156-47b	Massage Therapy Practice Act Rules	27548	CPR	03/07/2005	2005-3/51
R156-50	Private Probation Provider Licensing Act Rules	27435	CPR	01/18/2005	2004-24/58
R156-50	Private Probation Provider Licensing Act Rules	27435	AMD	01/18/2005	2004-20/12
R156-56	Utah Uniform Building Standard Act Rules	27489	AMD	01/01/2005	2004-21/6
R156-56-704	Statewide Amendments to the IBC	27490	AMD	01/01/2005	2004-21/11
R156-60c	Professional Counselor Licensing Act Rules	27749	5YR	03/14/2005	2005-7/75
R156-61-502	Unprofessional Conduct	27538	AMD	01/04/2005	2004-23/40
R156-71-202	Naturopathic Physician Formulary	27533	AMD	01/04/2005	2004-23/41
<u>Securities</u>					
R164-2	Investment Adviser - Unlawful Acts	27732	5YR	02/28/2005	2005-6/34
R164-9-1	Registration by Coordination	27777	EMR	03/25/2005	2005-8/53
<b>Community and Economic Development</b>					
<u>Community Development, Community Services</u>					
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**ABBREVIATIONS**

AMD = Amendment  
 CPR = Change in proposed rule  
 EMR = Emergency rule (120 day)  
 NEW = New rule  
 EXD = Expired  
 NSC = Nonsubstantive rule change  
 REP = Repeal  
 R&R = Repeal and reenact  
 5YR = Five-Year Review

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