

# UTAH STATE BULLETIN

OFFICIAL NOTICES OF UTAH STATE GOVERNMENT  
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Nancy L. Lancaster, Managing Editor

The *Utah State Bulletin (Bulletin)* is an official noticing publication of the executive branch of Utah state government. The Office of Administrative Rules, part of the Department of Administrative Services, produces the *Bulletin* under authority of Section 63G-3-402.

The Portable Document Format (PDF) version of the *Bulletin* is the official version. The PDF version of this issue is available at <https://rules.utah.gov/>. Any discrepancy between the PDF version and other versions will be resolved in favor of the PDF version.

Inquiries concerning the substance or applicability of an administrative rule that appears in the *Bulletin* should be addressed to the contact person for the rule. Questions about the *Bulletin* or the rulemaking process may be addressed to: Office of Administrative Rules, PO Box 141007, Salt Lake City, Utah 84114-1007, telephone 801-538-3003. Additional rulemaking information and electronic versions of all administrative rule publications are available at <https://rules.utah.gov/>.

The information in this *Bulletin* is summarized in the *Utah State Digest (Digest)* of the same volume and issue number. The *Digest* is available by e-mail subscription or online. Visit <https://rules.utah.gov/> for additional information.

Office of Administrative Rules, Salt Lake City 84114

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# SPECIAL NOTICES

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## Health Health Care Financing, Coverage and Reimbursement Policy

### Amendment to 1115 Demonstration Waiver

The Utah Department of Health, Division of Medicaid and Health Financing (DMHF), will hold public hearings to discuss an amendment to Utah's 1115 Demonstration Waiver.

DMHF is requesting authority to amend the State's 1115 Demonstration Waiver to implement the provisions of Senate Bill 11- "Medicaid Dental Coverage Amendments", which passed during the 2019 General Session. The provisions of this amendment will include:

1. Authority to provide full state plan dental benefits to Medicaid eligible individuals, age 65 and older.
2. Authority to provide Medicaid funds for porcelain and porcelain-to-metal crowns for Medicaid eligible individuals age 65 and over, as well as for Targeted Adult Medicaid beneficiaries who are eligible to receive dental benefits under the State's 1115 Demonstration Waiver.
3. Providing benefits through a fee-for-service model, and by contracting with an entity that:
  - a. Has demonstrated experience working with individuals who are being treated for both a substance use disorder and a major oral health disease;
  - b. Operates a program, targeted at the individuals described in this amendment, that has demonstrated, through a peer-reviewed evaluation, the effectiveness of providing dental treatment to those individuals;
  - c. Is willing to pay for an amount equal to the program's non-federal share of the cost of providing dental services to the population described.

A copy of the DMHF waiver amendment will be available online as of May 6, 2019, at <https://medicaid.utah.gov/waiver-application>

#### **Public Hearings:**

DMHF will conduct two public hearings to discuss the waiver amendment. The dates, times, and locations are listed below:

Monday, May 13, 2019  
4:00 p.m. to 6:00 p.m.  
Multi-Agency State Office Building  
195 N 1950 W, Salt Lake City, Utah  
Room 1020

Thursday, May 16, 2019  
2:00 p.m. to 4:00 p.m. (as part of the Medical Care Advisory Committee (MCAC) meeting)  
Cannon Health Building  
288 N 1460 W, Salt Lake City, Utah  
Room 125

A conference line is available for those who would like to participate by phone: 1-877-820-7831, passcode 378804#.

Individuals requiring an accommodation to fully participate in either meeting may contact Jennifer Meyer-Smart at 801-538-6338 by 5:00 p.m. on Thursday, May 9, 2019.

#### **Public Comment:**

*The public may comment on the proposed waiver amendment during the 30-day public comment period from May 6, 2019, through June 5, 2019. Comments may be submitted:*

Online: <https://medicaid.utah.gov/public-comments-0>

SPECIAL NOTICES

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*Email: [Medicaid1115waiver@utah.gov](mailto:Medicaid1115waiver@utah.gov)*

*Mail:*

*Utah Department of Health*

*Division of Medicaid and Health Financing*

*PO Box 143106*

*Salt Lake City, UT 84114-3106*

*Attn: Jennifer Meyer-Smart*

**End of the Special Notices Section**

## NOTICES OF PROPOSED RULES

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A state agency may file a **PROPOSED RULE** when it determines the need for a substantive change to an existing rule. With a **NOTICE OF PROPOSED RULE**, an agency may create a new rule, amend an existing rule, repeal an existing rule, or repeal an existing rule and reenact a new rule. Filings received between April 02, 2019, 12:00 a.m., and April 15, 2019, 11:59 p.m. are included in this, the May 01, 2019, 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 (example). Deletions made to existing rules are struck out with brackets surrounding them (~~example~~). Rules being repealed are completely struck out. A row of dots in the text between paragraphs (. . . . .) indicates that unaffected text from within a section was removed to conserve space. Unaffected sections are not usually printed. If a **PROPOSED RULE** is too long to print, the Office of Administrative Rules may 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 Office 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, 2019. The agency may accept comment beyond this date and will indicate 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 hold a hearing on a specific **PROPOSED RULE**. Section 63G-3-302 requires that a hearing request be received by the agency proposing the rule "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, 2019, the agency may notify the Office 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 seven calendar days after the close of the public comment period 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 Office of Administrative Rules does not receive a **NOTICE OF EFFECTIVE DATE OF A CHANGE IN PROPOSED RULE**, the **PROPOSED RULE** lapses.

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 Section 63G-3-301, Rule R15-2, and Sections R15-4-3, R15-4-4, R15-4-5a, R15-4-9, and R15-4-10.

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

**Administrative Services, Finance**  
**R25-7**  
**Travel-Related Reimbursements for State Employees**

**NOTICE OF PROPOSED RULE**

(Amendment)  
 DAR FILE NO.: 43656  
 FILED: 04/15/2019

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** Due to changes in the Internal Revenue Service (IRS) mileage reimbursement rates, and changes to the costs calculated to operate state vehicles, mileage reimbursement rates were revised. Also, out-of-state meal reimbursements were increased to match the Government Services Administration (GSA) base for meals and incidental expenses (M&IE). In-state meal reimbursements were increased due to inflation. Lastly, because some hotel booking rates have increased, certain lodging per diem rates have changed.

**SUMMARY OF THE RULE OR CHANGE:** These rule changes increase reimbursement rates for mileage, lodging, and food.

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Section 63A-3-106 and Section 63A-3-107

**ANTICIPATED COST OR SAVINGS TO:**

- ◆ **THE STATE BUDGET:** There will potentially be an increased cost to the state as reimbursements for meals, mileage, and hotels have increased.
- ◆ **LOCAL GOVERNMENTS:** There may be costs to local governments that are required to follow this rule.
- ◆ **SMALL BUSINESSES:** Some small businesses may see an inestimable increase in revenues because employees will be eligible for increased reimbursement for travel.
- ◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** Individuals eligible for reimbursement will see an increase in their reimbursement amounts. However, the Division of Finance cannot determine exactly what the increase will be as that depends on the amount of travel by individuals eligible for reimbursement.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** Because these amendments change reimbursement rates and do not require any new action on the part of persons applying for reimbursements, there are no compliance costs.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** I have reviewed these changes with the Division of Finance

Director and believe these changes are reasonable and warranted.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:  
 ADMINISTRATIVE SERVICES  
 FINANCE  
 ROOM 2110 STATE OFFICE BLDG  
 450 N STATE ST  
 SALT LAKE CITY, UT 84114-1201  
 or at the Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:  
 ◆ Cory Weeks by phone at 801-538-3100, or by Internet E-mail at cweeks@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 05/31/2019

THIS RULE MAY BECOME EFFECTIVE ON: 07/01/2019

AUTHORIZED BY: John Reidhead, Director

**Appendix 1: Regulatory Impact Summary Table\***

Fiscal Costs	FY 2019	FY 2020	FY 2021
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0
Other Person	\$0	\$0	\$0
<b>Total Fiscal Costs:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
Fiscal Benefits			
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0
Other Persons	\$0	\$0	\$0

<b>Total Fiscal Benefits:</b>	\$0	\$0	\$0
<b>Net Fiscal Benefits:</b>	\$0	\$0	\$0

\*This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts for State Government, Local Government, Small Businesses and Other Persons are described in the narrative. Inestimable impacts for Non-Small Businesses are described in Appendix 2.

**Appendix 2: Regulatory Impact to Non-Small Businesses**  
 These rule changes will have no effect on non-small businesses.

The Division Director, John Reidhead, has reviewed and approved this fiscal analysis.

**R25. Administrative Services, Finance.**

**R25-7. Travel-Related Reimbursements for State Employees.**

**R25-7-1. Purpose.**

The purpose of this rule is to establish procedures to be followed by departments to pay travel-related reimbursements to state employees.

**R25-7-2. Authority and Exemptions.**

This rule is established pursuant to:

(1) Section 63A-3-107, which authorizes the Division of Finance to make rules governing in-state and out-of-state travel expenses; and

(2) Section 63A-3-106, which authorizes the Division of Finance to make rules governing meeting per diem and travel expenses for board members attending official meetings.

**R25-7-3. Definitions.**

(1) "Agency" means any department, division, commission, council, board, bureau, committee, office, or other administrative subunit of state government.

(2) "Board" means a board, commission, council, committee, task force, or similar body established to perform a governmental function.

(3) "Department" means all executive departments of state government.

(4) "Finance" means the Division of Finance.

(5) "Home-Base" means the location the employee leaves from and/or returns to.

(6) "Per diem" means an allowance paid daily.

(7) "Policy" means the policies and procedures of the Division of Finance, as published in the "Accounting Policies and Procedures."

(8) "Rate" means an amount of money.

(9) "Reimbursement" means money paid to compensate an employee for money spent.

(10) "State employee" means any person who is paid on the state payroll system.

**R25-7-4. Eligible Expenses.**

(1) Reimbursements are intended to cover all normal areas of expense.

(2) Requests for reimbursement must be accompanied by original receipts for all expenses except those for which flat allowance amounts are established.

(3) Alcoholic Beverages are not reimbursable.

**R25-7-5. Approvals.**

(1) For insurance purposes, all state business travel, whether reimbursed by the state or not, must have prior approval by an appropriate authority. This also includes non-state employees where the state is paying for the travel expenses.

(2) Both in-state and out-of-state travel must be approved by the Executive Director or designee. The approval of in-state travel reimbursement forms may be considered as documentation of prior approval for in-state travel. Prior approval for out-of-state travel should be documented on form FI5 - "Request for Out-of-State Travel Authorization"[-], in the State's ESS Travel system or another system with equivalent controls and calculations.

(3) Exceptions to the prior approval for out-of-state travel must be justified in the comments section of the Request for Out-of-State Travel Authorization, form FI 5, in the State's ESS Travel system, another system with equivalent controls and calculations or on an attachment, and must be approved by the Department Director or the designee.

(4) The Department Director, the Executive Director, or the designee must approve all travel to out-of-state functions where more than two employees from the same department are attending the same function at the same time.

**R25-7-6. Reimbursement for Meals.**

(1) State employees who travel on state business may be eligible for a meal reimbursement.

(2) The reimbursement will include tax, tips, and other expenses associated with the meal.

(3) Allowances for in-state travel differ from those for out-of-state travel.

(a) The daily travel meal allowance for in-state travel is [~~\$43.00~~]\$45.00 and is computed according to the rates listed in the following table.

TABLE 1

In-State Travel Meal Allowances	
Meals	Rate
Breakfast	[ <del>\$10.00</del> ] <u>\$11.00</u>
Lunch	\$14.00
Dinner	[ <del>\$19.00</del> ] <u>\$20.00</u>
Total	[ <del>\$43.00</del> ] <u>\$45.00</u>

(b) The daily travel meal allowance for out-of-state travel is [~~\$46.00~~]\$50.00 and is computed according to the rates listed in the following table.

TABLE 2

Out-of-State Travel Meal Allowances

Meals	Rate
Breakfast	<del>[\$10.00]</del> <u>\$13.00</u>
Lunch	\$14.00
Dinner	<del>[\$22.00]</del> <u>\$23.00</u>
Total	<del>[\$46.00]</del> <u>\$50.00</u>

(4) When traveling to a Tier I premium location (Anchorage, Chicago, Hawaii, New York City, San Francisco, and Seattle), the traveler may choose to accept the per diem rate for out-of-state travel (as shown above) or to be reimbursed at the actual meal cost, with original receipts, up to ~~[\$69]~~ \$71 per day.

When traveling to a Tier II premium location (Atlanta, Baltimore, Boston, Dallas, Los Angeles, San Diego, and Washington, DC), the traveler may choose to accept the per diem rate for out-of-state travel (as shown above) or to be reimbursed at the actual meal cost, with original receipts, up to ~~[\$59]~~ \$61 per day.

(a) The traveler will qualify for premium rates on the day the travel begins and/or the day the travel ends only if the trip is of sufficient duration to qualify for all meals on that day.

(b) Complimentary meals of a hotel, motel and/or association and meals included in registration costs are deducted from the premium location allowance as follows:

Tier I Location

(i) If breakfast is provided deduct ~~[\$16]~~ \$18, leaving a premium allowance for lunch and dinner of actual up to \$53.

(ii) If lunch is provided deduct ~~[\$20]~~ \$19, leaving a premium allowance for breakfast and dinner of actual up to ~~[\$49]~~ \$52.

(iii) If dinner is provided deduct ~~[\$33]~~ \$34, leaving a premium allowance for breakfast and lunch of actual up to ~~[\$36]~~ \$37.

Tier II Location

(i) If breakfast is provided deduct ~~[\$13]~~ \$16, leaving a premium allowance for lunch and dinner of actual up to ~~[\$46]~~ \$45.

(ii) If lunch is provided deduct \$17, leaving a premium allowance for breakfast and dinner of actual up to ~~[\$42]~~ \$44.

(iii) If dinner is provided deduct ~~[\$29]~~ \$28, leaving a premium allowance for breakfast and lunch of actual up to ~~[\$30]~~ \$33.

(c) The traveler must use the same method of reimbursement for an entire day.

(d) Actual meal cost includes tips.

~~Alcoholic beverages are not reimbursable.~~

(5) When traveling in foreign countries, the traveler may choose to accept the per diem rate for out-of-state travel (as shown above) or to be reimbursed the actual meal cost, with original receipts, not to exceed the federal reimbursement rate for the location as of the date of travel.

(a) The traveler may use both reimbursement methods during a trip; however, they must use the same method of reimbursement for an entire day.

(b) Actual meal cost includes tips.

~~Alcoholic beverages are not reimbursable.~~

(6) The meal reimbursement calculation is comprised of three parts:

(a) The day the travel begins. The traveler's entitlement is determined by the time of day the traveler leaves their home base (the location the employee leaves from and/or returns to), as illustrated in the following table.

TABLE 3

The Day Travel Begins

1st Quarter a.m. 12:00-5:59 *B, L, D In-State [ <del>\$43.00</del> ] <u>\$45.00</u> \$0 Out-of-State [ <del>\$46.00</del> ] <u>\$50.00</u> \$0	2nd Quarter a.m. 6:00-11:59 *L, D In-State [ <del>\$33.00</del> ] <u>\$34.00</u> Out-of-State [ <del>\$36.00</del> ] <u>\$37.00</u> \$0	3rd Quarter p.m. 12:00-5:59 *D In-State [ <del>\$19.00</del> ] <u>\$20.00</u> Out-of-State [ <del>\$22.00</del> ] <u>\$23.00</u> \$0	4th Quarter p.m. 6:00-11:59 *no meals In-State [ <del>\$19.00</del> ] <u>\$20.00</u> Out-of-State [ <del>\$22.00</del> ] <u>\$23.00</u> \$0
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\*B = Breakfast, L = Lunch, D = Dinner

(b) The days at the location.

(i) Complimentary meals of a hotel, motel, and/or association and meals included in the registration cost are deducted from the total daily meal allowance. However, continental breakfasts will not reduce the meal allowance. Please Note: For breakfast, if a hot food item is offered, it is considered a complimentary meal, no matter how it is categorized by the hotel/conference facility. The meal is considered a "continental breakfast" if no hot food items are offered.

(ii) Meals provided on airlines will not reduce the meal allowance.

(c) The day the travel ends. The meal reimbursement the traveler is entitled to is determined by the time of day the traveler returns to their home base, as illustrated in the following table.

TABLE 4

The Day Travel Ends

1st Quarter a.m. 12:00- <del>[6:00]</del> <u>5:59</u> <del>[6:00]</del> <u>5:59</u> *no meals In-State \$0 <u>\$45.00</u> Out-of-State \$0 <u>\$50.00</u>	2nd Quarter a.m. <del>[6:01]</del> <u>6:00-11:59</u> <del>[6:01]</del> <u>6:00-11:59</u> *B In-State [ <del>\$10.00</del> ] <u>\$11.00</u> Out-of-State [ <del>\$10.00</del> ] <u>\$13.00</u>	3rd Quarter p.m. <del>[12:00]</del> <u>11:59</u> <del>[12:01]</del> <u>12:00-</u> *B, L In-State [ <del>\$24.00</del> ] <u>\$25.00</u> Out-of-State [ <del>\$24.00</del> ] <u>\$27.00</u>	4th Quarter p.m. <del>[12:01]</del> <u>12:00-</u> *B, L, D In-State [ <del>\$43.00</del> ] Out-of-State [ <del>\$46.00</del> ]
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\*B = Breakfast, L = Lunch, D = Dinner

(7) An employee may be authorized by the Department Director or designee to receive a taxable meal allowance when the employee's farthest destination is at least 100 miles one way from their home base and the employee does not stay overnight.

(a) Breakfast is paid when the employee leaves their home base before 6:00 a.m.

(b) Lunch is paid when the trip meets one of the following requirements:

(i) The employee is on an officially approved trip that warrants entitlement to breakfast and dinner.

(ii) The employee leaves their home base before 10 a.m. and returns after 2 p.m.

(iii) The Department Director provides prior written approval based on circumstances.

(c) Dinner is paid when the employee leaves their home base and returns at or after 6:00 p.m.

(d) The allowance is not considered an absolute right of the employee and is authorized at the discretion of the Department Director or designee.

**R25-7-7. Meals for Statutory Non-Salaried State Boards.**

(1) When a board meets and conducts business activities during mealtime, the cost of meals may be charged as public expense.

(2) Where salaried employees of the State of Utah or other advisors or consultants must, of necessity, attend such a meeting in order to permit the board to carry on its business, the meals of such employees, advisors, or consultants may also be paid. In determining whether or not the presence of such employees, advisors, or consultants is necessary, the boards are requested to restrict the attendance of such employees, advisors, or consultants to those absolutely necessary at such mealtime meetings.

**R25-7-8. Reimbursement for Lodging.**

State employees who travel on state business may be eligible for a lodging reimbursement.

(1) For stays at a conference hotel, the state will reimburse the actual cost plus tax and any mandatory fees charged by the hotel for both in-state and out-of-state travel. The traveler must include the conference registration brochure with the Travel Reimbursement Request, form FI 51A, FI 51B, or ESS Travel.

(2) For in-state lodging at a non-conference hotel, the state will reimburse the actual cost up to \$70 per night for single occupancy plus tax and any mandatory fees charged by the hotel except as noted in the table below:

TABLE 5  
Cities with Differing Rates

Beaver	\$75.00 plus tax and mandatory fees
Blanding	\$75.00 plus tax and mandatory fees
Bluff	\$95.00 plus tax and mandatory fees
Brigham City	\$80.00 plus tax and mandatory fees
Bryce Canyon City	\$80.00 plus tax and mandatory fees
Cedar City	\$80.00 plus tax and mandatory fees
Duchesne	<del>[\$85.00]</del> \$90.00 plus tax and mandatory fees
Ephraim	<del>[\$75.00]</del> \$80.00 plus tax and mandatory fees
Farmington	<del>[\$85.00]</del> \$90.00 plus tax and mandatory fees
Fillmore	<del>[\$75.00]</del> \$80.00 plus tax and mandatory fees
Garden City	\$80.00 plus tax and mandatory fees

<del>Green River</del>	<del>\$85.00 plus tax and mandatory fees]</del>
Hanksville	<del>[\$75.00]</del> \$85.00 plus tax and mandatory fees
Heber	\$85.00 plus tax and mandatory fees
Kanab	\$90.00 plus tax and mandatory fees
Layton	\$90.00 plus tax and mandatory fees
Logan	\$85.00 plus tax and mandatory fees
Mexican Hat	\$90.00 plus tax and mandatory fees
Moab/ <u>Green River</u>	\$110.00 plus tax and mandatory fees
Monticello	\$80.00 plus tax and mandatory fees
Ogden	\$90.00 plus tax and mandatory fees
Panguitch	\$75.00 plus tax and mandatory fees
Park City/Midway	\$110 plus tax and mandatory fees
Price	\$75.00 plus tax and mandatory fees
Provo/Orem/Lehi/American Fork/Springville	\$85.00 plus tax and mandatory fees
Roosevelt/Ballard	\$90.00 plus tax and mandatory fees
Salt Lake City Metropolitan Area (Draper to Centerville), Tooele	\$100.00 plus tax and mandatory fees
St. George/Washington/Springdale/Hurricane/ <u>La Verkin</u>	\$85.00 plus tax and mandatory fees
Torrey	<del>[\$85.00]</del> \$90.00 plus tax and mandatory fees
Tremonton	\$90.00 plus tax and mandatory fees
Vernal	\$95.00 plus tax and mandatory fees
All Other Utah Cities	\$70.00 plus tax and mandatory fees

(3) State employees traveling less than 50 miles from their home base are not entitled to lodging reimbursement. Miles are calculated from either the departure home-base or from the destination to the traveler's home-base. The traveler may leave from one home-base and return to a different home-base. For example, if the traveler leaves from their residence, then the home-base for departure calculations is their residence. If the traveler returns to where they normally work (ie. Cannon Health Building), then the home-base for arrival calculations is the Cannon Health Building.

(a) In some cases, agencies must use judgment to determine a traveler's home-base. The following are some things to consider when determining a traveler's home-base.

(i) Is the destination less than 50 miles from the traveler's home or normal work location? If the destination is less than 50 miles from either the traveler's home or from their normal work location, then generally the employee should not be reimbursed for lodging.

(ii) Is there a valid business reason for the traveler to go to the office (or to some other location) before driving to the destination?

(iii) Is the traveler required to work at the destination the next day?

(iv) Is the traveler going directly home after the trip, or is there a valid business reason for the traveler to first go to the office (or to some other location)?

(v) Even if "it is not specifically against policy", would the lodging be considered necessary, reasonable and in the best interest of the State?

(4) When the State of Utah pays for a person from out-of-state to travel to Utah, the in-state lodging per diem rates will apply.

(5) For out-of-state travel stays at a non-conference hotel, the state will reimburse the actual cost per night plus tax and any mandatory fees charged by the hotel, not to exceed the federal lodging rate for the location. These reservations must be made through the State Travel Office.

(6) The state will reimburse the actual cost per night plus tax and any mandatory fees charged by the hotel for in-state or out-of-state travel stays where the department/traveler makes reservations through the State Travel Office.

If lodging is not available at the allowable per diem rate in the area the employee needs to stay, the State Travel Office will book a hotel with the best available rate. In this circumstance, the employee will be reimbursed at the actual rate booked.

If an employee chooses to stay at a hotel that costs more than the allowable per diem rate, the employee will only be reimbursed for the allowable per diem rate plus tax and any mandatory fees charged by the hotel. These instances will be audited 100% by the State Finance Post-Auditors[-] for State Government travel.

(7) Lodging is reimbursed at the rates listed in Table 5 for single occupancy only. For double state employee occupancy, add \$20, for triple state employee occupancy, add \$40, for quadruple state employee occupancy, add \$60.

(8) Exceptions will be allowed for unusual circumstances when approved in writing by the traveler's Department Director or designee prior to the trip.

(a) For out-of-state travel, the approval may be on the form FI 5[-], in the State's ESS Travel system or another system with equivalent controls and calculations.

(b) Attach the written approval to the Travel Reimbursement Request, form FI 51B, FI 51D, or ESS Travel.

(9) A proper receipt for lodging accommodations must accompany each request for reimbursement.

A proper receipt is a copy of the registration form generally used by motels and hotels which includes the following information: name of motel/hotel, street address, town and state, telephone number, current date, name of person/persons staying at the motel/hotel, date(s) of occupancy, amount and date paid, number in the party, and (single, double, triple, or quadruple occupancy).

(10) When lodging is required, travelers should stay at the lodging facility nearest to the meeting/training/work location where

state lodging per diem rates are accepted in order to minimize transportation costs.

(11) Travelers may also elect to stay with friends or relatives or use their personal campers or trailer homes instead of staying in a hotel.

(a) With proof of staying overnight away from home on approved state business, the traveler will be reimbursed the following:

(i) \$25 per night with no receipts required or

(ii) Actual cost up to \$40 per night with a signed receipt from a facility such as a campground or trailer park, not from a private residence.

(12) Travelers who are on assignment away from their home base for longer than 90 days will be reimbursed as follows:

(a) First 30 days - follow regular rules for lodging and meals. Lodging receipt is required.

(b) After 30 days - \$46 per day for lodging and meals. No receipt is required.

#### **R25-7-9. Reimbursement for Incidentals.**

State employees who travel on state business may be eligible for a reimbursement for incidental expenses.

(1) Travelers will be reimbursed for actual out-of-pocket costs for incidental items such as baggage tips, maid service, and bellman. Gratuities/tips for various services such as assistance with baggage, maid service, and bellman, may be reimbursed up to a combined maximum of \$5.00 per day.

(a) Include an original receipt for each individual incidental item above \$19.99.

(2) The state will reimburse incidental ground transportation and parking expenses.

(a) Travelers shall document all official business use of taxi, bus, parking, and other ground transportation including dates, destinations, parking locations, receipts, and amounts.

(b) Personal use of such transportation to restaurants is not reimbursable.

(c) The maximum that airport parking will be reimbursed is the economy lot parking rate at the airport they are flying out of. A receipt is required for amounts of \$20 or more.

(d) Gratuities/Tips for ground transportation (taxi/shuttle/rideshare) will be reimbursed up to the greater of \$5 or 18% for each ride. Gratuities/Tips must be shown on an original receipt.

(3) Registration should be paid in advance on a state warrant, or with a state purchasing card.

(a) A copy of the approved FI 5 form must be included with the Payment Voucher for out-of-state registrations.

(b) If a traveler must pay the registration when they arrive, the agency is expected to process a Payment Voucher and have the traveler take the state warrant with them.

(4) Telephone calls related to state business are reimbursed at the actual cost.

(a) The traveler shall list the amount of these calls separately on the Travel Reimbursement Request, form FI 51A, FI 51B, or ESS Travel.

(b) The traveler must provide an original lodging receipt or original personal phone bill showing the phone number called and the dollar amount for business telephone calls and personal telephone calls.

(5) Allowances for personal telephone calls made while out of town on state business overnight may be based on the number of nights away from home. The traveler must provide an original lodging receipt or original personal phone bill showing the phone number called and the dollar amount for personal telephone calls.

- (a) Four nights or less - actual amount up to \$2.50 per night.
- (b) Five to eleven nights - actual amount up to \$20.00
- (c) Twelve nights to thirty nights - actual amount up to

\$30.00

- (d) More than thirty days - start over

(6) Actual laundry expenses up to \$18.00 per week will be allowed for trips in excess of six consecutive nights, beginning after the sixth night out.

(a) The traveler must provide receipts for the laundry expense.

(b) For use of coin-operated laundry facilities, the traveler must provide a list of dates, locations, and amounts.

(7) An amount of \$5 per day will be allowed for travelers away in excess of six consecutive nights beginning after the sixth night out.

(a) This amount covers miscellaneous incidentals not covered in this rule.

(b) This allowance is not available for travelers going to conferences.

(8) Travel on a Weekend during Trips of More Than 10 Nights' Duration - A department may provide for employees to return home on a weekend when a trip extends longer than ten nights. Reimbursements may be given for costs allowed by these policies.

#### **R25-7-10. Reimbursement for Transportation.**

State employees who travel on state business may be eligible for a transportation reimbursement.

(1) Air transportation is limited to Air Coach or Excursion class. Priority seating charges will not be reimbursed unless preapproved by the department director or designee.

(a) All reservations (in-state and out-of-state) should be made through the State Travel Office for the least expensive air fare available at the time reservations are made.

(b) Only one change fee per trip will be reimbursed.

(c) The explanation for the change and any other exception to this rule must be given and approved by the Department Director or designee.

(2) Travelers may be reimbursed for mileage to and from the airport and long-term parking or away-from-the-airport parking.

(a) The maximum reimbursement for parking, whether travelers park at the airport or away from the airport, is the long term parking rate at the airport they are flying out of.

(b) The parking receipt must be included with the Travel Reimbursement Request, form FI 51A, FI 51B, or ESS Travel for amounts of \$20 or more.

(c) Travelers may be reimbursed, up to the maximum reimbursements rate, for mileage to and from the airport to allow someone to drop them off and to pick them up.

(3) Travelers may use private vehicles with approval from the Department Director or designee.

(a) Only one person in a vehicle may receive the reimbursement, regardless of the number of people in the vehicle.

(b) Reimbursement for a private vehicle will be at the rate of [42]38 cents per mile or [54]58 cents per mile if a state vehicle is not available to the employee.

(i) To determine which rate to use, the traveler must first determine if their department has an agency vehicle (long-term leased vehicle from Fleet Operations) that meets their needs and is reasonably available for the trip (does not apply to special purpose vehicles). If reasonably available, the employee should use an agency vehicle. If an agency vehicle that meets their needs is not reasonably available, the agency may approve the traveler to use either a daily pool fleet vehicle or a private vehicle. If a daily pool fleet vehicle is not reasonably available, the traveler may be reimbursed at [54]58 cents per mile.

(ii) If a trip is estimated to average 100 miles or more per day, the agency should approve the traveler to rent a daily pool fleet vehicle if one is reasonably available. Doing so will cost less than if the traveler takes a private vehicle. If the agency approves the traveler to take a private vehicle, the employee will be reimbursed at the lower rate of [42]38 cents per mile.

(c) Agencies may establish a reimbursement rate that is more restrictive than the rate established in this Section.

(d) Any exceptions to this mileage reimbursement rate guidance must be approved in writing by the employees Executive Director or designee.

(e) A cost comparison worksheet is available at: <http://fleet.utah.gov/motor-pool-a/demand-motor-pool/personal-vehicle-vs-rental-vehicle/>

(f) Mileage will be computed using Mapquest or other generally accepted map/route planning website, or from the latest official state road map and will be limited to the most economical, usually traveled routes.

(g) If the traveler uses a private vehicle on official state business and is reimbursed for mileage, parking charges may be reimbursed as an incidental expense.

(h) An approved Private Vehicle Usage Report, form FI 40, should be included with the department's payroll documentation reporting miles driven on state business during the payroll period.

(i) Departments may allow mileage reimbursement on an approved Travel Reimbursement Request, form FI 51A, FI 51B, or ESS Travel, if other costs associated with the trip are to be reimbursed at the same time.

(4) A traveler may choose to drive instead of flying if preapproved by the Department Director or designee.

(a) If the traveler drives a state-owned vehicle, the traveler may be reimbursed for meals and lodging for a reasonable amount of travel time; however, the total cost of the trip must not exceed the equivalent cost of the airline trip. The traveler may also be reimbursed for incidental expenses such as toll fees and parking fees.

(b) If the traveler drives a privately-owned vehicle, reimbursement will be at the rate of [42]38 cents per mile or the airplane fare, whichever is less, unless otherwise approved by the Department Director or designee.

(i) The lowest fare available within 30 days prior to the departure date will be used when calculating the cost of travel for comparison to private vehicle cost.

(ii) A comparison printout which is available through the State Travel Office is required when the traveler is taking a private vehicle.

(iii) The traveler may be reimbursed for meals and lodging for a reasonable amount of travel time; however, the total cost of the trip must not exceed the equivalent cost of an airline trip.

(iv) If the traveler uses a private vehicle on official state business and is reimbursed for mileage, parking charges may be reimbursed as an incidental expense.

(c) When submitting the reimbursement form, attach a schedule comparing the cost of driving with the cost of flying. The schedule should show that the total cost of the trip driving was less than or equal to the total cost of the trip flying.

(d) If the travel time taken for driving during the employee's normal work week is greater than that which would have occurred had the employee flown, the excess time used will be taken as annual leave and deducted on the Time and Attendance System.

(5) Use of rental vehicles must be approved in writing in advance by the Department Director or designee.

(a) An exception to advance approval of the use of rental vehicles shall be fully explained in writing with the request for reimbursement and approved by the Department Director or designee.

(b) Detailed explanation is required if a rental vehicle is requested for a traveler staying at a conference hotel.

(c) When making rental car arrangements through the State Travel Office, reserve the vehicle you need. Upgrades in size or model made when picking up the rental vehicle will not be reimbursed.

(i) State employees should rent vehicles to be used for state business in their own names, using the state contract so they will have full coverage under the state's liability insurance.

(ii) Rental vehicle reservations not made through the State Travel Office must be approved in advance by the Department Director or designee.

(iii) The traveler will be reimbursed the actual rate charged by the rental agency.

(iv) The traveler must have approval for a rental car in order to be reimbursed for rental car parking.

(6) Travel by private airplane must be approved in advance by the Department Director or designee.

(a) The pilot must certify to the Department Director or designee that the pilot is certified to fly the plane being used for state business.

(b) If the plane is owned by the pilot/employee, the pilot must certify the existence of at least \$500,000 of liability insurance coverage.

(c) If the plane is a rental, the pilot must provide written certification from the rental agency that the insurance covers the traveler and the state as insured. The insurance must be adequate to cover any physical damage to the plane and at least \$500,000 for liability coverage.

(d) Reimbursement will be made at ~~53~~58 cents per mile.

(e) Mileage calculation is based on air mileage and is limited to the most economical, usually-traveled route.

(7) Travel by private motorcycle must be approved prior to the trip by the Department Director or designee. Travel will be reimbursed at 20 cents per mile.

(8) A car allowance may be allowed in lieu of mileage reimbursement in certain cases. Prior written approval from the Department Director, the Executive Director of the Department of Administrative Services, and the Governor is required.

**KEY: air travel, per diem allowances, state employees, transportation**

**Date of Enactment or Last Substantive Amendment: [September 21, 2018]2019**

**Notice of Continuation: February 8, 2018**

**Authorizing, and Implemented or Interpreted Law: 63A-3-107; 63A-3-106**

## Commerce, Real Estate R162-2f Real Estate Licensing and Practices Rules

### NOTICE OF PROPOSED RULE (Amendment)

DAR FILE NO.: 43643

FILED: 04/11/2019

### RULE ANALYSIS

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The purpose of these proposed amendments are to: 1) clarify the on-time renewal process; 2) add a mandatory three hour continuing education (CE) course with content approved by the Division of Real Estate (Division) for certification as a core CE course; 3) provide a certification process for CE instructors of the mandatory course; and 4) increase the amount of the value of a referral gift or payment to unlicensed individuals by a licensee in a property management transaction. If these proposed rule amendments are approved, completion of the mandatory CE course would be required of each licensee prior to renewal of a real estate license subsequent to the first renewal beginning 01/01/2020. The three hours of CE from the mandatory CE course are not in addition to the currently required 18 hours of CE required for renewal including nine hours of core curriculum. Rather, the three hour mandatory CE course would satisfy three of the nine hours of core curriculum currently required for license renewal.

**SUMMARY OF THE RULE OR CHANGE:** Section R162-2f-204 clarifies that for a licensee to renew on time without incurring a late fee, a licensee must complete all required continuing education credits prior to the 15th day of the month of license expiration; and establishes a mandatory three-hour CE course for all renewing licensees. Section R162-2f-206e requires that an instructor of the mandatory three-hour CE course certify by attending once every two years the instructor development workshop sponsored by the Division. Section R162-2f-401b increases the amount of a referral gift a licensee may pay for an unsolicited referral from \$150 to \$250, and increases the amount a property management company may pay an unlicensed employee or tenant from \$200 to \$250.

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Section 61-2f-103 and Section 61-2f-204 and Section 61-2f-206

**ANTICIPATED COST OR SAVINGS TO:**

◆ **THE STATE BUDGET:** The Division has the staff and budget in place to administer these proposed amendments. After conducting a thorough analysis, it was determined that these proposed rule amendments will not result in a fiscal impact that will affect those resources or result in any additional cost or savings to the state budget.

◆ **LOCAL GOVERNMENTS:** Local governments are not required to comply with or enforce the Real Estate Licensing and Practices Rules. After conducting a thorough analysis, it was determined that these proposed rule amendments will not result in a fiscal impact to local governments.

◆ **SMALL BUSINESSES:** All CE course providers have fewer than 50 employees and are therefore small businesses. CE course providers are not required to offer the proposed mandatory three hour CE course. Any CE provider who determines to offer the course will experience costs to develop and present the course curriculum. These development and presentation costs cannot be estimated and will be offset by additional revenue to the provider from students taking the course. The Division will provide a mandatory three CE course outline which will help to minimize the cost of developing the course curriculum. The proposed mandatory three hour CE course is expected to have a measurable fiscal impact on continuing education instructors who elect to certify as instructors of the mandatory three hour CE course. Under the proposed rule amendments, instructors of the mandatory three hour CE course would be required to certify to teach the course by attending the Instructor Development Workshop (IDW) once every two years. Instructors of other continuing education courses are not required to attend IDW. The cost of the IDW is \$75 for each instructor. It is estimated that approximately 20 instructors will incur this cost each year (for a total yearly cost of \$1,500). For 2019, the Division will provide an alternative training session for instructors of the mandatory three hour CE course at no cost to attendees as an alternative to attendance at IDW by course instructors.

◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** These proposed amendments do not create new obligations for persons other than small businesses, businesses, or local government entities, nor does it increase the costs associated with any existing obligation. After conducting a thorough analysis, it was determined that these proposed rule amendments will not result in a fiscal impact to persons other than small businesses, businesses, or local government entities.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** If these proposed rule amendments become effective, all licensees will be required to complete the mandatory three hour CE course prior to renewing their license beginning 01/01/2020. Approximately 12,000 licensees renew their license each year. However, the mandatory three hour CE

course hours qualify as three of the nine hours of core CE that all licensees must take in all events, so there will be no increased number of CE hours for any licensee. Therefore, the only cost increase for licensees would be if the cost of the mandatory three hour CE class is more than the cost of other core CE classes, a matter that at present has not been determined by providers of this training. The net cost/benefit to real estate licensees is expected to be approximately zero. Under the proposed rule, instructors of the mandatory three hour CE course would be required to certify to teach the course by attending the Instructor Development Workshop (IDW) once every two years. Instructors of other continuing education courses are not required to attend IDW. The cost of the IDW is \$75 for each instructor. It is estimated that approximately 20 instructors will incur this cost each year (for a total yearly cost of \$1,500). For 2019, the Division will provide an alternative training session for instructors of the mandatory three hour CE course at no cost to attendees as an alternative to attendance at IDW by course instructors. These costs to instructors who choose to certify to teach the mandatory three hour course are included above under other persons as these instructors are all categorized as small businesses.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:**

If the proposed rule amendments become effective, all licensees will be required to complete the mandatory three hour CE course prior to renewing their license beginning 01/01/2020. Approximately 12,000 licensees renew their license each year. However, the mandatory three hour CE course hours qualify as three of the nine hours of core CE that all licensees must take in all events, so there will be no increased number of CE hours for any licensee. Therefore, the only cost increase for licensees would be if the cost of the mandatory three hour CE class is more than the cost of other core CE classes, a matter that at present has not been determined by providers of this training. The net cost/benefit to real estate licensees is expected to approximate zero. CE course providers are not required to offer the proposed mandatory three hour CE course. Any CE provider who determines to offer the course will experience costs to develop and present the course curriculum. These development and presentation costs cannot be estimated and will be offset by additional revenue to the provider from students taking the course. The Division will provide a mandatory three CE course outline which will help to minimize the cost of developing the course curriculum. The proposed mandatory three hour CE course is expected to have a measurable fiscal impact on continuing education instructors who elect to certify as instructors of the mandatory three hour CE course. Under the proposed rule, instructors of the mandatory three hour CE course would be required to certify to teach the course by attending the IDW once every two years. Instructors of other continuing education courses are not required to attend IDW. The cost of the IDW is \$75 for each instructor. It is estimated that approximately 20 instructors will incur this cost each year (for a total yearly cost of \$1,500). For 2019, the Division will provide an alternative

training session for instructors of the mandatory three hour CE course at no cost to attendees as an alternative to attendance at IDW by course instructors. There are no non-small businesses in the state of Utah that are engaged in conducting CE training. Therefore, there is no expected cost to non-small businesses as a result of these rule changes.

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

COMMERCE  
 REAL ESTATE  
 HEBER M WELLS BLDG  
 160 E 300 S  
 SALT LAKE CITY, UT 84111-2316  
 or at the Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

◆ Justin Barney by phone at 801-530-6603, or by Internet E-mail at justinbarney@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 05/31/2019

THIS RULE MAY BECOME EFFECTIVE ON: 06/07/2019

AUTHORIZED BY: Jonathan Stewart, Director

Appendix 1: Regulatory Impact Summary Table\*

Fiscal Costs	FY 2019	FY 2020	FY 2021
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$1500	\$1500
Other Person	\$0	\$0	\$0
<b>Total Fiscal Costs:</b>	<b>\$0</b>	<b>\$1500</b>	<b>\$1500</b>
<b>Fiscal Benefits</b>			
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0

Other Persons	\$0	\$0	\$0
<b>Total Fiscal Benefits:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Net Fiscal Benefits:</b>	<b>\$0</b>	<b>-\$1500</b>	<b>-\$1500</b>

\*This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts for State Government, Local Government, Small Businesses and Other Persons are described in the narrative. Inestimable impacts for Non-Small Businesses are described in Appendix 2.

**Appendix 2: Regulatory Impact to Non-Small Businesses**

If the proposed rule amendments become effective, all licensees will be required to complete the mandatory three hour CE course prior to renewing their license beginning 01/01/2020. Approximately 12,000 licensees renew their license each year. However, the mandatory three hour CE course hours qualify as three of the nine hours of core CE that all licensees must take in all events, so there will be no increased number of CE hours for any licensee. Therefore, the only cost increase for licensees would be if the cost of the mandatory three hour CE class is more than the cost of other core CE classes, a matter that at present has not been determined by providers of this training. The net cost/benefit to real estate licensees is expected to approximate zero.

CE course providers are not required to offer the proposed mandatory three hour CE course. Any CE provider who determines to offer the course will experience costs to develop and present the course curriculum. These development and presentation costs cannot be estimated and will be offset by additional revenue to the provider from students taking the course. The Division will provide a mandatory three CE course outline which will help to minimize the cost of developing the course curriculum.

The proposed mandatory three hour CE course is expected to have a measurable fiscal impact on continuing education instructors who elect to certify as instructors of the mandatory three hour CE course. Under the proposed rule, instructors of the mandatory three hour CE course would be required to certify to teach the course by attending the Instructor Development Workshop (IDW) once every two years. Instructors of other continuing education courses are not required to attend IDW. The cost of the IDW is \$75 for each instructor. It is estimated that approximately 20 instructors will incur this cost each year (for a total yearly cost of \$1,500). For 2019, the Division will provide an alternative training session for instructors of the mandatory three hour CE course at no cost to attendees as an alternative to attendance at IDW by course instructors.

Francine A. Giani, Executive Director of the Commerce Department has reviewed and approved this fiscal analysis.

**R162. Commerce, Real Estate.  
 R162-2f. Real Estate Licensing and Practices Rules.  
 R162-2f-204. License Renewal.**

- (1) Renewal period and deadlines.
- (a) A license issued under these rules is valid for a period of two years from the date of licensure.
- ~~[(b) By the 15th day of the month of expiration, an applicant for renewal shall submit to the division proof of having completed all continuing education required under this Subsection (2) (b).~~
- ~~(c) In order to renew on time without incurring a late fee:~~

~~(i) an individual who is required to submit a renewal application through the online RELMS system shall complete the online process, including the completion and banking of continuing education credits, by the license expiration date; and~~

~~(ii) an individual whose circumstances require a "yes" answer to a disclosure question on the renewal application shall submit a paper renewal.](b) To renew on time without incurring a late fee, an applicant for renewal shall, by the 15th day of the month of expiration, have completed all continuing education credits required under subsection (2)(b) to ensure continuing education providers have time to bank continuing education hours prior to license expiration.~~

~~(c) An individual who is required to submit a renewal application through the online RELMS system shall complete the online process, including the completion and banking of continuing education credits, in the licensee's individual password protected RELMS account, by the license expiration date.~~

~~(d) An individual whose circumstances require a "yes" answer to a disclosure question on the renewal application shall submit a paper renewal application:~~

~~(i)[(A)] by the license expiration date, if that date falls on a day when the division is open for business; or~~

~~(ii)[(B)] on the next business day following the license expiration date, if that date falls on a day when the division is closed for business.~~

(2) Qualification for renewal.

(a) Character and competency.

(i) An individual applying for a renewed license shall evidence that the individual maintains character and competency as required for initial licensure.

(ii) An individual applying for a renewed license may not have:

(A) a felony conviction since the last date of licensure; or

(B) a finding of fraud, misrepresentation, or deceit entered against the applicant, related to activities requiring a real estate license, by a court of competent jurisdiction or a government agency since the last date of licensure, unless the finding was explicitly considered by the division in a previous application.

(b) Continuing education.

(i) To renew at the end of the first renewal cycle, an individual shall complete:

(A) the 12-hour new sales agent course certified by the division; and

(B) an additional six non-duplicative hours of continuing education:

(I) certified by the division as either core or elective; or

(II) acceptable to the division pursuant to this Subsection (2)

(b)(ii)(B).

(ii) To renew at the end of a renewal cycle subsequent to the first renewal, an individual shall:

(A) complete 18 non-duplicative hours of continuing education:

(I) certified by the division;

(II) including at least nine non-duplicative hours of core curriculum, three hours of which are for completion of the Mandatory 3-Hour CE Course, a required continuing education course approved by the division; and

(III) taken during the previous license period; or

(B) apply to the division by the 15th day of the month of expiration for a waiver of all or part of the required continuing

education hours by virtue of having completed non-certified courses that:

(I) were not required under Subsection R162-2f-206c(1)(a) to be certified; and

(II) meet the continuing education objectives listed in Subsection R162-2f-206c(2)(f).

(iii)(A) Completed continuing education courses will be credited to an individual when the hours are uploaded by the course provider pursuant to Subsection R162-2f-401d(1)(~~(k)~~)(j).

(B) If a provider fails to upload course completion information within the ten-day period specified in Subsection R162-2f-401d(1)(~~(k)~~)(j), an individual who attended the course may obtain credit by:

(I) filing a complaint against the provider; and

(II) submitting the course completion certificate to the division.

(c) Principal broker. In addition to meeting the requirements of this Subsection (2)(a) and (b), an individual applying to renew a principal broker license shall certify that:

(i) the business name under which the individual operates is current and in good standing with the Division of Corporations and Commercial Code; and

(ii) the trust account maintained by the principal broker is current and in compliance with Section R162-2f-403.

(3) Renewal and reinstatement procedures.

(a) To renew a license, an applicant shall, prior to the expiration of the license:

(i) complete the online renewal of the license in the applicant's password protected RELMS account; and~~submit the forms required by the division, including proof of having completed continuing education pursuant to this Subsection (2)(b); and]~~

(ii) pay a nonrefundable renewal fee.

(b) To reinstate an expired license, an applicant shall, according to deadlines set forth in Subsections 61-2f-204(2)(b) - (d):

(i) submit all forms required by the division, including proof of having completed continuing education pursuant to Subsection 61-2f-204(2); and

(ii) pay a nonrefundable reinstatement fee.

(4) Transition to online renewal. An individual licensee shall submit an application for renewal through the online RELMS system unless the individual's circumstances require a "yes" answer in response to a disclosure question.

#### **R162-2f-206e. Certification of Continuing Education Course Instructor.**

(1) An instructor shall certify with the division before teaching a continuing education course.

(2) To certify as an instructor for any continuing education course other than the Mandatory 3-Hour CE course, an applicant shall, within the 30-day period prior to the date on which the applicant proposes to begin instruction, provide the following:

(a) name and contact information of the applicant;

(b) evidence that the applicant meets the character requirements of Subsection R162-2f-201(1) and the competency requirements of Subsection R162-2f-201(2);

(c) evidence of having graduated from high school or achieved an equivalent education;

(d) evidence that the applicant understands the subject matter to be taught through:

(i) a minimum of two years of full-time experience as a real estate licensee;

(ii) college-level education related to the course subject; or

(iii) demonstrated expertise on the subject proposed to be taught;

(e) evidence of ability to teach through:

(i) a minimum of 12 months of full-time teaching experience; or

(ii) part-time teaching experience equivalent to 12 months of full-time teaching experience;

(f) a signed statement agreeing to allow the instructor's courses to be randomly audited on an unannounced basis by the division or its representative;

(g) a signed statement agreeing not to market personal sales products;

(h) any other information the division requires; and

(i) a nonrefundable application fee.

(3) To certify as an instructor of the Mandatory 3-Hour CE course, an applicant shall:

(a) attend the instructor development workshop at least once every two years or, if the division approves an alternative training session, attend the alternative training session at the time and location designated by the division; and

(b) comply with the requirements described in Subsection (2).

(4)(a)(~~3~~)(~~a~~) A continuing education course instructor certification expires 24 months from the date of issuance and must be renewed before the expiration date in order to remain active.

(b) To renew a continuing education course instructor certification, a person shall:

(i) submit all forms required by the division;

(ii)(A) evidence having taught, within the previous renewal period, a minimum of 12 continuing education credit hours; or

(B) submit written explanation outlining:

(I) the reason for not having taught a minimum of 12 continuing education credit hours; and

(II) documentation to the division that the applicant maintains satisfactory expertise in the subject area proposed to be taught; and

(iii) pay a nonrefundable renewal fee.

(c) To reinstate an expired continuing education instructor certification within 30 days following the expiration date, a person shall:

(i) comply with all requirements for a timely renewal; and

(ii) pay a nonrefundable late fee.

(d) To reinstate an expired continuing education instructor certification after 30 days and within six months following the expiration date, a person shall:

(i) comply with all requirements for a timely renewal; and

(ii) pay a non-refundable reinstatement fee.

(e) A certification that is expired for more than six months may not be reinstated. To obtain a certification, a person must apply as a new applicant.

(f) If a deadline specified in this Subsection (4)(~~3~~) falls on a day when the division is closed for business, the deadline shall be extended to the next business day.

#### **R162-2f-401b. Prohibited Conduct As Applicable to All Licensed Individuals.**

An individual licensee may not:

(1) engage in any of the practices described in Section 61-2f-401 et seq., whether acting as agent or on the licensee's own account, in a manner that:

(a) fails to conform with accepted standards of the real estate sales, leasing, or management industries;

(b) could jeopardize the public health, safety, or welfare; or

(c) violates any provision of Title 61, Chapter 2f et seq. or the rules of this chapter;

(2) require parties to acknowledge receipt of a final copy of any document prepared by the licensee prior to all parties signing a contract evidencing agreement to the terms thereof;

(3) make a misrepresentation to the division:

(a) in an application for license renewal; or

(b) in an investigation.

(4)(a) propose, prepare, or cause to be prepared a document, agreement, settlement statement, or other device that the licensee knows or should know does not reflect the true terms of the transaction; or

(b) knowingly participate in a transaction in which such a false device is used;

(5) participate in a transaction in which a buyer enters into an agreement that:

(a) is not disclosed to the lender; and

(b) if disclosed, might have a material effect on the terms or the granting of the loan;

(6) use or propose the use of a double contract;

(7) place a sign on real property without the written consent of the property owner;

(8) take a net listing;

(9) sell listed properties other than through the listing broker;

(10) subject a principal to paying a double commission without the principal's informed consent;

(11) enter or attempt to enter into a concurrent agency representation when the licensee knows or should know that the principal has an existing agency representation agreement with another licensee;

(12) pay a finder's fee or give any valuable consideration to an unlicensed person or entity for referring a prospect, except that:

(a) a licensee may give a gift valued at ~~\$250~~~~[\$150]~~ or less to an individual in appreciation for an unsolicited referral of a prospect that results in a real estate transaction; and

(b) as to a property management transaction, a licensee may compensate an unlicensed employee or previous or current tenant up to ~~\$250~~~~[\$200]~~ per lease for assistance in retaining an existing tenant or securing a new tenant;

(13) accept a referral fee from:

(a) a lender; or

(b) a mortgage broker;

(14) act as a real estate agent or broker in the same transaction in which the licensee also acts as a:

- (a) mortgage loan originator, associate lending manager, or principal lending manager;
- (b) appraiser or appraiser trainee;
- (c) escrow agent; or
- (d) provider of title services;
- (15) act or attempt to act as a limited agent in any transaction in which:
  - (a) the licensee is a principal in the transaction; or
  - (b) any entity in which the licensee is an officer, director, partner, member, manager, employee, or stockholder is a principal in the transaction;
- (16) make a counteroffer by striking out, whiting out, substituting new language, or otherwise altering:
  - (a) the boilerplate provisions of the Real Estate Purchase Contract; or
  - (b) language that has been inserted to complete the blanks of the Real Estate Purchase Contract;
- (17) advertise or offer to sell or lease property without the written consent of:
  - (a) the owner(s) of the property; and
  - (b) if the property is currently listed, the listing broker;
- (18) advertise or offer to sell or lease property at a lower price than that listed without the written consent of the seller or lessor;
- (19) represent on any form or contract that the individual is holding client funds without actually receiving funds and securing them pursuant to Subsection R162-2f-401a(24);
- (20) when acting as a limited agent, disclose any information given to the agent by either principal that would likely weaken that party's bargaining position if it were known, unless the licensee has permission from the principal to disclose the information;
- (21) disclose, or make any use of, a short sale demand letter outside of the purchase transaction for which it is issued;
- (22) in a short sale, have the seller sign a document allowing the licensee to lien the property; or
- (23) charge any fee that represents the difference between:
  - (a) the total concessions authorized by a seller and the actual amount of the buyer's closing costs; or
  - (b) in a short sale, the sale price approved by the lender and the total amount required to clear encumbrances on title and close the transaction.

**KEY: real estate business, operational requirements, trust account records, notification requirements**  
**Date of Enactment or Last Substantive Amendment:** [~~January 23,~~ 2019  
**Notice of Continuation:** August 12, 2015  
**Authorizing, and Implemented or Interpreted Law:** 61-2f-103(1); 61-2f-105; 61-2f-203(1)(e); 61-2f-206(3); 61-2f-206(4)(a); 61-2f-306; 61-2f-307

**Education, Administration**  
**R277-301**  
**Educator Licensing**

**NOTICE OF PROPOSED RULE**  
**(Amendment)**

DAR FILE NO.: 43654  
 FILED: 04/15/2019

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The reason for these rule changes is to increase the Utah State Board of Education (Board) oversight of the pedagogical performance assessment standards.

**SUMMARY OF THE RULE OR CHANGE:** These amendments to this rule require the Board to approve the pedagogical performance assessment standards established by the State Superintendent.

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Article X Section 3 and Section 53E-6-201 and Subsection 53E-3-401(4)

**ANTICIPATED COST OR SAVINGS TO:**

- ◆ **THE STATE BUDGET:** These rule changes are not expected to have any fiscal impact on state government revenues or expenditures. They clarify that the standards for passing a pedagogical performance assessment as part of educator licensing must be approved by the Board. These changes will not have a fiscal impact because they will not bring in any revenue or cause additional expenditures to ensure the standards have been approved by the Board.
- ◆ **LOCAL GOVERNMENTS:** These rule changes are not expected to have any fiscal impact on local governments' revenues or expenditures. They clarify that the standards for passing a pedagogical performance assessment as part of educator licensing must be approved by the Board. These changes will not have a fiscal impact because the pedagogical assessment is already in place and this clarification will not change anything for local education agencies (LEAs).
- ◆ **SMALL BUSINESSES:** These rule changes are not expected to have any fiscal impact on small businesses' revenues or expenditures. This rule applies to educator licensing and thus does not apply to small businesses since the Board is responsible for educator licensing.
- ◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** These rule changes are not expected to have any fiscal impact on persons other than small businesses', businesses', or local government entities' revenues or expenditures. They clarify that the standards for passing a pedagogical performance assessment as part of educator licensing must be approved by the Board. These changes will not have a fiscal impact because the pedagogical assessment is already in place and this clarification should not change anything for individuals seeking an educator license.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** There are no compliance costs for affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There are 1,241 entities with a NAICS code 611110 (Elementary and Secondary Schools) operating in Utah according to a "Firm Find Data" search through Utah's Department of Workforce Services. Most of the entities in the list are schools including public schools, charter schools, and private schools. Of the 1,241 entities, there are 15 private businesses, all of which are small businesses (there are no non-small businesses with a NAICS code 611110). These rule changes have no fiscal impact on LEAs and will not have a fiscal impact on non-small or small businesses. The Program Analyst at the Utah State Board of Education, Jill Curry, has reviewed and approved this fiscal analysis.

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

EDUCATION  
ADMINISTRATION  
250 E 500 S  
SALT LAKE CITY, UT 84111-3272  
or at the Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:  
♦ Angela Stallings by phone at 801-538-7550, by FAX at 801-538-7768, or by Internet E-mail at [angie.stallings@schools.utah.gov](mailto:angie.stallings@schools.utah.gov)

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 05/31/2019

THIS RULE MAY BECOME EFFECTIVE ON: 06/07/2019

AUTHORIZED BY: Angela Stallings, Deputy Superintendent of Policy

Appendix 1: Regulatory Impact Summary Table\*

Fiscal Costs	FY 2019	FY 2020	FY 2021
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0
Other Person	\$0	\$0	\$0
<b>Total Fiscal Costs:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Fiscal Benefits</b>			

State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0
Other Persons	\$0	\$0	\$0
<b>Total Fiscal Benefits:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Net Fiscal Benefits:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

\*This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts for State Government, Local Government, Small Businesses and Other Persons are described in the narrative. Inestimable impacts for Non-Small Businesses are described in Appendix 2.

**Appendix 2: Regulatory Impact to Non-Small Businesses**

There are 1,241 entities with a NAICS code 611110 (Elementary and Secondary Schools) operating in Utah according to a "Firm Find Data" search through Utah's Department of Workforce Services. Most of the entities in the list are schools including public schools, charter schools, and private schools. Of the 1,241 entities, there are 15 private businesses, all of which are small businesses (there are no non-small businesses with a NAICS code 611110). Thus, these rule changes are not expected to have any fiscal impact on non-small businesses' revenue or expenditures because there are no applicable non-small businesses and it does not require any expenditures or generate revenues for non-small businesses.

The Program Analyst at the Utah State Board of Education, Jill Curry, has reviewed and approved this fiscal analysis.

**R277. Education, Administration.**

**R277-301. Educator Licensing.**

**R277-301-1. Authority and Purpose.**

- (1) This rule is authorized by:
  - (a) Utah Constitution Article X, Section 3, which vests general control and supervision over public education in the Board;
  - (b) Subsection 53E-3-401(4), which allows the Board to make rules to execute the Board's duties and responsibilities under the Utah Constitution and state law; and
  - (c) Section 53E-6-201, which gives the Board power to issue licenses.

(2) This rule specifies the types of licenses and license areas of concentration available and the requirements and procedures for obtaining a license, required for employment as a licensed educator in the public schools of Utah.

**R277-301-2. Definitions.**

- (1) "Accredited school" means a public or private school that:
  - (a) meets standards essential for the operation of a quality school program; and

(b) has received formal approval through a regional accrediting association.

(2) "Comprehensive Administration of Credentials for Teachers in Utah Schools" or "CACTUS" means the electronic file maintained on all licensed Utah educators including information such as:

- (a) personal directory information;
- (b) educational background;
- (c) endorsements;
- (d) employment history; and
- (e) a record of disciplinary action taken against the educator.

(3) "Educator preparation program" means the same as that term is defined in R277-303-2.

(4) "Endorsement" means a designation on a license area of concentration earned through demonstrating required competencies established by the Superintendent that qualifies the individual to:

- (a) provide instruction in a specific content area; or
- (b) apply a specific set of skills in an education setting.

(5) "LEA" includes, for purposes of this rule, the Utah Schools for the Deaf and the Blind.

(6)(a) "License areas of concentration" or "license area" means a designation on a license of the specific educational setting or role for which the individual is qualified, to include the following:

- (i) Early Childhood;
- (ii) Elementary;
- (iv) Secondary;
- (v) Educational Leadership
- (vi) Career and Technical Education or "CTE";
- (vii) School Counselor;
- (viii) School Psychologist;
- (ix) Special Education;
- (x) Preschool Special Education;
- (xi) Deaf Education;
- (xii) Speech-Language Pathologist;
- (xiii) Speech-Language Technician;
- (xiv) School Social Worker; and
- (xv) Communication Disorders.

(7) "Licensing Jurisdiction" means the designated educator licensing authority in any foreign country or state of the United States of America and the Department of Defense Education Activity (DoDEA).

(8) "Renewal" means reissuing or extending the length of a license consistent with R277-500.

#### **R277-301-3. License Structure.**

- (1) Utah educator licenses include the following licenses:
  - (a) Associate educator license;
  - (b) Professional educator license; and
  - (c) LEA-specific educator license.

(2) All new Utah educator licenses shall include general, content knowledge, and pedagogical requirements.

(3) The Superintendent may only issue a single active Utah educator license to an individual.

(4) An educator license shall include at least one area of concentration.

(5) License areas of concentration and endorsements shall have a designation of:

- (a) associate;
- (b) professional; or
- (c) LEA-specific.

(6) An associate educator license may only include associate or LEA-specific license areas of concentration and endorsements.

(7) An LEA-specific educator license may only include LEA-specific license areas of concentration and endorsements.

(8) The Superintendent may establish deadlines and uniform forms and procedures for all aspects of licensing.

(9) The Superintendent shall review, adopt, and establish passing standards for all assessments required for educator licensing.

(10)(a) All licenses expire on June 30 of the year of expiration and may be renewed any time after January 1 of the same year.

(b) Responsibility for license renewal rests solely with the licensee.

#### **R277-301-4. Associate Educator License Requirements.**

(1) The Superintendent shall issue an associate educator license to an individual that applies for the license and that meets all requirements in this Section R277-301-4.

(2) An associate educator license, license area, or endorsement is valid for two years.

(3) The Superintendent may only renew an associate educator license if:

- (a) the individual has less than two years of experience in a Utah public or accredited private school; or
- (b) the individual is employed by a Utah public or accredited private school and the employer has requested a one year extension of the license.

(4) The general requirements for an associate educator license shall include:

(a) completion of a criminal background check including review of any criminal offenses and clearance in accordance with Rule R277-214;

(b) completion of the educator ethics review described in R277-500 within one calendar year prior to the application; and

(c) one of the following:

- (i) a bachelor's degree or higher from a regionally accredited institution;
- (ii) current enrollment in a university-based Board-approved educator preparation program that will result in a bachelor's degree or higher from a regionally accredited institution; or
- (iii) skill certification in a specific CTE area as established by the Superintendent.

(5) The content knowledge requirements for an associate educator license shall include:

(a) for an elementary license area, passage of an elementary content knowledge test, approved by the Superintendent, that distinctly measures content in:

- (i) mathematics;
- (ii) reading/language arts;
- (iii) social studies; and

- (iv) science;
- (b) for a secondary or CTE license area with a content endorsement, one of the following:
  - (i) passage of a content knowledge test approved by the Superintendent, where available;
  - (ii) a bachelor's degree or higher with a major in the content area from a regionally accredited university; or
  - (iii) enrollment in a program that will result in a degree described in Subsection (5)(b)(ii); and
  - (c) for all other license areas, enrollment in a university-based Board-approved educator preparation program.
- (6) Additional requirements for an associate educator license shall include:
  - (a) successful completion of professional learning modules created or approved by the Superintendent in:
    - (i) educator ethics;
    - (ii) classroom management and instruction;
    - (iii) basic special education law and instruction;
    - (iv) the Utah Effective Teaching Standards described in R277-530; or
    - (b) enrollment in a university-based Board-approved educator preparation program.
- (7) An individual holding a professional educator license may receive an associate license area or endorsement in additional areas if all the requirements of this section are met.
- (8) A license applicant who has received or completed license preparation activities inconsistent with this rule may present compelling information and documentation for review and approval by the Superintendent to satisfy the associate educator license requirements.
- (9) The Superintendent shall designate a panel of at least three Board staff members to review an appeal made under subsection (8).
- (10) An LEA that employs an individual that holds an associate educator license shall develop a personalized professional learning plan designed to support the educator in meeting the requirements for a professional educator license no later than 60 days after beginning work in the classroom, which shall:
  - (a) be provided to the Superintendent upon request;
  - (b) include a formal discussion and observation process no later than 30 days after beginning work in the classroom; and
  - (c) consider:
    - (i) previous education related experience; and
    - (ii) previous educational preparation activities.
- (11) An educator with an associate educator license may upgrade to a professional educator license at any time prior to expiration of the associate educator license if the educator meets all requirements of Section R277-301-5.

**R277-301-5. Professional Educator License Requirements.**

- (1) The Superintendent shall issue a professional educator license to an individual that applies for the license and meets all requirements in this Section R277-301-6.
- (2) A professional educator license, license area, or endorsement is valid for five years.
- (3) The general requirements for a professional educator license shall include:
  - (a) all general requirements for an associate educator license under Subsection R277-301-5(4);

- (b) completion of:
  - (i) a bachelor's degree or higher from a regionally accredited institution; or
  - (ii) skill certification in a specific CTE area as established by the Superintendent; and
  - (c) one of the following:
    - (i) a recommendation from a Board-approved educator preparation program; or
    - (ii) a standard educator license in the area issued by a licensing jurisdiction outside of Utah that is currently valid or is renewable consistent with Section 53E-6-307.
  - (4) The content knowledge requirements for a professional educator license shall include:
    - (a) all content knowledge requirements for an associate educator license under Subsection R277-301-4(5); and
    - (b) demonstration of all content knowledge competencies as established by the Superintendent.
  - (5) The pedagogical requirements for professional educator license shall include:
    - (a) demonstration of all pedagogical competencies as established by the Superintendent; and
    - (b) when applicable to the license area, passage of a pedagogical performance assessment meeting standards:
      - (i) established by the Superintendent; and
      - (ii) approved by the Board~~[, where available]~~.
  - (6) An individual holding a Utah level 1, level 2, or level 3 educator license on January 1, 2020 is considered to have met the pedagogical requirements described in Subsection (5).
  - (7) An individual holding a Utah level - APT educator license that is employed by a Utah LEA and an individual enrolled in ARL or a university-based Board-approved educator preparation program on January 1, 2020 may meet the content knowledge and pedagogical requirements described in this Section R277-301-6 by completing all requirements of the applicable program.
  - (8) An individual holding a Utah professional educator license and license area in early childhood education, elementary, secondary, CTE, special education, or deaf education is considered to have met the pedagogical performance assessment requirement of Subsection (5)(b) if applying to add any of the license areas in the subsection.
  - (9) A license applicant who has received or completed license preparation activities inconsistent with this rule may present compelling information and documentation for review and approval or denial by the Superintendent to satisfy the professional educator license requirements.
  - (10) The Superintendent shall designate a panel of at least three individuals, including at least two Board licensed educators not employed by the Board, to review an appeal and make a recommendation to the Superintendent for the Superintendent's review and decision described in Subsection (9).

**R277-301-6. Educator Licenses Issued by Licensing Jurisdictions Outside of Utah.**

- (1) The Superintendent shall review applications for a Utah educator license for individuals holding educator licenses issued by licensing jurisdictions outside of Utah to determine if the applicant has met the requirements for a Utah license under this rule.

(2) The Superintendent shall accept scores from an applicant that meet the Utah standard for passing on assessments from licensing jurisdictions outside of Utah that utilize the same assessment as Utah as meeting the requirements of this rule.

(3) The Superintendent shall accept scores from an applicant on reasonably equivalent content knowledge or pedagogical performance assessments utilized by licensing jurisdictions outside of Utah that meet the passing standard of that jurisdiction as meeting the requirements of this rule.

(4) The Superintendent shall accept demonstrations of content knowledge and pedagogical competencies from an applicant utilized by licensing jurisdictions outside of Utah that are reasonably equivalent to Utah competencies.

(5) Individuals with 4 or more years of successful experience in a public or accredited private school under a standard license issued by another jurisdiction shall be considered to have met both the content knowledge and pedagogical assessment requirements in the areas and subjects taught.

**R277-301-7. LEA-specific Educator License Requirements.**

(1) The Superintendent may issue an LEA-specific educator license to a candidate if:

(a) the LEA requesting the LEA-specific educator license has an adopted policy, posted on the LEA's website, which includes:

(i) educator preparation and support:

(A) as established by the LEA; and

(B) aligned with the Utah Effective Teaching Standards described in R277-530;

(ii) criteria for employing educators with an LEA-specific license; and

(iii) compliance with all requirements of this Rule R277-301;

(b) an LEA governing board applies on behalf of the the candidate

(c) the candidate meets all the requirements in this Section R277-301-7; and

(d) within the first year of employment, the LEA trains the candidate on:

(i) educator ethics;

(ii) classroom management and instruction;

(iii) basic special education law and instruction; and

(iv) the Utah Effective Teaching Standards described in R277-530.

(2)(a) Except as provided in Subsection (2)(b), an LEA governing board may request an LEA-specific educator license for a license area described in Subsection R277-301-2(6).

(b) An LEA may not request an LEA-specific educator license for a license area in:

(i) Special Education; or

(ii) Preschool Special Education.

(3) An LEA-specific license, license area, or endorsement is valid only within the requesting LEA.

(4) An LEA-specific license, license area, or endorsement is valid for one, two, or three years in accordance with the LEA governing board's application.

(5) The first renewal of an LEA-specific educator license, license area, or endorsement shall be approved or denied by the Board.

(6) The Board may require that subsequent renewals be approved by the Board on a case by case basis.

(7) An LEA-specific license expires immediately if the educator's employment with the LEA that requested the license ends.

(8) The general requirements for an LEA-specific educator license shall include:

(a) completion of a criminal background check including review of any criminal offenses and clearance in accordance with Rule R277-214;

(b) completion of the educator ethics review described in Rule R277-500 within one calendar year prior to the application; and

(c) approval of the request by the LEA governing board in a public meeting no more than 60 days prior to the application, which includes the LEA's rationale for the request.

(9) The content knowledge and pedagogical requirements for an LEA-specific educator license shall be established by the LEA governing board.

**R277-301-8. Requirements for LEAs.**

(1) An LEA shall provide a mentoring program that provides a trained mentor educator and annual mentoring plan:

(a) for educators holding an associate educator license;

(b) for at least two years for LEA-specific educator license holders; and

(c) for educators holding a professional educator license with less than three years of experience.

(2) A trained mentor educator under Subsection (1) shall hold a professional educator license and shall, where possible:

(a) perform substantially the same duties as the educator with release time to work as a mentor; or

(b) be assigned as an instructional coach or equivalent position.

(3) A trained mentor educator under Subsection (1) shall assist the educator to meet the Utah Effective Educator Standards established in Rule R277-530, but may not serve as an evaluator of the educator.

(4) A mentoring program under Subsection (1) shall include:

(a) a formal professional learning plan and LEA support in meeting the requirements of a professional license area; and

(b) if the educator holds an LEA-specific educator license, on-going training on educator ethics and special education.

(5) An LEA school that requests LEA-specific licenses, license areas, or endorsements shall prominently post the following information on each school's website:

(a) disclosure of the fact that the school employs individuals holding LEA-specific educator licenses, license areas, or endorsements;

(b) the percentage of the types of licenses, license areas, and endorsements held by educators employed in the school based on the employees' FTE in CACTUS; and

(c) a link to the Utah Educator Look-up tool provided by the Superintendent in accordance with Subsection R277-515-7(6).

**R277-301-9. Superintendent Annual Report to the Board.**

The Superintendent shall annually report to the Board on licensing, including:

- (1) educator licensing;
- (2) educator preparation; and
- (3) equitable distribution of teachers.

**R277-301-10. Effective Date.**

- (1) This rule will be effective beginning January 1, 2020.
- (2) This rule will supersede Rule R277-502 on January 1, 2020.

**KEY: professional competency, educator licensing****Date of Enactment or Last Substantive Amendment: [December 10, 2018]2019****Authorizing, and Implemented or Interpreted Law: Art X Sec 3; 53A-6-104; 53A-1-401**

Education, Administration  
**R277-303**  
 Educator Preparation Programs

**NOTICE OF PROPOSED RULE**  
 (Amendment)

DAR FILE NO.: 43657  
 FILED: 04/15/2019

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The reason for the amendment is to increase the Utah State Board of Education (Board) oversight of the pedagogical performance assessment standards.

**SUMMARY OF THE RULE OR CHANGE:** These amendments to this rule require the Board to approve the pedagogical performance assessment standards established by the Superintendent. In addition, these changes add an additional section of authority and clarify notice and appeal provision for educator preparation program applications that are denied.

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Article X Section 3 and Section 53E-6-302 and Subsection 53E-3-401(4) and Subsection 53E-6-201(3)(a)

**ANTICIPATED COST OR SAVINGS TO:**

◆ **THE STATE BUDGET:** These rule changes are not expected to have any substantive fiscal impact on state government revenues or expenditures. They clarify that the standards for passing a pedagogical performance assessment as part of educator licensing must be approved by the Board. They also outline an appeal process if the Superintendent denies an application for an educator preparation program. The educator preparation program may appeal to the Board in writing and the Board shall assign the appeal to a standing committee to make a recommendation to the full Board for final action. These changes will not have a fiscal impact on the Board because it will be handled in the capacity of existing meetings of the Board. Its fiscal impact

on educator preparation programs, Utah universities and colleges, should not be substantial because it just requires a written appeal to be submitted to the Board which will only be necessary in the case of a denial and should not necessitate additional resources for educator preparation programs to comply with the requirement.

◆ **LOCAL GOVERNMENTS:** These rule changes are not expected to have any fiscal impact on local governments' revenues or expenditures. They clarify that the standards for passing a pedagogical performance assessment as part of educator licensing must be approved by the Board. They also outline an appeal process if the Superintendent denies an application for an educator preparation program. The educator preparation program may appeal to the Board in writing and the Board shall assign the appeal to a standing committee to make a recommendation to the full Board for final action. These changes will not have a fiscal impact because they do not affect local education agencies or local governments more generally.

◆ **SMALL BUSINESSES:** These rule changes are not expected to have any fiscal impact on small businesses' revenues or expenditures. This rule applies to educator preparation programs and thus does not apply to small businesses since the Board is responsible for establishing standards for educator preparation programs (programs run through Utah colleges and universities).

◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** These rule changes are not expected to have any fiscal impact on persons other than small businesses', businesses', or local government entities' revenues or expenditures. They clarify that the standards for passing a pedagogical performance assessment as part of educator licensing must be approved by the Board. They also outline an appeal process if the Superintendent denies an application for an educator preparation program. The educator preparation program may appeal to the Board in writing and the Board shall assign the appeal to a standing committee to make a recommendation to the full Board for final action. These changes will not have a fiscal impact on other individuals because they apply to educator preparation programs and not individuals.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** There are no compliance costs for affected persons.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** There are 1,241 entities with a NAICS code 611110 (Elementary and Secondary Schools) operating in Utah according to a "Firm Find Data" search through Utah's Department of Workforce Services. Most of the entities in the list are schools including public schools, charter schools, and private schools. Of the 1,241 entities, there are 15 private businesses, all of which are small businesses (there are no non-small businesses with a NAICS code 611110). These rule changes have no fiscal impact on local education agencies and will not have a fiscal impact on non-small or small businesses. The Program Analyst at the Utah State

Board of Education, Jill Curry, has reviewed and approved this fiscal analysis.

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

EDUCATION  
ADMINISTRATION  
250 E 500 S  
SALT LAKE CITY, UT 84111-3272  
or at the Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:  
♦ Angela Stallings by phone at 801-538-7550, by FAX at 801-538-7768, or by Internet E-mail at [angie.stallings@schools.utah.gov](mailto:angie.stallings@schools.utah.gov)

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 05/31/2019

THIS RULE MAY BECOME EFFECTIVE ON: 06/07/2019

AUTHORIZED BY: Angela Stallings, Deputy Superintendent of Policy

<b>Total Fiscal Benefits:</b>	\$0	\$0	\$0
<b>Net Fiscal Benefits:</b>	\$0	\$0	\$0

\*This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts for State Government, Local Government, Small Businesses and Other Persons are described in the narrative. Inestimable impacts for Non-Small Businesses are described in Appendix 2.

**Appendix 2: Regulatory Impact to Non-Small Businesses**  
There are 1,241 entities with a NAICS code 611110 (Elementary and Secondary Schools) operating in Utah according to a "Firm Find Data" search through Utah's Department of Workforce Services. Most of the entities in the list are schools including public schools, charter schools, and private schools. Of the 1,241 entities, there are 15 private businesses, all of which are small businesses (there are no non-small businesses with a NAICS code 611110). Thus, these rule changes are not expected to have any fiscal impact on non-small businesses' revenue or expenditures because there are no applicable non-small businesses and it does not require any expenditures or generate revenues for non-small businesses.

The Program Analyst at the Utah State Board of Education, Jill Curry, has reviewed and approved this fiscal analysis.

**Appendix 1: Regulatory Impact Summary Table\***

Fiscal Costs	FY 2019	FY 2020	FY 2021
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0
Other Person	\$0	\$0	\$0
<b>Total Fiscal Costs:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Fiscal Benefits</b>			
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0
Other Persons	\$0	\$0	\$0

**R277. Education, Administration.**

**R277-303. Educator Preparation Programs.**

**R277-303-1. Authority and Purpose.**

- (1) This rule is authorized by:
  - (a) Utah Constitution Article X, Section 3, which vests general control and supervision over public education in the Board;
  - (b) Subsection 53E-3-401(4), which allows the Board to make rules to execute the Board's duties and responsibilities under the Utah Constitution and state law; ~~and~~
  - (c) Subsection 53E-6-201(3)(a), which allows the Board to establish the criteria for obtaining licenses ~~and~~
  - (d) Section 53E-6-302, which requires the Board to establish standards for approval of educator preparation programs.
- (2) The purpose of this rule is to establish criteria for educator preparation programs in the State of Utah.

**R277-303-2. Definitions.**

- (1)(a) "Educator preparation program" means a comprehensive program administered by an entity that is intended to prepare individuals to meet the requirements for a Utah professional license or license area of concentration.
- (b) "Educator preparation program" may include a program developed by or associated with an institution of higher education, individual LEA, or the Board.
- (2) "LEA" includes, for purposes of this rule, the Utah Schools for the Deaf and the Blind.
- (3) "License area" has the same meaning as set forth in Subsection R277-301-2(5)(a).
- (4) "Professional license" means the educator license described in Section R277-301-6.

**R277-303-3. Educator Preparation Program Review and Approval.**

(1) The Superintendent shall establish uniform procedures for initial approval and review of educator preparation programs to ensure compliance with this R277-303.

(2) The Superintendent shall approve an educator preparation program that meets the requirements of this rule and the standards for program approval established in:

- (a) Rule R277-304;
- (b) Rule R277-305;
- (c) Rule R277-306; and
- (d) all other applicable Board rules.

(3) The Superintendent shall conduct an on-going review of approved educator preparation programs and shall renew or deny approval for a program at least every seven years.

(4) The Superintendent may grant preliminary approval to a new educator preparation program within a Utah public college or university pending approval by the Utah State Board of Regents.

(5) The Superintendent shall make a report to the Board when an educator preparation program's initial application for approval is granted or denied.

(6) The Superintendent may place an approved educator preparation program on probation for:

- (a) failure to meet program requirements detailed in applicable Board rules; or
- (b) failure to submit complete and accurate information in a report required under this rule.

(7) The Board may revoke the approval of a probationary program that fails to meet probationary requirements with at least one year's notice to the educator preparation program.

(8) The Superintendent may require a program or subset of programs to submit reports to inform the annual report to the Board required in Section R277-301-10.

(9) The Superintendent shall accept an approved educator preparation program's recommendations for a professional license or license area if the prospective licensee has met all other requirements of Board rule.

**R277-303-4. Educator Preparation Programs.**

(1) An educator preparation program that applies for approval by the Superintendent shall demonstrate how it will ensure that participants:

- (a) are prepared to meet the Utah Effective Educator Standards established in R277-530;
- (b) successfully complete or are prepared to complete the pedagogical performance assessment required in R277-301;
- (c) have met the competencies required in R277-301; and
- (d) have sufficiently demonstrated the ability to work in the applicable license area and subject area.

(2) In addition to the requirements of Subsection (1), an educator preparation program that is not also a Utah LEA shall:

- (a) have a physical location in the state of Utah where participants attend classes; or
- (b) if the program provides only online instruction:
  - (i) have the program's primary headquarters located in Utah; and
  - (ii) be licensed to do business through the Utah Department of Commerce; and

(c) establish entry requirements that are designed to ensure that only high quality individuals enter the preparation program, which include measures of:

- (i) previous academic success;
- (ii) disposition for employment in an educational setting;

and

- (iii) basic skills in reading, writing, and mathematics; and
- (d) include a student teaching or intern experience that

meets the requirements detailed in:

- (i) Rule R277-304;
- (ii) Rule R277-305; and
- (iii) Rule R277-306; and

(e) include a pedagogical performance assessment meeting standards established by the Superintendent and approved by the Board for all new students enrolled in the program after January 1, 2020 in all license areas for which such an assessment is available.

(3)(a) If the Superintendent denies an application from an educator preparation program, the proposed educator preparation program may appeal the Superintendent's decision to the Board by submitting a written appeal to the Board Secretary.

(b) The Board shall assign an appeal under Subsection (3) (a) to a standing committee to make a recommendation to the full Board for final action.

~~(3)4~~ An approved educator preparation program may recommend an individual that completed the program for a professional license or license area for up to five years after the individual completed the program, as long as all current license requirements have been met.

~~(4)5~~ If five years have passed since an individual completed an approved educator preparation program, the program may recommend the individual for a professional license or license area if the program:

- (a) reviews the individual's program; and
- (b) requires the individual to complete any additional necessary requirements to meet current programs standards prior to making a licensing recommendation.

~~(5)6~~ Notwithstanding Subsections ~~(3)4~~ and ~~(4)5~~, an approved educator preparation program may recommend an individual who began the program before January 1, 2020 for a professional license or license area without meeting the pedagogical performance assessment requirement in R277-301, but must present documentation showing that the individual met the appropriate license requirements in effect prior to that date.

**R277-303-5. Superintendent Responsibilities.**

(1) The Superintendent shall provide support to educator preparation programs and potential licensees to the extent that funding allows by:

- (a) maintaining a website to:
  - (i) facilitate collaboration between educator preparation programs;
  - (ii) facilitate communication between potential educators and approved programs; and
  - (iii) provide access to up-to-date research on educator preparation and education practices;
- (b) reviewing third-party preparation materials for alignment with the Utah Effective Educator Standards in R277-530; and

- (c) working with potential licensed educators to help them become licensed educators.
- (2) The Superintendent shall design and maintain a model educator preparation program that:
  - (a) meets all requirements of this rule;
  - (b) may be adopted by an LEA or an accredited private school; and
  - (c) is overseen by staff distinct from the staff responsible for ensuring educator preparation program compliance with this Rule R277-303.

**R277-303-6. Effective Date.**

This rule will be effective beginning January 1, 2020.

**KEY: professional competency, educator preparation program, programs, pedagogical assessment**  
**Date of Enactment or Last Substantive Amendment:**  
~~December 10, 2018~~ 2019  
**Authorizing, and Implemented or Interpreted Law:** Art X Sec 3; 53E-3-401(4); 53E-6-201(3)(a)

**Education, Administration**  
**R277-406**

**Early Literacy Program and Benchmark Reading Assessment**

**NOTICE OF PROPOSED RULE**  
 (Amendment)

DAR FILE NO.: 43649  
 FILED: 04/15/2019

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The reason for the changes to Rule R277-406 are to update references to tests employed by the local education agencies (LEAs) and to update and clarify the process through which LEAs submit Early Literacy Plans to Utah State Board of Education (Board) staff.

**SUMMARY OF THE RULE OR CHANGE:** The changes in this rule include the amendment to the definition for "benchmark reading assessment". In Sections R77-406-3 and R277-406-4, unnecessary language is deleted and new clarifying language added. Also, dates are amended within this rule.

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Article X, Section 3 and Section 53E-4-307 and Subsection 53E-3-401(4) and Subsection 53F-2-503(14)(a)

**ANTICIPATED COST OR SAVINGS TO:**

◆ **THE STATE BUDGET:** These rule changes are not expected to have a fiscal impact on state government

revenues or expenditures. The funding for the program remains the same. This amendment removes language that is no longer applicable including: i) the DIBELS assessment name which is now called Acadience Reading; ii) the section of this rule that applied to LEAs not using a state-approved vendor since all LEAs are using a state-approved vendor moving forward; and iii) language for literacy plan approval for the 2018-2019 school year since it is no longer needed. Beginning in the 2019-2020 school year, some of the deadlines for LEAs related to literacy plans are extended which give LEAs more time, but this change will not have a fiscal impact.

◆ **LOCAL GOVERNMENTS:** These rule changes may have a fiscal impact on local governments. They add language which explicitly states that "if an LEA fails to timely resubmit an acceptable plan by November 1, the LEA is not eligible for funding in the current school year." Thus, LEAs that fail to timely resubmit an acceptable literacy plan may lose program funding in the current school year. It is difficult to provide an estimate of what this fiscal impact might be because the Board does not know how many LEAs will need to resubmit their plan and of those that do need to resubmit, how many fail to do so in a timely manner. None of the other rule changes will have a fiscal impact. Most of the changes extend deadlines for LEAs to comply with literacy plan requirements which should help in assisting LEAs with meeting the required deadlines.

◆ **SMALL BUSINESSES:** These rule changes are not expected to have any fiscal impact on small businesses' revenues or expenditures. This rule applies to early literacy plans submitted by LEAs and approved by the Board and thus does not apply to small businesses.

◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** These rule changes are not expected to have any fiscal impact on persons other than small businesses', businesses', or local government entities' revenues or expenditures. This rule applies to early literacy plans submitted by LEAs and approved by the Board and thus does not apply to other individuals.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** There are no compliance costs for affected persons.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** There are 1,241 entities with a NAICS code 611110 (Elementary and Secondary Schools) operating in Utah according to a "Firm Find Data" search through Utah's Department of Workforce Services. Most of the entities in the list are schools including public schools, charter schools, and private schools. Of the 1,241 entities, there are 15 private businesses, all of which are small businesses (there are no non-small businesses with a NAICS code 611110). These rule changes have no fiscal impact on LEAs and will not have a fiscal impact on non-small or small businesses. The Program Analyst at the Utah State Board of Education, Jill Curry, has reviewed and approved this fiscal analysis.

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

EDUCATION  
ADMINISTRATION  
250 E 500 S  
SALT LAKE CITY, UT 84111-3272  
or at the Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:  
♦ Angela Stallings by phone at 801-538-7550, by FAX at 801-538-7768, or by Internet E-mail at [angie.stallings@schools.utah.gov](mailto:angie.stallings@schools.utah.gov)

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 05/31/2019

THIS RULE MAY BECOME EFFECTIVE ON: 06/07/2019

AUTHORIZED BY: Angela Stallings, Deputy Superintendent of Policy

\*This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts for State Government, Local Government, Small Businesses and Other Persons are described in the narrative. Inestimable impacts for Non-Small Businesses are described in Appendix 2.

**Appendix 2: Regulatory Impact to Non-Small Businesses**

There are 1,241 entities with a NAICS code 611110 (Elementary and Secondary Schools) operating in Utah according to a "Firm Find Data" search through Utah's Department of Workforce Services. Most of the entities in the list are schools including public schools, charter schools, and private schools. Of the 1,241 entities, there are 15 private businesses, all of which are small businesses (there are no non-small businesses with a NAICS code 611110). Thus, these rule changes are not expected to have any fiscal impact on non-small businesses' revenue or expenditures because there are no applicable non-small businesses and it does not require any expenditures or generate revenues for non-small businesses.

The Program Analyst at the Utah State Board of Education, Jill Curry, has reviewed and approved this fiscal analysis.

**R277. Education, Administration.**

**R277-406. Early Literacy Program and Benchmark Reading Assessment.**

**R277-406-1. Authority and Purpose.**

- (1) This rule is authorized by:
  - (a) Utah Constitution[.] Article X, Section 3, which vests general control and supervision over public education in the Board;
  - (b) Subsection 53E-3-401(4), which allows the Board to make rules [in accordance with its responsibilities] to execute the Board's duties and responsibilities under the Utah Constitution and state law;
  - (c) Subsection 53F-2-503(14)(a), which directs the Board to develop rules for implementing the Early Literacy Program; and
  - (d) Section 53E-4-307, which requires the Board to approve a benchmark assessment for statewide use to assess the reading competency of students in grades one, two, and three.
- (2) The purpose of this rule is to outline the responsibilities of the Superintendent and LEAs for implementation of Section 53F-2-503 and the Board's administration of Early Literacy in the state, including to:
  - (a) set expectations for LEA Early Literacy Plans;
  - (b) establish timelines for LEA Early Literacy Plans;
  - (c) provide definitions and designate assessments required in Section 53E-4-307;
  - (d) provide testing reporting windows, and timelines; and
  - (e) require LEAs to submit student reading assessment data to the Board.

**R277-406-2. Definitions.**

- (1) "Benchmark reading assessment" means the [Dynamic Indicators of Basic Early Literacy Skills or DIBELS]Acadience Reading assessment that:
  - (a) is given three times each year;
  - (b) gives teachers information to:
    - (i) plan appropriate instruction; and
    - (ii) evaluate the effects of instruction; and
  - (c) provides data about the extent to which students are prepared to be successful on an end of year [C]riterion [R]eferenced [F]test.

**Appendix 1: Regulatory Impact Summary Table\***

Fiscal Costs	FY 2019	FY 2020	FY 2021
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0
Other Person	\$0	\$0	\$0
<b>Total Fiscal Costs:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Fiscal Benefits</b>			
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0
Other Persons	\$0	\$0	\$0
<b>Total Fiscal Benefits:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Net Fiscal Benefits:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

(2) "Evidence-based" means a strategy that has demonstrated a statistically significant effect on improving student outcomes.

(3) "Parental notification requirements" means notice by any reasonable means, including electronic notice, notice by telephone, written notice, or personal notice.

(4) "Plan" means the literacy proficiency improvement plan required in the Early Literacy Program that is submitted by a public school district or a charter school, as required in Subsection 53F-2-503(4).

(5) "Program money" means the same as that term is defined in Section 53F-2-503.

(6) "Reading below grade level" means that a student:

(a) performs below the benchmark score on the benchmark reading assessment; and

(b) requires additional instruction beyond that provided to typically-developing peers in order to close the gap between the student's current level of reading achievement and that expected of all students in that grade.

(7) "Reading remediation interventions" means reading instruction or reading activities, or both, given to students in addition to their regular reading instruction, during another time in the school day, outside regular instructional time, or in the summer, which is focused on specific needs as identified by reliable and valid assessments.

(8) "Utah eTranscript and Record Exchange" or "UTREx" means the same as that term is defined in Section R277-404-2.

**R277-406-3. Benchmark Reading Assessments.**

(1) An LEA shall administer the benchmark reading assessments in grade 1, grade 2, and grade 3 within the following testing windows:

- (a) the first benchmark before September 30;
- (b) the second benchmark between December 1 and January 31; and
- (c) the third benchmark between the middle of April and June 15.

(2) An LEA shall report benchmark reading assessment results to the Superintendent by:

- (a) October 30;
- (b) the last day of February; and
- (c) June 30.

(3) If the benchmark reading assessment indicates a student is reading below grade level, the LEA shall implement the parental notification requirements and evidence-based reading remediation interventions described in Section 53E-4-307.

(4) An LEA shall report benchmark reading assessment results to parents of students in grade 1, grade 2, and grade 3 by:

- (a) October 30;
- (b) the last day of February; and
- (c) June 30.

(5) An LEA shall submit to UTREx the following information from the benchmark reading assessment:

(a) whether or not each student received reading intervention; and

(b) UTREx Special Codes related to the benchmark reading assessment[; ~~and~~].

~~(c) for an LEA not using a state-approved vendor for the benchmark reading assessment;~~

~~(i) whether or not each student is reading on or above benchmark at each administration of the assessment; and~~

~~(ii) the composite score for each student at each administration of the assessment]~~

(6) An LEA that selects the reading assessment technology shall use the assessment consistent with Board directives.

**R277-406-4. Early Literacy Plans -- LEA and Superintendent Requirements - Timelines.**

(1) Beginning with the 2019-20 school year, [F]to receive program money, an LEA shall submit:

(a) a plan in accordance with Subsection 53F-2-503(4); and

(b) other required materials within established deadlines.

~~[(2) For the 2018-19 school year:~~

~~(a)(i) any time before August 15, an LEA may submit its plan to the Superintendent for pre-approval; and~~

~~(ii) for each LEA that submits a plan for pre-approval, the Superintendent shall provide feedback in preparation for the LEA submitting the plan to its local board;~~

~~(b) after its plan is approved by its local board, an LEA shall submit a final plan to the Superintendent by no later than October 1;~~

~~(c) within three weeks of an LEA submitting a final, local board-approved plan to the Superintendent, the Superintendent shall notify the LEA if the plan has been approved; and~~

~~(d)(i) if the Superintendent does not approve the LEA's plan, the LEA shall incorporate needed changes or provisions and resubmit the amended plan by December 1; and~~

~~(ii) the Superintendent shall approve a resubmitted plan that incorporated the requested changes by December 15.~~

~~(3) For the 2019-20 school year and subsequent school years:]~~

[(a)(i)](2)(a). [a]Any time before [June 15]July 1, an LEA may submit its plan to the Superintendent for pre-approval; and

[(ii)]b) [f]For each LEA that submits a plan for pre-approval, the Superintendent shall provide feedback in preparation for the LEA submitting the plan to its local board;

[(b)]3) [after its plan is approved by its local board, a]An LEA shall submit a final plan to the Superintendent by no later than August 15;

(4) Notwithstanding Subsection (3), by September 1 an LEA shall provide to the Superintendent:

(a) proof that the LEA's governing board reviewed and approved the LEA's plan in an open meeting; and

(b) if necessary, a revised plan reflecting changes made to the LEA's plan by the LEA's governing board.

[(e)]5) [w]Within three weeks of an LEA submitting a final, local board-approved plan to the Superintendent, the Superintendent shall notify the LEA if the plan has been approved or if modifications to the plan are required[; ~~and~~].

[(d)(i)](6). [i]If the Superintendent does not approve [the]an LEA's plan, the LEA shall may, by October 15:

(a) incorporate needed changes or provisions; [~~and~~]

(b) obtain approval for the amended plan from the LEA's governing board; and

(c) resubmit the amended plan[ ~~by October 1~~]; and

[(ii)]7) If an LEA timely resubmits a plan that includes the required modifications, the Superintendent shall approve [a-

~~resubmitted~~ the plan ~~[that incorporated the requested changes]~~ by ~~[October 15]~~ November 1.

(8) If an LEA fails to timely resubmit an acceptable plan by November 1, the LEA is not eligible for funding in the current school year.

([4]9) When reviewing an LEA plan for approval, the Superintendent shall evaluate:

(a) the extent to which the LEA's goals are ambitious, yet attainable; and

(b) ~~[if]~~ whether the plan uses evidence-based curriculum, materials, and practices, which will support the LEA in meeting its growth goals.

([5]10) All LEA plans shall be reported to the Superintendent using a digital reporting platform.

#### **R277-406-5. Accountability and Reporting on Early Literacy Plans.**

(1) An LEA shall report progress toward the goals outlined in the LEA's plan to the Superintendent by June 30 each year.

(2) In accordance with Section 53F-2-503, a growth goal in an LEA's plan:

(a) is calculated using the percentage of students in an LEA's grades 1 through 3 who made typical, above typical, or well-above typical progress from the beginning of the year to the end of the year, as measured by the benchmark reading assessment; and

(b) sets the target percentage of students in grades 1 through 3 making typical progress or better at a minimum of 60 percent.

(3) The Superintendent shall use the information provided by an LEA described in Subsection R277-406-4 to determine the progress of each student in grades 1 through 3 within the following categories:

(i) well-above typical;

(ii) above typical;

(iii) typical;

(iv) below typical; or

(v) well-below typical.

(4) If an LEA does not make sufficient progress toward its plan goals, as defined in Subsection (5), the LEA shall be in the Board System of Support and required to participate in interventions to improve early literacy.

(5) Sufficient progress toward plan goals means the LEA meets:

(a) the LEA's growth goal, as described in Subsection 53F-2-503(4)(a)(v); and

(b) at least one of the LEA-designated goals addressing performance gaps, as described in Subsection 53F-2-503(4)(a)(vi).

(6) The Superintendent shall establish the strategies, interventions, and techniques for schools that are in the Board System of Support to help schools achieve early literacy goals.

**KEY: reading, improvement, goals**

**Date of Enactment or Last Substantive Amendment:** ~~[August 7, 2018]~~ 2019

**Notice of Continuation:** June 7, 2018

**Authorizing, and Implemented or Interpreted Law:** Art X Sec 3; 53E-3-401(4); 53F-2-503(14)(a)

## Education, Administration **R277-417** Prohibiting LEAs and Third Party Providers from Offering Incentives or Disbursement for Enrollment or Participation

### NOTICE OF PROPOSED RULE

(Amendment)

DAR FILE NO.: 43658

FILED: 04/15/2019

### RULE ANALYSIS

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** Section R277-417-4 was moved into its own rule, R277-115, regarding local education agency (LEA) supervision and monitoring of contracts. Based on the Utah State Board of Education's (Board) approval of Rule R277-115, the changes in Rule R277-417 are necessary.

**SUMMARY OF THE RULE OR CHANGE:** Rule R277-417 is being amended to remove language referencing LEAs working with third party providers and eliminating Section R277-417-4 from this rule to create Rule R277-115.

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Article X Section 3 and Subsection 53E-3-401(4)

#### ANTICIPATED COST OR SAVINGS TO:

◆ **THE STATE BUDGET:** These rule changes are not expected to have a fiscal impact on state government revenues or expenditures. Section R277-417-4, which is marked for removal, was moved to its own rule, R277-115. The remainder of this rule is intact except for the addition of a definition for an educational good or service. Thus, there is no fiscal impact to the state from these changes.

◆ **LOCAL GOVERNMENTS:** These rule changes are not expected to have a fiscal impact on local governments' revenues or expenditures. Section R277-417-4, which is marked for removal, was moved to its own rule, R277-115. The remainder of this rule is intact except for the addition of a definition for an educational good or service. Thus, there is no fiscal impact to local governments from these changes.

◆ **SMALL BUSINESSES:** These rule changes are not expected to have any fiscal impact on small businesses' revenues or expenditures. Section R277-417-4, which is marked for removal, was moved to its own rule, R277-115. The remainder of this rule is intact except for the addition of a definition for an educational good or service. Thus, there is no fiscal impact to small businesses from these changes.

◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** These rule changes are not expected to have any fiscal impact on persons other than small businesses', businesses',

or local government entities' revenues or expenditures. Section R277-417-4, which is marked for removal, was moved to its own rule, R277-115. The remainder of this rule is intact except for the addition of a definition for an educational good or service. Thus, there is no fiscal impact to other individuals from these changes.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** There are no compliance costs for affected persons.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** There are 1,241 entities with a NAICS code 611110 (Elementary and Secondary Schools) operating in Utah according to a "Firm Find Data" search through Utah's Department of Workforce Services. Most of the entities in the list are schools including public schools, charter schools, and private schools. Of the 1,241 entities, there are 15 private businesses, all of which are small businesses (there are no non-small businesses with a NAICS code 611110). These rule changes have no fiscal impact on LEAs and will not have a fiscal impact on non-small or small businesses. The Program Analyst at the Utah State Board of Education, Jill Curry, has reviewed and approved this fiscal analysis.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:  
 EDUCATION  
 ADMINISTRATION  
 250 E 500 S  
 SALT LAKE CITY, UT 84111-3272  
 or at the Office of Administrative Rules.

**DIRECT QUESTIONS REGARDING THIS RULE TO:**  
 ♦ Angela Stallings by phone at 801-538-7550, by FAX at 801-538-7768, or by Internet E-mail at [angie.stallings@schools.utah.gov](mailto:angie.stallings@schools.utah.gov)

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 05/31/2019

THIS RULE MAY BECOME EFFECTIVE ON: 06/07/2019

AUTHORIZED BY: Angela Stallings, Deputy Superintendent of Policy

**Appendix 1: Regulatory Impact Summary Table\***

Fiscal Costs	FY 2019	FY 2020	FY 2021
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0

Other Person	\$0	\$0	\$0
<b>Total Fiscal Costs:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Fiscal Benefits</b>			
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0
Other Persons	\$0	\$0	\$0
<b>Total Fiscal Benefits:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Net Fiscal Benefits:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

\*This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts for State Government, Local Government, Small Businesses and Other Persons are described in the narrative. Inestimable impacts for Non-Small Businesses are described in Appendix 2.

**Appendix 2: Regulatory Impact to Non-Small Businesses**

There are 1,241 entities with a NAICS code 611110 (Elementary and Secondary Schools) operating in Utah according to a "Firm Find Data" search through Utah's Department of Workforce Services. Most of the entities in the list are schools including public schools, charter schools, and private schools. Of the 1,241 entities, there are 15 private businesses, all of which are small businesses (there are no non-small businesses with a NAICS code 611110). Thus, these rule changes are not expected to have any fiscal impact on non-small businesses' revenue or expenditures because there are no applicable non-small businesses and it does not require any expenditures or generate revenues for non-small businesses.

The Program Analyst at the Utah State Board of Education, Jill Curry, has reviewed and approved this fiscal analysis.

**R277. Education, Administration.**

**R277-417. Prohibiting LEAs and Third Party Providers from Offering Incentives or Disbursement for Enrollment or Participation.**

**R277-417-1. Authority and Purpose.**

- (1) This rule is authorized by:
  - (a) Utah Constitution Article X, Section 3, which vests general control and supervision over public education in the Board; and
  - (b) Subsection 53E-3-401(4), which allows the Board to make rules to execute the Board's duties and responsibilities under the Utah Constitution and state law.
- (2) The purpose of this rule is[=

~~\_\_\_\_\_ (a) ] to provide standards and procedures for prohibiting LEAs and third party providers from offering incentives for student enrollment. ] and~~

~~\_\_\_\_\_ (b) to provide standards for an LEA working with a third party provider to ensure the third party provider complies with this R277-417.]~~

**R277-417-2. Definitions.**

(1)(a) "Disbursement" means the payment of money or provision of other item of value greater than \$10, per school year, offered as payment or compensation to a student or to a parent or guardian for:

- (i) a student's enrollment in an LEA; or
- (ii) a student's participation in an LEA's program.

(b) "Disbursement" does not include a reimbursement paid by an LEA to a student, parent or guardian, for an expenditure incurred by the student, parent or guardian on behalf of the LEA if:

- (i) the expenditure is for an item that will be the property of the LEA; and
- (ii) the expenditure was preauthorized by the LEA, as evidenced by preauthorization documentation.

(2) "Educational good or service" means the same as that term is defined in Section 53E-3-401.

~~(2)(3)~~(3) "Incentive" means one of the following given to a student or to the student's parent or guardian by an LEA or by a third party provider as a condition of the student's enrollment in an LEA or specific program for any length of time, during any school year:

- (a) money greater than \$10; or
- (b) an item of value greater than \$10.

~~(3)(4)~~(4) "Program" means a program within a school that is designed to accomplish a predetermined curricular objective or set of objectives.

~~(4)(5)~~(5) "Section 504 accommodation plan" required by Section 504 of the Rehabilitation Act of 1973, means a plan designed to accommodate an individual who has been determined, as a result of an evaluation, to have a physical or mental impairment that substantially limits one or more major life activities.

~~(5)(6)~~(6) "Third party provider" means a third party who provides an educational good or service[s] on behalf of an LEA.

**R277-417-3. LEA and Third Party Provider Use of Public Funds for Incentives and Disbursement.**

(1) An LEA or a third party provider may not use public funds, as defined under Subsection 51-7-3(26), to provide the following to a student, parent or guardian, individual, or group of individuals:

- (a) an incentive for a student's:
  - (i) enrollment in an LEA; or
  - (ii) participation in an LEA's program; or
- (b) a referral bonus for a student's:
  - (i) enrollment in an LEA; or
  - (ii) participation in an LEA's program.

(2) An LEA or third party provider may not use public funds to provide a disbursement to a student or the student's parent or guardian for:

- (a) curriculum exclusively selected by a parent;
- (b) instruction not provided by the LEA;
- (c) private lessons or classes not provided by:

- (i) an employee of the LEA; or
- (ii) a third party provider who meets all of the requirements of ~~[R277-417-4]~~R277-115;

(d) technology devices exclusively selected by a parent; or

(e) other educational expense exclusively selected by a parent.

(3) An LEA may use public funds to provide:

(a) uniforms, technology devices, curriculum, or materials and supplies to a student if the uniforms, technology devices, curriculum, or materials and supplies are:

(i) available to all students enrolled in the LEA or program within the LEA; or

(ii) authorized by the student's college and career readiness plan, IEP, or Section 504 accommodation plan; or

(b) internet access for instructional purposes to a student:

(i) in kindergarten through grade 6; or

(ii) in grade 7 through grade 12 if:

(A) the internet access is provided in accordance with the fee waiver policy requirements of Section R277-407-8[6]; or

(B) failure to provide the internet access will cause economic hardship on the student or parent.

(4) An LEA or third party provider shall ensure that equipment purchased or leased by the LEA or third party provider remains the property of the LEA and is subject to the LEA's asset policies if:

(a) the LEA or third party provider purchases equipment; and

(b) provides the equipment to a student or to the student's parent or guardian.

~~**[R277-417-4. Third Party Provider Provision of Educational Services.**~~

~~\_\_\_\_\_ (1) An LEA that contracts with a third party provider to provide services on behalf of the LEA shall:~~

~~\_\_\_\_\_ (a) establish monitoring and compliance procedures to ensure that a third party provider who provides educational services to a student on behalf of the LEA complies with the provisions of this rule;~~

~~\_\_\_\_\_ (b) develop a written monitoring plan to supervise the activities and services provided by the third party provider;~~

~~\_\_\_\_\_ (c) ensure the third party provider is complying with:~~

- ~~\_\_\_\_\_ (i) federal law;~~
- ~~\_\_\_\_\_ (ii) state law; and~~
- ~~\_\_\_\_\_ (iii) Board rules;~~

~~\_\_\_\_\_ (d) monitor and supervise all activities of the third party provider related to services provided by the third party provider to the LEA; and~~

~~\_\_\_\_\_ (e) maintain documentation of the LEA's supervisory activities consistent with the LEA's administrative records retention schedule.~~

~~\_\_\_\_\_ (2) An LEA shall:~~

~~\_\_\_\_\_ (a) verify the accuracy and validity of a student's enrollment verification data, prior to enrolling a student in the LEA; and~~

~~\_\_\_\_\_ (b) provide a student and the student's parent or guardian with notification of the student's enrollment in a school or program within the LEA.~~

~~(3) The Board or the Superintendent may require an LEA to repay public funds to the Superintendent if:~~  
~~(a) the LEA or the LEA's third party provider fails to comply with the provisions of this rule; and~~  
~~(b) the repayment is made in accordance with the procedures established in R277-114.]~~

**KEY: students, enrollment, incentives**  
**Date of Enactment or Last Substantive Amendment: [March 14, 2017|2019**  
**Authorizing, and Implemented or Interpreted Law: Art X Sec 3; 53E-3-401(4)**

**Education, Administration**  
**R277-463**  
**Class Size Average and Pupil-Teacher Ratio Reporting**

**NOTICE OF PROPOSED RULE**  
 (Amendment)  
 DAR FILE NO.: 43652  
 FILED: 04/15/2019

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** Rule R277-463 was reviewed for the five-year review process by the Utah State Board of Education (Board) and changes were deemed necessary.

**SUMMARY OF THE RULE OR CHANGE:** There were minor language amendments to this rule in Section R277-463-5, deleting the word "shall" and replacing it with "by".

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Article X, Section 3 and Section 53E-3-301 and Subsection 53E-3-401(4)

**ANTICIPATED COST OR SAVINGS TO:**  
 ♦ **THE STATE BUDGET:** This rule change is not expected to have any fiscal impact on state government revenues or expenditures. The only change in this rule is a wording clean-up so there are no substantive changes to this rule, and thus no fiscal impact.  
 ♦ **LOCAL GOVERNMENTS:** This rule change is not expected to have any fiscal impact on local governments' revenues or expenditures. The only change in this rule is a wording clean-up so there are no substantive changes to this rule, and thus no fiscal impact.  
 ♦ **SMALL BUSINESSES:** This rule change is not expected to have any fiscal impact on small businesses' revenues or expenditures. This rule applies to class size averages and pupil-teacher ratio reporting and thus does not apply to small businesses.

♦ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** This rule change is not expected to have any fiscal impact on persons other than small businesses', businesses', or local government entities' revenues or expenditures. The only change in the rule is a wording clean-up so there are no substantive changes to this rule, and thus no fiscal impact.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** There are no compliance costs for affected persons.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** There are 1,241 entities with a NAICS code 611110 (Elementary and Secondary Schools) operating in Utah according to a "Firm Find Data" search through Utah's Department of Workforce Services. Most of the entities in the list are schools including public schools, charter schools, and private schools. Of the 1,241 entities, there are 15 private businesses, all of which are small businesses (there are no non-small businesses with a NAICS code 611110). This rule change has no fiscal impact on local education agencies and will not have a fiscal impact on non-small or small businesses. The Program Analyst at the Utah State Board of Education, Jill Curry, has reviewed and approved this fiscal analysis.

**THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:**  
 EDUCATION  
 ADMINISTRATION  
 250 E 500 S  
 SALT LAKE CITY, UT 84111-3272  
 or at the Office of Administrative Rules.

**DIRECT QUESTIONS REGARDING THIS RULE TO:**  
 ♦ Angela Stallings by phone at 801-538-7550, by FAX at 801-538-7768, or by Internet E-mail at [angie.stallings@schools.utah.gov](mailto:angie.stallings@schools.utah.gov)

**INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 05/31/2019**

**THIS RULE MAY BECOME EFFECTIVE ON: 06/07/2019**

**AUTHORIZED BY:** Angela Stallings, Deputy Superintendent of Policy

**Appendix 1: Regulatory Impact Summary Table\***

Fiscal Costs	FY 2019	FY 2020	FY 2021
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0

Non-Small Businesses	\$0	\$0	\$0
Other Person	\$0	\$0	\$0
<b>Total Fiscal Costs:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Fiscal Benefits</b>			
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0
Other Persons	\$0	\$0	\$0
<b>Total Fiscal Benefits:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Net Fiscal Benefits:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

\*This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts for State Government, Local Government, Small Businesses and Other Persons are described in the narrative. Inestimable impacts for Non-Small Businesses are described in Appendix 2.

**Appendix 2: Regulatory Impact to Non-Small Businesses**

There are 1,241 entities with a NAICS code 611110 (Elementary and Secondary Schools) operating in Utah according to a "Firm Find Data" search through Utah's Department of Workforce Services. Most of the entities in the list are schools including public schools, charter schools, and private schools. Of the 1,241 entities, there are 15 private businesses, all of which are small businesses (there are no non-small businesses with a NAICS code 611110). This rule change has no fiscal impact on local education agencies and will not have a fiscal impact on non-small or small businesses.

The Program Analyst at the Utah State Board of Education, Jill Curry, has reviewed and approved this fiscal

**R277. Education, Administration.**

**R277-463. Class Size Average and Pupil-Teacher Ratio Reporting.**

**R277-463-1. Authority and Purpose.**

- (1) This rule is authorized by:
  - (a) Utah Constitution Article X, Section 3, which places general control and supervision of the public school system under the Board;
  - (b) Section 53E-3-301, which directs the Board to report average class sizes and pupil-teacher ratios; and
  - (c) Subsection 53E-3-401(4), which allows the Board to make rules to execute the Board's duties and responsibilities under the Utah Constitution and state law.

(2) The purpose of this rule is to establish uniform class size and pupil-teacher ratio reporting procedures, including definitions and codes.

**R277-463-2. Definitions.**

- (1) "Course" means the subject matter taught to students.
  - (a) Elementary courses are designated by grade level.
  - (b) Secondary courses are determined by course content.
- (2) "EL" means English Learner.
- (3)(a) "Individual class" means a group of students organized for instruction and assigned to one or more teachers or other staff members for a designated time period.
  - (b) A class may include:
    - (i) students from multiple grades; or
    - (ii) students taking multiple courses.
  - (c) The Superintendent shall determine an individual class from course data submitted to the Superintendent using a combination of course elements, such as:
    - (i) CACTUS identification number;
    - (ii) teacher of record;
    - (iii) class period;
    - (iv) term of student enrollment; and
    - (v) course cycle.
- (4) "Pupil" means a student enrolled in a public school as of October 1 of the reported school year.
- (5) "Teacher" means a full-time equivalent licensed educator, such as:
  - (a) a regular classroom teacher;
  - (b) a school-based specialist; or
  - (c) a special education teacher.

**R277-463-3. Class Size Average for Elementary Classes.**

- (1)(a) An LEA shall report student level course data providing sufficient course information to determine the number of students in individual classes.
- (b) An LEA shall calculate a class with students in multiple grades as one class.
- (c) An LEA shall calculate an extended day classes in which one portion of the class arrives early and the other portion stays late as one class.
- (2)(a) The Superintendent shall calculate average class size by grade.
  - (b) The Superintendent shall exclude special education, EL, online, and other non-traditional classes from class size average calculations.
  - (3) The Superintendent shall derive state and district-level class sizes from the median of school-level class sizes.

**R277-463-4. Class Size Average for Secondary Classes.**

- (1)(a) An LEA shall report student level course data providing sufficient course information to determine the number of students in individual classes.
- (b) An LEA shall calculate classes including students enrolled in multiple courses as one class.
- (2)(a) The Superintendent shall calculate average class size for core language arts, mathematics, and science courses.
  - (b) The Superintendent shall exclude special education, EL, online, and other non-traditional classes from class size averages.

(3) The Superintendent shall derive state and district-level class sizes from taking the median of school-level class sizes.

**R277-463-5. Pupil-Teacher Ratio Calculation.**

(1)(a) The Superintendent shall calculate pupil-teacher ratios by school.

(b) The Superintendent shall calculate the pupil-teacher ratio for each school [shall]by dividing the number of enrolled pupils by the number of full-time equivalent teachers assigned to the school.

(2) The Superintendent shall derive district-level ratios by taking the median of school-level ratios.

(3) The Superintendent shall derive state-level ratios for charter schools and traditional schools by taking the median of school-level data.

**R277-463-6. Reporting Format and Timeline.**

The Superintendent shall report school, district and state-level ratios and class size averages to the public as required under Section 53E-3-301.

**KEY: public schools, enrollment reporting, class size average reporting, pupil-teacher ratio reporting**

**Date of Enactment or Last Substantive Amendment: [August 7, 2018]2019**

**Notice of Continuation: June 10, 2014**

**Authorizing, and Implemented or Interpreted Law: Art. X, Sec 3; 53E-3-301; 53E-3-401(4)**

**Education, Administration  
R277-480  
Charter School Revolving Account**

**NOTICE OF PROPOSED RULE  
(Amendment)**

DAR FILE NO.: 43647  
FILED: 04/15/2019

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** Rule R277-480 was reviewed for the five-year review process by the Utah State Board of Education (Board) and changes were deemed necessary.

**SUMMARY OF THE RULE OR CHANGE:** Rule R277-480 has been amended to provide technical, conforming, and stylistic changes in accordance with the Rulewriting Manual for Utah and Board policies, and language has been updated in Section R277-480-2 plus clarifying language has been added throughout the rule.

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Article X Section 3 and Subsection 53E-3-401(4) and Subsection 53F-9-203(2)(b)

**ANTICIPATED COST OR SAVINGS TO:**

♦ **THE STATE BUDGET:** These rule changes are not expected to have any fiscal impact on state government revenues or expenditures. Staff have reviewed this rule and determined that it continues to be necessary. This rule has been amended to provide technical, conforming, and stylistic changes in accordance with the Rulewriting Manual for Utah and Board policies. None of these changes substantively change the process so there is no fiscal impact.

♦ **LOCAL GOVERNMENTS:** These rule changes are not expected to have any fiscal impact on local governments' revenues or expenditures. This rule has been amended to provide technical, conforming, and stylistic changes in accordance with the Rulewriting Manual for Utah and Board policies. None of these changes substantively change the process so there is no fiscal impact.

♦ **SMALL BUSINESSES:** These rule changes are not expected to have any fiscal impact on small businesses' revenues or expenditures. This rule applies to the charter school revolving account and thus does not apply to small businesses.

♦ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** These rule changes are not expected to have any fiscal impact on persons other than small businesses, businesses, or local government entities revenues or expenditures. This rule has been amended to provide technical, conforming, and stylistic changes in accordance with the Rulewriting Manual for Utah and Board policies. None of these changes substantively change the process so there is no fiscal impact.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** There are no compliance costs for affected persons.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** There are 1,241 entities with a NAICS code 611110 (Elementary and Secondary Schools) operating in Utah according to a "Firm Find Data" search through Utah's Department of Workforce Services. Most of the entities in the list are schools including public schools, charter schools, and private schools. Of the 1,241 entities, there are 15 private businesses, all of which are small businesses (there are no non-small businesses with a NAICS code 611110). These rule changes have no fiscal impact on local education agencies and will not have a fiscal impact on non-small or small businesses. The Program Analyst at the Utah State Board of Education, Jill Curry, has reviewed and approved this fiscal analysis.

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

EDUCATION  
ADMINISTRATION  
250 E 500 S  
SALT LAKE CITY, UT 84111-3272  
or at the Office of Administrative Rules.

**DIRECT QUESTIONS REGARDING THIS RULE TO:**  
 ♦ Angela Stallings by phone at 801-538-7550, by FAX at 801-538-7768, or by Internet E-mail at [angie.stallings@schools.utah.gov](mailto:angie.stallings@schools.utah.gov)

**INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 05/31/2019**

**THIS RULE MAY BECOME EFFECTIVE ON: 06/07/2019**

**AUTHORIZED BY: Angela Stallings, Deputy Superintendent of Policy**

**Appendix 1: Regulatory Impact Summary Table\***

Fiscal Costs	FY 2019	FY 2020	FY 2021
State Government	\$0	\$0	\$0
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<b>Total Fiscal Costs:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Fiscal Benefits</b>			
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0
Other Persons	\$0	\$0	\$0
<b>Total Fiscal Benefits:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Net Fiscal Benefits:</b>			
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**Appendix 2: Regulatory Impact to Non-Small Businesses**

There are 1,241 entities with a NAICS code 611110 (Elementary and Secondary Schools) operating in Utah according to a "Firm Find Data" search through Utah's Department of Workforce Services. Most of the entities in the list are schools including public schools, charter schools, and private schools. Of the 1,241 entities, there are 15 private businesses, all of which are small businesses (there are no non-small businesses with a NAICS code 611110). Thus, these rule changes are not expected to have any fiscal impact on non-small businesses' revenue or expenditures because there are no applicable non-small businesses and it does not require any expenditures or generate revenues for non-small businesses.

The Program Analyst at the Utah State Board of Education, Jill Curry, has reviewed and approved this fiscal analysis.

**R277. Education, Administration.  
 R277-480. Charter School Revolving Account.  
 R277-480-[2]1. Authority and Purpose.**

~~[A-](1)~~ This rule is authorized ~~[under]~~by:  
 (a) ~~Utah Constitution Article X, Section 3,~~ which vests general control and supervision over public education in the Board[;];  
 (b) ~~Subsection 53E-3-401(4), which allows the Board to adopt rules to execute the Board's duties and responsibilities under the Utah Constitution and state law; and~~  
 (c) ~~Subsection 53F-9-203(2)(b), which requires the Board to administer the Charter School Revolving Account[;—and Subsection 53E-3-401(4), which allows the Board to adopt rules in accordance with its responsibilities].~~  
~~[B-](2)~~ The purpose of this rule is to:  
 (a) establish procedures for administering the Charter School Revolving Account;  
 (b) ~~[to]~~determine membership of the Charter School Revolving Account Committee[;]; and~~[to]~~  
 (c) determine loan amounts and loan repayment conditions.

**R277-480-[1]2. Definitions.**

~~[A-]~~ A. "Board" means the Utah State Board of Education.  
~~[B-]~~ B. "Charter schools" means schools acknowledged as charter schools by local boards of education under Section 53G-5-305, by the Board under Section 53G-5-304, and by boards of trustees of higher education institutions under Section 53G-5-306.  
 (1) "Charter school" means a public school created in accordance with the provisions of Title 53G, Chapter 5, Charter Schools.  
~~[C-](2)~~ "Charter School Revolving Account" means a restricted account created within the Uniform School fund to provide assistance to charter schools to:  
 ([1]a) meet school building construction and renovation needs; and  
 ([2]b) pay for expenses related to the start up of a new charter school or the expansion of an existing charter school[s].  
~~[D-](3)~~ "Charter School Revolving Account Committee" means the committee established by the Board under Subsection 53F-9-203(6).  
~~[E-]~~ E. "Superintendent" means the State Superintendent of Public Instruction as designated under 53E-3-301-]

~~(4) "Executive Director" means the Executive Directors of the State Charter School Board or the Executive Director's designee.~~

~~[F-](4)(a) "Urgent facility need[;]" [as provided for in Subsection 53F-9-203(5), -] means an unexpected exigency at a charter school that is entitled to priority under Subsection 53F-9-203(5)[that] because it affects the health and safety of students[ -such as-].~~

~~(b) An "urgent facility need" may include:~~

~~(1) [i] [to satisfy] an unforeseen condition that precludes a school's qualification for an occupancy permit; or~~

~~(2) [ii] [to address] an unforeseen circumstance that keeps the school from satisfying provisions of public safety, public health, or public school laws or Board rules.~~

~~[ -G. "USOE" means the Utah State Office of Education.-]~~

#### **R277-480-3. Charter School Revolving Account Committee.**

~~[A-](1) The Board shall establish a Charter School Revolving Account Committee [consistent]in accordance with Subsection 53F-9-203(6).~~

~~[B-](2) The State Charter School Board shall submit a list of at least three nominees per vacancy who meet the requirements of Subsection 53F-9-203(6)(b) for appointment by the Board consistent with timelines established by the Board.~~

~~[C-](3) The Board shall annually accept nominations of individuals provided by the State Charter School Board who meet the qualifications of Subsection 53F-9-203(6)(b).~~

~~[D-](4) The Board may only select Charter School Revolving Account Committee members who satisfy conditions of Subsection 53F-9-203(6).~~

~~[E-](5) Charter School Revolving Account Committee members [appointed by the Board after May 1, 2010 shall be appointed for]shall serve two year terms.~~

~~[F-](6) The [USOE Charter School]Executive Director [or designee-]shall be a non-voting Charter School Revolving Account Committee member.~~

#### **R277-480-4. Charter School Revolving Account Application and Conditions.**

~~[A-](1) The Charter School Revolving Account Committee shall develop [and the USOE shall make available-]a loan application that [includes criteria designated under]is consistent with Section 53F-9-203, including criteria for urgent facility needs[ -criteria].~~

~~[B-](2) The Charter School Revolving Account Committee [shall include other criteria or information from loan applicants that the committee or the Board determines to be necessary and helpful, including considerations of Subsection 53F-9-203(5);]may request any criteria or information from an applicant that the committee finds necessary and helpful in making final recommendations to the [Superintendent, the-]State Charter School Board and the Board.~~

~~[C-](3)(a) The Charter School Revolving Account Committee shall accept applications for loans [on an ongoing basis]annually by April 30, subject to eligibility criteria and availability of funds.~~

~~(b) If the Charter School Revolving Account Committee does not distribute all available funds during its initial application~~

~~process, the committee may set deadlines to review additional applications.~~

~~(1) [4] To apply for a loan, a charter school shall submit the information requested on the Board's most current loan application form together with the requested supporting documentation.~~

~~(2) [5] [The]A charter school's application shall include a resolution from the governing board of the charter school that the governing board, at a minimum:~~

~~(a) agrees to enter into the loan as provided in the application materials;~~

~~(b) agrees to the interest established by the Charter School Revolving Account Committee and repayment schedule of the loan designated by the Charter School Revolving Account Committee and the Board;~~

~~(c) agrees that loan funds shall only be used consistent with the purposes of Section 53F-9-203 and [the purpose of-]the approved charter;~~

~~(d) agrees to any and all inspections, audits or financial reviews ordered by the Charter School Revolving Account Committee or the Board; and~~

~~(e) [understands that repayment, including interest, shall be deducted automatically from the charter school's monthly fund transfers, as appropriate.]agrees to all terms required for the loan by the State Division of Finance, including:~~

~~(i) servicing by the State Division of Finance;~~

~~(ii) payment of an annual servicing fee;~~

~~(iii) agreement to execute an electronic funds transfer agreement for monthly payments by the school; and~~

~~(iv) in the case of default, agreement to terms established by the State Division of Finance for collection.~~

~~[D-](6) The Charter School Revolving Account Committee shall establish terms and conditions for loan repayment, consistent with Section 53F-9-203. Terms shall include:~~

~~(1) [7] The terms established under Subsection (6) shall include a [A] tiered schedule of loan fund distribution as follows:~~

~~(a) 50 percent (up to \$150,000) disbursed no more than 12 months prior to August 15 in the school's first year of operations;~~

~~(b) 25 percent (up to \$75,000) disbursed no more than six months prior to August 15 in the school's first year of operation;~~

~~(c) the balance of loan funds disbursed no more than three months prior to August 15 in the school's first year of operations.~~

~~(2) [8] The loan amount to a charter school board awarded under Section 53F-9-203 [shall]may not exceed:~~

~~(a) \$1,000 per pupil based on the most recent October 1 enrollment count for operational schools; or~~

~~(b) \$1,000 per pupil based on approved enrollment capacity of the first year of operation for pre-operational schools; or~~

~~(c) \$300,000 of the total of all current loan awards by the Board to a charter school board.~~

#### **R277-480-5. Charter School Revolving Account Committee Recommendations and Board Approval.**

~~[A-](1) The Charter School Revolving Account Committee shall make recommendations to the State Charter School Board and the Board only upon receipt of complete and satisfactory information from the applicant and upon a majority~~

recommendation from the Charter School Revolving Account Committee.

~~[B-](2)~~ The submission of intentionally false, incomplete or inaccurate information from a loan applicant may result in:

- ~~(a)~~ immediate cancellation of any previous loan~~[(s)];~~
- ~~(b)~~ the requirement for immediate repayment of any funds received~~[-];~~
- ~~(c)~~ denial of subsequent applications for a 12 month period from the date of the initial application~~[-];~~ and~~[-possible-Board]~~
- ~~(d)~~ a recommendation to a school's authorizer to consider revocation of ~~[a]the school's~~ charter.

~~[C-](3)~~ The ~~[Board-staff]~~Superintendent and ~~[State-Charter Board-staff]~~Executive Director shall review recommendations from the Charter School Revolving Account Committee.

~~(4)~~ The Charter School Revolving Account Committee shall submit recommendations for loan funding to the State Charter School Board for review.

~~[D-](5)~~ ~~[Final recommendations from the]~~The ~~[Charter School Revolving Account Committee]~~State Charter School Board shall ~~[be submitted]~~submit final recommendations to the Board no more than ~~[60]90~~ days after submission of all information and materials from the loan applicant to the Charter School Revolving Account Committee.

~~[E-](6)~~ ~~[The]~~Either the State Charter School Board or the Board may request additional information from loan applicants or a reconsideration of a recommendation by the Charter School Revolving Account Committee.

~~[F-](7)~~ The Board's approval or denial of a loan application~~[s]~~ constitutes the final administrative action in the charter school building revolving loan process.

**KEY: charter schools, revolving account**

**Date of Enactment or Last Substantive Amendment:** ~~[August 7, 2014]2019~~

**Notice of Continuation:** June 10, 2014

**Authorizing, and Implemented or Interpreted Law:** Art X, Sec 3; 53F-9-203(2)(b); 53E-3-401(4)

## Education, Administration

### R277-511

## Academic Pathway to Teaching (APT)

### Level 1 License

#### NOTICE OF PROPOSED RULE

(Amendment)

DAR FILE NO.: 43648

FILED: 04/15/2019

#### RULE ANALYSIS

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** In the Utah State Board of Education's (Board) redesign of the educator licensing system, the need for this rule has been eliminated.

**SUMMARY OF THE RULE OR CHANGE:** The amendments to this rule add a sunset date of 06/30/2020 and establish a transition procedure for educators who may be in the Academic Pathway to Teaching (APT) licensing pipeline at the time this rule sunsets.

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Article X Section 3 and Subsection 53E-3-401(4) and Subsection 53E-6-201(2)(a)

**ANTICIPATED COST OR SAVINGS TO:**

♦ **THE STATE BUDGET:** These rule changes are not expected to have any fiscal impact on state government revenues or expenditures. In the Board's redesign of the educator licensing system, the need for this rule has been eliminated. Thus, these rule changes add a sunset date of 06/30/2020 and establish a transition procedure for educators who may be in the APT pipeline at the time the rule sunsets.

♦ **LOCAL GOVERNMENTS:** These rule changes are not expected to have any fiscal impact on local governments' revenues or expenditures. In the Board's redesign of the educator licensing system, the need for this rule has been eliminated. Thus, these rule changes add a sunset date of 06/30/2020 and establish a transition procedure for educators who may be in the APT pipeline at the time this rule sunsets.

♦ **SMALL BUSINESSES:** These rule changes are not expected to have any fiscal impact on small businesses' revenues or expenditures. This rule applies to educator licensing and thus does not apply to small businesses since the Board is responsible for educator licensing.

♦ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** These rule changes are not expected to have any fiscal impact on persons other than small businesses', businesses', or local government entities' revenues or expenditures. In the Board's redesign of the educator licensing system, the need for this rule has been eliminated. Thus, these rule changes add a sunset date of 06/30/2020 and establish a transition procedure for educators who may be in the APT pipeline at the time the rule sunsets.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** There are no compliance costs for affected persons.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** There are 1,241 entities with a NAICS code 61110 (Elementary and Secondary Schools) operating in Utah according to a "Firm Find Data" search through Utah's Department of Workforce Services. Most of the entities in the list are schools including public schools, charter schools, and private schools. Of the 1,241 entities, there are 15 private businesses, all of which are small businesses (there are no non-small businesses with a NAICS code 61110). These rule changes have no fiscal impact on local education agencies and will not have a fiscal impact on non-small or small businesses. The Program Analyst at the Utah State Board of Education, Jill Curry, has reviewed and approved this fiscal analysis.

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

EDUCATION  
ADMINISTRATION  
250 E 500 S  
SALT LAKE CITY, UT 84111-3272  
or at the Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:  
♦ Angela Stallings by phone at 801-538-7550, by FAX at 801-538-7768, or by Internet E-mail at [angie.stallings@schools.utah.gov](mailto:angie.stallings@schools.utah.gov)

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 05/31/2019

THIS RULE MAY BECOME EFFECTIVE ON: 06/07/2019

AUTHORIZED BY: Angela Stallings, Deputy Superintendent of Policy

\*This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts for State Government, Local Government, Small Businesses and Other Persons are described in the narrative. Inestimable impacts for Non-Small Businesses are described in Appendix 2.

**Appendix 2: Regulatory Impact to Non-Small Businesses**

There are 1,241 entities with a NAICS code 611110 (Elementary and Secondary Schools) operating in Utah according to a "Firm Find Data" search through Utah's Department of Workforce Services. Most of the entities in the list are schools including public schools, charter schools, and private schools. Of the 1,241 entities, there are 15 private businesses, all of which are small businesses (there are no non-small businesses with a NAICS code 611110). Thus, these rule changes are not expected to have any fiscal impact on non-small businesses' revenue or expenditures because there are no applicable non-small businesses and it does not require any expenditures or generate revenues for non-small businesses.

The Program Analyst at the Utah State Board of Education, Jill Curry, has reviewed and approved this fiscal analysis.

**R277. Education, Administration.**

**R277-511. Academic Pathway to Teaching (APT) Level 1 License.**

**R277-511-1. Authority and Purpose.**

- (1) This rule is authorized by:
  - (a) Utah Constitution Article X, Section 3, which vests general control and supervision over public education in the Board;
  - (b) Subsection 53E-6-201(2)(a), which allows the board by rule, to rank, endorse, or otherwise to:
    - (i) classify licenses; and
    - (ii) establish the criteria for an educator to obtain or retain a license; and
  - (c) Subsection 53E-3-401(4), which allows the Board to make rules to execute the Board's duties and responsibilities under the Utah Constitution and state law.

- (2) The purpose of this rule is to provide standards and procedures:
  - (a) for an applicant to obtain an Academic Pathway to Teaching (APT) level 1 license; and
  - (b) for an APT level 1 license holder to obtain a level 2 license.

**R277-511-2. Definitions.**

- (1)(a) "APT level 1 license" means a license obtained through the academic path to teaching process as described in this rule.
  - (b) "APT level 1 license" includes:
    - (i) an APT level 1 license with an Elementary (K-6) Concentration; and
    - (ii) an APT Level 1 License with a Secondary (6-12) Concentration and an Endorsement.
  - (2) "LEA administrator" means a school building principal or LEA administrator who:
    - (i) supervises an APT level 1 licensee; and
    - (ii) may recommend the APT level 1 licensee for Level 2 licensure to the Superintendent as described in Section R277-511-7.
  - (3) "Teacher leader" means a teacher designated as a teacher leader as described in R277-513.

**Appendix 1: Regulatory Impact Summary Table\***

Fiscal Costs	FY 2019	FY 2020	FY 2021
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0
Other Person	\$0	\$0	\$0
<b>Total Fiscal Costs:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Fiscal Benefits</b>			
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0
Other Persons	\$0	\$0	\$0
<b>Total Fiscal Benefits:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Net Fiscal Benefits:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

**R277-511-3. Superintendent Responsibilities.**

(1) The Superintendent shall create an application for an APT level 1 license and publish the application on the Board's website.

(2) The Superintendent shall approve an application for an APT level 1 license if the applicant meets all of the requirements of Section R277-511-4 or Section R277-511-5.

**R277-511-4. Requirements for an APT Level 1 License with an Elementary (K-6) Concentration.**

(1) To qualify for an APT level 1 license with an Elementary (K-6) Concentration, an applicant shall:

(a) complete the application described in Subsection R277-511-3(1);

(b) have completed a bachelor's degree or higher;

(c) submit postsecondary transcripts to the Superintendent;

(d) receive a passing score on the Elementary Education: Multiple Subjects Praxis Assessment;

(e) complete the educator ethics review on the Board's website;

(f) successfully pass a background check as described in R277-516; and

(g) pay the applicable licensing fee.

(2) An APT level 1 license with an Elementary (K-6) Concentration is:

(a) equivalent to the Level 1 license as described in R277-500 and R277-502 as to length and professional development expectations; and

(b) subject to the same renewal procedures.

**R277-511-5. Requirements for an APT Level 1 License with a Secondary (6-12) Concentration and an Endorsement.**

(1) To qualify for an APT Level 1 License with a Secondary (6-12) Concentration and an Endorsement, an applicant shall:

(a) complete the application described in Subsection R277-511-3(1);

(b) have completed a bachelor's degree or higher;

(c) submit postsecondary transcripts to the Superintendent;

(d) receive a passing score on one of the following that is related to the subject, field, or area to which they are seeking an APT Level 1 License with a Secondary (6-12) Concentration and an Endorsement:

(i) a Praxis II Subject Assessment; or

(ii) another Board-approved content knowledge assessment;

(e) complete the educator ethics review on the Board's website;

(f) successfully pass a background check as described in R277-516; and

(g) pay the applicable licensing fee.

(2) Except as provided in Subsection (3), an APT Level 1 License with a Secondary (6-12) Concentration and an Endorsement is:

(a) equivalent to the Level 1 license as described in R277-500 and R277-502 as to length and professional development expectations; and

(b) subject to the same renewal procedures.

(3) An APT Level 1 License with a Secondary (6-12) Concentration and an Endorsement holder may only seek an additional endorsement after the APT Level 1 License with a Secondary (6-12) Concentration holder obtains a level 2 license.

**R277-511-6. Requirements for an LEA that Employs an APT Level 1 License Holder.**

If an LEA employs an APT level 1 license holder, the LEA shall:

(1) assign a teacher leader to serve as a mentor to the APT level 1 license holder;

(2) prepare the APT level 1 license holder to meet the Utah Effective Educator Standards described in R277-530-5;

(3) prepare a mentoring plan for each APT Level 1 license holder; and

(4) provide an APT Level 1 license holder's mentoring plan to the Superintendent upon request.

**R277-511-7. Requirements for an APT Level 1 License Holder to Gain a Level 2 License.**

(1) To receive a Level 2 license, an APT level 1 license holder shall:

(a)(i) complete three years of teaching full-time in one LEA under supervision of the teacher leader mentor and LEA administrator; or

(ii) complete four years of at least 0.4 FTE teaching in one LEA under the supervision of a teacher leader mentor and the LEA administrator;

(b) satisfy all Entry Years Enhancement for Quality Teaching requirements designated in R277-522;

(c) complete the requirements of the APT Level 1 license holder's mentoring plan;

(d) complete any additional requirements of the recommending LEA, including coursework and professional learning that the recommending LEA requires;

(e) complete the educator ethics review on the Board's website;

(f) renew the educator's background check as required in R277-516; and

(g) obtain a recommendation from the LEA administrator; and

(h) pay applicable licensing fees.

(2)(a) An APT level 1 license holder seeking a level 2 license may request a one year extension of the APT level 1 license at the recommendation of the LEA Administrator up to a maximum of two one-year extensions.

(b) Unless required by the recommending LEA, the years of teaching in Subsection (1)(a) do not need to be consecutive.

**R277-511-8. Sunset Clause.**

(1) This rule will sunset on June 30, 2020.

(2) Notwithstanding Subsection (1), the Superintendent shall convert the license of an educator with an APT Level 1 License prior to June 30, 2020, with a current teaching position in a Utah LEA, to an Associate Educator license.

(3) An educator with a converted license under Subsection (2) may receive a Professional Educator license by completing the requirements of Section R277-511-7.

(4)(a) The Superintendent may not accept new applications for APT licenses after September 1, 2019.

(b) Notwithstanding Subsection (4)(a), the Superintendent may accept an application for an APT license, for an applicant with a position in a Utah LEA through November 1, 2019.

**KEY: Academic Pathway to Teaching, educator licensure**  
**Date of Enactment or Last Substantive Amendment:**  
**[December 8, 2016]2019**  
**Authorizing, and Implemented or Interpreted Law: Art X Sec 3; 53E-6-201; 53E-3-401(4)**

**Education, Administration**  
**R277-707**  
**Enhancement for Accelerated Students Program**

**NOTICE OF PROPOSED RULE**  
(Amendment)

DAR FILE NO.: 43651  
FILED: 04/15/2019

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The Utah State Board of Education (Board) discussed whether the funding should be based entirely on advanced placement (AP) course enrollment or based on a split between AP course enrollment and the number of students receiving a two or higher on AP exams.

**SUMMARY OF THE RULE OR CHANGE:** This rule has been amended to include new language for a split approach to funding allocation for AP courses, and to clarify requirements to promote equity of access to Gifted and Talented, Advanced Placements and International Baccalaureate programs.

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Article X Section 3 and Section 53F-2-408 and Subsection 53E-3-401(4)

**ANTICIPATED COST OR SAVINGS TO:**

♦ **THE STATE BUDGET:** These rule changes are not expected to have a fiscal impact on state government revenues or expenditures. This rule applies to the Enhancement for Accelerated Students program which is funded with a state appropriation and that is not affected by the changes in this rule.

♦ **LOCAL GOVERNMENTS:** These rule changes will have a fiscal impact on local education agencies (LEAs). They change the funding distribution formula for the advanced placement program for LEA. Prior to the change, the funds were distributed based on advanced placement exams passed. With these rule changes, these funds will be distributed with 50 percent of the funds for exams passed and 50 percent for enrollment in AP classes. The total amount of

funding going to LEAs for AP will remain the same, but some LEAs may receive more funding for AP and other LEAs may receive less funding for AP depending on enrollment and exams passed.

♦ **SMALL BUSINESSES:** These rule changes are not expected to have any fiscal impact on small businesses' revenues or expenditures. This rule applies to the Enhancement for Accelerated Students program which is state funded and thus does not apply to small businesses.

♦ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** These rule changes are not expected to have any fiscal impact on persons other than small businesses', businesses', or local government entities' revenues or expenditures. This rule applies to the Enhancement for Accelerated Students program which is state funded and thus does not apply to other individuals.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** There are no compliance costs for affected persons.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** There are 1,241 entities with a NAICS code 611110 (Elementary and Secondary Schools) operating in Utah according to a "Firm Find Data" search through Utah's Department of Workforce Services. Most of the entities in the list are schools including public schools, charter schools, and private schools. Of the 1,241 entities, there are 15 private businesses, all of which are small businesses (there are no non-small businesses with a NAICS code 611110). These rule changes have no fiscal impact on LEAs and will not have a fiscal impact on non-small or small businesses. The Program Analyst at the Utah State Board of Education, Jill Curry, has reviewed and approved this fiscal analysis.

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

EDUCATION  
ADMINISTRATION  
250 E 500 S  
SALT LAKE CITY, UT 84111-3272  
or at the Office of Administrative Rules.

**DIRECT QUESTIONS REGARDING THIS RULE TO:**

♦ Angela Stallings by phone at 801-538-7550, by FAX at 801-538-7768, or by Internet E-mail at [angie.stallings@schools.utah.gov](mailto:angie.stallings@schools.utah.gov)

**INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 05/31/2019**

**THIS RULE MAY BECOME EFFECTIVE ON: 06/07/2019**

**AUTHORIZED BY:** Angela Stallings, Deputy Superintendent of Policy

Appendix 1: Regulatory Impact Summary Table\*

Fiscal Costs	FY 2019	FY 2020	FY 2021
State Government	\$0	\$0	\$0
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Small Businesses	\$0	\$0	\$0
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<b>Fiscal Benefits</b>			
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0
Other Persons	\$0	\$0	\$0
<b>Total Fiscal Benefits:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Net Fiscal Benefits:</b>			
	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

\*This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts for State Government, Local Government, Small Businesses and Other Persons are described in the narrative. Inestimable impacts for Non-Small Businesses are described in Appendix 2.

**Appendix 2: Regulatory Impact to Non-Small Businesses**

There are 1,241 entities with a NAICS code 611110 (Elementary and Secondary Schools) operating in Utah according to a "Firm Find Data" search through Utah's Department of Workforce Services. Most of the entities in the list are schools including public schools, charter schools, and private schools. Of the 1,241 entities, there are 15 private businesses, all of which are small businesses (there are no non-small businesses with a NAICS code 611110). Thus, these rule changes are not expected to have any fiscal impact on non-small businesses' revenue or expenditures because there are no applicable non-small businesses and it does not require any expenditures of or generate revenues for non-small businesses.

The Program Analyst at the Utah State Board of Education, Jill Curry, has reviewed and approved this fiscal analysis.

**R277. Education, Administration.**

**R277-707. Enhancement for Accelerated Students Program.**

**R277-707-1. Authority and Purpose.**

(1) This rule is authorized by:

(a) Utah Constitution Article X, Section 3, which vests general control and supervision over public education in the Board;

(b) Section ~~[53A-17a-165]~~53F-2-408, which ~~[allows]~~requires the Board to ~~[adopt rules]~~establish a distribution formula for the expenditure of funds appropriated for the Enhancement for Accelerated Students Program; and

(c) Subsection ~~[53A-1-401]~~53E-3-401(4), which allows the Board to make rules to execute the Board's duties and responsibilities under the Utah Constitution and state law.

(2)(a) The purpose of this rule is to specify the procedures for distributing funds appropriated under Section ~~[53A-17a-165]~~53F-2-408 to LEAs.

(b) The intent of this appropriation is to provide resources to LEAs to enhance the academic growth of accelerated students, [whose academic achievement is accelerated.]

**R277-707-2. Definitions.**

(1) "Accelerated students" means ~~[children and youth whose superior academic performance or potential for accomplishment requires a differentiated and challenging instructional model]~~students participating in accelerated programs.

(2) "Accelerated programs" means student services with increased depth, complexity, or rigor, which may include above-grade level coursework, including:

(a) Gifted and Talented programs;

(b) IB programs; or

(c) AP courses.

~~[(2)3]~~ "Advanced placement" or "AP" courses means rigorous courses developed by the College Board where:

(a) each course is developed by a committee composed of college faculty and AP teachers, and covers the breadth of information, skills, and assignments found in the corresponding college course; and

(b) students who perform well on the AP exam may be:

(i) granted credit; or

(ii) advanced standing at participating colleges or universities.

~~[(3)4]~~(a) "Gifted and talented programs" means programs to:

~~(a)~~ assist individual students to develop their high potential and enhance their academic growth; and

~~(b)~~ identify ~~[students]~~, through multiple assessment instruments, and serve students with outstanding abilities who ~~[are capable of]~~have potential for high performance in the following areas:

(i) general intellectual ability;

(ii) specific academic aptitude; and

(iii) creative or productive thinking.

(b) Instruments for identifying gifted and talent students shall not be solely dependent upon English vocabulary or comprehension skills and shall take into consideration abilities of culturally diverse students and students with disabilities.

([4]5) "International Baccalaureate" or "[{IB}]" Program means one of the following programs established by the International Baccalaureate Organization:

- (a) the Diploma Program;
- (b) the Middle Years Program; or
- (c) the Primary Years Program.

(6) "Parent" means a student's parent, legal guardian, or a responsible adult with a power of attorney meeting the requirements of Subsection 53G-6-302(4).

(7) "Underrepresented students" means a subset of students, as determined by an LEA and approved by the Superintendent, that holds a smaller percentage in a program as compared to the overall school population.

([5]8) "Weighted Pupil Unit" means the basic state funding unit.

[~~(6) "Utah Consolidated Application" or "UCA" means the web-based grants management tool employed by the Board through which LEAs submit plans and budgets for approval by the Superintendent.~~]

**R277-707-3. Eligibility[;] and Application[; ~~Distribution and Use of Funds~~].**

(1) All LEAs are eligible to apply for the Enhancement for Accelerated Students Program funds [~~using the UCA~~]annually.

(2)[~~(a)~~] An LEA shall have a process for identifying students whose potential could be supported by accelerated programs[~~academic achievement is accelerated based upon multiple assessment instruments~~].

[~~(b) These instruments shall not be solely dependent upon English vocabulary or comprehension skills and shall take into consideration abilities of culturally diverse students and students with disabilities~~].

(3) To receive program money, an LEA shall submit an application to the Superintendent that includes an LEA's plan for:

(a) how the LEA intends to engage all parents so that parents understand the opportunities available for their children in elementary, middle school, high school and beyond, including how the LEA will comply with Rule R277-462;

(b) how the LEA intends to spend program money; and

(c) how the LEA intends to eliminate barriers and increase enrollment of underrepresented students in accelerated academic programs.

(4) The Superintendent shall publish outlines and required submission dates related to an LEA application and plan for increasing enrollment of underrepresented students in accelerated academic programs.

[~~(3) The distribution formula includes an allocation of money for:~~

[~~(a) Advanced Placement courses:~~

[~~(i) The designated funds for the advanced placement program equal 0.38 multiplied by the difference between the funds appropriated for the Enhancement for Accelerated Students Program less the allotment under Subsection 53A-17a-165(3):~~

[~~(ii)(A) The total funds designated for the advanced placement program are divided by the total number of Advanced Placement exams passed with a grade of 3 or higher by students:~~

[~~(B) This calculation results in a fixed amount per exam passed with each participating LEA receiving that amount for each exam successfully passed by one of its students:~~

[~~(b) Gifted and Talented programs:~~

[~~(i) The designated funds for the Gifted and Talented Program equal 0.62 multiplied by the difference between the funds appropriated for the Enhancement for Accelerated Students Program less the allotment under Subsection 53A-17a-165(3):~~

[~~(ii) Each LEA shall receive its share of funds in the proportion that the LEA's number of weighted pupil units for kindergarten through grade twelve bears to the state total:~~

[~~(iii) An LEA shall expend Gifted and Talented program funds in accordance with the UCA guidelines:~~

[~~(c) IB: LEAs shall have an IB authorized program to qualify for funds:~~

[~~(i) Fifty percent of the total funds designated for IB consistent with Subsection 53A-17a-165(3) shall be equally distributed among all authorized IB programs in the state:~~

[~~(ii) The remaining fifty percent of allocation shall be distributed to LEAs with Diploma Programs where students scored a grade of 4 or higher on IB exams, resulting in a fixed amount of dollars per exam passed:]~~

**R277-707-4. Distribution and Use of Funds.**

(1) The Superintendent shall distribute Enhancement of Accelerated Students program funds as follows:

(a) the greater of 1.5% or \$100,000 to support IB programs;

(b) 60% of funds to LEAs to support Gifted and Talented programs; and

(c) the remaining funds to LEAs to support AP programs.

(2)(a) The Superintendent shall determine funding to be awarded to an LEA's IB programs by:

(i) dividing the number of students enrolled in an LEA's IB program by the total enrollment of students in IB programs throughout the state; and

(ii) multiplying the result from Subsection (2)(a)(i) by the total IB allocation.

(b) The Superintendent shall determine 50% of the funding to be awarded for an LEA AP programs by:

(i) dividing the number of students enrolled in an LEA's AP classes by the total enrollment of students in AP classes throughout the state; and

(ii) multiplying the result from Subsection (2)(b)(i) by half of the total AP allocation.

(c) The Superintendent shall determine 50% of the funding to be awarded for LEA AP programs by:

(i) dividing the number of students in the LEA receiving a two or higher on an AP examination by the total number of students receiving a two or higher on an AP examination throughout the state; and

(ii) multiplying the result from Subsection (2)(c)(i) by half of the total AP allocation.

(3) If an LEA fails to demonstrate progress in meeting plan goals for placing and retaining underrepresented students in accelerated programs, the Superintendent may:

(a) place the LEA on probation and provide targeted technical assistance; and

(b) reduce funding to the LEA.

(4) Subject to the general requirements of Section R277-700-7:

(a) A middle school or high school;

~~\_\_\_\_\_ (i) shall provide all course registration opportunities to each student; and~~

~~\_\_\_\_\_ (ii) through consultation with students, parents, educators, and administrators, may consider academic readiness, but may not require prerequisites for enrolling in an AP or IB course.~~

~~\_\_\_\_\_ (b) A school that offers a program eligible for funding under Section 53F-2-408, may not prohibit a student from enrolling in the course based on the student's:~~

~~\_\_\_\_\_ (i) grades or grade point average;~~

~~\_\_\_\_\_ (ii) state standardized assessment scores; or~~

~~\_\_\_\_\_ (iii) referral or lack of a referral from an educator;~~

~~\_\_\_\_\_ (c) In addition to the restrictions listed in Subsection (d), a middle school or high school may not prohibit a student from enrolling in a course based on the student's:~~

~~\_\_\_\_\_ (i) grade level;~~

~~\_\_\_\_\_ (ii) participation in or passing a pre-requisite course;~~

~~\_\_\_\_\_ (iii) participation in or passing an honors-level or college-preparatory course; or~~

~~\_\_\_\_\_ (iv) requirements over the summer.~~

~~\_\_\_\_\_ (5) An LEA may use Enhancement for Accelerated Students Program funds for:~~

~~\_\_\_\_\_ (a) gifted and talented programs, including professional learning for teachers;~~

~~\_\_\_\_\_ (b) identification of underrepresented students;~~

~~\_\_\_\_\_ (c) Advanced Placement courses;~~

~~\_\_\_\_\_ (d) Advanced Placement test fees of eligible low-income students, as defined in Section 53F-2-408;~~

~~\_\_\_\_\_ (e) International Baccalaureate programs; or~~

~~\_\_\_\_\_ (f) International Baccalaureate test fees of eligible low-income students, as defined in Section 53F-2-408.~~

#### **R277-707-[4]5. Performance Criteria and Reports.**

~~(1) An LEA receiving funds[~~, as set forth in Section R277-707-3,~~] shall [~~be required to~~] submit an annual evaluation report to the Superintendent consistent with Section [~~53A-17a-165~~]53F-2-408.~~

~~(2) An LEA shall present the evaluation report identified in Subsection (1) to the LEA's local board in a public meeting.~~

~~(3) The report shall include the following performance criteria related to the identified students whose academic achievement is accelerated, which shall be disaggregated by groups as defined in the State Accountability System:~~

~~\_\_\_\_\_ (a) number of identified students disaggregated by subgroups;~~

~~\_\_\_\_\_ (b) graduation rates for identified students;~~

~~\_\_\_\_\_ (a) number of elementary, middle school, and high school students participating in Gifted and Talented programs;~~

~~\_\_\_\_\_ ([e]b) number of AP classes taken, completed, and exams passed with a score of [~~3~~]2 or above[~~by identified students~~];~~

~~\_\_\_\_\_ ([d]c) number of IB classes taken, completed, and exams passed with a score of 4 or above[~~by identified students~~]; and~~

~~\_\_\_\_\_ (d) evidence of stakeholder input demonstrating that the LEA engaged parents;~~

~~\_\_\_\_\_ (c) number of Concurrent Enrollment classes taken and credit earned by identified students;~~

~~\_\_\_\_\_ (f) ACT or SAT data, including the number of students participating, at or above the college readiness standards;~~

~~\_\_\_\_\_ (g) gains in proficiency in language arts; and~~

~~\_\_\_\_\_ (h) gains in proficiency in mathematics.]~~

~~(4) As part of the LEA's annual report under Subsection (1), an LEA shall provide assurances that the LEA is:~~

~~\_\_\_\_\_ (a) increasing enrollment of underrepresented students in the LEA's accelerated academic courses; or~~

~~\_\_\_\_\_ (b) meeting goals in the LEA's plan to increase enrollment and retention of underrepresented students in the LEA's accelerated academic courses.~~

~~[\_\_\_\_\_ (2) The Superintendent shall submit an annual report on program effectiveness to the Public Education Appropriations Subcommittee of the Utah State Legislature consistent with Subsection 53A-17a-165(6).]~~

**KEY: accelerated learning, enhancement programs**

**Date of Enactment or Last Substantive Amendment: [July 11, 2016]2019**

**Notice of Continuation: May 16, 2016**

**Authorizing, and Implemented or Interpreted Law: Art X Sec 3; [53A-17a-165]53F-2-408; [53A-17a-165(5); 53A-1-401]53E-3-401(4)**

## Education, Administration R277-926 Certification of Residential Treatment Center Special Education Program

### NOTICE OF PROPOSED RULE

(New Rule)

DAR FILE NO.: 43655

FILED: 04/15/2019

### RULE ANALYSIS

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The purpose of this rule is to provide a certification process and procedure for residential treatment centers where a public education entity's Individualized Education Program (IEP) team places an in-state or out-of-state student receiving special education services for purposes of receiving a free and appropriate public education.

**SUMMARY OF THE RULE OR CHANGE:** This rule is being created to provide a certification process for special education programs provided by residential treatment centers (RTC). A local education agency (LEA) in any state may send a student receiving special education to an RTC in Utah or other states for the purposes of fulfilling the IEP of a student. Several states including California and Illinois now require that an LEA only send a student to an out of state RTC if the receiving state's LEA has a certification process for the RTC's special education program. This rule creates that certification process for Utah RTCs and this rule will allow the Utah RTC's to continue to serve students from other states.

STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Article X Section 3 and Subsection 53E-3-401(4)

ADMINISTRATION  
250 E 500 S  
SALT LAKE CITY, UT 84111-3272  
or at the Office of Administrative Rules.

ANTICIPATED COST OR SAVINGS TO:

◆ THE STATE BUDGET: This rule change is not expected to have any fiscal impact on state government revenues or expenditures. This rule is being created to provide a certification process for special education programs provided by RTCs. An LEA in any state may send a special education student to an RTC in Utah or other states for the purposes of fulfilling the IEP of a student. Several states including California and Illinois now require that an LEA only send a student to an out-of-state RTC if the receiving state's education agency has a certification process for an RTC's special education program. This rule creates that certification process for Utah RTCs. This proposed rule will not have a fiscal impact to the state because the Legislature appropriated funding to the Utah State Board of Education (Board) for RTC compliance during the 2019 General session.

◆ LOCAL GOVERNMENTS: This proposed rule is not expected to have any fiscal impact on local governments' revenues or expenditures. This rule applies to RTCs and does not include an organization or agency that operates as a public agency or offers public service so it does not include local governments.

◆ SMALL BUSINESSES: This proposed rule is not expected to have a fiscal impact on small businesses' revenues or expenditures. This rule is being created to provide a certification process for special education programs provided by RTCs. RTCs, some of which are small businesses, will need to apply for certification, but any fiscal impact from the application process is inestimable.

◆ PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES: This proposed rule is not expected to have any fiscal impact on persons other than small businesses', businesses', or local government entities' revenues or expenditures. This rule applies to RTCs and a certification process through the Board and thus it does not have a fiscal impact on other entities.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There were no compliance costs for affected persons.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This proposed rule is not expected to have a fiscal impact on businesses' revenues or expenditures. This rule is being created to provide a certification process for special education programs provided by RTCs. RTCs will need to apply for certification, but any fiscal impact from the application process is inestimable. The Program Analyst at the Utah State Board of Education, Jill Curry, has reviewed and approved this fiscal analysis.

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

DIRECT QUESTIONS REGARDING THIS RULE TO:

◆ Angela Stallings by phone at 801-538-7550, by FAX at 801-538-7768, or by Internet E-mail at [angie.stallings@schools.utah.gov](mailto:angie.stallings@schools.utah.gov)

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 05/31/2019

THIS RULE MAY BECOME EFFECTIVE ON: 06/07/2019

AUTHORIZED BY: Angela Stallings, Deputy Superintendent of Policy

Appendix 1: Regulatory Impact Summary Table\*

Fiscal Costs	FY 2019	FY 2020	FY 2021
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0
Other Person	\$0	\$0	\$0
<b>Total Fiscal Costs:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
Fiscal Benefits			
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0
Other Persons	\$0	\$0	\$0
<b>Total Fiscal Benefits:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Net Fiscal Benefits:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

\*This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in

this table. Inestimable impacts for State Government, Local Government, Small Businesses and Other Persons are described in the narrative. Inestimable impacts for Non-Small Businesses are described in Appendix 2.

**Appendix 2: Regulatory Impact to Non-Small Businesses**

This rule is not expected to have a fiscal impact on non-small business revenues or expenditures. This rule is being created to provide a certification process for special education programs provided by residential treatment centers. Residential treatment centers, some of which are non-small businesses, will need to apply for certification, but any fiscal impact from the application process is inestimable.

The Program Analyst at the Utah State Board of Education, Jill Curry, has reviewed and approved this fiscal analysis.

**R277. Education, Administration.**

**R277-926. Certification of Residential Treatment Center Special Education Program.**

**R277-926-1. Authority and Purpose.**

(1) This rule is authorized by:

(a) Utah Constitution Article X, Section 3, which vests general control and supervision of public education in the Board; and

(b) Subsection 53E-3-401(4), which allows the Board to make rules to execute the Board's duties and responsibilities under the Utah Constitution and State of Utah law.

(2) The purpose of this rule is to provide a certification process and procedure for residential treatment centers where IEP teams place an in-state or out-of-state special education students for purposes of receiving a free and appropriate public education.

**R277-926-2. Definitions.**

(1) "Nonsectarian" means a nonpublic school or agency that is not owned, operated, controlled by, or formally affiliated with a religious group or sect, whatever might be the actual character of the education program or the primary purpose of the facility.

(2)(a) "Residential Treatment Center" or "RTC" means a private, or nonsectarian establishment that provides related services necessary for a student with special needs to benefit educationally from the student's IEP.

(b) "Residential Treatment Center" or "RTC" does not include an organization or agency that operates as a public agency or offers public service, including:

(i) a state or local agency;

(ii) an affiliate of a state or local agency including:

(A) a private, nonprofit corporation established or operated by a state or local agency;

(B) a public university or college; or

(C) a public hospital.

(3) "Qualified personnel" means an in-classroom staff member who:

(a) provides assistance with a student's education;

(b) has met requirements for federal and state certification, licensing, registration, or other comparable training requirements that apply to the area in which the staff member is providing related services, including board approved or recognized requirements; and

(c) actively adheres to the standards of professional practice established in federal and State of Utah law or regulation.

**R277-926-3. Certification of a Residential Treatment Center.**

(1) An RTC shall have the RTC's special needs program certified by the Superintendent before providing services for a free and appropriate public education to in-state or out-of-state students with special education needs and a current IEP from an LEA.

(2) An RTC seeking certification shall apply for an initial or renewal certification in a form prescribed by the Superintendent.

(3) An RTC's application shall include:

(a) a detailed description of the RTC's special education program provided, including:

(i) minimum instructional minutes for each grade level served;

(ii) specially designed instruction for:

(A) social skills;

(B) counseling; and

(C) parent training;

(iii) evidence of age appropriate core curriculum that aligns with the Utah core standards or aligns with the core standards of the student's state of origin;

(iv) for grades K-8, evidence showing the use of at least one resource, including a textbook or curricular program, adopted by the student's state of origin or Utah for each core standard subject including:

(A) English language arts;

(B) Math; and

(C) Science;

(v) for grades 9-12, evidence showing alignment of curriculum for core standard subjects with an LEA's curriculum in Utah or the student's state of origin;

(b) evidence, including educator licenses or employee resumes, of qualified personnel for each subject area including:

(i) English language arts;

(ii) Math; and

(iii) Science;

(c) evidence that each aide assisting in a student's education has received training in appropriate behavior as regulated by the Utah Department of Human Services and academic content areas specific to an aide's classroom assignment, including training required by state of Utah and federal law;

(d) an assurance that each student, aged 14 years and above, has a transition plan as described in Subsection R277-926-4(3)(a);

(e) evidence that an RTC is collaborating with a student's LEA of origin's fully constituted IEP team to:

(i) carry out the specific requirements of the student's IEP, including the general requirements described in Subsection R277-926-4(3)(b);

(ii) facilitate an annual IEP review; and

(iii) when necessary, participate in the student's triennial evaluation, including:

(A) an outlined process for the evaluation;

(B) the ability to allow on-site accessibility to third parties required for evaluation participation; and

(C) collaborate with the LEA of origin for the administration of the assessment.

(f) a description of the RTC's behavior intervention plan, including the incident management procedures and reporting requirements described in Subsection R277-926-4(3)(c);

(g) evidence of how meaningful parental involvement is facilitated;

(h) documentation showing all staff at the RTC have been fingerprinted and have passed state and federal criminal background checks before being allowed to have contact with any student;

(i) an assurance showing participation in the LEA of origin with federal Child Find mandates as outlined in 20 U.S.C. 1412(a)(3);

(j) an assurance that the RTC is a nonsectarian RTC; and

(k) if applicable, a copy of the Private School Affidavit filed with a student's state of origin.

(4) Except as provided in Subsection (7), an RTC may apply for an initial certification and receive notification of certification approval or denial within 60 days.

(5) An RTC shall apply for certification renewal no later than June 1<sup>st</sup> for the upcoming school year.

(6) Except as provided in Subsection (7), the Superintendent shall provide the RTC notice of the Superintendent's approval or denial of the RTC's application for certification within 60 days of receipt of the RTC's application.

(7) For an application received before January 1, 2020, the Superintendent shall notify an RTC of the Superintendent's approval or denial of the RTC's request for certification within 45 days.

(8) An RTC with a pending application shall be subject to an on-site review by the Superintendent within 45 days of the RTC submitting the RTC's application.

(9) An RTC's application for certification and on-site review shall be reviewed collectively by the Superintendent in considering approval or denial of certification.

(10) If approved, an RTC's certification lasts for two years from the date of approval and is subject to monitoring protocols as described in Subsection R277-926-4.

(11) If the Superintendent denies an RTC's application for certification, the Superintendent shall provide the reason for the denial in writing to the RTC.

(12) If an RTC operates a special needs program at more than one site, the RTC shall submit a separate certification application for each site.

#### **R277-926-4. Certification Maintenance and General Monitoring.**

(1) An RTC that has been certified is subject to periodic monitoring and review.

(2) An RTC shall ensure general compliance with the requirements of this rule, state law, and federal law by providing the Superintendent with:

(a) documentation, including:

(i) applicable student and program records; and

(ii) information for which the Board is responsible;

(b) access to on-site visits at any time; and

(c) any combination of Subsections (a) and (b).

(3) An RTC that has been certified shall comply with all requirements of this rule, State of Utah law and federal law, including the following requirements:

(a) collaborating with an LEA of origin to maintain and facilitate a transition plan for each student served by the RTC that includes:

(i) a list of a relevant course of study related to needs and ability of the student;

(ii) a list of all required transition assessments needed;

(iii) a plan for transitions to and from restrictive placement; and

(iv) age of majority documentation in a form approve by the Superintendent;

(b) collaborating with the LEA of origin on a student's IEP through:

(i) timely and appropriate IEP progress monitoring;

(ii) documentation of a student's specially designed instruction and related services including:

(A) service provisions;

(B) treatment notes; and

(C) service logs;

(iii) sign-in or attendance sheets for each IEP meeting held for a student; and

(iv) adhering to all other applicable state and federal laws;

(c) when appropriate, establishing a discipline guide consistent with IDEA that includes a behavior intervention plan with the following minimum components:

(i) general behavior goals;

(ii) crisis de-escalation and restraint training and training frequency;

(iii) restraint and seclusion policies and procedures consistent with state and federal law; and

(iv) parental notification policies requiring notice within at least 24-hours.

(4) An RTC shall notify the Superintendent within 30 days if the RTC makes any material change to the RTC's special education program.

(5) If a certified RTC is found to be noncompliant with a provision of R277-926, State of Utah law, or federal law, the Superintendent may suspend or revoke the RTC's certification as outlined in Subsection R277-926-5.

#### **R277-926-5. Revocation of Certification.**

(1) The Superintendent may revoke an RTC's certification at any time if the RTC fails to comply with the requirements of R277-926, State of Utah law, or federal law.

(2) The Superintendent shall provide the reason for revocation of the RTC's certification in writing to the RTC and provide a 30-day cure period before revocation may occur.

(3) If an RTC does not cure identified non-compliance described in Subsection (2) within the 30-day cure period, the Superintendent shall revoke the RTC's certification.

(4) If an RTC's certification is revoked, the RTC:

(a) may not receive new students into the RTC's special education program; and

(b) may maintain the students currently attending the RTC's special education program.

(5) An RTC may reapply for certification within 12 months following the RTC's completed corrective action in response to the Superintendent's reasons for revocation described in Subsection (2).

**R277-926-6. Request for Review.**

(1) A public education agency that contracts with a certified RTC may request the Superintendent to review the status of the RTC's certification.

(2) The Superintendent shall establish a mechanism for referrals, complaints, and information related to the status of an RTC's certification.

(3) The Superintendent shall conduct a review pursuant to this in accordance with all requirements in Sections R277-926-4 and R277-926-5.

**R277-926-7. RTC Appeal of Certification Application Denial or Certification Revocation.**

(1) An RTC may file an appeal to the Board of an adverse decision of the Superintendent resulting in the denial of application or revocation of a certification.

(2) An appeal pursuant to this rule shall be an informal adjudication.

(3) An appeal described in Subsection (1) shall be made in writing and within 30 days of the date of the Superintendent's action.

(4) The Board may:

(a) review the appeal as a full board; or

(b) refer the appeal to the Board's audit committee to make a recommendation to the Board for action.

**KEY:** residential treatment centers, special education, certification

**Date of Enactment or Last Substantive Amendment:** 2019

**Authorizing, and Implemented or Interpreted Law:** Art X Sec 3; 53E-3-401(4)

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

**NOTICE OF PROPOSED RULE**

(Amendment)

DAR FILE NO.: 43659

FILED: 04/15/2019

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** The purpose of this rule amendment is to adopt changes as a result of the Medicare Access and CHIP Reauthorization Act of 2016, a bipartisan legislation signed into law on 04/16/2015. This federal legislation estimated coverage of the Part B deductible in Plans C and F for newly eligible individuals on or after 01/01/2020.

**SUMMARY OF THE RULE OR CHANGE:** The revisions include: removal of the definition of creditable coverage; change the definition of issuer to singular, rather than plural; and add a definition for newly eligible. Effective 01/01/2020,

Plan C is redesignated as Plan D; Plan F is redesignated as Plan G; and Plan F High Deductible is Redesignated Plan G High Deductible. These changes clarify that Plans C, F, and F High Deductible may not be offered to individuals newly eligible for Medicare on or after 01/01/2010, but may be continued to be offered to persons eligible for Medicare prior to 01/01/2020. These revisions create a new annual filing requirement: Annual Filing of Rate and Enrollment Data.

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

**MATERIALS INCORPORATED BY REFERENCE:**

- ◆ Adds Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2020, published by National Association of Insurance Commissioners, 08/29/2016
- ◆ Updates Medicare Supplement Refund Calculation Form, published by National Association of Insurance Commissioners, 08/29/2016
- ◆ Updates Reporting Form for the Calculation of Benchmark Ratio Since Inception for Group Policies, published by National Association of Insurance Commissioners, 08/29/2016
- ◆ Updates Reporting Form for the Calculation of Benchmark Ratio Since Inception for Individual Policies, published by National Association of Insurance Commissioners, 08/29/2016
- ◆ Updates Form for Reporting Medicare Supplement Policies, published by National Association of Insurance Commissioners, 08/29/2016
- ◆ Updates Disclosure Statements, published by National Association of Insurance Commissioners, 08/29/2016
- ◆ Removes Outline of Medicare Supplement Coverage, published by National Association of Insurance Commissioners, 10/07/2008

**ANTICIPATED COST OR SAVINGS TO:**

- ◆ **THE STATE BUDGET:** It is anticipated that an insurer who wishes to offer these redesignated plans will incorporate the revisions as part of their annual filing process, which will not increase the Insurance Department's (Department) workload, or affect the state budget.
- ◆ **LOCAL GOVERNMENTS:** There is no anticipated cost or savings to local governments.
- ◆ **SMALL BUSINESSES:** There is no anticipated cost or savings to small businesses.
- ◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** This rule sets standards for specific Medicare supplement plans, but it does not require an insurer to offer the plans. If an insurer selects to offer the plans, the insurer will be required to file revisions to create the redesignated plans. There is not a filing fee for submission of the filing.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** This rule sets standards for specific Medicare supplement plans, but it does not require an insurer to offer the plans. If an

insurer selects to offer the plans, the insurer will be required to file the new plans with the Department. There is not a filing fee for submission of the filing. The new filing requirement for the Annual Filing of Rate and Enrollment Data is a simple spreadsheet. The information is not new data to be created, but rather a way to collect information in a uniform manner. There is not a filing fee associated with submission of the new filing requirement.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** After conducting a thorough analysis, it was determined that these proposed rule changes will not result in a fiscal impact to businesses.

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 Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:  
 ♦ Steve Gooch by phone at 801-538-3803, by FAX at 801-538-3829, or by Internet E-mail at sgooch@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 05/31/2019

THIS RULE MAY BECOME EFFECTIVE ON: 06/07/2019

AUTHORIZED BY: Steve Gooch, Information Specialist

<b>Net Fiscal Benefits:</b>	\$0	\$0	\$0
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\*This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts for State Government, Local Government, Small Businesses and Other Persons are described in the narrative. Inestimable impacts for Non-Small Businesses are described in Appendix 2.

**Appendix 2: Regulatory Impact to Non-Small Businesses**  
 These rule changes are not expected to have any fiscal impact on non-small businesses' revenues or expenditures, because insurers are not required to offer the new redesignated plans. The new required report is not new information, but rather a uniform way to submit the information. There is not a filing fee for an insurer to submit a redesignated plan or report. Therefore, with no new fees or additional work required, there are no expected fiscal impacts.

The head of the Insurance Department, Commissioner Todd E. Kiser, has reviewed and approved this fiscal analysis.

**R590. Insurance, Administration.**  
**R590-146. Medicare Supplement Insurance Standards.**  
**R590-146-1. Authority.**

This rule is issued pursuant to the authority vested in the commissioner under Section 31A-22-620 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; 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 thereof, 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.

**Appendix 1: Regulatory Impact Summary Table\***

<b>Fiscal Costs</b>	<b>FY 2019</b>	<b>FY 2020</b>	<b>FY 2021</b>
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0
Other Person	\$0	\$0	\$0
<b>Total Fiscal Costs:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Fiscal Benefits</b>			
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0
Other Persons	\$0	\$0	\$0
<b>Total Fiscal Benefits:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

B. "Bankruptcy" means when a Medicare Advantage 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. ~~"Creditable coverage" has the same meaning as provided in Section 31A-1-301.~~

~~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 when an issuer, licensed to transact the business of insurance in this state, has had 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.

~~I.~~ "Issuer" means an ~~insurer~~ ~~includes~~ ~~insurance~~ ~~companies~~ ~~company~~, fraternal benefit ~~societies~~ ~~society~~, health care service ~~plans~~ ~~plan~~, health maintenance ~~organizations~~ ~~organization~~, and any other entity delivering or issuing for delivery in this state a Medicare supplement ~~policies or certificates~~ ~~policy or certificate~~.

~~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 plan" means a plan of coverage for health benefits under Medicare Part C as defined in 42 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 plan medical savings account; and

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

~~L.~~ (1) "Medicare supplement policy" means a group or individual policy of accident and health 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.

(2) "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.~~ "Newly eligible" means those individuals who become eligible for Medicare due to age, disability or end-stage renal disease on or after January 1, 2020.

~~N.~~ "Pre-Standardized Medicare supplement benefit plan," "Pre-Standardized benefit plan" or "Pre-Standardized plan" means a group or individual policy of Medicare supplement insurance issued prior to December 12, 1994.

~~O.~~ "1990 Standardized Medicare supplement benefit plan," "1990 Standardized benefit plan" or "1990 plan" means a group or individual policy of Medicare supplement insurance issued on or after July 30, 1992 and with an effective date of coverage prior to June 1, 2010 and includes Medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

~~P.~~ "2010 Standardized Medicare supplement benefit plan," "2010 Standardized benefit plan" or "2010 plan" means a group or individual policy of Medicare supplement insurance issued with an effective date of coverage on or after June 1, 2010.

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

~~R.~~ "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, that 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.

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 7.A.(1), 8.A.(1), and 8a.A.(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 that duplicate benefits provided by Medicare.

D.(1) Subject to Subsections 7.A.(4), (5) and (7) and 8.A.(4) and (5) of this rule, a Medicare supplement policy with benefits for outpatient prescription 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 Pre-Standardized Medicare Supplement Benefit Plan 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, copayment, or coinsurance amounts. 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 nonrenewed 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 nonrenew 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 this 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 8a.B. 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 policy.

(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 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.

B. Minimum Benefit Standards. Every issuer shall include the following benefits:

(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, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment 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; and

(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 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After July 30, 1992 and with an Effective Date for Coverage Prior to June 1, 2010.**

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 and with an effective date for coverage prior to June 1, 2010. 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 may 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, co-payment, or coinsurance amounts. 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 nonrenew the policy solely on the ground of health status of the individual.

(b) The issuer shall not cancel or nonrenew 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 (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 (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 eliminates 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, 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.

(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 certificateholder 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 the loss.

(d) Reinstitution of coverages as described in Subsections (b) and (c):

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

(ii) shall provide for resumption of coverage 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.

(8) If an issuer makes a written offer to the Medicare supplement policyholders or certificateholders of one or more of its plans, to exchange during a specified period from his or her 1990 plan, as described in Section 9 of this rule, to a 2010[-] plan[-], as described in Section 9a of this rule, the offer and subsequent exchange shall comply with the following requirements:

(a) An issuer need not provide justification to the commissioner if the insured replaces a 1990 Plan policy or certificate with an issue age rated 2010 Plan policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer shall be filed with the commissioner.

(b) The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.

(c) An issuer may not apply new pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 plan policy for certificate of the insured, but may apply pre-existing condition limitations of no more than six months to any added benefits contained in the new 2010 plan policy or certificate not contained in the exchanged policy.

(d) The new policy or certificate shall be offered to all policyholders or certificateholders within a given plan, except where the offer or issue would be in violation of state or federal law.

B. Standards for Basic, Core, Benefits Common to All Benefit Plans A through 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 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 paid under a prospective payment system, the copayment 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 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 post hospital skilled nursing facility care eligible under Medicare Part A.

(3) Medicare Part B Deductible: Coverage for all 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.

(a) Coverage for the following preventive health services not covered by Medicare:

(i) 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; and

(ii) preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

(b) 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; and

(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.

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 21<sup>st</sup> 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 D.(1)(a), (b), (c) and (i);

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

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

**R590-146-8a. Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery with an Effective Date for Coverage on or After June 1, 2010.**

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date of coverage on or after June 1, 2010. 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. No issuer may offer any 1990 plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage prior to June 1, 2010 remain subject to the requirements of Section 9 of this rule.

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 6 months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may 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 6 months before the effective date of coverage.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from a 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, copayment, or coinsurance amounts. 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 nonrenew the policy solely on the ground of health status of the individual.

(b) The issuer shall not cancel or nonrenew 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 A.(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 (A)(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.

(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 any period that may be 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 certificateholder 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 the loss.

(d) Reinstatement of coverages as described in Subsections (7)(b) and (c):

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

(ii) shall provide for resumption of coverage that is substantially equivalent to 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 Medicare Supplement Insurance Benefit Plans A, B, C, D, F, F with High Deductible, G, M, N. Every issuer of Medicare supplement insurance benefit plans 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 61<sup>st</sup> day through the 90<sup>th</sup> 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 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 3 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 paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(6) Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with High Deductible, G, M, N as provided by Section 9a.

(1) Medicare Part A Deductible: Coverage for 100% of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Medicare Part A Deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period.

(3) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21<sup>st</sup> day through the 100<sup>th</sup> day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

(4) Medicare Part B Deductible: Coverage for 100% of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

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

(6) 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.

**R590-146-9. Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery After July 30, 1992 and with an Effective Date for Coverage Prior to June 1, 2010.**

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 8.B. 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 9.G. and Section 10 of this rule.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans A through L 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 8.B. and 8.C., or 8.D. 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.

E. 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 8.B. of this rule.

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

(3) Standardized Medicare supplement benefit plan C shall include only the following: The core benefit as defined in Subsection 8.B. 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 8.C.(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 8.B. 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 8.C.(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 8.B. 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 8.C.(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 8.B. 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 8.C.(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 8.B. 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 8.C.(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

8.B. 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 8.C.(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 8.B. 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 8.C.(1), (2), (6) and (8) respectively. The prescription drug benefit shall not be included in a 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 8.B. 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 8.C.(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 8.B. 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 8.C.(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 8.B. 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 8.C.(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.

(F) 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 Subsection 8.D.(1).

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

(G) 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 that is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

**R590-146-9a. Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery with an Effective Date for Coverage on or After June 1, 2010.**

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. 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 plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates with an effective date of coverage before June 1, 2010 remain subject to the requirements of Sections 8a and 9 of this rule.

A.(1) 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 8a.B. of this rule.

(2) If an issuer makes available any of the additional benefits described in Subsection 8a.C., or offers standardized benefit Plan K or L, as described in Subsections 9a.E.(8) and (9) of this rule, then the issuer shall make available to each prospective policyholder and certificateholder, in addition to a policy form or certificate form with only the basic core benefits as described in Subsection (1), a policy form or certificate form containing either standardized benefit Plan C, as described in Subsection 9a.E.(3) of this rule, or standardized benefit Plan F, as described in Subsection 9a.E.(5) of this rule.

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this Subsection shall be offered for sale in this state, except as may be permitted in Subsection 9a.F. and in Section 10 of this rule.

C. Benefit plan shall be uniform in structure, language, designation and format to the standard benefit plans listed in this subsection and conform to the definitions in Section 4 of this rule. Each benefit shall be structured in accordance with the format provide in Subsections 8a.B. and C. of this rule; or, in the case of plans K or L, in Subsections 9a.E.(8) or (9) of this rule and list the benefits in the order shown. For purposes of this subsection, "structure, language, and format" means style, arrangement and overall content of a benefit.

D. In addition to the benefit plan designations required in Subsection C, an issuer may use other designations to the extent permitted by law.

E. Make-up of 2010 Standardized Benefit Plans:

(1) Standardized Medicare supplement benefit Plan A shall include only the following: The basic core benefits as defined in Subsection 8a.B. of this rule.

(2) Standardized Medicare supplement benefit Plan B shall include only the following: the basic core benefit as defined in Subsection 8a.B. of this rule, plus 100% of the Medicare Part A deductible as defined in Subsection 8a.C.(1) of this rule.

(3) Standardized Medicare supplement benefit Plan C shall include only the following: The basic core benefit as defined in Subsection 8a.B. of this rule, plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in Subsections 8a.C.(1), (3), (4), and (6) of this rule, respectively.

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

(5) Standardized Medicare supplement benefit Plan F shall include only the following: The basic core benefit as defined in Subsection 8a.B. of this rule, plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of 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 8a.C.(1), (3), (4), (5), and (6) of this rule, respectively.

(6) Standardized Medicare supplement benefit Plan F With High Deductible shall include only the following: 100% of covered expenses following the payment of the annual deductible set forth in Subsection (b).

(a) The basic core benefit as defined in Subsection 8a.B. of this rule, 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of 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 8a.C.(1), (3), (4), (5), and (6) of this rule, respectively.

(b) The annual deductible in Plan F With High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be \$1500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services 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 ten dollars.

(7) Standardized Medicare supplement benefit Plan G shall include only the following: The basic core benefit as defined in Subsection 8a.B. of this rule, plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Subsections 8a.C.(1), (3), (5), and (6) of this rule, respectively. Effective January 1, 2020, the standardized benefit plans described in Section 9b.A.(4) of this rule, Redesignated Plan G High Deductible, may be offered to any individual who was eligible for Medicare prior to January 1, 2020.

(8) Standardized Medicare supplement benefit Plan K is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(a) Part A Hospital Coinsurance 61<sup>st</sup> through 90<sup>th</sup> days: Coverage of 100% of the Part A hospital coinsurance amount for each

day used from the 61<sup>st</sup> through the 90<sup>th</sup> day in any Medicare benefit period:

(b) Part A Hospital Coinsurance, 91<sup>st</sup> through 150<sup>th</sup> days: Coverage of 100% of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91<sup>st</sup> through the 150<sup>th</sup> day in any Medicare benefit period:

(c) Part A Hospitalization After 150 Days: 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 21<sup>st</sup> day through the 100<sup>th</sup> 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 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) Blood: Coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first 3 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) Part B Cost Sharing: Except for coverage provided in Subsection (i), coverage of 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):

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

(j) Cost Sharing After Out-of-Pocket Limits: Coverage of 100% of all cost sharing under Medicare Parts 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 Parts 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.

(9) Standardized Medicare supplement benefit Plan L is mandated by The Medicare Prescription Drug Improvement and Modernization Act of 2003, and shall include only the following:

(a) The benefits described in Subsections (8)(a), (b), (c) and (i);

(b) The benefit described in Subsections (8)(d), (e), (f), (g) and (h), but substituting 75% for 50%; and

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

(10) Standardized Medicare supplement benefit Plan M shall include only the following:

The basic core benefit as defined in Subsection 8a.B. of this rule, plus 50% of the Medicare Part A deductible, skilled nursing

facility care, and medically necessary emergency care in a foreign county as defined in Subsections 8a.C.(2), (3) and (6) of this rule, respectively.

(11) Standardized Medicare supplement benefit Plan N shall include only the following: The basic core benefit as defined in Subsection 8a.B. of this rule, plus 100% of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Subsections 8a.C.(1), (3) and (6) of this rule, respectively, with copayments in the following amounts;

(a) the lesser of \$20 or the Medicare Part B coinsurance or copayment for each covered health care provider office visit, including visits to medical specialists; and

(b) the lesser of \$50 or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

F. 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 standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost effective. Approval of new or innovative benefits shall not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

**R590-146-9b. Standard Medicare Supplement Benefit Plans for 2020 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery to Individuals Newly Eligible for Medicare on or After January 1, 2020.**

The Medicare Access and CHIP Reauthorization Act of 2015, MACRA, requires the following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare with an effective date of coverage on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of Section 9 for policies issued after July 30, 1992 and prior to June 1, 2010; or 9a for policies issued after May 31, 2010 and prior to January 1, 2020.

A. Benefit Requirements. The standards and requirements of Section 9b shall apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions:

(1) Standardized Medicare supplement benefit Plan C is redesignated as Plan D and shall provide the benefits contained in

Section 9a.E.(3) of this rule but shall not provide coverage for 100% or any portion of the Medicare Part B deductible.

(2) Standardized Medicare supplement benefit Plan F is redesignated as Plan G and shall provide the benefits contained in Section 9a.E.(5) of this rule but shall not provide coverage for 100% or any portion of the Medicare Part B deductible.

(3) Standardized Medicare supplement benefit plans C, F, and F With High Deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.

(4) Standardized Medicare supplement benefit Plan F With High Deductible is redesignated as Plan G With High Deductible and shall provide the benefits contained in Section 9a.E.(6) of this regulation but shall not provide coverage for 100% or any portion of the Medicare Part B deductible; provided further that, the Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible.

(5) The reference to Plans C or F contained in Section 9a.A.(2) is deemed a reference to Plans D or G for purposes of this section.

B. Applicability to Certain Individuals. This Section 9b, applies to only individuals that are newly eligible for Medicare on or after January 1, 2020:

(1) By reason of attaining age 65 on or after January 1, 2020; or

(2) By reason of entitlement to benefits under part A pursuant to Section 226(b) or 226A of the Social Security Act, or who is deemed to be eligible for benefits under Section 226(a) of the Social Security Act on or after January 1, 2020.

C. Guaranteed Issue for Eligible Persons. For purposes of Section 12.E, in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F, including F With High Deductible, shall be deemed to be a reference to Medicare supplement policy D or G, including G With High Deductible, respectively, that meet the requirements of this Section 9b.A.

D. Offer of Redesignated Plans to Individuals Other Than Newly Eligible. On or after January 1, 2020, the standardized benefit plans described in Subparagraph A(4), above may be offered to any individual who was eligible for Medicare prior to January 1, 2020, in addition to the standardized plans described in Section 9a.E of this rule.

#### **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.

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; and

(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; and

(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.

(2) Any changes to the list of network providers shall be filed with the commissioner within 30 days of the change. The submission must include all network providers and clearly identify the new and discontinued providers.

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 providers 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; and

(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 March 31 of each calendar year 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 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 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.(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 not 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 seek to enroll under the policy during the period specified in Subsection C, and who submit evidence of the date of termination, 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 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.

B. Eligible Persons.

An eligible person is an individual described in any of the following 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) The individual is enrolled with a Medicare Advantage organization under a 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 Advantage plan:

(a) the certification of the organization or plan has been terminated;

(b) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(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;

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

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

(e) the individual meets such other exceptional conditions as the Secretary may provide.

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

(i) an eligible organization under a contract under Section 1876 of the Social Security Act, Medicare 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) 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 Subsection 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 a producer 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 Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act, Medicare cost, any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act or a Medicare Select policy; and

(b) The subsequent enrollment under 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 Advantage plan under part C of Medicare, or in a PACE provider 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 period and, at the time of 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 Subsections 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:

(a) 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

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

(2) In case of an individual described in Subsections B(2), (3), (5) or (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:

(a) 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

(b) 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 Subsections B(2), (4)(b) and (c), (5) or (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 Trial 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 an organization or provider described in Subsection B(5)(a) 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 Subsection B(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 Subsection B(6).

(3) For the purposes of Subsections B(5) and (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.

#### E. Products to Which Eligible Persons are Entitled

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

(1) Subsections B(1), (2), (3), (4), and (8) is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F, including F with a high deductible, K or L offered by any issuer.

(2)(a) Subject to Subsection (b), Subsection B(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 (1);

(b) After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with a outpatient prescription 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 B(6) shall include any Medicare supplement policy offered by any issuer;

(4) Subsection B(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.

F. Notification provisions.

(1) At the time of an event described in Subsection B 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 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 A. 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~~] Filing Requirements.**

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) The loss ratio shall be 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, and comply with the requirements of R590-85.

(3) For purposes of applying Subsections (1) and 15.D.(3) only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising, including both print and broadcast advertising, shall be deemed to be individual policies.

(4) 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 Subsections 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 Subsections 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 each applicable form;

(a) Medicare Supplement Refund Calculation;

(b) Calculation of Benchmark Ratio Since Inception for Group Policies; and

(c) Calculation of the Benchmark Ratio Since Inception For Individual Policies.

(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 each year.

(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. Filing of Premium Rates.

##### (1) Annual Filing of Premium Rates Report.

(a) 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 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.

(b) The Annual Filing of Premium Rates Report shall be filed no later than May 31 each year, and in compliance with R590-220.

##### (2) 2010 Medicare Supplement Rate and Enrollment Data.

(a) An issuer shall annually file by May 31 the Utah rate and enrollment information for 2010 Medicare Supplement plans as specified in the "2010MedSuppRateDataUT\_v1.0.xlsx" spreadsheet.

(b) The Annual Filing of Rate and Enrollment Data shall be filed no later than May 31 each year, and in compliance with R590-220.

(3)(a) 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, 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.

([2]4) 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 of Policies, 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 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.

C.(1) 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 for acceptance in accordance with the filing requirements and procedures prescribed by the commissioner, and Rule R590-85.

(2) During an applicant's open enrollment period described in Section 12, an issuer shall offer the lowest rate available to any applicant without regard to health or smoker status.

(3) A policy form issued under Section 9b is not considered a new policy form, and is not a permissible separate rating class.

D.(1) Except as provided in Subsection (2) an issuer shall not file 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 producer 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.

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 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 subsection.

(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.

F.(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 a producer 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 producers and no 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 finder's 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 section 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 Centers for Medicare and Medicaid Services, CMS, 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.

(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 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, or the Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2020, adopted August 2016, as incorporated by reference herein, is available for public inspection at the Insurance Department.

**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.; a 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 Subsection 25.E., 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 Medicare supplement Medicare Advantage, Medicaid coverage, or another 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 producer 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, 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.

(6) 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) **If yes, [W]ill** 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 / /

B. Producers 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 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 producer, 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 producer, except where the coverage is sold without a producer, 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 12-point type:

TABLE II  
NOTICE TO APPLICANT REGARDING REPLACEMENT  
OF MEDICARE SUPPLEMENT INSURANCE  
OR MEDICARE ADVANTAGE

(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 or Medicare Advantage coverage.

You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.  
STATEMENT TO APPLICANT BY ISSUER, PRODUCER (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 that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay 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 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 Producer, Broker or Other Representative)

(Typed Name and Address of Issuer, Producer or Broker)

.....  
(Applicant's Signature)

.....  
(Date)

Signature not required for direct response sales.

F. 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, file for use a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio, electronic, or television medium.

**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 producers will be fair and accurate;
- (2) establish marketing procedures to assure excessive insurance is not sold or issued.
- (3) display prominently by type, in bold font, 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-23a[-302], Part 4, 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 producer 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 a producer shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

B. Any sale of Medicare supplement 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 of each year, an issuer shall file the report form under Subsection 25.D. 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. Prohibition Against Use of Genetic Information and Requests for Genetic Testing.**

[~~This section applies to all policies with policy years beginning on or after May 21, 2009.~~]

A. An issuer of a Medicare supplement policy or certificate:

(1) shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) on the basis of the genetic information with respect to such individual; and

(2) shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

B. Nothing in Subsection A shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from

(1) Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

(2) Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group.

C. An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

D. Subsection C shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under part C of title XI and section 264 of the Health Insurance Portability and Accountability Act of 1996 as may be revised from time to time) and consistent with Subsection A.

E. For purposes of carrying out Subsection D, an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

F. Notwithstanding Subsection C, an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

(1) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(2) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:

(a) compliance with the request is voluntary; and

(b) non-compliance will have no effect on enrollment status or premium or contribution amounts.

(3) No genetic information collected or acquired under this subsection shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

(4) The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted.

(5) The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this subsection.

G. An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

H. An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

I. If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of Subsection H if such request, requirement, or purchase is not in violation of Subsection G.

J. For the purposes of this section only:

(1) "Issuer of a Medicare supplement policy or certificate" includes third-party administrator, or other person acting for or on behalf of such issuer.

(2) "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

(3) "Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual, who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an

individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.

(4) "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

(5) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(6) "Underwriting purposes" means,

(a) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

(b) the computation of premium or contribution amounts under the policy;

(c) the application of any pre-existing condition exclusion under the policy; and

(d) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

**R590-146-25. Documents Incorporated by Reference.**

The following filing documents are hereby incorporated by reference within this rule and are available for public inspection at the Insurance Department or at [www.insurance.utah.gov](http://www.insurance.utah.gov). These forms were adopted by the National Association of Insurance Commissioners' Model Regulation number 651, as approved [~~October 2008~~] August 2016:

A. "MEDICARE SUPPLEMENT REFUND CALCULATION FORM;"

B. "REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR GROUP POLICIES;"

C. "REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES;"

D. "FORM FOR REPORTING MEDICARE SUPPLEMENT POLICIES;" and

E. "DISCLOSURE STATEMENTS," ~~and~~

~~F. "OUTLINE OF MEDICARE SUPPLEMENT COVERAGE;"~~

**R590-146-26. Penalties.**

A person found to be in violation of this rule shall be subject to penalties as provided under 31A-2-308.

**R590-146-27. [Enforcement Date]**

~~The commissioner will begin enforcing the provisions of this rule 45 days from the effective date of the rule.~~

**R590-146-28. [Severability]**

If any provision or clause of this rule or its application to any person or situation is held to be invalid, that invalidity shall not affect any other provision or application of this rule which can be

given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

**KEY: insurance**

**Date of Enactment or Last Substantive Amendment:** [~~September 15, 2009~~] 2019

**Notice of Continuation:** April 4, 2017

**Authorizing, and Implemented or Interpreted Law:** 31A-22-620

**Insurance, Administration**  
**R590-218**  
**Permitted Language for Reservation of Discretion Clauses**

**NOTICE OF PROPOSED RULE**

(Repeal)

DAR FILE NO.: 43653

FILED: 04/15/2019

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** During the 2018 General Session, the Legislature passed S.B. 135, Insurance Contracts Amendments, which prohibits discretionary clauses in certain insurance contracts as set forth in Section 31A-21-314. The revision makes this regulation obsolete.

**SUMMARY OF THE RULE OR CHANGE:** This change repeals the rule because S.B. 135 passed during the 2018 General Session prohibits discretionary clauses in certain insurance contracts as set forth in Section 31A-21-314. That change makes this regulation obsolete. This rule is repealed in its entirety.

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Subsection 31A-2-201(1) and Subsection 31A-2-201(3)(a) and Subsection 31A-21-201(3) and Subsection 31A-21-314(2)

**ANTICIPATED COST OR SAVINGS TO:**

♦ **THE STATE BUDGET:** There is no anticipated cost or savings to the state budget. The repeal of this rule requires no action or compliance by any persons.

♦ **LOCAL GOVERNMENTS:** There is no anticipated cost or savings to local governments. The repeal of this rule requires no action or compliance by any persons.

♦ **SMALL BUSINESSES:** There is no anticipated cost or savings to small businesses. The repeal of this rule requires no action or compliance by any persons.

♦ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** There is no anticipated cost or savings to other persons. The repeal of this rule requires no action or compliance by any other persons.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** There are no compliance costs for any affected persons. The repeal of this rule requires no action or compliance of any sort by any persons.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** After conducting a thorough analysis, it was determined that this rule repeal will not result in a fiscal impact to businesses.

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 Office of Administrative Rules.

**DIRECT QUESTIONS REGARDING THIS RULE TO:**  
♦ Steve Gooch by phone at 801-538-3803, by FAX at 801-538-3829, or by Internet E-mail at sgooch@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 05/31/2019

THIS RULE MAY BECOME EFFECTIVE ON: 06/07/2019

AUTHORIZED BY: Steve Gooch, Information Specialist

**Appendix 1: Regulatory Impact Summary Table\***

Fiscal Costs	FY 2019	FY 2020	FY 2021
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0
Other Person	\$0	\$0	\$0
<b>Total Fiscal Costs:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Fiscal Benefits</b>			
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0

Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0
Other Persons	\$0	\$0	\$0
<b>Total Fiscal Benefits:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Net Fiscal Benefits:</b>			
	\$0	\$0	\$0

\*This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts for State Government, Local Government, Small Businesses and Other Persons are described in the narrative. Inestimable impacts for Non-Small Businesses are described in Appendix 2.

**Appendix 2: Regulatory Impact to Non-Small Businesses**

This repeal is not expected to have any fiscal impacts on non-small businesses revenues or expenditures, because the repeal of this rule requires no action or compliance by any persons. During the 2018 General Session, the Legislature passed S.B. 135 which prohibits discretionary clauses in certain insurance contracts as set forth in 31A-21-314. The revision makes this regulation obsolete.

The head of the Insurance Department, Todd E. Kiser, has reviewed and approved this fiscal analysis.

**R590. Insurance, Administration.**

**[R590-218. Permitted Language for Reservation of Discretion Clauses.**

**R590-218-1. Authority.**

This rule is promulgated pursuant to Subsections 31A-2-201(1) and 31A-2-201(3)(a) in which the commissioner is empowered to administer and enforce this title and to make rules to implement the provisions of this title. Further authority to regulate the use of reservation of discretion clauses in forms filed by insurers with the department is found in Subsections 31A-21-201(3) and 31A-21-314(2).

**R590-218-2. Purpose.**

This rule prohibits the use of reservation of discretion clauses in forms that are not associated with ERISA employee benefit plans. It creates a safe harbor for insurance companies that provide insurance to ERISA employee benefit plans sponsored by employers, allowing insurers to know what language in insurance forms is acceptable to the department.

**R590-218-3. Applicability.**

This rule applies to all forms filed with the department, regardless of the insurance line or type of form.

**R590-218-4. Definitions.**

For the purpose of this rule the commissioner adopts the definitions set forth in Section 31A-1-301 and the following:

(1) "Employee benefit plan" means an employee welfare benefit plan as defined in 29 U.S.C. 1002(1) or an employee pension

benefit plan as defined in 29 U.S.C. 1002(2) or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.

(2) "ERISA" means the Employee Retirement Income Security Act of 1974.

(3) "ERISA employee benefit plan" means an employee benefit plan subject to ERISA.

(4) "Form" is used as defined in Section 31A-1-301.

(5) "Reservation of discretion clause" means language in a form that purports to reserve discretion to interpret the terms of the contract, to determine eligibility for benefits under the plan, or to establish a scope of judicial review or standards of interpretation, to the plan administrator, the insurance company acting in the capacity of a plan administrator in an employee benefit plan, or the insurance company acting as the insurer.

**~~R590-218-5. Reservation of Discretion Clauses Prohibited—Exception—Safe Harbor Language.~~**

(1) The commissioner finds reservation of discretion clauses in forms to be in violation of Subsections 31A-21-201(3) and 31A-21-314(2). Accordingly, such clauses are not permitted in a form unless provided otherwise by this rule. Any reservation of discretion language previously accepted or approved by the department is hereby prohibited. Any use of reservation of discretion clause in a form required to be filed with the department is a violation of Subsections 31A-21-201(3) and 31A-21-314(2) and is prohibited, regardless of whether the form has been filed with or prohibited by the department.

(2) Notwithstanding Subsection (1), a reservation of discretion clause may be included in a form if the form is used only in ERISA employee benefit plans and the reservation of discretion clause has language that is the same as, or substantially similar to, the language in Subsection (3).

(3) The following language may be used in a reservation of discretion clause in forms filed for use in ERISA employee benefit plans (Parenthesis indicate that the company filing the form may use a name or pronouns as applicable):

"Benefits under this plan will be paid only if (the plan administrator) decides in its discretion that (the claimant) is entitled to them. (The plan administrator) also has discretion to determine eligibility for benefits and to interpret the terms and conditions of the benefit plan. Determinations made by (the plan administrator) pursuant to this reservation of discretion do not prohibit or prevent a

claimant from seeking judicial review in federal court of (the plan administrator's) determinations.

The reservation of discretion made under this provision only establishes the scope of review that a federal court will apply when (a claimant) seeks judicial review of (the plan administrator's) determination of eligibility for benefits, the payment of benefits, or interpretation of the terms and conditions applicable to the benefit plan.

(The plan administrator) is an insurance company that provides insurance to this benefit plan and the federal court will determine the level of discretion that it will accord (the plan administrator's) determinations."

(4) A reservation of discretion clause in a form that is used in an ERISA employee benefit plan must be highlighted in the form by use of a bold font that is not less than 12 point type.

**~~R590-218-6. Filing Procedures.~~**

Rather than filing multiple forms for ERISA employee benefit plans and benefit plans not subject to ERISA, an insurer may elect to file one form with the department that has the reservation of discretion language included as a variable element, between brackets, with an accompanying notation stating that the reservation of discretion language will only be included in forms used for ERISA employee benefit plans.

**~~R590-218-7. Severability.~~**

If any provision or clause of this rule or its application to any person or situation is held invalid, such invalidity may not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

**~~KEY: insurance, discretion clauses~~**

**~~Date of Enactment or Last Substantive Amendment: March 21, 2003~~**

**~~Notice of Continuation: January 4, 2018~~**

**~~Authorizing, and Implemented or Interpreted Law: 31A-2-201; 31A-21-201; 31A-21-314]~~**

**End of the Notices of Proposed Rules Section**



## 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 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.

While the law does not designate a comment period for a **CHANGE IN PROPOSED RULE**, it does provide for a 30-day waiting period. An agency may accept additional comments during this period and, at its option, may designate a comment period or may hold a public hearing. The 30-day waiting period for **CHANGES IN PROPOSED RULES** published in this issue of the *Utah State Bulletin* ends May 31, 2019.

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 (*example*). Deletions made to the rule appear struck out with brackets surrounding them (~~example~~). A row of dots in the text between paragraphs (. . . . .) indicates that unaffected text, either whole sections or subsections, was removed to conserve space. If a **CHANGE IN PROPOSED RULE** is too long to print, the Office of Administrative Rules may include only the **RULE ANALYSIS**. A copy of rules that are too long to print is available from the agency or from the Office of Administrative Rules.

From the end of the 30-day waiting period through August 29, 2019, an agency may notify the Office 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 the **CHANGE IN PROPOSED RULE**. If the agency designates a public comment period, the effective date may be no fewer than seven calendar days after the close of the public comment period nor more than 120 days after the publication date. Alternatively, the agency may file another **CHANGE IN PROPOSED RULE** in response to additional comments received. If the Office of Administrative Rules does not receive a **NOTICE OF EFFECTIVE DATE** or another **CHANGE IN PROPOSED RULE** by the end of the 120-day period after publication, the **CHANGE IN PROPOSED RULE** filing, along with its associated **PROPOSED RULE**, lapses.

**CHANGES IN PROPOSED RULES** are governed by Section 63G-3-303, Rule R15-2, and Sections R15-4-3, R15-4-4, R15-4-5b, R15-4-7, R15-4-9, and R15-4-10.

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**The Changes in Proposed Rules Begin on the Following Page**

**Insurance, Administration**  
**R590-155**  
**Utah Life and Health Insurance**  
**Guaranty Association Summary**  
**Document**

**NOTICE OF CHANGE IN PROPOSED RULE**  
 DAR FILE NO.: 43486  
 FILED: 04/15/2019

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** This rule is being changed to correct the name of the notice that shall be used by insurers in a disclosure to their policy or contract holders.

**SUMMARY OF THE RULE OR CHANGE:** This change corrects the name of the Notice of Protection Provided by the Utah Life and Health Insurance Guaranty Association that includes text that must be disclosed to policy or contract holders regarding the insurer's contractual guarantees. (EDITOR'S NOTE: The original proposed amendment upon which this change in proposed rule (CPR) was based was published in the February 15, 2019, issue of the Utah State Bulletin, on page 5. 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 CPR and the proposed amendment together to understand all of the changes that will be enforceable should the agency make this rule effective.)

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Subsection 31A-2-201(3)(a) and Subsection 31A-28-119(3)

**ANTICIPATED COST OR SAVINGS TO:**

- ◆ **THE STATE BUDGET:** There is no anticipated cost or savings to the state budget. This change merely corrects the name of a form that is included in this rule.
- ◆ **LOCAL GOVERNMENTS:** There is no anticipated cost or savings to local governments. This change merely corrects the name of a form that is included in this rule.
- ◆ **SMALL BUSINESSES:** There is no anticipated cost or savings to small businesses. This change merely corrects the name of a form that is included in this rule.
- ◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** There is no anticipated cost or savings to any other persons. This change merely corrects the name of a form that is included in this rule.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** There are no compliance costs for any affected persons. This change merely corrects the name of a form that is included in this rule.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** After conducting a thorough analysis, it was determined that this proposed rule change will not result in a fiscal impact to businesses.

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 Office of Administrative Rules.

**DIRECT QUESTIONS REGARDING THIS RULE TO:**  
 ◆ Steve Gooch by phone at 801-538-3803, by FAX at 801-538-3829, or by Internet E-mail at sgooch@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 05/31/2019

THIS RULE MAY BECOME EFFECTIVE ON: 06/07/2019

AUTHORIZED BY: Steve Gooch, Information Specialist

**Appendix 1: Regulatory Impact Summary Table\***

Fiscal Costs	FY 2019	FY 2020	FY 2021
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0
Other Person	\$0	\$0	\$0
<b>Total Fiscal Costs:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Fiscal Benefits</b>			
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0

Other Persons	\$0	\$0	\$0
<b>Total Fiscal Benefits:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Net Fiscal Benefits:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

\*This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts for State Government, Local Government, Small Businesses and Other Persons are described in the narrative. Inestimable impacts for Non-Small Businesses are described in Appendix 2.

**Appendix 2: Regulatory Impact to Non-Small Businesses**

This change in proposed rule is not expected to have any fiscal impacts on non-small businesses revenues or expenditures, because the change merely corrects the name of a notice that includes text that must be disclosed to policy or contract holders regarding the insurer's contractual guarantees. It requires no action or compliance by any persons.

The head of the Insurance Department, Todd E. Kiser, has reviewed and approved this fiscal analysis.

**R590. Insurance, Administration.**

**R590-155. Utah Life and Health Insurance Guaranty Association Summary Document.**

**R590-155-1. Authority.**

This rule is promulgated pursuant to:

(1) Subsection 31A-2-201(3)(a), in which the commissioner is empowered to administer and enforce this title and to make rules to implement the provisions of this title; and

(2) Subsection 31A-28-119(3), to provide guidelines for the Utah Life and Health Insurance Guaranty Association summary and disclaimer document.

**R590-155-2. Purpose and Scope.**

(1) The purpose of this rule is to specify the form and content of the summary and disclaimer document for insurers to disclose to policy or contract holders the extent that contractual guarantees are not covered or have limited coverage by the Utah Life and Health Insurance Guaranty Association as required by Section 31A-28-119.

(2) The rule shall apply to all insurance transactions in this state involving life and health insurance policies and annuity contracts as specified in Section 31A-28-103.

**R590-155-3. Rule.**

(1) An insurer authorized to do business in this state, which is subject to the Utah Life and Health Insurance Guaranty Association Act, shall disclose to its policy or contract holders that its contractual guarantees may not be covered by the Utah Life and Health Insurance Guaranty Association.

(2) For the purpose of this rule, the term "policy or contract holders" shall also mean insureds, subscribers, or certificate holders of group policies.

(3) Disclosure shall be made in writing using the text in the ~~[Utah Life and Health Insurance Guaranty Association~~

~~Disclaimer]~~ Notice of Protection Provided by the Utah Life and Health Insurance Guaranty Association, which is available on the department website, <https://insurance.utah.gov>.

(4) Disclosure shall be given before or at the time of delivery of the policy, contract, or certificate. The summary and disclaimer document shall also be available upon request by a policy or contract holder.

(5) Each insurer shall file with the commissioner a copy of the summary and disclaimer document.

**R590-155-4. Penalties.**

A person found to be in violation of this rule shall be subject to penalties as provided under Section 31A-2-308.

**R590-155-5. Severability.**

If any provision of this rule or its application to any person or situation is held to be invalid, that invalidity shall not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

**KEY: insurance**

**Date of Enactment or Last Substantive Amendment: 2019**

**Notice of Continuation: December 8, 2017**

**Authorizing, and Implemented or Interpreted Law: 31A-2-201; 31A-28-119**

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Insurance, Administration  
**R590-277**  
 Managed Care Health Benefit Plan  
 Policy Standards

**NOTICE OF CHANGE IN PROPOSED RULE**

DAR FILE NO.: 43427

FILED: 04/15/2019

**RULE ANALYSIS**

**PURPOSE OF THE RULE OR REASON FOR THE CHANGE:** This rule is being amended as a result of H.B. 336, Health Reform Amendments, passed during the 2017 General Session. The effective date for the applicable provisions in this rule have a delayed effective date of January 1, 2020. These changes revise the previously filed language for illegal activities in Section R590-277-4.

**SUMMARY OF THE RULE OR CHANGE:** This revision clarifies that an insurer may only exclude coverage for an insured's participation in an illegal activity if the insured is found guilty in a criminal proceeding, or liable in a civil proceeding. (EDITOR'S NOTE: The original proposed new rule upon which this change in proposed rule (CPR) was based was published in the January 1, 2019, issue of the Utah State Bulletin, on page 33. Underlining in the rule below indicates text that has been added since the publication of the proposed new rule mentioned above; strike-out indicates text

that has been deleted. You must view the CPR and the proposed new rule together to understand all of the changes that will be enforceable should the agency make this rule effective.)

**STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE:** Section 31A-2-202 and Section 31A-23a-412 and Section 31A-45-103 and Subsection 31A-2-201(3)(a) and Subsection 31A-23a-402(8)

**ANTICIPATED COST OR SAVINGS TO:**

◆ **THE STATE BUDGET:** There is no anticipated cost or savings to the state budget. This rule adopts standards that are currently required under an administrative rule that applies not only to managed care contracts, but also other types of health insurance contracts.

◆ **LOCAL GOVERNMENTS:** There is no anticipated cost or savings to local governments. If a local government plan offered their employees a self-funded health plan, this rule would not apply. If a local government plan offered their employees a fully insured health plan, it is not anticipated that there will be additional costs or savings. This rule adopts standards that are currently required under an administrative rule that applies not only to managed care contracts, but also other types of health insurance contracts.

◆ **SMALL BUSINESSES:** There is no anticipated cost or savings to small businesses. This rule adopts standards that are currently required under an administrative rule that applies not only to managed care contracts, but also other types of contracts.

◆ **PERSONS OTHER THAN SMALL BUSINESSES, BUSINESSES, OR LOCAL GOVERNMENTAL ENTITIES:** There is no anticipated cost or savings to persons other than small businesses, businesses, or local government entities. Other than revisions to the illegal activities provision, this rule adopts standards that are currently required under an administrative rule that applies not only to managed care contracts, but also other types of contracts. All but one insurer reported no concerns with the changes to the illegal activities provision. That insurer provided only one example in which they currently were experiencing a loss of approximately \$150,000. However, this loss is not applicable under this rule. It is for a self-funded plan, which is exempt from state law. Additionally, the insurer would have the ability to bring civil lawsuit in the situation to exclude the \$150,000 claim, thereby completely avoiding payment of any claim, and having no cost impact under these rule changes.

**COMPLIANCE COSTS FOR AFFECTED PERSONS:** There are no anticipated compliance costs for affected persons. The revisions to this rule are being filed timely so that affected persons are able to incorporate them into their annual filing process.

**COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES:** After conducting a thorough analysis, it was determined that this proposed rule will not result in a fiscal impact to businesses.

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 Office of Administrative Rules.

**DIRECT QUESTIONS REGARDING THIS RULE TO:**

◆ Steve Gooch by phone at 801-538-3803, by FAX at 801-538-3829, or by Internet E-mail at sgooch@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS NO LATER THAN AT 5:00 PM ON 05/31/2019

THIS RULE MAY BECOME EFFECTIVE ON: 06/07/2019

AUTHORIZED BY: Steve Gooch, Information Specialist

**Appendix 1: Regulatory Impact Summary Table\***

Fiscal Costs	FY 2019	FY 2020	FY 2021
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<b>Fiscal Benefits</b>			
State Government	\$0	\$0	\$0
Local Government	\$0	\$0	\$0
Small Businesses	\$0	\$0	\$0
Non-Small Businesses	\$0	\$0	\$0
Other Persons	\$0	\$0	\$0
<b>Total Fiscal Benefits:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Net Fiscal Benefits:</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

\*This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts for State Government, Local Government, Small Businesses and Other Persons are described in the narrative. Inestimable impacts for Non-Small Businesses are described in Appendix 2.

**Appendix 2: Regulatory Impact to Non-Small Businesses**

This change in proposed rule is not expected to have any fiscal impacts on non-small businesses revenues or expenditures, because its main purpose is to clarify that an insurer may only exclude coverage for an insured's participation in an illegal activity if the insured is found guilty in a criminal proceeding, or liable in a civil proceeding. Other than the revision to the illegal activities provision, this rule adopts standards that are currently required

under an administrative rule that applies not only to managed care contracts, but also other types of contracts.

The head of the Insurance Department, Todd E. Kiser, has reviewed and approved this fiscal analysis.

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

#### **R590-277. Managed Care Health Benefit Plan Policy Standards.**

##### **R590-277-1. Authority.**

This rule is promulgated by the commissioner pursuant to Subsections 31A-2-201(3)(a), 31A-2-202, 31A-23a-402(8), 31A-23a-412, and 31A-45-103.

##### **R590-277-2. Purpose and Scope.**

(1) The purpose of this rule is to provide reasonable standardization and simplification of terms and coverages of a managed care health benefit plan policy in order to:

- (a) facilitate public understanding and comparison;
- (b) prohibit provisions which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims; and
- (c) provide for full disclosure.

(2) This rule applies to any health benefit plan issued by a managed care organization to an individual or group, including policies issued to an association, trust, discretionary group, or other similar group.

(3) This rule does not apply to short-term limited duration health insurance that complies with both R590-85, Individual Accident and Health Insurance and Individual and Group Medicare Supplement rates, and R590-126, Accident and Health Insurance Standards.

##### **R590-277-3. Definitions.**

The definitions in Sections 31A-1-301, 31A-22-625, 31A-30-103 and 31A-45-102, and Rules R590-126, R590-192, R590-261 and R590-266, shall apply for the purposes of this rule.

##### **R590-277-4. Prohibited Policy Provisions.**

(1) A health benefit plan may not impose any preexisting condition limitation or exclusion provisions.

(2) Limitations or exclusions. Unless otherwise required by law, a policy may not limit or exclude coverage or benefits by type of illness, accident, treatment, or medical condition, except as follows:

- (a) abortion;
- (b) acupuncture and acupressure services;
- (c) administrative charges for completing insurance forms, duplication services, interest, finance charges, or other administrative charges;
- (d) administrative exams and services;
- (e) applied behavioral analysis therapy, except as required by Section 31A-22-642;
- (f) aviation;
- (g) axillary hyperhidrosis;
- (h) benefits provided under:
  - (i) Medicare or other governmental program, except Medicaid;
  - (ii) state or federal worker's compensation; or
  - (iii) employer's liability or occupational disease law;
- (i) fitness training, exercise equipment, or membership fees to a spa or health club;

- (j) charges for appointments scheduled and not kept;
- (k) chiropractic care;
- (l) complementary and alternative medicine;
- (m) corrective lenses, and examination for the prescription or fitting thereof, except lens implant following cataract surgery and as required by R590-266;

(n) cosmetic surgery; reversal, revision, repair, complications, or treatment related to a non-covered cosmetic surgery. This exclusion does not apply to reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved party; or reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect;

- (o) custodial care;
- (p) dental care or treatment;
- (q) dietary products, except as required by R590-194;
- (r) educational and nutritional training, except as required by R590-200;

(s) experimental or investigational services;

(t) expenses before coverage begins or after coverage ends;

(u) felony, riot or insurrection, when it has been determined the covered person was a voluntary participant;

(v) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, including orthotics. The exclusion of routine foot care does not apply to cutting or removal of corns, calluses, or nails when provided to a person who has a systemic disease, such as diabetes with peripheral neuropathy or circulatory insufficiency, of such severity that unskilled performance of the procedure would be hazardous;

(w) gastric or intestinal bypass services including lap banding, gastric stapling, and other similar procedures to facilitate weight loss; the reversal, or revision of such procedures; or services required for the treatment of complications from such procedures;

(x) gender reassignment, except as required by Section 1557 of the Patient Protection and Affordable Care Act;

- (y) gene therapy;
- (z) genetic testing;
- (aa) hearing aids, and examination for the prescription or fitting thereof;

(bb)(i) a loss directly related to ~~[an illegal]~~the insured's voluntary participation in an activity~~[when it has been determined the covered person voluntarily committed the illegal activity. This exclusion does not apply to] where the insured:~~

~~[(i)A] [an exclusion prohibited by the nondiscrimination provisions of the Health Insurance Portability and Accountability Act] is found guilty of an illegal activity in a criminal proceeding; or~~

~~[(ii)B] [a loss resulting from the covered person being under the influence of alcohol, unless it has been determined the loss is directly related to and a result of the covered person illegally operating a motor vehicle under the influence of alcohol, as determined under 41-6a-502. If the loss occurs in a state other than Utah, the determination shall be made under the laws of such jurisdiction] is found liable for the activity in a civil proceeding.~~

(ii) A guilty finding includes a plea of guilty, a no contest plea, and a plea in abeyance;

- (cc) infertility services;
- (dd) mental health and substance use disorder services, except as required by Section 31A-22-625 and R590-266;

(ee) injury as a result of a motor vehicle, to the extent the covered person is required by law to have no-fault coverage. The exclusion applies only to charges up to the minimum coverage required by law, whether or not such coverage is in effect;

(ff) nuclear release;

(gg) refractive eye surgery;

(hh) rehabilitation or habilitative therapy services, such as physical, speech, and occupational, except as required to correct an impairment caused by a covered accident or illness, or as required by R590-266;

(ii) respite care;

(jj) rest cures;

(kk) service in the armed forces or units auxiliary to it;

(ll) services that are not medically necessary;

(mm) services performed by the covered person's parent, spouse, sibling or child, including a step or in-law relationship;

(nn) services for which no charge is normally made in the absence of insurance;

(oo) services in connection with a prearranged surrogacy agreement where the covered person relinquishes a baby and receives payment or other compensation arising out of such services. This exclusion does not apply to services for the baby;

(pp) sexual dysfunction procedures, equipment and drugs;

(qq) shipping and handling;

(rr) telephone/electronic consultations;

(ss) territorial limitations outside the United States;

(tt) terrorism, including acts of terrorism;

(uu) transplants, except as required by R590-266;

(vv) transportation, except medically necessary ambulance services;

(ww) war or act of war, whether declared or undeclared; or

(xx) others that in the opinion of the commissioner are not inequitable, misleading, deceptive, obscure, unjust, unfair or unfairly discriminatory to the policyholder, beneficiary or covered person under the policy.

#### **R590-277-5. General Requirements.**

(1) Policy definitions. No policy subject to this rule may contain definitions respecting the matters defined in R590-277-3 unless such definitions comply with the requirements of that section.

(2) Rights of spouse and dependents. Except for an employer sponsored health plan, a policy;

(a) may not provide for termination of coverage of the spouse or a dependent solely because of the occurrence of an event specified for termination of coverage of the policyholder, other than for nonpayment of premium; and

(b) shall provide that in the event of the policyholder's death the spouse of the insured shall become the insured.

(3) Cancellation, renewability, and termination. A policy cancellation, renewability and termination provision shall comply with Sections 31A-22-618.6 or 31A-22-618.7.

(4) Transplant donor coverage. A policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medically necessary transplant expenses of a live donor.

(5) Notice of premium change. A notice of change in premium shall be given no fewer than 45 days before the renewal date.

(6)(a) Except as provided in Subsection (b), a completed application shall be made part of the policy. A copy of the completed application shall be provided to the applicant prior to, or upon delivery, of the policy.

(b) Subsection (6)(a) does not apply to:

(i) an employer sponsored health benefit plan; or

(ii) an individual policy where application was effectuated directly through healthcare.gov.

(7) A managed care organization offering a health benefit plan to an individual or small employer:

(a) shall offer coverage to all individuals and eligible employees on a guaranteed basis without regard to health status;

(b) may modify coverage at the time of renewal to the extent that such modification is consistent with federal and state law and effective on a uniform basis among all individuals in the health benefit plan; and

(c) must renew or continue coverage at the option of the policyholder, subject to Subsections 31A-22-618.6 and 618.7.

#### **R590-277-6. Required Provisions.**

(1) A policy and certificate shall include a renewal, continuation, and nonrenewal provision. The provision shall be appropriately captioned, appear on the first page of the policy and certificate, and clearly state the duration of coverage.

(2) Endorsement acceptance.

(a) Except for an endorsement by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, an endorsement added to a policy after date of issue or at reinstatement or renewal that reduces or eliminates benefits or coverage in the policy shall require signed acceptance by the policyholder.

(b) After the date of policy issue, an endorsement that increases benefits or coverage with a concurrent increase in premium during the policy term, must be agreed to in writing signed by the policyholder, except if the increased benefits or coverage is required by law.

(3) Additional premium. Where a separate additional premium is charged for benefits provided in connection with an endorsement, the premium charge shall be set forth in the policy or certificate.

(4) Benefit payment standard. A policy or certificate that provides for the payment of benefits based on standards described as usual and customary, reasonable and customary, or words of similar import, shall include a definition of the terms and an explanation of the terms in its accompanying outline of coverage or certificate.

#### **R590-277-7. Restrictions Relating to Premium Rates.**

(1) The premium charged shall not be adjusted more frequently than annually, except that the premium rates may be changed:

(a) to reflect changes to the enrollment;

(b) to reflect changes to the health benefit plan; or

(c) as expressly permitted by federal or state law.

(2) Premium rates may vary only with respect to the particular coverage involved on the basis of the following:

(a) whether the plan covers an individual or family;

(i) the total family premium shall include only the premiums for all covered family members over the age of twenty-one and the three oldest children under the age of twenty one; and

(ii) any rating variation on the basis of age or tobacco use must be applied separately to the portion of the premium attributable to each covered family member;

(b) geographic rating area, determined by the policyholder's primary address, as follows:

(i) Area 1, comprised of Cache and Rich counties;

(ii) Area 2, comprised of Box Elder, Morgan, and Weber counties;

(iii) Area 3, comprised of Davis, Salt Lake, Summit, Tooele, and Wasatch counties;

(iv) Area 4, comprised of Utah county;

(v) Area 5, comprised of Iron and Washington counties; and

(vi) Area 6, comprised of Beaver, Carbon, Daggett, Duchesne, Emery, Garfield, Grand, Juab, Kane, Millard, Piute, San Juan, Sanpete, Sevier, Uintah, and Wayne counties;

(c) age of each enrollee, as of the date of the policy issuance or renewal, in accordance with the Utah Individual and Small Employer Health Benefit Plan Age Curve; and

(d) tobacco rate factor, not greater than 1.5.

(3) R590-277-7(2) does not apply to:

(a) a large employer health benefit plan; or

(b) an individual or small employer health benefit plan issued prior to January 1, 2014 in which the policy rating complies with:

(i) Title 31A-30, Individual, Small Employer, and Group Health Insurance Act; and

(ii) Rule R590-167, Individual, Small Employer, and Group Health Benefit Plan Rule.

**R590-277-8. Existing Policies.**

A policy issued prior to the effective date of this rule shall be amended to comply with this rule on the first policy anniversary following the effective date of this rule.

**R590-277-9. Penalties.**

A person found to be in violation of this rule shall be subject to penalties as provided under Section 31A-2-308.

**R590-277-10. Enforcement Date.**

The commissioner will begin enforcing the provisions of this rule for policies issued or renewed on or after January 1, 2020.

**R590-277-11. Severability.**

If any provision or clause of this rule or its application to any person or situation is held invalid, that invalidity may not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

**KEY: insurance, health insurance**

**Date of Enactment or Last Substantive Amendment: 2019**

**Authorizing, and Implemented or Interpreted Law: 31A-45-103; 31A-2-201(3)(a); 31A-23a-402(8); 31A-23a-412; 31A-2-202**

**End of the Notices of Changes in Proposed Rules Section**



# 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 agency is required to review the rule. This review is intended to help the agency determine, and to notify the public, that the administrative rule in force is still authorized by statute and necessary. Upon reviewing a rule, an agency may: repeal the rule by filing a **PROPOSED RULE**; continue the rule as it is by filing a **FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION (REVIEW)**; or amend the rule by filing a **PROPOSED RULE** and by filing a **REVIEW**. By filing a **REVIEW**, the agency indicates that the rule is still necessary.

A **REVIEW** is not followed by the rule text. The rule text that is being continued may be found in the online edition of the *Utah Administrative Code* available at <https://rules.utah.gov/>. The rule text may also be inspected at the agency or the Office of Administrative Rules. **REVIEWS** are effective upon filing.

**REVIEWS** are governed by Section 63G-3-305.

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## Administrative Services, Facilities Construction and Management

### **R23-23**

## Health Reform -- Health Insurance Coverage in State Contracts -- Implementation

### **FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION**

DAR FILE NO.: 43642

FILED: 04/11/2019

### **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: This rule is to comply with the provisions of Section 63A-5-205.5, which requires this rule related to health insurance provisions in certain design and/or construction contracts. This rule is authorized under Subsection 63A-5-103(2)(a), which directs the Utah State Building Board to make rules necessary to the discharge of the duties of the Division of Facilities Construction and Management.

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 comments have been received.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule sets forth the guidelines and

requirements for health insurance coverage for contractors and subcontractors performing work for the state. Therefore, this rule should be continued.

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

ADMINISTRATIVE SERVICES  
FACILITIES CONSTRUCTION AND MANAGEMENT  
ROOM 4110 STATE OFFICE BLDG  
450 N STATE ST  
SALT LAKE CITY, UT 84114-1201  
or at the Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

- ◆ Cecilia Niederhauser by phone at 801-538-3261, by FAX at 801-538-9694, or by Internet E-mail at [cniederhauser@utah.gov](mailto:cniederhauser@utah.gov)
- ◆ Jeff Reddoor by phone at 801-971-9830, or by Internet E-mail at [jreddoor@utah.gov](mailto:jreddoor@utah.gov)
- ◆ Michael Kelley by phone at 801-538-3105, or by Internet E-mail at [mkelley@agutah.gov](mailto:mkelley@agutah.gov)
- ◆ Nicole Alder by phone at 801-538-3240, or by Internet E-mail at [nicolealder@agutah.gov](mailto:nicolealder@agutah.gov)

AUTHORIZED BY: Ned Carnahan, Building Board Chair

EFFECTIVE: 04/11/2019

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## Agriculture and Food, Marketing and Development

### **R65-12**

## Utah Small Grains and Oilseeds Marketing Order

**FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION**

DAR FILE NO.: 43641  
 FILED: 04/11/2019

**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: Promulgated under authority of Subsection 4-2-2(1)(e), which authorizes issuing marketing orders to promote orderly market conditions for agricultural products.

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 comments have been received by the Department of Agriculture and Food (Department) regarding this rule.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: The Department is in the process of reviewing this rule and assessing the continued need with producers. The Department is engaging with producers affected to determine the ongoing need for this marketing order, but at this time the Department needs to renew this rule until the discussions have been concluded. Therefore, this rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:  
 AGRICULTURE AND FOOD  
 MARKETING AND DEVELOPMENT  
 350 N REDWOOD RD  
 SALT LAKE CITY, UT 84116-3034  
 or at the Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:  
 ♦ Andy Pierucci by phone at 801-538-4913, or by Internet E-mail at [apierucci@utah.gov](mailto:apierucci@utah.gov)  
 ♦ Melissa Ure by phone at 801-538-4976, or by Internet E-mail at [mure@utah.gov](mailto:mure@utah.gov)

AUTHORIZED BY: LuAnn Adams, Commissioner

EFFECTIVE: 04/11/2019

**FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION**

DAR FILE NO.: 43636  
 FILED: 04/08/2019

**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: This rule is authorized by Utah Constitution, Article X, Section 3, which places general control and supervision of the public school system under the Utah State Board of Education (Board); Section 53E-3-301, which directs the Board to report average class sizes and pupil-teacher ratios; and Subsection 53E-3-401(4), which allows the Board to make rules to execute the Board's duties and responsibilities under the Utah Constitution and state law.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: There were no written comments received.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule continues to be necessary because it establishes uniform class size and pupil-teacher ratio reporting procedures, including definitions and codes. Therefore, this rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:  
 EDUCATION  
 ADMINISTRATION  
 250 E 500 S  
 SALT LAKE CITY, UT 84111-3272  
 or at the Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:  
 ♦ Angela Stallings by phone at 801-538-7550, by FAX at 801-538-7768, or by Internet E-mail at [angie.stallings@schools.utah.gov](mailto:angie.stallings@schools.utah.gov)

AUTHORIZED BY: Angela Stallings, Deputy Superintendent of Policy

EFFECTIVE: 04/08/2019

Education, Administration  
**R277-463**

Class Size Average and Pupil-Teacher Ratio Reporting

Education, Administration  
**R277-472**

Charter School Student Enrollment and  
Transfers and School District Capacity  
Information

**FIVE-YEAR NOTICE OF REVIEW AND STATEMENT  
OF CONTINUATION**  
DAR FILE NO.: 43637  
FILED: 04/08/2019

**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: This rule is authorized under Utah Constitution, Article X, Section 3, which vests general control and supervision over public education in the Utah State Board of Education (Board), Subsection 53G-6-503(2), which directs the Board to make rules for students transferring between charter schools and district schools, and enrolling and withdrawing from charter schools; and Subsection 53E-3-401(4), which allows the Board to adopt rules in accordance with its responsibilities.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: There were no written comments received.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule continues to be necessary because it provides procedures for students transferring between district public schools and charter schools; defines capacity in district public schools to allow for transfers into district schools from charter schools; and provides notice to parents and students of schools that have space available. Therefore, this rule should be continued.

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

EDUCATION  
ADMINISTRATION  
250 E 500 S  
SALT LAKE CITY, UT 84111-3272  
or at the Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:  
♦ Angela Stallings by phone at 801-538-7550, by FAX at 801-538-7768, or by Internet E-mail at [angie.stallings@schools.utah.gov](mailto:angie.stallings@schools.utah.gov)

AUTHORIZED BY: Angela Stallings, Deputy Superintendent of Policy

EFFECTIVE: 04/08/2019

Education, Administration  
**R277-493**

Kindergarten Supplemental Enrichment  
Program

**FIVE-YEAR NOTICE OF REVIEW AND STATEMENT  
OF CONTINUATION**  
DAR FILE NO.: 43638  
FILED: 04/08/2019

**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: This rule is authorized by Utah Constitution, Article X, Section 3, which vests general control and supervision over public education in the Utah State Board of Education (Board); Subsection 53E-3-401(4), which allows the Board to make rules to execute the Board's duties and responsibilities under the Utah Constitution and state law; and Subsection 53F-4-205(7), which directs the Board to adopt rules to implement the kindergarten supplemental enrichment program.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: There were no written comments received.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule continues to be necessary because this rule makes rules to establish reporting procedures, and administer the kindergarten supplemental enrichment program established in Section 53F-4-205. Therefore, this rule should be continued.

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

EDUCATION  
ADMINISTRATION  
250 E 500 S  
SALT LAKE CITY, UT 84111-3272  
or at the Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:  
 ♦ Angela Stallings by phone at 801-538-7550, by FAX at 801-538-7768, or by Internet E-mail at [angie.stallings@schools.utah.gov](mailto:angie.stallings@schools.utah.gov)

AUTHORIZED BY: Angela Stallings, Deputy Superintendent of Policy

EFFECTIVE: 04/08/2019

**Environmental Quality, Water Quality  
 R317-401  
 Graywater Systems**

**FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION**  
 DAR FILE NO.: 43633  
 FILED: 04/08/2019

**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: The Water Quality Board is authorized by Subsection 19-5-104(1)(A)(v) to make rules in order to protect the public health for the design, construction, operation, and maintenance of underground wastewater disposal systems. The Director of the Division of Water Quality is authorized by Section 19-5-105 to: 1) develop programs for the prevention, control, and abatement of new or existing pollution of the waters of the state; 2) enforce rules created by the Board; 3) require permits for the construction of treatment facilities; 4) review plans and specifications; and 5) adopt other measures to prevent, control, or abate pollution of waters of the state.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: This rule was first promulgated on 07/02/2004. No written comments have been received. However, during a recent review by the Conference of Local Environmental Health Administrators (CLEHA) Onsite Wastewater Partnership, the members expressed their support for the existing rule and its importance to the overall effort to prevent pollution and protect public health.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule was developed in response to a number of inquiries from the public and local health departments regarding the use, under certain conditions, of graywater originating from laundries, showers, tubs, and lavatories for subsurface irrigation. This rule sets out the

requirements for use of graywater and is required for adequate protection of the state's water resources. Therefore, this rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:  
 ENVIRONMENTAL QUALITY  
 WATER QUALITY  
 THIRD FLOOR  
 195 N 1950 W  
 SALT LAKE CITY, UT 84116  
 or at the Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:  
 ♦ Judy Etherington by phone at 801-536-4344, by FAX at 801-536-4301, or by Internet E-mail at [jetherington@utah.gov](mailto:jetherington@utah.gov)

AUTHORIZED BY: Erica Gaddis, Director

EFFECTIVE: 04/08/2019

**Health, Health Care Financing,  
 Coverage and Reimbursement Policy  
 R414-14A  
 Hospice Care**

**FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION**  
 DAR FILE NO.: 43634  
 FILED: 04/08/2019

**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: Section 26-1-5 grants the Department of Health (Department) the authority to adopt, amend or rescind rules as necessary to implement the Medicaid program, and Section 26-18-3 requires the Department to implement the Medicaid program through administrative rules. Additionally, 42 U.S.C. 1395x(dd) authorizes coverage for hospice care services.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: The Department did not receive any written comments regarding this rule.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: The Department will continue this rule because it sets forth eligibility, access, and coverage for

Medicaid clients. The Department will also continue this rule because it includes provisions for concurrent care, in-home care, general care, respite care, continuous care, adult client rights, notices, discharge, payment, contracts, enrollment, marketing, and waivers.

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 Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

♦ Craig Devashrayee by phone at 801-538-6641, by FAX at 801-538-6099, or by Internet E-mail at [cdevashrayee@utah.gov](mailto:cdevashrayee@utah.gov)

AUTHORIZED BY: Joseph Miner, MD, Executive Director

EFFECTIVE: 04/08/2019

Health, Family Health and  
Preparedness, Licensing  
**R432-45**

Nurse Aide Training and Competency  
Evaluation Program

**FIVE-YEAR NOTICE OF REVIEW AND STATEMENT  
OF CONTINUATION**

DAR FILE NO.: 43630  
FILED: 04/05/2019

**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: Title 26, Chapter 21, is the health code that mandates the licensing of health care facilities.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: There have been no written comments from any party regarding this rule.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: The Nurse Aide Training and Competency Evaluation Program is authorized by the Omnibus Budget

Reconciliation Act of 1987 (OBRA), Pub. L. No. 100, 203, 101 Stat. 1330, Subsections 4211, (b)(5)(A)(B)(C)(D)(E)(F)(G), (e)(1)(2), f(2)(A)(B), which the Department of Health (Department) adopts and incorporates by reference. The purpose of this program is to allow a certified nurse aide (CNA) to provide quality nursing services to nursing facility residents. The Department agrees with the need to continue this rule.

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

HEALTH  
FAMILY HEALTH AND PREPAREDNESS,  
LICENSING  
3760 S HIGHLAND DR  
SALT LAKE CITY, UT 84106  
or at the Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

♦ Kristi Grimes by phone at 801-273-2821, or by Internet E-mail at [kristigrimes@utah.gov](mailto:kristigrimes@utah.gov)

AUTHORIZED BY: Joseph Miner, MD, Executive Director

EFFECTIVE: 04/05/2019

Health, Disease Control and  
Prevention, Medical Examiner  
**R448-10**

Unattended Death and Reporting  
Requirements

**FIVE-YEAR NOTICE OF REVIEW AND STATEMENT  
OF CONTINUATION**

DAR FILE NO.: 43631  
FILED: 04/05/2019

**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: This rule is authorized by Section 26-1-5. This rule clarifies the meaning of unintended under the provisions of Subsection 26-4-28(8), and the requirements of Section 26-4-8.

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 were received during and since the last five-year review.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY

DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule clarifies the definition of what is an "unattended death". This rule's provisions help assure that deaths which can be appropriately certified by a treating health practitioner do not unnecessarily come to the Office of the Medical Examiner for investigation, examination, and certification. Therefore, this rule should be continued.

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

HEALTH  
DISEASE CONTROL AND PREVENTION,  
MEDICAL EXAMINER  
48 N MEDICAL DR  
SALT LAKE CITY, UT 84113-1105  
or at the Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:  
♦ Emily Sagers by phone at 801-538-6180, by FAX at 801-538-6540, or by Internet E-mail at esagers@utah.gov

AUTHORIZED BY: Joseph Miner, MD, Executive Director

EFFECTIVE: 04/05/2019

**Health, Disease Control and  
Prevention, Medical Examiner  
R448-20**

**Access to Medical Examiner Reports**

**FIVE-YEAR NOTICE OF REVIEW AND STATEMENT  
OF CONTINUATION**

DAR FILE NO.: 43632  
FILED: 04/05/2019

**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: This rule is authorized by Section 26-1-5. This rule establishes who may, under the provisions of Subsection 26-4-17(3), access the medical examiner reports generated in the investigation of a death.

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 were received during and since the last five-year review.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE

RULE, IF ANY: This rule clarifies the definition of next-of-kin and/or a legal representative for the purposes of who may obtain records from the Office of the Medical Examiner. Therefore, this rule should be continued.

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

HEALTH  
DISEASE CONTROL AND PREVENTION,  
MEDICAL EXAMINER  
48 N MEDICAL DR  
SALT LAKE CITY, UT 84113-1105  
or at the Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:  
♦ Emily Sagers by phone at 801-538-6180, by FAX at 801-538-6540, or by Internet E-mail at esagers@utah.gov

AUTHORIZED BY: Joseph Miner, MD, Executive Director

EFFECTIVE: 04/05/2019

**Insurance, Administration  
R590-93  
Replacement of Life Insurance and  
Annuities**

**FIVE-YEAR NOTICE OF REVIEW AND STATEMENT  
OF CONTINUATION**

DAR FILE NO.: 43627  
FILED: 04/03/2019

**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: Section 31A-2-201 authorizes the Insurance Commissioner to write rules to implement the provisions of the Insurance Code, Title 31A. Subsection 31A-23a-402(8) authorizes the Insurance Commissioner to define methods of competition, acts, and practices found to be unfair or deceptive. Subsection 31A-22-429 authorizes the Insurance Commissioner to require statements regarding existing insurance and to adopt the notice regarding replacement.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: The Insurance Department has received no written comments regarding this rule during the past five years.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule provides consumer protection and sets minimum standards to be followed by producers and insurers during the replacement of life insurance policies and annuity contracts. This rule informs the consumer, who is contemplating replacing existing coverage, to think about the benefits that the old policy may provide over those in a new policy. Therefore, this rule should be continued.

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 Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

◆ Steve Gooch by phone at 801-538-3803, by FAX at 801-538-3829, or by Internet E-mail at sgooch@utah.gov

AUTHORIZED BY: Steve Gooch, Information Specialist

EFFECTIVE: 04/03/2019

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**Insurance, Administration**  
**R590-98**  
**Unfair Practice in Payment of Life**  
**Insurance and Annuity Policy Values**

**FIVE-YEAR NOTICE OF REVIEW AND STATEMENT  
OF CONTINUATION**

DAR FILE NO.: 43628  
FILED: 04/03/2019

**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: Section 31A-2-201 authorizes the Insurance Commissioner to write rules to implement the provisions of the Insurance Code, Title 31A. Subsection 31A-23a-401(8) authorizes the Insurance Commissioner to define methods of competition, acts, and practices found to be unfair or deceptive.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: The Insurance Department has

received no written comments regarding this rule during the past five years.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule is necessary to protect policyholders who request payment of life and annuity policy values. This rule requires a prompt response by a life insurance and annuity company to a policyholder's request for policy values. This rule limits the exercise of the statutory deferral option to situations in which the financial stability of the insurer is at risk. Some insurers think they can delay payment up to six months; however, such a delay must first be approved by the Insurance Commissioner. Therefore, this rule should be continued.

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 Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

◆ Steve Gooch by phone at 801-538-3803, by FAX at 801-538-3829, or by Internet E-mail at sgooch@utah.gov

AUTHORIZED BY: Steve Gooch, Information Specialist

EFFECTIVE: 04/03/2019

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**Insurance, Administration**  
**R590-166**  
**Home Protection Service Contract Rule**

**FIVE-YEAR NOTICE OF REVIEW AND STATEMENT  
OF CONTINUATION**

DAR FILE NO.: 43626  
FILED: 04/03/2019

**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 31A-2-201(3) authorizes the Insurance Commissioner to adopt rules to implement the provisions of the Insurance Code, Title 31A. Section 31A-6a-110 authorizes the Insurance Commissioner to make rules to enforce Chapter 6a, and establish certain exemptions from its requirements.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: The Insurance Department has received no written comments regarding this rule during the past five years.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule was intended to be a temporary fix to a problem facing home warranty companies having problems finding reimbursement insurance. This rule was intended to be a stop-gap measure to allow them to provide "alternative security" for the warranties they issue until the reimbursement insurance market could be developed. This market has still not been developed to date, making it necessary to keep this rule in effect. Therefore, this rule should be continued.

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 Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:  
 ♦ Steve Gooch by phone at 801-538-3803, by FAX at 801-538-3829, or by Internet E-mail at [sgooch@utah.gov](mailto:sgooch@utah.gov)

AUTHORIZED BY: Steve Gooch, Information Specialist

EFFECTIVE: 04/03/2019

enforce and write rules to implement the provisions of the Insurance Code, Title 31A. Subsection 31A-2-202(4) authorizes the Insurance Commissioner to issue rules requiring timely response to written inquiries from the Commissioner. Subsection 31A-26-301(1) authorizes the Insurance Commissioner to write rules to provide for the timely payment of claims. Section 31A-26-301 and Subsection 31A-21-312(5) authorize rules dealing with proof of loss and notice of loss time limitations under insurance policies. Subsection 31A-26-303(4) authorizes the Insurance Commissioner to write rules to define unfair claims settlement practices or acts.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: The Insurance Department has received no written comments regarding this rule during the past five years.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule is a critical guide for the insurance industry and their insureds to use in the claim settlement and complaint process for automobile, homeowners, and title policies. This rule must be continued to ensure such guidance is available to both consumers and the industry.

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 Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:  
 ♦ Steve Gooch by phone at 801-538-3803, by FAX at 801-538-3829, or by Internet E-mail at [sgooch@utah.gov](mailto:sgooch@utah.gov)

AUTHORIZED BY: Steve Gooch, Information Specialist

EFFECTIVE: 04/03/2019

**Insurance, Administration  
 R590-190**

**Unfair Property, Liability and Title  
 Claims Settlement Practices Rule**

**FIVE-YEAR NOTICE OF REVIEW AND STATEMENT  
 OF CONTINUATION**  
 DAR FILE NO.: 43625  
 FILED: 04/03/2019

**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: Subsections 31A-2-201(1) and 31A-2-201(3) authorize the Insurance Commissioner to

**Insurance, Administration  
 R590-191**

**Unfair Life Insurance Claims  
 Settlement Practices Rule**

**FIVE-YEAR NOTICE OF REVIEW AND STATEMENT  
 OF CONTINUATION**  
 DAR FILE NO.: 43629  
 FILED: 04/03/2019

**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: Subsections 31A-2-201(1) and 31A-2-201(3)(a) authorize the Insurance Commissioner to administer and make rules to implement the provisions of the Insurance Code, Title 31A. Subsection 31A-26-301(1) authorizes the Insurance Commissioner to require timely payment of claims. Section 31A-26-301 and Subsection 31A-21-312(5) authorize rules dealing with proof of loss and notice of loss time limitations under insurance policies. Subsection 31A-26-303(4) authorize the Insurance Commissioner to write rules defining unfair claims settlement practices or acts. Subsection 31A-2-202(4) authorizes the Insurance Commissioner to issue rules requiring timely response to written inquiries from the Commissioner. Section 31A-22-428 authorizes the Insurance Commissioner to require payment of interest on death proceeds.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: The Insurance Department has received no written comments regarding this rule during the past five years.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule is a critical guide for the insurance industry and their insureds to use in the claim settlement and complaint process for life insurance policies. This rule must be continued to ensure such guidance is available to both consumers and the industry.

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 Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:  
♦ Steve Gooch by phone at 801-538-3803, by FAX at 801-538-3829, or by Internet E-mail at [sgooch@utah.gov](mailto:sgooch@utah.gov)

AUTHORIZED BY: Steve Gooch, Information Specialist

EFFECTIVE: 04/03/2019

Money Management Council,  
Administration  
**R628-19**  
Requirements for the Use of  
Investment Advisers by Public  
Treasurers

**FIVE-YEAR NOTICE OF REVIEW AND STATEMENT  
OF CONTINUATION**

DAR FILE NO.: 43645

FILED: 04/12/2019

**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 51-7-18(2) states that the Money Management Council (Council) may make rules establishing standards and requirements for the use of certified investment advisers.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: There have been no written comments either supporting or opposing this rule since the last five-year review.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule describes the basic requirements for public treasurers to be aware of when they consider using an investment adviser to invest public funds. This rule describes the minimum standards that the treasurer needs to assure are in place with the investment adviser, such as certification of an adviser by the Council as described in Rule R628-15, a written advisory services agreement, and the review of SEC form ADV Part II by the treasurer. The Council reviewed this rule in their February meeting and found it current, and noted that this rule needs to be in place as use of advisory services by public treasurers continues to grow. Therefore, this rule should be continued.

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

MONEY MANAGEMENT COUNCIL  
ADMINISTRATION  
ROOM 180 UTAH STATE CAPITOL COMPLEX  
350 N STATE ST  
SALT LAKE CITY, UT 84114  
or at the Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:  
 ♦ Ann Pedroza by phone at 801-538-1883, by FAX at 801-538-1465, or by Internet E-mail at apedroza@utah.gov

AUTHORIZED BY: Douglas DeFries, Chair

EFFECTIVE: 04/12/2019

**Money Management Council,  
 Administration**

**R628-20**

**Foreign Deposits for Higher Education  
 Institutions**

**FIVE-YEAR NOTICE OF REVIEW AND STATEMENT  
 OF CONTINUATION**

DAR FILE NO.: 43646

FILED: 04/12/2019

**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 51-7-11(1)(c) says that a public treasurer may make a deposit in accordance with Section 53B-7-601 in a foreign depository as defined in Section 7-1-103. Section 53B-7-601 allows higher education institutions to deposit funds in a foreign depository for purposes of conducting academic research or clinical activities in that country. These deposits must meet the criteria set forth in the rules of the Money Management Council (Council).

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 either supporting or opposing this rule have been received since it was put in place.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: Utah higher education institutions are opening campuses in other countries and have a need, either dictated by a grant or the country, to open bank accounts in those countries. This rule sets up guidelines to provide rating requirements for financial institutions in those countries, and also prohibits institutions that are subject to sanctions by regulatory bodies or are on a list of high risk jurisdictions. This rule also instructs the higher education institution to monitor the institution they are banking with and report semi-annually on their deposits with these institutions to the Council. Higher education has campuses in other countries

so this rule needs to be continued. The Council reviewed the rule in their February meeting and agreed that it was current and needs to be continued.

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

MONEY MANAGEMENT COUNCIL  
 ADMINISTRATION  
 ROOM 180 UTAH STATE CAPITOL COMPLEX  
 350 N STATE ST  
 SALT LAKE CITY, UT 84114  
 or at the Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:  
 ♦ Ann Pedroza by phone at 801-538-1883, by FAX at 801-538-1465, or by Internet E-mail at apedroza@utah.gov

AUTHORIZED BY: Douglas DeFries, Chair

EFFECTIVE: 04/12/2019

**Money Management Council,  
 Administration**

**R628-21**

**Conditions and Procedures for the Use  
 of Reciprocal Deposits**

**FIVE-YEAR NOTICE OF REVIEW AND STATEMENT  
 OF CONTINUATION**

DAR FILE NO.: 43644

FILED: 04/12/2019

**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: Reciprocal deposits are an allowed investment for public treasurers under Subsection 51-7-11(3)(o). They are to be made in accordance with Subsection 51-7-17(4), which allows deposits to be made in these types of investments outside of Utah, in accordance with rules made by the Money Management Council (Council) under Subsection 51-7-18(2).

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: There have been no written comments regarding reciprocal deposits either for or against.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: The Council reviewed this rule for its

continuation in their monthly meeting, and agreed that it needs to be in place as the instrument is allowed in statute and is directed to rules to provide additional criteria for the investment of public funds in this type of investment. This rule provides the conditions for the use of reciprocal deposits by public treasurers. This includes limits on the amount of public funds a entity may place in the deposits and that the entity must report the amount of public funds they have in these deposits to the Council semi-annually. This rule also requires that the provider of these reciprocal deposits to maintain errors and omission insurance coverage, and also that the provider report these deposits to the Department of Financial Institutions. This provides additional layers of protection for Utah public funds. Therefore, this rule should be continued.

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

MONEY MANAGEMENT COUNCIL  
ADMINISTRATION  
ROOM 180 UTAH STATE CAPITOL COMPLEX  
350 N STATE ST  
SALT LAKE CITY, UT 84114  
or at the Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:  
♦ Ann Pedroza by phone at 801-538-1883, by FAX at 801-538-1465, or by Internet E-mail at [apedroza@utah.gov](mailto:apedroza@utah.gov)

AUTHORIZED BY: Douglas DeFries, Chair

EFFECTIVE: 04/12/2019

## Natural Resources, Wildlife Resources

### **R657-62**

#### Drawing Application Procedures

#### **FIVE-YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION**

DAR FILE NO.: 43639

FILED: 04/09/2019

#### **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: Under authority of Sections 23-14-18 and 23-14-19, the Wildlife Board has established this rule for drawing applications and procedures. Specific season dates, bag and possession limits, areas open, number of permits, and other administrative details that may change annually are published in the respective guidebooks of the Wildlife Board.

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 supporting or opposing Rule R657-62 were received since April 2014, when the rule was last reviewed.

REASONED JUSTIFICATION FOR THE CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: Rule R657-62 provides the authority, standards, and procedures for accepting applications for wildlife drawings. Continuation of this rule is necessary for continued success with the annual drawings.

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 Office of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:  
♦ Staci Coons by phone at 801-538-4718, by FAX at 801-538-4709, or by Internet E-mail at [stacicoons@utah.gov](mailto:stacicoons@utah.gov)

AUTHORIZED BY: Mike Fowlks, Director

EFFECTIVE: 04/09/2019

**End of the Five-Year Notices of Review and Statements of Continuation Section**



## NOTICES OF RULE EFFECTIVE DATES

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State law provides for agencies to make their administrative rules effective and enforceable after publication in the *Utah State Bulletin*. In the case of **PROPOSED RULES** or **CHANGES IN PROPOSED RULES** with a designated comment period, the law permits an agency to make a rule effective no fewer than seven calendar days after the close of the public comment period, nor more than 120 days after the publication date. In the case of **CHANGES IN PROPOSED RULES** with no designated comment period, the law permits an agency to make a rule effective on any date including or after the thirtieth day after the rule's publication date, but not more than 120 days after the publication date. If an agency fails to file a **NOTICE OF EFFECTIVE DATE** within 120 days from the publication of a **PROPOSED RULE** or a related **CHANGE IN PROPOSED RULE** the rule lapses.

Agencies have notified the Office of Administrative Rules that the rules listed below have been made effective.

**NOTICES OF EFFECTIVE DATE** are governed by Subsection 63G-3-301(12), Section 63G-3-303, and Sections R15-4-5a and R15-4-5b.

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### Abbreviations

AMD = Amendment

CPR = Change in Proposed Rule

NEW = New Rule

R&R = Repeal & Reenact

REP = Repeal

### Commerce

Occupational and Professional Licensing

No. 43522 (AMD): R156-15A. State Construction Code Administration and Adoption of Approved State Construction Code Rule

Published: 03/01/2019

Effective: 04/08/2019

### Education

Administration

No. 43511 (REP): R277-117. Utah State Board of Education Protected Documents

Published: 03/01/2019

Effective: 04/08/2019

No. 43512 (AMD): R277-400. School Facility Emergency and Safety

Published: 03/01/2019

Effective: 04/08/2019

No. 43532 (AMD): R277-407. School Fees

Published: 03/01/2019

Effective: 04/08/2019

No. 43515 (NEW): R277-483. LEA Reporting and Accounting Requirements

Published: 03/01/2019

Effective: 04/08/2019

No. 43516 (AMD): R277-486. Professional Staff Cost Program

Published: 03/01/2019

Effective: 04/08/2019

No. 43531 (AMD): R277-495. Required Policies for Electronic Devices in Public Schools

Published: 03/01/2019

Effective: 04/08/2019

No. 43519 (AMD): R277-704. Financial and Economic Literacy: Integration into Core Curriculum and Financial and Economic Literacy Student Passports

Published: 03/01/2019

Effective: 04/08/2019

### Environmental Quality

Waste Management and Radiation Control, Radiation

No. 43530 (AMD): R313-28-31. General and Administrative Requirements

Published: 03/01/2019

Effective: 04/15/2019

Waste Management and Radiation Control, Waste Management

No. 43529 (AMD): R315-15-14. DIYer Reimbursement

Published: 03/01/2019

Effective: 04/15/2019

No. 43526 (AMD): R315-260. Hazardous Waste Management System

Published: 03/01/2019

Effective: 04/15/2019

No. 43527 (AMD): R315-261. General Requirements — Identification and Listing of Hazardous Waste

Published: 03/01/2019

Effective: 04/15/2019

No. 43528 (AMD): R315-262. Hazardous Waste Generator Requirements

Published: 03/01/2019

Effective: 04/15/2019

NOTICES OF RULE EFFECTIVE DATES

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Human Services

Child and Family Services

No. 43518 (AMD): R512-43. Adoption Assistance

Published: 03/01/2019

Effective: 04/08/2019

Public Safety

Fire Marshal

No. 43455 (NEW): R710-12. Hazardous Materials Training and Certification

Published: 01/15/2019

Effective: 04/09/2019

**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 2, 2019 through April 15, 2019. The Rules Index is published in the Utah State Bulletin and in the annual Utah Administrative Rules 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).

Questions regarding the index and the information it contains should be addressed to the Office of Administrative Rules (801-538-3003).

A copy of the **RULES INDEX** is available for public inspection at the Office of Administrative Rules (5110 State Office Building, Salt Lake City, UT), or may be viewed online at the Office's web site (<https://rules.utah.gov/>).

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**RULES INDEX - BY AGENCY (CODE NUMBER)**

**ABBREVIATIONS**

AMD = Amendment (Proposed Rule)	LNR = Legislative Nonreauthorization
CPR = Change in Proposed Rule	NEW = New Rule (Proposed Rule)
EMR = 120-Day (Emergency) Rule	NSC = Nonsubstantive Rule Change
EXD = Expired Rule	R&R = Repeal and Reenact (Proposed Rule)
EXP = Expedited Rule	REP = Repeal (Proposed Rule)
EXT = Five-Year Review Extension	5YR = Five-Year Notice of Review and Statement of Continuation
GEX = Governor's Extension	

CODE REFERENCE	TITLE	FILE NUMBER	ACTION	EFFECTIVE DATE	BULLETIN ISSUE/PAGE
<b>ADMINISTRATIVE SERVICES</b>					
<u>Facilities Construction and Management</u>					
R23-3	Planning, Programming, Request for Capital Development Projects and Operation and Maintenance Reporting for State Owned Facilities	43524	NSC	03/01/2019	Not Printed
R23-3	Planning, Programming, Request for Capital Development Projects and Operation and Maintenance Reporting for State Owned Facilities	43569	5YR	03/06/2019	2019-7/59
R23-23	Health Reform -- Health Insurance Coverage in State Contracts -- Implementation	43642	5YR	04/11/2019	Not Printed
R23-29	Delegation of Project Management	43525	NSC	03/01/2019	Not Printed
R23-29	Delegation of Project Management	43567	5YR	03/06/2019	2019-7/60
R23-33	Rules for the Prioritization and Scoring of Capital Improvements by the Utah State Building Board	43568	5YR	03/06/2019	2019-7/60
<u>Finance</u>					
R25-10	State Entities' Posting of Financial Information to the Utah Public Finance Website	43404	AMD	01/23/2019	2018-24/6
R25-11	Utah Transparency Advisory Board, Procedures for Electronic Meetings	43471	5YR	01/07/2019	2019-3/43
<u>Risk Management</u>					
R37-4	Adjusted Utah Governmental Immunity Act Limitations on Judgments	43235	AMD	01/18/2019	2018-21/2
<b>AGRICULTURE AND FOOD</b>					
<u>Animal Industry</u>					
R58-20	Domesticated Elk Hunting Parks	43469	5YR	01/07/2019	2019-3/43
<u>Marketing and Development</u>					
R65-1	Utah Apple Marketing Order	43546	NSC	03/13/2019	Not Printed
R65-5	Utah Red Tart and Sour Cherry Marketing Order	43547	NSC	03/13/2019	Not Printed
R65-8	Management of the Junior Livestock Show Appropriation	43545	NSC	03/13/2019	Not Printed
R65-11	Utah Sheep Marketing Order	43548	NSC	03/13/2019	Not Printed
R65-12	Utah Small Grains and Oilseeds Marketing Order	43549	NSC	03/13/2019	Not Printed
R65-12	Utah Small Grains and Oilseeds Marketing Order	43641	5YR	04/11/2019	Not Printed

<u>Plant Industry</u>						
R68-25	Industrial Hemp Research Pilot Program for Processors	43571	NSC	03/21/2019	Not Printed	
COMMERCE						
<u>Consumer Protection</u>						
R152-34a	Utah Postsecondary School State Authorization Act Rule	43612	5YR	04/01/2019	2019-8/101	
<u>Occupational and Professional Licensing</u>						
R156-15A	State Construction Code Administration and Adoption of Approved State Construction Code Rule	43522	AMD	04/08/2019	2019-5/8	
R156-20a (Changed to R156-20b)	Environmental Health Scientist Act Rule	43466	NSC	01/11/2019	Not Printed	
R156-28	Veterinary Practice Act Rule	43189	AMD	03/25/2019	2018-19/7	
R156-28	Veterinary Practice Act Rule	43189	CPR	03/25/2019	2019-4/40	
R156-60	Mental Health Professional Practice Act Rule	43543	5YR	02/26/2019	2019-6/41	
R156-80a	Medical Language Interpreter Act Rule	43465	5YR	01/02/2019	2019-2/19	
<u>Real Estate</u>						
R162-2f	Real Estate Licensing and Practices Rules	43407	AMD	01/23/2019	2018-24/8	
CORRECTIONS						
<u>Administration</u>						
R251-105	Applicant Qualifications for Employment with Department of Corrections	43218	AMD	02/11/2019	2018-20/12	
R251-111	Government Records Access and Management	43596	5YR	03/19/2019	2019-8/102	
EDUCATION						
<u>Administration</u>						
R277-100	Definitions for Utah State Board of Education (Board) Rules	43479	AMD	03/13/2019	2019-3/2	
R277-117	Utah State Board of Education Protected Documents	43511	REP	04/08/2019	2019-5/19	
R277-122	Board of Education Procurement	43441	AMD	02/07/2019	2019-1/17	
R277-308	New Educator Induction and Mentoring	43442	NEW	02/07/2019	2019-1/22	
R277-400	School Facility Emergency and Safety	43507	5YR	02/08/2019	2019-5/95	
R277-400	School Facility Emergency and Safety	43512	AMD	04/08/2019	2019-5/21	
R277-404	Requirements for Assessments of Student Achievement	43450	AMD	02/22/2019	2019-2/6	
R277-407	School Fees	43532	AMD	04/08/2019	2019-5/25	
R277-419	Pupil Accounting	43475	NSC	01/15/2019	Not Printed	
R277-437	Student Enrollment Options	43397	AMD	01/09/2019	2018-23/6	
R277-463	Class Size Average and Pupil-Teacher Ratio Reporting	43636	5YR	04/08/2019	Not Printed	
R277-470	Charter Schools - General Provisions	43374	REP	01/09/2019	2018-23/9	
R277-472	Charter School Student Enrollment and Transfers and School District Capacity Information	43637	5YR	04/08/2019	Not Printed	
R277-481	Charter School Oversight, Monitoring and Appeals	43399	REP	01/09/2019	2018-23/12	
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R277-502-4	License Levels, Procedures, and Periods of Validity	43600	NSC	04/01/2019	Not Printed
R277-509	Licensure of Student Teachers and Interns	43373	AMD	01/09/2019	2018-23/19
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R277-551	Charter Schools - General Provisions	43478	AMD	03/13/2019	2019-3/10
R277-552	Charter School Timelines and Approval Processes	43394	NEW	01/09/2019	2018-23/26
R277-553	Charter School Oversight, Monitoring and Appeals	43401	NEW	01/09/2019	2018-23/31
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R277-600	Student Transportation Standards and Procedures	43375	AMD	01/09/2019	2018-23/38
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R277-724	Criteria for Sponsors Recruiting Day Care Facilities in the Child and Adult Care Food Program	43579	5YR	03/13/2019	2019-7/61
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R277-912	Law Enforcement Related Incident Reporting	43439	NEW	02/07/2019	2019-1/26
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R309-210-8	Disinfection Byproducts - Stage 1 Requirements	43382	AMD	01/15/2019	2018-23/80
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R309-215-10	Residual Disinfectant	43384	AMD	01/15/2019	2018-23/91
R309-215-16	Groundwater Rule	43385	AMD	01/15/2019	2018-23/93
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**ABBREVIATIONS**

AMD = Amendment (Proposed Rule)	LNR = Legislative Nonreauthorization
CPR = Change in Proposed Rule	NEW = New Rule (Proposed Rule)
EMR = 120-Day (Emergency) Rule	NSC = Nonsubstantive Rule Change
EXD = Expired Rule	R&R = Repeal and Reenact (Proposed Rule)
EXP = Expedited Rule	REP = Repeal (Proposed Rule)
EXT = Five-Year Review Extension	5YR = Five-Year Notice of Review and Statement of Continuation
GEX = Governor's Extension	

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	43212	R307-110-10	CPR	03/05/2019	2019-3/40
	42976	R307-110-17	AMD	01/03/2019	2018-13/35
	42976	R307-110-17	CPR	01/03/2019	2018-21/134
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	43211	R307-511	CPR	03/05/2019	2019-3/41
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	43401	R277-553	NEW	01/09/2019	2018-23/31
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	43371	R884-24P-27	AMD	01/10/2019	2018-23/119
	43438	R884-24P-74	AMD	03/28/2019	2019-1/54
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	43400	R277-550	NEW	01/09/2019	2018-23/21	
	43393	R277-551	NEW	01/09/2019	2018-23/24	
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hemp oil

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higher education

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	43429	R590-186-5	AMD	02/07/2019	2019-1/31	
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	43485	R590-102-21	AMD	03/26/2019	2019-4/4	
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	43356	R501-7	AMD	02/12/2019	2018-23/105
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	43483	R414-516	AMD	03/21/2019	2019-3/23
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