NOTICES OF PROPOSED RULEMAKING

Unless exempted by A.R.S. § 41-1005, each agency shall begin the rulemaking process by first submitting to the Secretary of State's Office a Notice of Rulemaking Docket Opening followed by a Notice of Proposed Rulemaking that contains the preamble and the full text of the rules. The Secretary of State's Office publishes each Notice in the next available issue of the *Register* according to the schedule of deadlines for *Register* publication. Under the Administrative Procedure Act (A.R.S. § 41-1001 et seq.), an agency must allow at least 30 days to elapse after the publication of the Notice of Proposed Rulemaking in the *Register* before beginning any proceedings for making, amending, or repealing any rule. (A.R.S. §§ 41-1013 and 41-1022)

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 27. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) HEALTH CARE FOR PRIVATE EMPLOYER GROUPS/AHCCCS ADMINISTERED

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-27-101	Amend
R9-27-201	Amend
R9-27-202	Amend
R9-27-203	Amend
R9-27-204	Amend
R9-27-205	Amend
R9-27-206	Amend
R9-27-207	Amend
R9-27-208	Amend
R9-27-209	Amend
R9-27-210	Amend

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

Authorizing statute: A.R.S. § 36-2903.01 (F)

Implementing statute: A.R.S. § 36-2912 (I) (5)

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

Notice of Rulemaking Docket Opening: 10 A.A.R. 4489, November 5, 2004

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

Name: Jane McVay

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

Telephone: (602) 417-4135

Fax: (602) 253-9115

E-mail: AHCCCSRules@ahcccs.state.az.us

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

Healthcare Group was created as a division within the Administration in 1985 to provide affordable and accessible health care benefit plans for Arizona small businesses with 50 or less employees. According to a study by St. Luke's Health Initiatives, only 30% of these small Arizona employers offer health care coverage to their employees. Many of these employees are low wage earners, whose income is on the verge of eligibility for AHCCCS coverage. Legislation was enacted in 2004, which allows Healthcare Group to offer health care benefit plans to employees of political subdivisions in the state, in addition to small businesses. Currently, Healthcare Group insures over 11,000 persons in the state.

The Administration is updating the Healthcare Group rules on program-related definitions and the scope of services in order to conform them to current practice and to make them more clear, concise, and understandable. The Group Service Agreement (GSA), the contract that employer groups sign with Healthcare Group, contains many provisions pertaining to the scope of Healthcare Group services. Because these provisions should not be duplicated in the rules, some language is removed from the rules.

In order to continue to provide health care coverage to an increasing number of employees and to help reduce the substantial number of uninsured Arizona citizens, Healthcare Group intends to offer a greater variety of affordable health care benefit plans. This will allow employees in the rural areas of the state, in which Healthcare Group coverage is not currently available, to obtain affordable health care coverage. A greater number and more diverse types of benefit plans will be offered to employees, who may otherwise not have affordable health care coverage.

Additional provisions are added to the rule to conform to emergency medical service provisions of the Balanced Budget Act of 1997 for Healthcare Group members receiving out of network emergency services.

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

The Administration did not review any studies relating to the rule.

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

The rule has no impact on the authority of political subdivisions.

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

The availability of affordable health care coverage to employees, who might otherwise be eligible for health care coverage from AHCCCS, will have a positive economic impact on the state due to savings of state general fund appropriations. According to a study by St. Luke's Health Initiatives, small businesses provide health care coverage to approximately 30 percent of Arizona's citizens. Many businesses and employees are unable to find affordable health care coverage. Over 1,000,000 persons currently receive health care services under all the AHCCS programs. The availability of additional health care coverage options through Healthcare Group may provide an option for this population to obtain affordable health care coverage. In addition, the availability of more Healthcare Group Plans benefits employees and businesses, who will have additional health care coverage plan options from which to choose. Expansion of health care coverage will benefit consumers, particularly in rural areas, who have limited health care coverage choices.

Health care coverage plans are currently provided by commercial insurers who contract with Healthcare Group. Healthcare Group plans to continue to invite commercial insurers to provide health care coverage to Arizonans, so the approval of these rules will not have a negative impact on commercial insurers. In addition, the statutory requirement for employees to have a “bare period” of 180 days with no health care coverage in order to be eligible to enroll in Healthcare Group Plans, ensures that these employees did not have health care coverage during this period through a commercial insurance company. Finally, Healthcare Group is not competing with commercial insurers to insure the same employees because many of them work part-time, work in high-risk businesses with environmental problems, or work in small businesses. For these reasons, commercial insurers are not interested in insuring these employees.

Availability of affordable health care coverage through Healthcare Group provides an important option for unemployed persons who meet the eligibility requirements to obtain health care coverage. By increasing the number of insured persons who enroll in more benefit plans, state funds will be saved that have provided financial support to Healthcare Group and AHCCCS programs. Many uninsured employees wait until they have an illness or emergency and “spend down” to become eligible for AHCCCS coverage. The increase to over 1,000,000 Arizonans receiving health care coverage through AHCCCS has created a huge medical and financial liability for the state. The rate of growth of AHCCCS' uninsured population far exceeds the rate of growth of the state general fund. The result will be a structural deficit in the future with inadequate money in the state general fund to pay health care costs for an increasing AHCCCS membership. For these reasons, these rules will have a positive economic impact on small business, consumers, and the state.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name:	Jane McVay
Address:	AHCCCS Office of Legal Assistance 701 E. Jefferson, Mail Drop 6200 Phoenix, AZ 85034
Telephone:	(602) 417-4135
Fax:	(602) 253-9115

E-mail: AHCCCSRules@ahcccs.state.az.us

Proposed rule language will be available on the AHCCCS web site www.ahcccs.state.az.us the week of November 29, 2004. Please send written comments to the above address by 5:00 p.m., January 31, 2005. E-mail comments will be accepted.

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

Date: January 31, 2005
Time: 10:00 a.m.
Location: AHCCCS
701 East Jefferson, Gold Room
Phoenix, AZ 85034
Nature: Public Hearing

Date: January 31, 2005
Time: 10:00 a.m.
Location: ALTCS: Arizona Long-term Care System
110 South Church, Suite 1360
Tucson, AZ 85701
Nature: Public Hearing

Date: January 31, 2005
Time: 10:00 a.m.
Location: ALTCS: Arizona Long-term Care System
3480 East Route 66, Conference Room
Flagstaff, AZ 86004
Nature: Public Hearing

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

Not applicable

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

None

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 27. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM HEALTH CARE FOR PRIVATE EMPLOYER GROUPS/AHCCCS ADMINISTERED

ARTICLE 1. DEFINITIONS

Section
R9-27-101. Location of Definitions

ARTICLE 2. SCOPE OF SERVICES

Section
R9-27-201. ~~Scope of Services~~ Repealed
R9-27-202. Covered Services
R9-27-203. Exclusions and Limitations
R9-27-204. ~~Out-of-service Area Coverage~~ Out of Network Coverage of Emergency Medical Services
R9-27-205. ~~Outpatient Health Services~~ Repealed
R9-27-206. ~~Laboratory, Radiology, and Medical Imaging Services~~ Repealed
R9-27-207. ~~Pharmaceutical Services~~ Repealed
R9-27-208. ~~Inpatient Hospital Services~~ Repealed

R9-27-209. ~~Emergency Medical Services~~ Repealed
R9-27-210. Pre-existing Conditions

ARTICLE 1. DEFINITIONS

R9-27-101. Location of Definitions

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

Definition	Section or Citation
"Accountable health plan"	A.R.S. § 20-2301
"ADHS"	R9-27-101
"AHCCCS"	R9-27-101
~~"Administrative law judge"~~	~~A.R.S. § 41-1092~~
~~"Adverse action"~~	~~R9-27-101~~
~~"Administrative review"~~	~~R9-27-101~~
"Ambulance"	A.R.S. § 36-2201
"Certification"	29 U.S.C. 1181
"Clean claim"	A.R.S. § 36-2904
"COBRA continuation provisions	A.R.S. § 36-2912
"Coinsurance"	R9-27-101
~~"Complainant"~~	~~R9-27-101~~
"Copayment"	R9-27-101
"Covered services"	R9-27-101
"Creditable coverage"	A.R.S. § 36-2912
~~"Date of notice"~~	~~R9-27-101~~
"Day"	R9-27-101
"Deductible"	R9-27-101
"Dependent"	R9-27-101
"Disability"	R9-27-101
~~"Durable medical equipment" or "DME"~~	~~R9-27-101~~
"Eligible employee"	A.R.S. § 36-2912
"Emergency ambulance service"	R9-27-101
"Emergency medical services"	R9-27-101
~~"Employer group"~~	~~R9-27-101~~
"Employee member"	R9-27-101
"Employer group"	R9-27-101
"Enrollment"	R9-27-101
"Experimental services"	R9-22-101
"FDA"	R9-27-101
"Full-time employee"	R9-27-101
~~"Grievance"~~	~~R9-27-101~~
~~"Group Service Agreement" or~~ "GSA"	R9-27-101
~~"Healthcare Group Administration" or "HCGA"~~	~~R9-27-101~~
"HCG"	R9-27-101
"HCGA"	R9-27-101
"HCG benefit plan"	R9-27-101
"HCG Plan"	R9-27-101
"Health care coverage"	R9-27-101
"Health care practitioner"	R9-27-101
~~"Hearing"~~	~~R9-27-101~~
"Hospital"	R9-27-101
"Inpatient hospital services"	R9-27-101
~~"Late enrollee"~~	~~A.R.S. § 36-2912~~
~~"Life threatening"~~	~~R9-27-101~~
~~"Medical record"~~	~~R9-27-101~~
"Medical services"	A.R.S. § 36-401
"Medically necessary"	R9-27-101
"Member"	R9-27-101
"Member handbook and evidence of coverage" or "member handbook"	R9-27-101

"Network"	R9-27-101
"Network provider"	R9-27-101
~~"Noncontracting provider"~~	~~R9-27-101~~
~~"Office of Administrative Hearings" or "OAH"~~	~~A.R.S. § 41-1092~~
~~"Outpatient service"~~	~~R9-27-101~~
~~"Party"~~	~~R9-27-101~~
~~"Pharmaceutical service"~~	~~R9-27-101~~
~~"Physician service"~~	~~R9-27-101~~
"Political subdivision"	R9-27-101
"Pre-existing condition"	A.R.S. § 36-2912
"Pre-existing condition exclusion"	A.R.S. § 36-2912
"Premium"	R9-27-101
"Pre-payment"	R9-27-101
~~"Prescription"~~	~~R9-27-101~~
~~"Primary care practitioner"~~	~~R9-27-101~~
~~"Primary care provider"~~	~~R9-27-101~~
"Prior authorization"	R9-27-101
"Qualifying event"	R9-27-101
~~"Quality management"~~	~~R9-27-101~~
~~"Referral"~~	~~R9-27-101~~
"Renewal date"	R9-27-101
~~"Respondent"~~	~~R9-27-101~~
"Scope of services"	R9-27-101
~~"Service area"~~	~~R9-27-101~~
"Spouse"	R9-27-101
"Subcontract"	R9-27-101
"Substantial gainful activity"	R9-27-101
~~"Utilization control"~~	~~R9-27-101~~
~~"Utilization review"~~	~~R9-27-101~~
"Waiting period"	A.R.S. § 36-2912

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

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

"AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to an eligible member.

~~"Adverse action" means any action under this Chapter, including adverse eligibility actions, for which a party may file a grievance or request a hearing under A.R.S. § 41-1092 et seq. under 9 A.A.C. 27, Article 6.~~

~~"Administrative review" means that portion of the grievance process beginning with the filing of a grievance with the Administration or its contractor and concluding with the issuance of a final decision by the Administration or its contractor that advises the party of formal hearing rights under A.R.S. § 41-1092 et seq.~~

"Coinsurance" means a predetermined amount a member agrees to pay to a provider for covered services. A coinsurance payment is a percentage of the fee schedule rate for the services.

~~"Complainant" means an applicant, member, person, or entity filing a grievance or request for hearing.~~

"Copayment" means a monetary amount specified by the HCGA that a member or dependent pays directly to a provider at the time a covered service is rendered.

"Covered services" means the health and medical services described in 9 A.A.C. 27, Article 2~~.~~, the GSA, and the member handbook.

~~"Date of notice" means the date on a notice of action.~~

"Day" means a calendar day unless otherwise specified in the text.

"Deductible" means a fixed annual dollar amount a member agrees to pay for certain covered services before the HCG plan agrees to pay.

"Dependent" means the eligible spouse and children of an employee member under 9 A.A.C. 27, Article 3. "Disability" means the inability to do any substantial gainful activity by reason of any impairment (or combination of impairments) which is expected to be permanent and continuous. The impairment must result from anatomical, physiological or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques. An impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by the member's statement of symptoms.

"~~Durable Medical Equipment" or "DME" means durable items or appliances, as determined by the HCG Plan to be a medically necessary item or supply and a benefit under the Employer's GSA. The DME is:~~
~~Able to withstand repeated use;~~
~~Designed to serve a medical purpose;~~
~~Generally not useful to a person in the absence of a medical condition, illness, or injury;~~
~~Not customarily found in a physician's office;~~
~~Is not disposable; and~~
~~Is needed for functional rather than cosmetic reasons~~.
"Effective date of coverage" means the date on which an employee can receive HCG coverage.
"Emergency ambulance service" means~~:~~ transportation by a ground or an air ambulance company for a member requiring emergency medical services in which the emergency medical services are provided by a person certified by ADHS to provide the services before, during, or after a member is transported by a ground or an air ambulance company.
~~Transportation by an ambulance or air ambulance company for a member requiring emergency medical services. Emergency medical services that are provided by a person certified by ADHS to provide the services before, during, or after a member is transported by an ambulance or air ambulance company.~~
"Emergency medical services" means medical services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention ~~could reasonably be expected~~ to result in:
Placing a patient's health in serious jeopardy,
Serious impairment to bodily functions, or
Serious dysfunction of any bodily organ.
~~"Employer group" means the aggregate enrollment of an employer group or business with a HCG Plan for covered services.~~
"Employee member" means an enrolled employee of an employer group~~.~~, or a person who is self-employed, or a person who is eligible for a federal health coverage tax credit under Section 35 of the Internal Revenue Code of 1986. A self-employed person shall meet the criteria specified in A.A.C. R9-27-301.
"Employer group" means a group that meets the criteria specified in R9-27-301. An employer group also includes a self-employed person who meets the criteria specified in R9-27-301.
"Enrollment" means the process ~~by~~ in which an ~~applicant applies for coverage under an employer group contracted with HCGA.~~ eligible employee and dependents, if any, qualify to receive HCG services by selecting an HCG benefit plan, completing and submitting all necessary documentation specified by HCGA under R9-27-302, HCG provides the eligible employee and dependent with written notification of the effective date of coverage, and the HCGA Plan receives the full required premium no later than the date specified in the GSA.
"Experimental services" means services that are associated with treatment or diagnostic evaluation that are not generally and widely accepted as a standard of care in the practice of medicine in the United States unless:
1. The authoritative evidence of peer reviewed articles in medical journals published in the United States documents the safety and effectiveness of the service, or
2. For services which are rarely used, novel, or relatively unknown in the general professional medical community, there is authoritative evidence of the safety and effectiveness of the service from specialists who provide such services.
"FDA" means the U.S. Food and Drug Administration.
"Full-time employee" means an employee who works at least 20 hours per week and expects to continue employment for at least five months following enrollment.
~~"Grievance" means a complaint that initiates an administrative review that does not involve a hearing under A.R.S. § 41-1092 et seq. A party may request a hearing under A.R.S. § 41-1092 et seq. after an administrative review.~~
"GSA" means Group Service Agreement, a contract between an employer group and HCGA~~.~~, or between HCGA and a person eligible for the federal health coverage tax credit.
~~"Healthcare Group Administration" or "HCGA" means the section within AHCCCS that directs, determines eligibility, and regulates the continuous development and operation of the HCG Program.~~
"HCG" means Healthcare Group of Arizona, the registered name of the Healthcare Group Program, a ~~prepaid~~ medical coverage product marketed by the HCGA to small uninsured businesses and political subdivisions within the state.
"HCGA" means the section within AHCCCS that directs, determines eligibility, and regulates the continuous development and operation of the HCG Program.
"HCG benefit plan" means the scope of health care and prescription benefit coverage that the member selects on enrollment or renewal.
"HCG Plan" means a ~~Healthcare Group prepaid health plan~~ health plan offered by HCG or by an entity that is ~~cur-~~

~~rently~~ under contract with the HCGA to provide covered or administrative services to ~~a member of an employer group.~~ members.

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

1. Accident only, dental only, vision only, disability income only or long-term care only insurance, fixed or hospital indemnity coverage, limited benefit coverage, specified disease coverage, credit coverage or Taft-Hartley trusts.
2. Coverage that is issued as a supplement to liability insurance.
3. Medicare supplemental insurance.
4. Workers' compensation insurance.
5. Automobile medical payment insurance.

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

~~Physician,~~
~~Physician assistant,~~
~~Nurse practitioner; or~~
~~Other person who is licensed or certified under Arizona law to deliver health care services.~~

~~"Hearing" means an administrative hearing under Title 41, Chapter 6, Article 10.~~

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

"Inpatient hospital services" means ~~a medically necessary service that requires an inpatient stay in~~ services received at ~~an acute care~~ a hospital~~.~~ that result in an inpatient admission. An inpatient hospital service is provided by or under the direction of a physician or other health care practitioner upon referral from a member's primary care provider.

~~"Life threatening" means any condition for which a delay in obtaining pre-authorization or traveling to an approved medical facility would have a severe adverse effect on a patient's condition.~~

~~"Medical record" means a single, complete record kept at the site of a member's primary care provider that documents the medical services received by a member, including inpatient discharge summary, outpatient care, and emergency care.~~

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

Prevent disease, disability, and other adverse health condition or its progression; or Prolong life.

"Member" means an employee member or a dependent who is enrolled with an HCG Plan.

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

"Network" means the providers who have subcontracts with HCG health plans in which members are enrolled.

"Network provider" means a provider who renders covered services to a member and has a subcontract with the member's HCG Plan.

~~"Noncontracting provider" means a provider who renders covered services to a member but who does not have a subcontract with the member's HCG Plan.~~

~~"Outpatient service" means a medically necessary service that may be provided in any setting on an outpatient basis that does not require an overnight stay in an inpatient hospital. An outpatient service is provided by or under the direction of a physician or other health care practitioner, upon referral from a member's primary care provider.~~

~~"Party" means a person or entity by or against whom a grievance or request for hearing is brought.~~

~~"Pharmaceutical service" means a medically necessary medication prescribed by a physician, a practitioner, or a dentist upon referral by a primary care provider and dispensed under 9 A.A.C. 27, Article 2.~~

~~"Physician service" means a service provided within the scope of practice of medicine or osteopathy as defined by state law, by, or under the direction of a person licensed under state law to practice medicine or osteopathy.~~

"Political subdivision" means the state of Arizona, a county, a city, a town, or a school district within the state~~.~~, or another entity whose employees are eligible for hospitalization and medical care under Arizona Revised Statutes, Title 38, Chapter 4, Article 4.

"Premium" means the monthly pre-payment amount ~~submitted~~ due to HCGA by the employer group.

"Pre-payment" means submission of the employer group's full premium payment at least 30 days in advance of ~~the effective date of~~ coverage under the GSA. ~~under 9 A.A.C. 27, Article 3.~~

~~"Prescription" means an order for covered services for a member that is signed or transmitted by a provider licensed~~

~~under applicable state law to prescribe or order the service~~.
~~"Primary care practitioner" means a physician assistant or a registered nurse practitioner who is certified and practicing in an appropriate affiliation with a physician, as authorized by law.~~
~~"Primary care provider" means a member's primary care physician or a primary care practitioner.~~
"Prior authorization" means the process by which the HCG Plan authorizes, in advance, the delivery of a covered service~~.~~, but is not a guarantee of payment.
"Qualifying event" means a situation that enables an individual to enroll outside a designated open enrollment period or to obtain continuation coverage, if applicable.
~~"Quality management" means a methodology used by professional health personnel to assess the degree of conformance to desired medical standards and practices and to implement activities designed to continuously improve and maintain quality service and care, and which is performed through a formal program with involvement of multiple organizational components and committees.~~
~~"Referral" means the process by which a primary care provider directs a member to another appropriate provider or resource for diagnosis or treatment.~~
"Renewal date" means the annual anniversary date for an employer group, which occurs one year from the date that the GSA for the employer group became effective.
~~"Respondent" means a party responsible for the adverse action that is the subject of a grievance or request for hearing~~.
"Scope of services" means the covered, limited, and excluded services listed in 9 A.A.C. 27, Article 2~~.~~, the GSA, and the member handbook.
~~"Service area" means the geographic area designated by HCGA where each HCG Plan shall provide covered health care benefits to members directly or through subcontracts.~~
"Spouse" means a husband or a wife of an HCG member who has entered into a marriage recognized as valid by Arizona.
"Subcontract" means an agreement entered into by HCGA or an HCG Plan with any of the following:
A provider of health care services who agrees to furnish covered services to members,
A marketing organization, or
Any other organization to serve the needs of the HCG Plan or HCGA.
"Substantial gainful activity" means work that:
Involves doing significant and productive physical or mental duties; and
Is done (or intended) for pay or profit.
~~"Utilization control" means an overall accountability program encompassing quality management and utilization review.~~
~~"Utilization review" means a methodology used by professional health personnel to assess the medical indications, appropriateness, and efficiency of care provided~~.

ARTICLE 2. SCOPE OF SERVICES

R9-27-201. ~~Scope of Services~~ Repealed

~~**A.** HCGA shall provide a list of covered services to each HCG Health Plan. Each HCG Plan shall provide, either directly or through subcontracts, a list of the covered services specified in this Article.~~
~~**B.** Provision of covered services. The HCG Plans shall ensure that covered services are provided by, or under the direction of, a primary care provider.~~
~~**C.** Scope of covered services. An HCG Plan shall not further delineate, expand, or limit the list of covered services beyond the standard covered services under this Article, or GSA~~.

R9-27-202. Covered Services

Covered services. Subject to the exclusions and limitations specified in ~~these rules~~ this Article, ~~and~~ the GSA, and the member handbook, and subject to coinsurance, copayments and deductible requirements, an HCG Plan shall cover ~~the following services:~~ services specified under the GSA. Not all medically necessary services are covered services.

~~1. Outpatient services;~~
~~2. Laboratory, radiology, and medical imaging services;~~
~~3. Prescription drugs;~~
~~4. Inpatient hospital services;~~
~~5. Emergency medical services under R9-27-209 in and out of the service area;~~
~~6. Emergency ambulance services;~~
~~7. Maternity care;~~
~~8. Cornea transplants;~~
~~9. Kidney transplants;~~
~~10. Durable medical equipment, orthotics, and prostheses as specified in the GSA; and~~

~~11. Other services as agreed under the GSA.~~

R9-27-203. Exclusions and Limitations

~~**A.** Excluded medical services. Any medical service not specifically provided for in this Article is not a covered medical service.~~

~~**B.**~~**A.** Excluded services. An HCG Plan shall not cover the following:

~~1. Services or items furnished solely for cosmetic purposes except for breast reconstruction performed by an HCG Plan following a mastectomy, and services or items provided to reconstruct or improve personal appearance after an illness or injury as specified in the GSA;~~
~~2. Services or items requiring prior authorization for which prior authorization has not been obtained;~~
~~3. Services or items furnished gratuitously or for which charges are not usually made;~~
~~4. Hearing aids, eye examinations for prescriptive lenses, prescriptive lenses and surgery for the correction of myopia;~~
~~5. Long-term care services, including nursing services;~~
~~6. Private or special duty nursing services, provided in a hospital unless medically necessary and prior authorized by the HCG Plan Medical Director.~~
~~7. Care for health conditions that are required by state or local law to be treated in a public facility;~~
~~8. Care for military service disabilities treatable through governmental facilities if the member is legally entitled to treatment and the facilities are reasonably available;~~
~~9. Gastric stapling or diversion for weight loss;~~
~~10. Reports, evaluations, or physical examinations not required for health reasons including employment, insurance, or governmental licenses, sports, and court-ordered forensic or custodial evaluations;~~
~~11. Treatment of temporomandibular joint dysfunction, unless treatment is prior authorized and determined medically necessary by the HCG Plan Medical Director or designee;~~
~~12. Pregnancy termination under A.R.S. § 35-196.02;~~
~~13. Medical and hospital care and costs for the child of a dependent, unless the child is otherwise eligible under the GSA;~~
~~14. Nonmedical ancillary services including vocational rehabilitation, employment counseling, psychological counseling and training, and physical therapy for learning disabilities;~~
~~15. Treatment of gender dysphoria including gender reassignment surgeries and reversal of voluntarily induced infertility (sterilization);~~
~~16. Services not deemed medically necessary by the HCG Plan Medical Director, or the responsible primary care provider;~~
~~17. Routine foot care;~~
~~18. Blood products, blood derivatives, synthetic blood, including artificial and genetic derivatives and coagulation factors and the associated charges for the administrative costs which are separately billed;~~
~~19. Organ transplants except as specified in R9-27-202;~~
~~20. Bone marrow transplants including autologous, allogeneic-related, and allogeneic-unrelated;~~
~~21. Mental health services;~~
~~22. Acupuncture;~~
~~23. Dental services;~~
~~24. Transportation other than emergency ambulance services;~~
~~25. Psychotherapeutic drugs;~~
~~26. Charges for injuries incurred as the result of:~~
~~a. Participating in a riot;~~
~~b. Committing, or attempting to commit a felony or assault;~~
~~c. Committing intentional acts of self inflicted injuries; or~~
~~d. Attempting suicide.~~
~~27. Infertility testing, in vitro fertilization and all other fertilization treatments;~~
~~28. Allergy testing and hyposensitization treatment;~~
~~29. Experimental services as determined by the HCGA, or services provided primarily for the purpose of research;~~
~~30. Alternative medicine;~~
~~31. Chiropractic services;~~
~~32. Osteopathic manipulation therapy; and~~
~~33. Other services under the GSA.~~

1. Excluded services as specified in the GSA and the member handbook.
2. Services not covered in the member's choice of HCG benefit options;
3. Services which require prior authorization for which prior authorization has not been obtained;
4. Care for health conditions that are required by state or local law to be treated in a public facility;
5. Care for military service disabilities treatable through governmental facilities if the member is legally entitled to treatment and the facilities are reasonably available;

6. Pregnancy termination, except as required by law;
7. Treatment of gender dysphoria including gender reassignment surgeries and reversal of voluntarily induced infertility (sterilization);
8. Services not deemed medically necessary;
9. Charges for injuries incurred as the result of:
   a. Participating in a riot;
   b. Committing, or attempting to commit a felony or assault;
   c. Committing intentional acts of self inflicted injuries; or
   d. Attempting suicide.
10. Infertility testing, in vitro fertilization and all other fertilization treatments;
11. Experimental services as determined by the HCGA; and
12. Medications not approved by the FDA for the purpose prescribed;

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

1. Inpatient hospital accommodations are ~~limited to no more than a semi-private rate, except when a patient must be isolated for medical reasons.~~ as specified in the GSA and the member handbook.
2. Alternative levels of care instead of hospitalization are covered if cost-effective and medically necessary as determined by the HCG Plan Medical Director, or designee.
3. Dialysis is limited to services not covered by Title XVIII, of the Social Security Act, as amended.
4. ~~Hospice services are limited to the terms in the GSA.~~
5. ~~Home infusion therapy is limited to the terms in the GSA.~~
6. ~~Home Health Care is limited to the terms in the GSA.~~

R9-27-204. ~~Out-of-service Area Coverage~~ Out of Network Coverage of Emergency Medical Services

~~Out-of-service area coverage. As specified in R9-27-209, a member is entitled to only emergency services when outside the member's HCG Plan service area. The Administration shall not cover services outside the United States.~~

A. Emergency medical services provided outside the HCG plan's network shall be covered, based on the prudent layperson standard under 42 U.S.C. 1396 (u)-(2), if:

1. The member presents for emergency medical services at the nearest medical facility capable of providing necessary emergency services; and
2. The member or provider notifies the HCG Plan no later than 48 hours from the day that the member presented for the emergency service. Failure to provide timely notice constitutes cause for denial of payment.

B. Emergency ambulance services required to transport the member to the nearest medical facility capable of providing emergency services shall be covered if the provider notifies the HCG Plan within 10 working days from the day that the member presented for emergency ambulance service. Failure to provide notice within 10 working days constitutes cause for denial of payment.

C. Coverage authorized under this Section may not constitute full payment of the cost of emergency medical or ambulance services provided by an out of network provider, and the member may be responsible for the balance due, if any.

D. Payment for out of state inpatient and outpatient hospital services, including emergency services, shall be made in accordance with A.A.C. R9-22-703 (E).

R9-27-205. ~~Outpatient Health Services~~ Repealed

~~Outpatient services. The HCG Plan shall provide the following covered services if medically necessary:~~

1. ~~Ambulatory surgery and anesthesiology services not specifically excluded;~~
2. ~~Physician's services;~~
3. ~~Pharmaceutical services and prescribed drugs to the extent authorized in this Article and under the GSA;~~
4. ~~Laboratory services;~~
5. ~~Radiology and medical imaging services;~~
6. ~~Services of other health care practitioners when supervised by a physician;~~
7. ~~Nursing services provided in an outpatient health care facility;~~
8. ~~The use of emergency, examining, or treatment rooms when required for the provision of physician services;~~
9. ~~Specialty care physician services referred by a primary care provider or health plan;~~
10. ~~Physical examinations, periodic health examinations, health assessments, physical evaluations, or diagnostic work-ups that include treatments or procedures to:~~
    a. ~~Determine risk of disease,~~
    b. ~~Provide early detection of disease,~~
    c. ~~Detect the presence of injury or disease at any stage,~~
    d. ~~Establish a treatment plan for injury or disease at any stage,~~
    e. ~~Evaluate the results or progress of a treatment plan or treatment decision, or~~

f. ~~Establish the presence and characteristics of a physical disability that may be the result of disease or injury.~~

11. ~~Short-term rehabilitation is provided as specified in the GSA, if in the judgment of the HCG Plan Medical Director or designee, the treatment can be expected to result in the significant improvement of a member's condition.~~

R9-27-206. ~~Laboratory, Radiology, and Medical Imaging Services~~ Repealed

~~A.~~ ~~Coverage of medically necessary laboratory, radiology, and medical imaging services. Medically necessary laboratory, radiology, and medical imaging services shall be provided by a licensed or certified health care provider as prescribed by the member's primary care provider. These services shall be provided through the HCG Plan in a hospital, a clinic, a physician's office or other health facility.~~

~~B.~~ ~~Satisfaction of applicable license and certification requirements. A clinical laboratory, radiology, or medical imaging service provider must satisfy all applicable state and federal license and certification requirements and shall provide only services that are within the categories stated in the provider's license or certification.~~

R9-27-207. ~~Pharmaceutical Services~~ Repealed

~~A.~~ ~~Provision of pharmaceutical services. The HCG Plan shall ensure that pharmaceutical services are available to members during customary business hours. The services shall be located within reasonable travel distance as determined by the HCGA within the HCG Plan's service area.~~

~~B.~~ ~~Limitations. The HCG Plan shall adhere to the following limitations when providing a pharmaceutical service:~~

1. ~~Drugs personally dispensed by a physician or a dentist are not covered, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.~~
2. ~~Prescription drugs are prescribed up to a 30-day supply unless the HCG Plan determines a longer supply is more cost-effective.~~
3. ~~Members are eligible for immunosuppressant drugs only as part of the post-operative treatment for a covered kidney or cornea transplant authorized by an HCG Plan as specified in R9-27-202.~~
4. ~~Over-the-counter drugs are not covered.~~

R9-27-208. ~~Inpatient Hospital Services~~ Repealed

~~A.~~ ~~Inpatient hospital services. The HCG Plan shall provide the following inpatient hospital covered services if medically necessary:~~

1. ~~Routine services, including:~~
   a. ~~Hospital accommodations;~~
   b. ~~Specialty units;~~
   c. ~~Nursing services necessary and appropriate for a member's medical condition;~~
   d. ~~Dietary services;~~
   e. ~~Medical supplies, appliances, and equipment furnished to hospital inpatients, billed as part of routine services, and included in the daily room and board charge;~~
2. ~~Ancillary services, including:~~
   a. ~~Labor, delivery and recovery rooms, and birthing centers;~~
   b. ~~Surgery and recovery rooms;~~
   c. ~~Laboratory services;~~
   d. ~~Radiological and medical imaging services;~~
   e. ~~Anesthesiology services;~~
   f. ~~Rehabilitation services as specified in the GSA;~~
   g. ~~Pharmaceutical services and prescribed drugs;~~
   h. ~~Respiratory therapy;~~
   i. ~~Maternity services;~~
   j. ~~Nursery and related services;~~
   k. ~~Chemotherapy; and~~
   l. ~~Dialysis as limited in this Article.~~

~~B.~~ ~~Limitations. The HCG Plan shall adhere to the following coverage limitations when providing inpatient hospital services:~~

1. ~~Inpatient hospital accommodations are limited to no more than a semi-private rate, except when a patient must be isolated for medical reasons.~~
2. ~~Dialysis is limited to services not covered by Title XVIII, of the Social Security Act, as amended.~~
3. ~~Alternative levels of care instead of hospitalization are covered if cost effective and medically necessary as determined by the HCG Plan Medical Director, or designee.~~

R9-27-209. ~~Emergency Medical Services~~ Repealed

~~A.~~ ~~Emergency medical services provided within the HCG Plan's service area.~~

1. ~~Emergency medical services shall be provided to a member 24 hours-a-day, seven days-a-week based on the prudent layperson standard under 42 U.S.C. 1396u-2.~~

~~2. The member or provider shall notify the HCG Plan no later than 24 hours after the initiation of treatment.~~
~~3. If a member is incapacitated, the provider is responsible for notifying the HCG Plan no later than 24 hours after the member is capable of verifying coverage under the HCGA. Failure to provide timely notice constitutes cause for denial of payment.~~

~~**B.** Emergency medical services provided outside the HCG Plan's service area.~~
~~1. Emergency medical services provided outside the HCG Plan's service area is based on the prudent layperson standard under 42 U.S.C. 1396u-2.~~
~~2. The member or provider shall notify the HCG Plan no later than 48 hours after the initiation of treatment.~~
~~3. If a member is incapacitated, the provider is responsible for notifying the HCG Plan no later than 48 hours after the member is capable of verifying coverage under the HCGA. Failure to provide timely notice constitutes cause for denial of payment.~~

~~**C.** Ambulance services.~~
~~1. Within the HCG Plan's service area. A member is entitled to emergency ambulance services within the HCG Plan's service area. The provider shall notify the HCG Plan within 10 working days after providing emergency ambulance service to the member. Failure to provide notice within 10 working days constitutes cause for denial of payment.~~
~~2. Outside the HCG Plan's service area. A member is entitled to ambulance services outside the HCG Plan's service area to transport the member to the nearest medical facility capable of providing necessary emergency services. The provider shall notify the HCG Plan within 10 working days after providing emergency ambulance service to the member. Failure to provide notice within 10 working days constitutes cause for denial of payment.~~

R9-27-210. Pre-existing Conditions

A. Pre-existing conditions exclusions. Subject to subsection (B), an HCG Plan shall not cover any services related to a pre-existing condition as specified in A.R.S. § 36-2912.

B. ~~Failure to impose a pre-existing condition exclusion~~. Pre-existing conditions coverage. An HCG Plan shall ~~not impose a pre-existing condition exclusion against an eligible employee who meets the following standards:~~ cover pre-existing conditions for the following:
1. Newborns from the time of birth, adopted children, and children placed for adoption, if enrolled within the time-frames ~~under R9-27-308;~~ set forth in the GSA;
~~2. Eligible employees who meet the portability requirements of A.R.S. § 20-2308~~:
~~a. A person who had continuous coverage for a one-year period and during that year had no breaks in coverage totaling more than 31 days; and~~
~~b. A person's prior coverage ended within 63 days before the date of enrollment~~.
2. Creditable coverage. An eligible employee described in R9-27-302(A)(1) for whom, as of the date on which the employee seeks enrollment in HCG, the aggregate of the periods of creditable coverage, calculated under A.R.S. § 36-2912 (S), is three months or longer.

C. Credit for prior health coverage. An HCG Plan shall apply a credit toward meeting the 12 month pre-existing condition exclusion of one month for each month of continuous coverage that an eligible employee had under another HCG Plan or accountable health plan under A.R.S. § 36-2912. Upon request, a contracted health plan or an accountable health plan that provided continuous coverage to an individual shall disclose the coverage provided.

D. Late enrollee pre-existing conditions time-frames. An HCG Plan shall exclude coverage for a preexisting condition for a late enrollee under A.R.S. § 36-2912 as follows:
1. For 12 months if the member enrolls within 30 days of the designated enrollment time-frame, or
2. For 18 months if the member enrolls 31 or more days after the designated time-frame for enrollment.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 27. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) HEALTH CARE FOR PRIVATE EMPLOYER GROUPS/AHCCCS ADMINISTERED

PREAMBLE

1. Sections Affected	Rulemaking Action
R9-27-301	Amend
R9-27-302	Amend
R9-27-303	Amend
R9-27-305	Amend
R9-27-306	Amend

R9-27-307	Amend
R9-27-308	Amend
R9-27-309	Amend
R9-27-310	Amend

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

Authorizing statute: A.R.S. § 36-2903.01 (F)

Implementing statute: A.R.S. § 36-2912 (I) (5)

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

Notice of Rulemaking Docket Opening: 10 A.A.R. 4489, November 5, 2004

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

Name: Jane McVay

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

Telephone: (602) 417-4135

Fax: (602) 253-9115

E-mail: AHCCCSRules@ahcccs.state.az.us

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

The rule revises and clarifies the enrollment criteria for eligible employees and dependents, states how COBRA continuation coverage impacts HCG coverage, when members may enroll in an HCG benefit plan, and the circumstances under which a member's coverage can be terminated. The Administration is updating the existing Healthcare Group rules on eligibility and enrollment to make them consistent with current practices and statutory changes, and to make them clear, concise, and understandable. The rule contains changes to conform to recent statutory changes enacted in Chapter 332, Laws 2004, including the requirement that Healthcare Group is not allowed to enroll an employer group before 180 days have elapsed after their previous health plan is discontinued. Persons who are unemployed and are eligible for a federal health coverage tax credit are now also eligible for Healthcare Group coverage. The Group Service Agreement (GSA), the contract that employer groups sign with Healthcare Group, contains many provisions pertaining to the scope of Healthcare Group services. Because these provisions should not be duplicated in the rules, some language is removed from the rules.

Healthcare Group was created as a division within the Administration in 1985 to provide affordable and accessible health care benefit plans for Arizona small businesses with 50 or less employees. According to a study by St. Luke's Health Initiatives, only 30% of these small Arizona employers offer health care coverage to their employees. Many of these employees are low wage earners, whose income is on the verge of eligibility for AHCCCS coverage. Legislation was enacted in 2004,which allows Healthcare Group to offer health care benefit plans to employees of political subdivisions in the state, in addition to small businesses. Currently, 11,000 persons in the state have health care coverage through Healthcare Group.

In order to continue to provide health care coverage to an increasing number of employees and to help reduce the substantial number of uninsured Arizona citizens, Healthcare Group intends to offer a greater variety of affordable health care benefit plans. Healthcare Group intends to provide health care coverage in the rural areas of the state in which Healthcare Group coverage is not currently available. A greater number and more diverse types of benefit plans will be offered to employees, who may otherwise not have affordable health care coverage.

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

No studies were reviewed relevant to this rule.

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

The rule does not impact the authority of political subdivisions.

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

Healthcare Group provides affordable and accessible health care benefit plans for Arizona small businesses with 50 or less employees. According to a study by St. Luke's Health Initiatives, only 30% of these small Arizona employers offer health care coverage to their employees. Many of these employees are low wage earners, whose income is on the verge of eligibility for AHCCCS coverage. Legislation was enacted in 2004, which allows Healthcare Group to

offer health care benefit plans to employees of political subdivisions in the state, in addition to small businesses. Currently, Healthcare Group insures over 11,000 persons in the state.

Availability of health care coverage through Healthcare Group allows individuals in many small companies to obtain affordable health care coverage. Without this coverage, some employees would not have affordable health care coverage, or in the event of illness would need to "spend down" to qualify for health care coverage through AHCCCS. Currently, AHCCCS provides health care coverage to over 1,000,000 Arizona residents, including adults and children. AHCCCS currently receives a substantial state appropriation, which constitutes a substantial, growing portion of the state budget. The rate of growth of AHCCCS' uninsured population far exceeds the rate of growth of the state general fund. The availability of health care benefit plans through Healthcare Group to individuals who do not currently have health care coverage and may otherwise be eligible for AHCCCS, has a beneficial economic, small business, and consumer impact on the state.

Senate Bill 1166, enacted as Chapter 332, Laws 2004, imposes a bare period of 180 days, after which individuals who do not have creditable health care coverage, may be eligible to enroll in health care benefit plans offered through their employer by Healthcare Group. The legislation also expands eligibility for Health Care Group benefit plans to persons who are unemployed and do not have health care coverage. Since these individuals are not enrolled in other commercial health care benefit plans, this does not negatively impact commercial insurers. Due to the 180 day bare period, it is unlikely that employers will switch or drop their existing health care coverage from commercial carriers to benefit plans offered by Healthcare Group.

This rule will allow Healthcare Group to offer employees more flexible and diverse health care coverage plans to a growing market of individuals who need affordable health care coverage.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name:	Jane McVay
Address:	AHCCCS Office of Legal Assistance 701 E. Jefferson, Mail Drop 6200 Phoenix, AZ 85034
Telephone:	(602) 417-4135
Fax:	(602) 256-6756
E-mail:	AHCCCSRules@ahcccs.state.az.us

Proposed rule language will be available on the AHCCCS web site www.ahcccs.state.az.us the week of November 29, 2004. Please send written comments to the above address by 5:00 p.m., January 31, 2005. E-mail comments will be accepted.

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

Date:	January 31, 2005
Time:	10:00 a.m.
Location:	AHCCCS 701 E. Jefferson Phoenix, AZ 85034
Nature:	Public Hearing
Date:	January 31, 2005
Time:	10:00 a.m.
Location:	ALTCS: Arizona Long-term Care System 110 S. Church, Suite 1360 Tucson, AZ 85701
Nature:	Public Hearing
Date:	January 31, 2005
Time:	10:00 a.m.
Location:	ALTCS: Arizona Long-term Care System 3480 E. Route 66 Flagstaff, AZ 86004

Nature: Public Hearing

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

Not applicable

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

None

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 27. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM HEALTH CARE FOR PRIVATE EMPLOYER GROUPS/AHCCCS ADMINISTERED

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

Section

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-27-301. Eligibility Criteria for Employer Groups

A. Criteria for employer groups.

1. ~~An employer group shall conduct business~~: In order to be eligible to obtain health care coverage through an HCG plan, an employer group shall conduct business within a county in Arizona that has an HCG plan for at least 60 days before applying to be an employer group and before the effective date of coverage of an employer group.
    a. ~~Within Arizona for at least 60 days before making application to be an employer group eligible for HCG coverage; and~~
    b. ~~Within a county which has an HCG Plan.~~
2. ~~The HCGA shall determine eligibility for an employer group and its employees through documentation of one or more of the following:~~ An employer group shall have a minimum of one and a maximum of 50 eligible full-time employees on the effective date of the first GSA with HCGA.
    a. ~~Participation in state unemployment insurance;~~
    b. ~~Participation in state worker's compensation;~~
    c. ~~Personal tax return with schedule C, SE, or SEZ; or~~
    d. ~~Other verifiable proof that the applicant is conducting a business in Arizona.~~

B. ~~Amount of eligible employees and enrollment. Other than the state of Arizona and political subdivisions of the state, an employer group shall have a minimum of one and a maximum of 50 eligible employees at the effective date of the first GSA with HCGA. Acceptable proof of the number of eligible employees may include canceled checks, bookkeeping records, and personnel records.~~

B. Employer group's prior health care coverage. HCGA shall not enroll an employer group in Healthcare Group sooner than one hundred eighty days after the date that the employer's health care coverage under an accountable health plan is discontinued. Enrollment in Healthcare Group is effective on the first day of the month after the one hundred eighty day period. This subsection does not apply to an employer group if the employer's accountable health plan discontinues offering the health plan of which the employer is a member.

C. Required enrollment of a ~~particular number~~ minimum percentage of eligible employees. Other than state employees and employees of political subdivisions of the state, employers with one to 50 eligible full-time employees may contract with HCGA if the employer group:

1. Has five or fewer eligible full-time employees and enrolls 100~~%~~ percent of these employees in an HCG Plan, or

2. Has six or more eligible full-time employees and enrolls 80~~%~~ percent of these employees in an HCG Plan.

~~**D.** HCGA does not include employees who work less than 20 hours per week when determining participation requirements.~~

~~**E.**~~**D.** ~~Employees~~ Full-time employees with proof of other ~~insurance.~~ health care coverage. ~~Employees~~ Full-time employees with proof of existing health care coverage who elect not to participate in an HCG Plan shall not be considered when determining the required percentage of ~~the required number of~~ enrollees, specified in subsection (C), if the health care coverage is~~:~~ one of the following:

1. Group coverage ~~offered~~ provided through a spouse, ~~a~~ parent, ~~or a~~ legal guardian~~;~~, or another employer~~.~~;
2. ~~Coverage available from a government-subsidized health care program.~~ Medical assistance provided by a government-subsidized health care program;
3. Medical assistance provided pursuant to A.R.S. § 36-2982, subsection (I); or
4. Individual employee or other health care coverage.

~~**F.**~~**E.** Post-enrollment changes in group size. Changes in group size that occur during the term of the GSA or during any renewal periods shall not affect eligibility.

~~**G.**~~**F.** Review and verification of eligibility determinations. The HCGA may conduct random reviews of eligibility determinations of an employer group and its employees.

R9-27-302. Eligibility and Enrollment **Criteria for** ~~Employee Members~~ Employees

~~**A.** Residence. An employee member shall reside, work, or reside and work in Arizona and in a county with an HCG Plan.~~

~~**B.** Eligible employer group. An employee member shall be employed by an eligible employer group specified in R9-27-301.~~

~~**C.** Days of consecutive employment. An employee member shall have been employed at least 60 consecutive days before the effective date of coverage.~~

~~**D.** Hours of employment per week. A member working for an employer group or a self-employed person shall work at least 20 hours per week, with anticipated employment of at least five months following enrollment.~~

A. Eligibility criteria for employees. An eligible employee shall:

1. Be eligible for a federal health coverage tax credit under Section 35 of the Internal Revenue Code of 1986 as specified in A.R.S. § 36-2912 (AA)(4)(d); or
2. Be on an employer's payroll or be self-employed by an eligible employer group specified in R9-27-301 for a period of at least 60 calendar days before the effective date of coverage; and
   a. Work at least 20 hours per week for the employer group; and
   b. Expect to continue employment by the employer group for at least five months following enrollment.

B. Enrollment criteria for eligible employees. In order for an eligible employee and dependents, if any, to receive HCG coverage, all of the following shall occur:

1. The eligible employee shall select an HCG benefit plan.
2. The eligible employee shall complete and submit all necessary documentation specified by HCGA, including but not limited to the employee enrollment information and health history forms.
3. HCG shall provide the eligible employee and dependent written notification of the effective date of coverage.
4. HCGA shall receive the full required premium no later than the date specified in the GSA.

~~**E.**~~**C.** Eligibility for government subsidized health care programs. The HCGA shall provide written information to members who may be eligible for a government subsidized health care program.

D. Continuation Coverage. Employee members of HCG and their dependents who are entitled to continuation coverage under COBRA continuation provisions after termination of employment, may retain HCG coverage until the benefit expires or the premium is not paid by the employee, whichever is earlier. The employer shall pay the premium to the employer group, which shall pay the premium to HCGA.

R9-27-303. Eligibility Criteria for Dependents

~~**A.**~~ Eligible dependents. An eligible dependent of an employee member ~~shall reside in Arizona, in a county with an HCG Plan and~~ includes:

1. A legal spouse;
2. Unmarried children less than the age of 19, or less than the age of 24 if the child is a full-time student, and is:
   a. A natural child,
   b. An adopted child~~,~~ or a child who is placed for adoption,
   c. A step-child, or
   d. A child for whom the employee member is a legal guardian.
3. ~~A child~~ An unmarried child of any age with a disability that existed ~~incapable of self-sustaining support by reason of mental or physical disability existing~~ before the child's 19th birthday, as determined by the HCG plan medical director or designee.

~~**B.** Limitations. A grandchild of an employee member shall be eligible to receive covered services only if the grandchild meets the eligibility requirements in subsection (A)(2)(b), (c), and (d) or (A)(3).~~

R9-27-305. ~~Health History Form~~ Repealed

~~Completion of a health history form. An eligible employee and dependents shall complete the HCG health history form before enrollment. An eligible employee or a dependent shall not be denied enrollment as a result of conditions described on the health history form. Pre-existing conditions limit the benefits available to a member as specified in R9-27-210. Failure to provide complete and accurate information on the health history form is cause for immediate termination from the HCG Plan~~.

R9-27-306. ~~Effective Date of Coverage~~ Repealed

~~A.~~ ~~Payment in advance of effective date. Employer groups shall submit payment 30 days in advance of the effective date of coverage. If the Administration receives the full premium payment on or before the 15th day of the month, enrollment will begin on the first day of the next month. If the Administration receives the full premium payment after the 15th day of the month, coverage begins on the first day of the second month. No retroactive coverage is available.~~

~~B.~~ ~~Other effective date options. For other effective date options, an employer group shall complete and submit the enrollment documents and initial premium payment by the time-frames specified in the GSA.~~

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

~~A.~~ ~~Open enrollment. Enrollment of an employee member shall occur only during one of the following open enrollment periods:~~

1. ~~Thirty days following the effective date of the GSA for a newly enrolled employer group;~~
2. ~~A 31-day period to start 60 days from the date of employment for a new employee in an enrolled employer group, or a 31-day period after the completion of an employer's waiting period on eligibility for health care coverage, whichever period is greater; or~~
3. ~~A 31-day period to begin 105 days before and conclude at least 75 days before the employer group's renewal date, as determined by the HCGA.~~

~~B.~~ ~~New dependent enrollment. Enrollment of new dependents shall occur:~~

1. ~~Within the 31-day period following the addition of a new dependent defined in R9-27-303(A), or~~
2. ~~Under R9-27-308 if the dependent is a newborn.~~

A. Enrollment. A member who meets the eligibility requirements may enroll in an HCG benefit plan under the terms and during the time periods specified in the GSA, including, but not limited to the following situations:

1. When an employer member signs the GSA;
2. When a qualifying event occurs as prescribed in the GSA; or
3. When the open enrollment period occurs as specified in the GSA; or
4. When the existing health care coverage for an eligible employee and any dependents terminates.

B. Effective date of coverage. The effective date of coverage for an employer group or an employee member under an HCG benefit plan shall be as determined by the GSA and shall be provided to the employee member.

R9-27-308. ~~Enrollment of Newborns~~ Repealed

~~Newborn enrollment. A newborn shall be enrolled 30 days following the birth to be eligible for coverage. Upon enrollment, the newborn's premium is due to the HCGA 30 days following the birth for coverage retroactive to the first day of the month in which the birth occurred.~~

R9-27-309. ~~Enrollment of Newly Eligible Employee and Dependent Due to Loss of Own Coverage~~

~~A.~~ ~~Enrollment of newly eligible employee due to loss of own coverage. An eligible employee who had health care coverage through a spouse, is eligible to enroll as a member within 30 days of the loss of coverage, if that loss of separate health care coverage is due to:~~

1. ~~Death of the eligible employee's spouse,~~
2. ~~Divorce,~~
3. ~~Termination of employment of the eligible employee's spouse,~~
4. ~~Legal separation,~~
5. ~~Reduction in hours of employment, or~~
6. ~~Retirement.~~

~~B.~~ ~~Enrollment of newly eligible dependent due to loss of own coverage. An eligible dependent, who had individual or family health care coverage separate from the member's coverage is eligible to enroll as a dependent member within 30 days of the loss of coverage, if that loss of separate health care coverage is due to:~~

1. ~~Death,~~
2. ~~Divorce,~~
3. ~~Termination of employment,~~
4. ~~Legal separation,~~
5. ~~Reduction in hours of employment, or~~
6. ~~Retirement.~~

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

~~**A.** Denial of enrollment. An employer group, an employee, or a dependent who fails to meet the eligibility requirements of this Article shall be denied enrollment.~~

~~**B.** Termination of enrollment. Termination of enrollment and coverage for an employer group, an employee member, or a dependent shall occur on the last day of the month that:~~

~~1. The employer group loses eligibility,~~
~~2. The employee member loses eligibility, or~~
~~3. The dependent loses eligibility.~~

~~**C.** Exclusion from enrollment. The HCGA may exclude an employer group or an employee member from enrollment who has committed fraud or misrepresentation while enrolled with another HCG Plan or health benefits carrier.~~

A. Immediate termination of a member. The HCGA or HCG Plan shall have the authority to terminate a member's coverage effective on the date that written notice is mailed to the member's last known address, for any of the following reasons:

1. Fraud or misrepresentation when applying for coverage or obtaining services;
2. Committing or threatening to commit violence or other substantially abusive behavior toward employees or agents of HCGA, an HCG Plan, network providers, or out of network providers.

Except as provided in subsection (C), coverage for all persons insured through the employee member shall terminate at midnight on the date that written notice of termination of the member's coverage is mailed to the member.

B. Termination with prior written notice. The HCGA or an HCG plan shall have the authority to terminate a member's coverage at midnight on the last day of the month that written notice of termination of coverage was mailed to the member's last known address for any of the following reasons:

1. Repeated and unreasonable demands for unnecessary medical services;
2. Failure to pay any copayment, coinsurance, deductible, or required financial obligation;
3. Violation of any material provision of the member handbook;
4. Termination of employment;
5. Change in age or other status of the member or dependent that is required for eligibility;
6. Failure of the member's employer to pay the premium; or
7. Loss of the participating health plan with which the employer group is enrolled, if there is no other participating health plan available to serve the employer group.

Except as provided in subsection (C), coverage for all persons insured through the employee member shall terminate at midnight on the last day of the month that written notice of termination of the member's coverage is mailed to the member.

C. Effective date of termination of hospitalized member. Subject to continuation coverage as described in R9-27-302 (D), on the effective date of termination of coverage, the HCG Plan shall have no further obligation to provide services and benefits to a member whose coverage has been terminated, except that a member confined to a hospital on the effective date of termination shall continue to have coverage until the HCG Plan Medical Director or designee determines that care in the hospital is no longer medically necessary for the condition for which the member was admitted to the hospital. Coverage for all persons, who are not hospitalized on the effective date of termination and are insured through the employee member, shall terminate at midnight on the effective date of termination of the employee member's coverage. In order for coverage to continue under this Article, HCGA shall continue to receive timely paid premiums for the hospitalized member.

D. Exclusion from eligibility and enrollment. The HCGA shall have the authority to exclude, as ineligible to enroll or re-enroll, an employer group, an employee member, or a dependent whose prior health care coverage has been terminated by an HCG Plan, or other accountable health plan, for any of the following reasons:

1. Fraud or misrepresentation when applying for coverage or obtaining services;
2. Committing or threatening to commit violence or other substantially abusive behavior toward employees or agents of HCGA, an HCG Plan, another accountable health plan, network providers, or out of network providers;
3. Repeated and unreasonable demands for unnecessary medical services;
4. Failure to pay any copayment, coinsurance, deductible, or required financial obligation;
5. Violation of any material provision of the member handbook.