NOTICES OF FINAL RULEMAKING

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

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

[R07-156]

PREAMBLE

1. Sections Affected | **Rulemaking Action**

R9-22-701	Amend
R9-22-712.05	New Section

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

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

Implementing statute: A.R.S. § 36-2903.01(H)(9)

3. The effective date of the rules:

June 30, 2007

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

Notice of Rulemaking Docket Opening: 13 A.A.R. 41, January 5, 2007

Notice of Proposed Rulemaking: 13 A.A.R. 200, January 26, 2007

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

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

In 2006 the 47th Legislature approved additional funds for distribution to training hospitals for graduate medical education (GME) programs. The funds are in addition to the funds allocated yearly to teaching hospitals, and are designated to support programs that have expanded, and will expand, their educational efforts. R9-22-712.05 establishes the methodology for distributing the funds. In general, the rule: (i) defines hospitals eligible to receive distributions, (ii) defines residency positions on which distributions will be based, (iii) requires reporting of information necessary to determine distributions, (iv) describes the process of calculating allocations to programs, and (v) describes the process for distributing allocated amounts among eligible hospitals.

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

No study was reviewed during this rulemaking and the Agency does not anticipate reviewing any studies.

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

Not applicable

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

It is anticipated that the rulemaking will have a minimal to moderate economic impact on graduate medical education programs (GME) that are currently in place and any newly created GME programs as of July 1, 2006.

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

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

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

The Administration did not receive any comments regarding the rules.

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

Not applicable

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

Not applicable

14. Were these rules previously made as emergency rules?

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-22-701. Standard for Payments Related Definitions
R9-22-712.05. ~~Reserved~~ Graduate Medical Education Fund Allocation

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-701. Standard for Payments Related Definitions

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Article have the following meanings unless the context explicitly requires another meaning:

"Accommodation" means room and board services provided to a patient during an inpatient hospital stay and includes all staffing, supplies, and equipment. The accommodation is semi-private except when the member must be isolated for medical reasons. Types of accommodation include hospital routine medical/surgical units, intensive care units, and any other specialty care unit in which room and board are provided.

"Aggregate" means the combined amount of hospital payments for covered services provided within and outside the GSA.

"AHCCCS inpatient hospital day or days of care" means each day of an inpatient stay for a member~~,~~ beginning with the day of admission and including the day of death, if applicable, but excluding the day of discharge, provided that all eligibility, medical necessity, and medical review requirements are met.

"Ancillary service" mean all hospital services for patient care other than room and board and nursing services, including but not limited to, laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, and occupational).

"APC" means the Ambulatory Payment Classification system under 42 CFR Part 419.31 used by Medicare for grouping clinically and resource-similar procedures and services.

"Billed charges" means charges for services provided to a member that a hospital includes on a claim consistent with the rates and charges filed by the hospital with Arizona Department of Health Services (ADHS).

"Business agent" means a company such as a billing service or accounting firm that renders billing statements and receives payment in the name of a provider.

"Capital costs" means costs as reported by the hospital to CMS as required by 42 CFR 413.20.

"Copayment" means a monetary amount, specified by the Director, that a member pays directly to a contractor or provider at the time covered services are rendered.

"Cost-To-Charge Ratio" (CCR) means a hospital's costs for providing covered services divided by the hospital's charges for the same services. The CCR is the percentage derived from the cost and charge data for each revenue code provided to AHCCCS by each hospital.

"Covered charges" means billed charges that represent medically necessary, reasonable, and customary items of expense for covered services that meet medical review criteria of AHCCCS or a contractor.

"CPT" means Current Procedural Terminology, published and updated by the American Medical Association. CPT is a nationally-accepted listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians that provides a uniform language to accurately designate medical, surgical, and diagnostic services.

"Critical Access Hospital" is a hospital certified by Medicare under 42 CFR 485 Subpart F and 42 CFR 440.170(g).

"DRI inflation factor" means Global Insights Prospective Hospital Market Basket.

"Eligibility posting" means the date a member's eligibility information is entered into the AHCCCS Pre-paid Medical Management Information System (PMMIS).

"Encounter" means a record of a medically-related service rendered by an AHCCCS-registered provider to a member enrolled with a contractor on the date of service.

"Existing outpatient service" means a service provided by a hospital before the hospital files an increase in its charge master as defined in R9-22-712(G), regardless of whether the service was explicitly described in the hospital charge master before filing the increase

"Expansion funds" means funds appropriated to support GME program expansions as described under A.R.S. § 36-2903.01(H)(9)(b).

"Factor" means a person or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold, or transferred to the organization for an added fee or a deduction of a portion of the accounts receivable. Factor does not include a business agent.

"Fiscal intermediary" means an organization authorized by CMS to make determinations and payments for Part A and Part B provider services for a given region.

"Free Standing ~~Children~~ Children's Hospital" means a separately standing hospital with at least 120 pediatric beds that is dedicated to provide the majority of the hospital's services to children.

~~"Global Insights Prospective Hospital Market Basket" means the Global Insights CMS Hospital price index for prospective hospital reimbursement, published by Global Insights.~~

"Graduate medical education (GME) program" means an approved residency program that prepares a physician for independent practice of medicine by providing didactic and clinical education in a medical environment to a medical student who has completed a recognized undergraduate medical education program.

"HCPCS" means the Health Care Procedure Coding System, published and updated by Center for Medicare and Medicaid Services (CMS). HCPCS is a listing of codes and descriptive terminology used for reporting the provision of physician services, other health care services, and substances, equipment, supplies or other items used in health care services.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as specified under 45 CFR Part 162, that establishes standards and requirements for the electronic transmission of certain health information by defining ~~codes~~ code sets used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

"ICU" means the intensive care unit of a hospital.

"Intern and Resident Information System" means a software program used by teaching hospitals and the provider community for collecting and reporting information on resident training in hospital and non-hospital settings.

"Medical education costs" means direct hospital costs for intern and resident salaries, fringe benefits, program costs, nursing school education, and paramedical education, as described in the Medicare Provider Reimbursement Manual.

"Medical review" means a clinical evaluation of documentation conducted by AHCCCS or a contractor for purposes of prior authorization, concurrent review, post-payment review, or determining medical necessity. The criteria for medical review are established by AHCCCS or a contractor based on medical practice standards that are updated periodically to reflect changes in medical care.

"National Standard code sets" means codes that are accepted nationally in accordance with federal requirements under 45

CFR 160 and 45 CFR 164.

"New hospital" means a hospital for which Medicare Cost Report claim and encounter data are not available for the fiscal year used for initial ratesetting or rebasing.

"NICU" means the neonatal intensive care unit of a hospital that is classified as a Level II or Level III perinatal center by the Arizona Perinatal Trust.

"Non-IHS Acute Hospital" means a hospital that is not run by Indian Health Services, is not a free-standing psychiatric hospital, such as an IMD, and is paid under ADHS rates.

"Observation day" means a physician-ordered evaluation period of less than 24 hours to determine whether a person needs treatment or needs to be admitted as an inpatient.

"Operating costs" means AHCCCS-allowable accommodation costs and ancillary department hospital costs excluding capital and medical education costs.

"Organized health care delivery system" means a public or private organization that delivers health services. It includes, but is not limited to, a clinic, a group practice prepaid capitation plan, and a health maintenance organization.

"Outlier" means a hospital claim or encounter in which the operating costs per day for an AHCCCS inpatient hospital stay meet the criteria described under this Article and A.R.S. § 36-2903.01(H)

"Outpatient hospital service" means a service provided in an outpatient hospital setting that does not result in an admission.

"Ownership change" means a change in a hospital's owner, lessor, or operator under 42 CFR 489.18(a).

"Participating institution" means an institution at which portions of a graduate medical education program are regularly conducted and to which residents rotate for an educational experience for at least one month.

"Peer group" means hospitals that share a common, stable, and independently definable characteristic or feature that significantly influences the cost of providing hospital services, including specialty hospitals that limit the provision of services to specific patient populations, such as rehabilitative patients or children.

"PPC" means prior period coverage. PPC is the period of time, prior to the member's enrollment, during which a member is eligible for covered services. The time-frame is the first day of the month of application or the first eligible month, whichever is later, to the day a member is enrolled with a contractor.

"PPS bed" means Medicare-approved Prospective Payment beds for inpatient services as reported in the Medicare cost reports for the most recent fiscal year for which the Administration has a complete set of Medicare cost reports for every rural hospital as determined as of the first of February of each year.

"Procedure code" means the numeric or alphanumeric code listed in the CPT or HCPCS manual by which a procedure or service is identified.

"Prospective rates" means inpatient or outpatient hospital rates set by AHCCCS in advance of a payment period and representing full payment for covered services excluding any quick-pay discounts, slow-pay penalties, and first-and third-party payments regardless of billed charges or individual hospital costs.

"Public hospital" means a hospital that is owned and operated by county, state, or hospital health care district.

"Rebase" means the process by which the most currently available and complete Medicare Cost Report data for a year and AHCCCS claim and encounter data for the same year, are collected and analyzed to reset the Inpatient Hospital Tiered per diem rates, or the Outpatient Hospital Capped Fee-For-Service Schedule.

"Reinsurance" means a risk-sharing program provided by AHCCCS to contractors for the reimbursement of specified contract service costs incurred by a member beyond a certain monetary threshold.

"Remittance advice" means an electronic or paper document submitted to an AHCCCS-registered provider by AHCCCS to explain the disposition of a claim.

"Resident" means a physician engaged in postdoctoral training in an accredited graduate medical education program, including an intern and a physician who has completed the requirements for the physician's eligibility for board certification.

"Revenue Code" means a numeric code, that identifies a specific accommodation, ancillary service, or billing calculation, as defined by the National Uniform Billing committee for UB-92 forms.

"Specialty facility" means a facility where the service provided is limited to a specific population, such as rehabilitative services for children.

"Sponsoring institution" means the institution or entity that is recognized by the GME accrediting organization and designated as having ultimate responsibility for the assurance of academic quality and compliance with the terms of accreditation

"Tier" means a grouping of inpatient hospital services into levels of care based on diagnosis, procedure, or revenue codes,

peer group, NICU classification level, or any combination of these items.

"Tiered per diem" means an AHCCCS capped fee schedule in which payment is made on a per-day basis depending upon the tier (or tiers) into which an AHCCCS inpatient hospital day of care is assigned.

R9-22-712.05. ~~Reserved.~~ Graduate Medical Education Fund Allocation

A. Graduate medical education (GME) reimbursement as of September 30, 1997. Subject to legislative appropriation, the Administration shall make a distribution based on direct graduate medical education costs as described in A.R.S. § 36-2903.01(H)(9)(a).

B. Subject to available funds and approval by CMS, the Administration shall annually distribute monies appropriated for the expansions of GME programs approved by the Administration to hospitals for direct program costs eligible for funding under A.R.S. § 36-2903.01(H)(9)(b). A GME program approved by the Administration means a GME program that has been approved by a national organization as described in 42 CFR 415.152. A GME program is deemed to be established as of the date of its original accreditation. All determinations that are necessary to make distributions described by this subsection shall be made using information possessed by the Administration as of the date of reporting under subsection (E).

C. Eligible health care facilities. A health care facility is eligible for distributions under subsection (B) if all of the following apply:

1. It is a hospital in Arizona that is the sponsoring institution of, or a participating institution in, one or more of the GME programs in Arizona;
2. It incurs direct costs for the training of residents in the GME programs, which costs are or will be reported on the hospital's Medicare Cost Report;
3. It is not administered by or does not receive its primary funding from an agency of the federal government.

D. Eligible resident positions. For purposes of determining program allocation amounts under subsection (F) the following resident positions are eligible for consideration to the extent that the resident training takes place in Arizona and not at a health care facility made ineligible under subsection (C)(3):

1. Filled resident positions in approved programs established as of October 1, 1999 at hospitals that receive funding as described in A.R.S. § 36-2903.01(H)(9)(a) that are additional to the number of resident positions that were filled as of October 1, 1999; and
2. All filled resident positions in approved programs other than GME programs described in A.R.S. § 36-2903.01(H)(9)(a); and
3. For approved programs established on or after July 1, 2006 that have been established for less than one year as of the date of reporting under subsection (E) and have not yet filled their first-year resident positions, all prospective residents reasonably expected by the program to be enrolled as a result of the most recently completed annual resident match.

E. Annual reporting. By April 1st of each year, each GME program and each hospital seeking a distribution under subsection (B) shall provide the applicable information listed in this subsection to the Administration:

1. A GME program shall provide all of the following:
   a. The program name and number assigned by the accrediting organization;
   b. The original date of accreditation;
   c. The names of the sponsoring institution and all participating institutions current as of the date of reporting;
   d. The number of approved resident positions and the number of filled resident positions current as of the date of reporting;
   e. For programs described under subsection (D)(3), the number of residents expected to be enrolled as a result of the most recently completed annual resident match;
   f. For programs established as of October 1, 1999, the number of resident positions that were filled as of October 1, 1999, if the program has not already provided this information to the Administration;
   g. For programs established on or after July 1, 2006, the academic year rotation schedule on file with the program current as of the date of reporting.
2. A hospital seeking a distribution under subsection (B) shall provide all of the following that apply:
   a. If the hospital uses the Intern and Resident Information System (IRIS) for tracking and reporting its resident activity to the fiscal intermediary, copies of the IRIS master and assignment files for the hospital's two most recently completed Medicare cost reporting years as filed with the fiscal intermediary;
   b. If the hospital does not use the IRIS or has less than two cost reporting years available in the form of the IRIS master and assignment files, the information normally contained in the IRIS master and assignment files in an alternative format for the hospital's two most recently completed Medicare cost reporting years;
   c. At the request of the Administration, a copy of the hospital's Medicare Cost Report or any part of the report for the most recently completed cost reporting year.

F. Allocation of expansion funds. Annually the Administration shall allocate available funds to each approved GME program in the following manner:

1. Information provided by hospitals under subsection (E)(2) shall be used to determine the program in which each eli-

gible resident is enrolled and the number of days that each eligible resident worked in any area of the hospital complex or in a non-hospital setting under agreement with the reporting hospital during the period of assignment to that hospital. For this purpose, the Administration shall use data relating to the most recent 12-month period that is common to all information provided under subsections (E)(2)(a) and (b).

2. For approved programs established on or after July 1, 2006 whose first-year resident positions have been filled but whose first year of operation is not complete as of the date of reporting under subsection (E)(2), information provided by GME programs under subsection (E)(1) shall be used to determine the number of days that each eligible resident is assigned to work at each participating institution.
3. For eligible residents described by subsection (D)(3), information provided by GME programs under subsection (E)(1) shall be used to determine a number of days that each prospective first-year resident is expected to work at each participating institution.
4. The number of eligible residents allocated to each participating institution within each approved GME program shall be determined by totaling the number of days determined for each participating institution under subsections (F)(1) through (F)(3) and dividing each total by 365.
5. The number of allocated residents determined under subsection (F)(4) shall be adjusted for Arizona Medicaid utilization using the most recent Medicare Cost Report information on file with the Administration as of the date of reporting under subsection (E) and the Administration's inpatient hospital claims and encounter data for the time period corresponding to the Medicare Cost Report information for each hospital. The Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were adjudicated by the Administration as of the date of reporting under subsection (E). The Medicaid-adjusted eligible residents shall be determined as follows:
   a. For each hospital, the total AHCCCS inpatient hospital days of care shall be divided by the total Medicare Cost Report inpatient hospital days, multiplied by 100 and rounded up to the nearest multiple of 5 percent.
   b. The number of allocated residents determined for each participating hospital under subsection (F)(4) shall be multiplied by the percentage derived under subsection (F)(5)(a) for that hospital. The number of allocated residents determined under subsection (F)(4) for a participating institution that is not a hospital and not a health care facility made ineligible under subsection (C)(3) shall be multiplied by the percentage derived under subsection (F)(5)(a) for the program's sponsoring institution or, if the sponsoring institution is not a hospital, the sponsoring institution's affiliated hospital. The number of allocated residents determined under subsection (F)(4) for a participating institution that is made ineligible under subsection (C)(3) shall be multiplied by 0 percent.
6. The total allocation for each approved program shall be determined by multiplying the Medicaid-adjusted eligible residents determined under subsection (F)(5)(b) by the per resident conversion factor determined below and totaling the resulting dollar amounts for all participating institutions in the program. The per resident conversion factor shall be determined as follows:
   a. Calculate the total direct GME costs from the most recent Medicare Cost Reports on file with the Administration for all hospitals that have reported such costs.
   b. Calculate the total allocated residents determined under subsection (F)(4) for those hospitals described under subsection (F)(6)(a).
   c. Divide the total GME costs calculated under subsection (F)(6)(a) by the total allocated residents calculated under subsection (F)(6)(b).

G. Distribution of expansion funds. On an annual basis subject to available funds, the Administration shall distribute the allocated amounts determined under subsection (F) in the following manner:

1. The allocated amounts shall be distributed in the following order of priority:
   a. To eligible hospitals that do not receive funding in accordance with A.R.S. § 36-2903.01(H)(9)(a) for the direct costs of programs established before July 1, 2006;
   b. To eligible hospitals that receive funding in accordance with A.R.S. § 36-2903.01(H)(9)(a) for the direct costs of programs established before July 1, 2006;
   c. To any eligible hospital for the direct costs of programs established on or after July 1, 2006.
2. The allocated amounts shall be distributed to the eligible hospitals in each approved program in proportion to the number of Medicaid-adjusted eligible residents allocated to each hospital within that program under subsection (F)(5)(b).
3. If funds are insufficient to cover all distributions within any priority group described under subsection (G)(1), the Administration shall adjust the distributions proportionally within that priority group.

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

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

[R07-157]

PREAMBLE

1. **Sections Affected** / **Rulemaking Action**

R9-27-101	Amend
R9-27-202	Amend
R9-27-204	Amend
R9-27-210	Amend
R9-27-301	Amend
R9-27-302	Amend
R9-27-303	Amend
R9-27-307	Amend
R9-27-310	Amend
R9-27-311	New Section
R9-27-312	New Section
Article 4	Repeal
R9-27-401	Repeal
R9-27-509	Amend
Article 7	Amend
R9-27-702	Amend
R9-27-703	Amend
R9-27-704	Amend

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

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

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

3. **The effective date of the rules:**

June 30, 2007

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

Notice of Rulemaking Docket Opening: 13 A.A.R. 209, January 26, 2007

Notice of Proposed Rulemaking: 13 A.A.R. 297, February 9, 2007

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

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

The reasons for initiating the rulemaking are to make needed changes to the Healthcare Group rules to reflect program changes and to make the rules more clear, concise, and understandable. The rules revise definitions used in the Healthcare Group program, modify the scope of services, clarify the enrollment and eligibility criteria for employers and dependents, and modify provisions regarding termination of Healthcare Group coverage.

In 1988, the Arizona Legislature created the Healthcare Group (HCG) Program to offer health care coverage to a segment of the market, small businesses, that the Legislature felt were not adequately served by commercial insurers. Typically, commercial insurers "rate" small groups; that is, the premium for the group is based on the health histories

of the individual members. As a result, the premiums for the employee with a history of illness and the other members of the group are often prohibitively expensive. Under A.R.S. § 36-2912, the Healthcare Group Program was designed to offer health coverage to small groups without "rating" prospective members based on individual histories. In effect, the risk is spread over all participants in the program equally rather than being assigned to the individual employer.

The Healthcare Group Program consists of contracts between the Health Care Group Administration (HCGA) and small employers that wish to offer, as an employment benefit, health coverage for themselves, their employees and their dependents. These contracts are known as Group Service Agreements or GSAs. HCGA has responsibility for the design of those contracts and for determining the eligibility of employers and covered persons. HCGA also establishes premium rates sufficient to cover the risk and collects those payments from the employer.

Currently, the HCG Program offers four different options to participating employers, employees, and their dependents. In general terms, these options vary based on the level of copayments, coinsurance, and deductibles, and to some extent on the scope of covered services (that is, some of the options are more comprehensive than others). Although HCGA does not consider the health history of individuals in setting premiums, each of the options has a different premium schedule that takes into consideration the age, sex, and location of the member, as well as the option selected. Individual employees of an employer can select from the available options. HCGA does not prescribe any level of employer participation in the financial cost – they may cover the cost themselves, share the cost with the employees, or simply allow payroll deduction for the employee, with the employee carrying the full cost.

In general, participation in Healthcare Group is limited to employers of fewer than 50 persons. Under the current statute, the employer must not have offered group health insurance during the 180-day period prior to HCG coverage. This limitation was designed to provide reasonable assurance to the commercial health insurance industry that the market consisted of the uninsured, thereby minimizing the loss of commercial carriers to Healthcare Group. Since July 1, 2005, the program has been funded solely by the premiums paid. Participation on both the employer level and the individual employee level is voluntary.

With respect to the actual delivery of services, HCGA currently assigns employers to a managed care entity ("health plan") under contract with HCGA, or where choice is available, allows the employer to select from HCG-contracted managed care entities. The contracts between HCGA and the health plan define the network of providers from whom service is received and the responsibility for medical management and payment of claims consistent with the terms of the health plan contract and the contract between HCGA and the employer. These health plans are "at risk"; that is, the agency pays the health plan on a per member per month basis, and in return, the health plan is obligated to cover the costs of all medical care covered under the GSA regardless of the actual cost of those services. Essentially, they operate like Health Maintenance Organizations.

At the outset of the HCG Program, the agency exercised its discretion to administer the Program in a fashion similar to the other health programs administered by the agency. At the time, all of the participating health plans also participated in the other AHCCCS programs, thus the uniformity offered the advantage of simplified administration for both the agency and its contracted health plans. During the past few years and legislative sessions, there has been a recognition that the HCG Program can more effectively meet the needs of small business through greater program flexibility. For instance, recent statutory changes permit the agency to contract directly with providers and with third parties to assist with the administration of the program. This enables the Program to offer a Preferred Provider Network ("PPO"), in addition to the closed network of the HMO-style product offered through the health plans. Under the PPO model, the agency manages the risk itself and adjusts premiums, if necessary, through contract amendments to cover the claims experience associated with the PPO product.

Of particular importance are modifications to the rules that define the scope of services offered by the Program. By statute, the agency has the discretion to establish the scope of services under the GSAs. However, the current rules restrict the program from offering a broader array of services that many employers are willing to pay for. It is also possible that the current rules could be interpreted to require the coverage of certain services that are perceived as of little value to employers or are offered under terms that make the fiscally sound premiums excessive from the employer's perspective. These rules set forth the basic terms of coverage without unduly restricting or mandating services. As noted in the rules, the details of coverage are reflected in the terms of the Group Service Agreement and are described in the member handbooks that are available to prospective members and provided to all active members. In effect, these rules provide notice to the public of the availability of the program, but permit the agency the flexibility to tailor health care benefit options to the needs of different segments of the target market.

Essentially, the HCG Program consists of a series of voluntary contracts between the agency and small employers, between the agency and HMO-style managed care entities, and potentially between the agency and providers and administrative entities. Under A.R.S. § 41-1005(15), matters relating to state contracts are exempt from the requirements of formal rulemaking. The agency's objective is to use the published rules as a means by which interested employers or employees can obtain basic information regarding the program but to refer them to the actual contracts for details.

The Healthcare Group Program consists of contracts between the Health Care Group Administration and small employers that wish to offer, as an employment benefit, health coverage for themselves, their employees and their dependents. These contracts are known as Group Service Agreements or GSAs. HCGA has responsibility for the

design of those contracts and for determining the eligibility of employers and covered persons. HCGA also establishes premium rates sufficient to cover the risk and collects those payments from the employer.

HCGA was created as a division within the Administration in 1988 to provide affordable and accessible health care benefit plans for Arizona small businesses with 50 or fewer employees. Only 28% 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. State legislation was enacted in 2004 that allows Healthcare Group to offer health care plans to employees of political subdivisions in the state, in addition to small businesses. As of November 1, 2006, Healthcare Group provided health care coverage to 24,011 subscribers in all fifteen counties in the state.

HCGA intends to offer a greater variety of affordable health care plans in order to provide health care coverage to an increasing number of employees and to help reduce the substantial number of uninsured Arizona citizens. Healthcare Group provides health care coverage in the rural areas of the state through the PPO Plan and intends to offer additional health care options in the rural areas. A greater number and more diverse types of health plans will be offered to employees, who may otherwise not have affordable health care coverage.

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

None

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

Not applicable

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

The rules are expected to have a minimal economic impact on consumers and small businesses. A minimal impact is defined as under $1,000. The rules modify definitions and other provisions relating to health care coverage available from Healthcare Group to small businesses with 1 to 50 employees, employees of political subdivisions in the state, and to persons who qualify for the federal health care coverage tax credit. The Administration will incur a minimal cost to prepare and publish the rulemaking.

The rules offer small businesses and employees who qualify for health care coverage through Healthcare Group an option to obtain affordable individual or family health care coverage, which is beneficial to the employers, employees, and their families. Now one out of every five residents or approximately 1,000,000 Arizona residents is uninsured. Availability of this coverage allows employees and their families to obtain health care coverage rather than being uninsured or enrolling in government-subsidized coverage, such as AHCCCS or Kids Care, thereby saving taxpayers substantial amounts of both state and federal monies. Savings of state and federal dollars results due to employers and employees choosing to pay for their health care coverage rather than enrolling in government-subsidized coverage. The premium for Healthcare Group coverage is paid by the employer, the employee, or by both the employer and the employee. The Healthcare Group program does not receive any state general fund appropriations to operate the program and is self-supporting from premium collections, so there is no additional cost to the state to operate the program.

Cost savings will also accrue to hospitals due to more individuals obtaining health care coverage rather than remaining uninsured and increasing hospital uncompensated care costs when hospitalization is required. Another positive impact of increasing the number of individuals with health care coverage is the reduction of sick leave usage with no reduction in worker productivity.

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

The following difference in rule language was made between the proposed rules and the final rules identified below.

In rule R9-27-310 (C)(3) and (F)(5), a cause for termination was described as a "violation of a provision of the member handbook"; the Administration decided to retain "material" from the existing language. The provisions now read: "violation of a material provision of the member handbook."

The Administration made the rules more clear, concise, and understandable by making grammatical, verb tense, punctuation, and structural changes throughout the rules.

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

The Administration did not receive any comments regarding the rules.

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

Not applicable

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

Not applicable

14. Were these rules previously adopted as emergency rules?

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

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

ARTICLE 1. DEFINITIONS

Section
R9-27-101. Location of Definitions

ARTICLE 2. SCOPE OF SERVICES

Section
R9-27-202. Covered Services
R9-27-204. ~~Out-of-Network Coverage of~~ Emergency Medical Services
R9-27-210. Pre-existing Conditions

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

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

ARTICLE 4. ~~CONTRACTS AND GSAS~~ Repealed

Section
R9-27-401. ~~General~~ Repealed

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

Section
R9-27-509. Information to ~~Enrolled Members~~ Subscribers

ARTICLE 7. ~~STANDARD~~ STANDARDS FOR PAYMENTS

Section
R9-27-702. ~~Prohibition Against Charges to Members~~ Charges to Members
R9-27-703. Payments by an HCG ~~Plans~~ Plan
R9-27-704. ~~HCG Plan's Liability to Noncontracting Hospitals for the Provision of Emergency and Subsequent Care to Enrolled Members~~ Liability of an HCG Plan to a Noncontracting Hospital for the Provision of Emergency and Post-stabilization Services to Members

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
"Ambulance"	A.R.S. § 36-2201
"Certification"	29 U.S.C. 1181
"Clean claim"	A.R.S. § 36-2904

"COBRA continuation provisions"	A.R.S. § 36-2912
"Coinsurance"	R9-27-101
"Copayment"	R9-27-101
"Covered services"	R9-27-101
"Creditable coverage"	A.R.S. § 36-2912
"Day"	R9-27-101
"Deductible"	R9-27-101
"Dependent"	R9-27-101
"Disability"	R9-27-303
"Effective date of coverage"	R9-27-101
"Eligible employee"	A.R.S. § 36-2912
"Emergency ambulance service"	R9-27-101
"Emergency medical services"	R9-27-101
"Employee" ~~member"~~	R9-27-101
~~"Employer group"~~	~~R9-27-101~~
"Employer"	R9-27-101
"Employer group"	R9-27-101
"Enrollment"	R9-27-101
~~"Evidence of coverage (EOC)"~~	~~R9-27-101~~
"Experimental ~~Services"~~ services"	R9-27-101
~~"FDA"~~	~~R9-27-101~~
"Full-time employee"	R9-27-101
"GSA"	R9-27-101
"HCG"	R9-27-101
"HCGA" ~~or "Healthcare Group Administration"~~	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
"Hospital"	R9-27-101
"Inpatient hospital services"	R9-27-101
"Late enrollee"	R9-27-101
"Medical services"	A.R.S. § 36-401
"Medically necessary"	R9-27-101
"Member"	R9-27-101
"Member handbook and evidence of coverage" or "member handbook"	R9-27-101
"Network"	R9-27-101
"Network provider"	R9-27-101
"Political subdivision"	R9-27-101
"Post-stabilization services"	R9-27-101
"Pre-existing condition"	A.R.S. § 36-2912
"Pre-existing condition exclusion"	A.R.S. § 36-2912
"Premium"	R9-27-101
"Pre-payment"	R9-27-101
"Prior authorization"	R9-27-101
"Qualifying event"	R9-27-101
"Scope of services"	R9-27-101
"Spouse"	R9-27-101
"Subcontract"	R9-27-101
"Subscriber"	R9-27-101
"Subscriber enrollment form"	R9-27-101
"Substantial gainful activity"	R9-27-303
"United States"	R9-27-101
"Waiting period"	A.R.S. § 36-2912

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

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

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

~~"Coinsurance" means an amount specified in a GSA that 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.~~

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

~~"Copayment" means an amount specified in a GSA that a member pays directly to a provider at the time a covered service is rendered.~~

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

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

"Day" means a calendar day unless otherwise specified.

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

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

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

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

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

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

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

"Employee" means a person employed by an employer, a person who is self-employed, or a person who is eligible for a federal health coverage tax credit under 26 U.S.C. 35. A self-employed person shall meet the criteria specified in R9-27-301.

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

~~"Employer group" means a group or a self-employed person who meets the criteria specified in R9-27-301.~~

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

~~"Employee member" means an enrolled employee of an employer group, a person who is self-employed, or a person who is eligible for a federal health coverage tax credit under 26 U.S.C. 35. A self-employed person shall meet the criteria specified in R9-27-301.~~

~~"Enrollment" means the process in which an eligible employee and dependents, if any, are qualified to receive HCG services by selecting an HCG benefit plan and completing and submitting all necessary documentation specified by HCGA under R9-27-302; and the HCG Plan receiving the full required premium no later than the date specified in the GSA.~~

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

~~"Evidence of Coverage (EOC)" means a document that lists covered services, limitations, exclusions, coinsurance, copayments, and deductibles that apply to the member's choice of coverage.~~

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

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

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

~~"FDA" means the U.S. Food and Drug Administration.~~

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

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

~~"HCG" means Healthcare Group of Arizona, the registered name of the Healthcare Group Program, a medical coverage product marketed by the HCGA to small uninsured businesses and political subdivisions within the state.~~

~~"HCGA" or "Healthcare Group Administration" 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 a member selects on enrollment or renewal.~~

~~"HCG Plan" means a health plan offered by HCGA or by an entity that is under contract with the HCGA to provide covered or administrative services to members.~~

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

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

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

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

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

Coverage that is issued as a supplement to liability insurance;

Medicare supplemental insurance;

Workers' compensation insurance; or

Automobile medical payment insurance.

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

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

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

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

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

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

Prolong life.

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

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

~~"Member handbook" means the written description that HCGA provides to each member on enrollment, of the rights and responsibilities of members of HCG.~~

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

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

"Network" means the affiliation of physicians, hospitals and other providers that provide health care services to members through contracts with HCGA or HCG Plans.

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

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

"Post-stabilization services" means covered services related to an emergency medical condition provided after the condition is stabilized.

"Premium" means the entire monthly pre-payment amount due to HCGA by the employer ~~group.~~ for coverage of medical benefits for all subscribers and dependents.

"Pre-payment" means the monthly submission ~~of the employer group's~~ by the employer or any eligible employee of the full premium payment at least 30 days in advance of coverage under the GSA.

"Prior authorization" means the process by which the HCGA or the HCG Plan informs a provider that it has made a preliminary determination that a requested service is medically necessary, appropriate, and is a covered service. Prior authorization is not a guarantee of payment

"Qualifying event" means a situation as described in the GSA that enables a person to enroll outside a designated open enrollment period without being considered a late enrollee, or to obtain continuation coverage, if applicable.

"Scope of services" means the covered, limited, and excluded services listed in Article 2 of this Chapter, the GSA, and the member handbook**.**

"Spouse" means a husband or a wife of an HCG ~~member~~ subscriber who has entered into a marriage recognized as valid by the state of Arizona.

"Subcontract" means an agreement entered into by HCGA or an HCG Plan with any of the following:
A provider of health care services who agrees to furnish covered services to members,
A marketing organization, or
Any other organization to serve the needs of the HCG Plan**.**

"Subscriber" means an enrolled HCG employee, including a person who meets the eligibility requirements for the federal health coverage tax credit under 26 U.S.C. 35 (Section 35 of the Internal Revenue Code of 1986).

"Subscriber enrollment form" means the form that a subscriber fills out to select and enroll in an HCG Plan and to choose a deductible.

"United States" means the 50 states, the District of Columbia, and includes the territorial waters adjoining these entities. A ship or an aircraft, even of American registry, is not considered to constitute American territory when it is not within or above the land area or territorial waters of the United States.

ARTICLE 2. SCOPE OF SERVICES

R9-27-202. Covered Services

~~Covered services. Subject to the exclusions and limitations specified in this Article, the GSA, and the member handbook, and subject to coinsurance, copayments, and deductible requirements, an HCG Plan shall cover services specified under the GSA.~~
Covered services. HCGA or an HCG Plan shall provide covered services to members as specified in the GSA.

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

~~**A.** Emergency medical services provided outside the HCG Plan's network are covered, based on the prudent layperson standard under 42 U.S.C. 1396u-2, if:~~
~~1. The member presents for emergency medical services at a medical facility; and~~
~~2. The member or provider notifies the HCG Plan no later than 48 hours from the day that the member presents for the emergency service. Failure to provide timely notice constitutes cause for denial of payment unless the member or provider shows good cause.~~
~~**B.** Emergency ambulance services required to transport a member to a medical facility that provides emergency services are covered if the provider notifies the HCG Plan within 10 working days from the day that the member presents for emer-~~

~~gency ambulance service. Failure to provide notice within 10 working days constitutes cause for denial of payment unless the provider shows good cause.~~

~~**C.** The financial liability of HCG for coverage for out-of-network emergency services may be limited under the terms of the GSA. Members receiving out-of-network emergency services may be financially liable to an out-of-network provider to the extent charges by the provider exceed the financial liability established in the GSA.~~

A. Emergency medical services provided at a medical facility in the United States are covered when a member presents for emergency medical services regardless of whether the services are provided within or outside the network if the member or provider notifies the selected HCG Plan no later than 48 hours from the day that the member presents for the emergency service. Failure to provide timely notice constitutes cause for denial of payment unless the member or provider shows good cause. All emergency medical services are subject to review after services are received to ensure that the services are emergent and are covered, medically necessary services.

B. Emergency medical services provided outside the United States are not covered.

R9-27-210. Pre-existing Conditions

A. Pre-existing conditions exclusions. ~~Subject to subsection (B), an HCG Plan shall not cover~~ Except as provided in subsection (B), any health and medical services related to a pre-existing condition are not covered as specified in A.R.S. § 36-2912 and the GSA.

B. Pre-existing conditions coverage. ~~An HCG Plan shall cover pre-existing conditions for the following:~~ Health and medical services relating to pre-existing conditions for the following individuals are covered:

1. Newborns from the time of birth, adopted children, and children placed for adoption, if enrolled within the timeframes set forth in the GSA;
2. ~~An employee~~ A subscriber eligible under ~~R9-27-302(A)(1)~~ R9-27-302 who meets the aggregate periods of creditable coverage as calculated under A.R.S. § 36-2912 of 12 months or 18 months in the case of a late enrollee.

C. Credit for prior health coverage. ~~An HCG Plan shall apply~~ A member shall receive a credit toward meeting the 12-month or 18-month pre-existing condition exclusion period of one month for each month of continuous coverage that ~~an eligible employee had~~ a member received ~~under another HCG Plan~~ from HCG/HCGA or an accountable health plan under A.R.S. § 36-2912. Upon request, ~~a contracted health plan~~ an HCG Plan ~~or an accountable health plan~~ that provided continuous coverage to a person shall disclose the coverage provided.

~~**D.** Late enrollee pre-existing conditions time-frames. An HCG Plan shall exclude coverage for a pre-existing condition for a late enrollee according to A.R.S. § 36-2912.~~

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-27-301. Eligibility Criteria for ~~Employer Groups~~ Employers

A. Criteria for ~~employer groups.~~ employers.

~~1. The eligibility requirements for an employer group to obtain health care coverage through an HCG Plan are as follows:~~

~~a. The employer group shall conduct business for at least 60 days within Arizona before applying to HCGA; and~~

~~b. The employer group shall conduct business in a county with an established HCG Plan.~~

~~2. 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.~~

1. To be eligible for health care coverage through HCG, an employer shall:
   a. Conduct business in the state of Arizona for at least 60 days before applying to HCGA.
   b. Have a minimum of one (self-employed) and a maximum of 50 eligible full-time employees on the effective date of the first GSA with HCGA.
2. R9-27-301(A)(1)(b) does not apply to political subdivisions.

B. ~~Employer group's~~ Employer's prior health care coverage. HCGA shall not enroll an employer ~~group~~ in Healthcare Group sooner than 180 days after the date that the employer's health care coverage under an accountable health plan is discontinued. ~~An employer group's~~ An employer's enrollment in ~~Healthcare Group~~ HCG is effective on the first day of the month after the 180-day period. The 180-day enrollment restriction does not apply to an employer ~~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 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:~~ Required initial enrollment of a minimum percentage of eligible employees. An employer other than a political subdivision shall meet the following enrollment percentages on the effective date of the first GSA with HCGA:

1. ~~Has five or fewer eligible full-time employees and enrolls~~ An employer with five or fewer eligible full-time employees shall enroll 100 percent of these employees in an HCG Plan, or
2. ~~Has six or more eligible full-time employees and enrolls~~ An employer with six or more eligible full-time employees shall enroll at least 80 percent of these employees in an HCG Plan.

D. Full-time employees with proof of other health care coverage. Full-time employees with proof of existing health care coverage who elect not to participate in ~~an HCG Plan~~ HCG shall not be considered when determining the required percentage

of enrollees, specified in subsection (C), if the health care coverage is one of the following:
1. Group coverage provided through a spouse, parent, legal guardian; or
2. Medical assistance provided by a government-subsidized health care program; or
3. Medical assistance provided under A.R.S. § 36-2982; or
4. Individual coverage or health care coverage through another employer.

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

F. Review and verification of eligibility. ~~determination. The HCGA may conduct random reviews of an eligibility determination of an employer group and its employees.~~ HCGA may conduct random reviews for continued eligibility of an employer and the members.

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

A. Eligibility criteria for employees. An eligible employee shall:
1. Be eligible for a federal health coverage tax credit under 26 U.S.C. 35 as specified in A.R.S. § 36-2912 (AA)(4)(d); or
2. ~~Be employed or 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:~~ Be employed by an enrolled employer with a contract with HCG as specified in R9-27-301; and
   a. Work at least 20 hours per week for the ~~employer group; and~~ employer; and
   b. Meet other requirements as specified in the GSA.

B. Enrollment criteria for eligible employees. An eligible employee ~~and dependent~~ and an eligible dependent may receive HCG coverage if all of the following occur:
1. ~~The~~ An eligible employee selects ~~an HCG benefit plan;~~ health care coverage through HCG;
2. ~~The~~ An eligible employee completes and submits all necessary documentation specified by HCGA, including the ~~employee~~ subscriber enrollment ~~information~~ form and health history forms~~;~~ for the eligible employee and each applying family member; and
3. HCGA receives the full required premium no later than the date specified in the GSA.

C. After completion of the actions in subsection (B), HCGA shall send written notification of the effective date of coverage to the ~~eligible employee and dependent.~~ subscriber and dependent.

D. 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.

~~**E.** Continuation Coverage. An employee member and dependent who are entitled to continuation coverage under COBRA continuation provisions after termination of employment may retain HCG coverage until the benefit expires, the continuation coverage ends, or the premium is not paid by the employee, whichever is earlier.~~

R9-27-303. ~~Eligibility Criteria for Dependents~~ Dependent Eligibility Criteria

A. Eligible dependents. An eligible dependent of an employee member includes:
1. A legal spouse;
2. ~~Unmarried children~~ An unmarried child less than the age of 19 or less than the age of 24 if the child is a full-time student, and is:
   a. A natural child,
   b. An adopted child or a child who is placed for adoption,
   c. A step-child, or
   d. A child for whom the ~~employee member~~ subscriber or enrolled spouse is a legal guardian.
3. An unmarried child, as specified in subsection (A)(2), of any age with a disability that existed before the child's 19th birthday, as determined by HCGA through ~~its~~ the HCGA Medical Director.

B. For the purposes of this Section:
1. "Disability" means the inability to do any substantial gainful activity by reason of any impairment or combination of impairments that HCGA through the ~~HCG~~ HCGA Medical Director expects to be permanent and continuous. The impairment must result from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques. Medical evidence consisting of signs, symptoms, and laboratory findings, not only the member's statement of symptoms, establishes an impairment.
2. "Substantial gainful activity" means work that:
   a. Involves doing significant and productive physical or mental duties, and
   b. Is done or intended for pay or profit.

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

A. Enrollment. ~~A member who meets the eligibility requirements may select an HCG benefit plan under the terms and during the periods specified in the GSA, including the following situations:~~ A member who meets the eligibility requirements may select and enroll in HCG coverage under the terms of the GSA at any time. In order not to be considered a late enrollee, an eligible member shall enroll during the qualifying event periods specified in the GSA:
1. ~~When an employer member signs the GSA;~~ Within 31 days following the effective date of the initial GSA with the

employer;
2. ~~When a qualifying event occurs as prescribed in the GSA;~~ Within 31 days after the qualifying event occurs;
3. When the open enrollment period occurs as specified in the GSA; or
4. ~~When the existing health care coverage for an eligible employee or any dependent terminates.~~ Within 31 days following the termination of health care coverage for an eligible subscriber or dependent.

B. Effective date of coverage. The HCGA shall establish the effective date of coverage for an employer group or ~~an employee member under an HCG benefit plan~~ a subscriber or dependent and shall provide written notice of the effective date of coverage to the ~~employee member and the employer group.~~ employer as provided under this Chapter.

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

~~**A.** Termination of a member's coverage within 10 days. The HCGA or HCG Plan may terminate a member's coverage effective 10 days from the date the HCGA or HCG Plan mails a written notice of termination of coverage to the member's last known address, for any of the following reasons:~~
~~1. Clear and convincing evidence of fraud or misrepresentation material to enrollment or factors listed in A.R.S. § 36-2912(P) that impact the premium when the member applies for coverage or obtains services;~~
~~2. Committing or threatening to commit violence toward employees or agents or HCGA, an HCG Plan, network providers, or out-of-network providers.~~

~~**B.** Termination with 30-day written notice. The HCGA or an HCG plan may terminate a member's coverage effective 30 days from the date the HCGA or HCG Plan mails a written notice of termination of coverage 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, or deductible;~~
~~3. Violating a material provision of the member handbook;~~
~~4. Terminating employment;~~
~~5. Change in age or other status of the member that is required for eligibility under R9-27-302;~~
~~6. Changes to the eligibility criteria for a dependent under R9-27-303;~~
~~7. Failure of the member's employer to pay the premium; or~~
~~8. 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.~~

~~**C.** Effective date of termination of hospitalized member. Subject to continuation coverage as described in R9-27-302(E), on the effective date of termination of coverage, the HCG Plan has no further obligation to provide services and benefits to a member whose coverage terminates, except that a member who is an inpatient 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 members, except a hospitalized member, shall terminate on the effective date of the termination of the employee member's coverage. For coverage of a hospitalized member to continue under this Article, HCGA shall continue to receive timely paid premiums.~~

~~**D.** Exclusion from eligibility and enrollment. The HCGA may 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 for any of the following reasons:~~
~~1. Clear and convincing evidence of fraud or misrepresentation material to enrollment or factors listed in A.R.S. § 36-2912(P) that impact the premium when the member applies for coverage or obtains services;~~
~~2. Committing or threatening to commit violence toward employees or agents of HCGA, an HCG Plan, network providers, or out-of-network providers;~~
~~3. Repeated and unreasonable demands for unnecessary medical services;~~
~~4. Failure to pay any copayment, coinsurance, or deductible; or~~
~~5. Violating a material provision of the member handbook.~~

A. Immediate termination of a member's coverage. HCGA may terminate a member's coverage effective immediately for any of the following reasons:
1. Clear and convincing evidence of fraud or misrepresentation regarding enrollment or factors listed in A.R.S. § 36-2912 when the member applies for coverage or obtains services;
2. Committing or threatening to commit violence toward an employee or an agent of HCGA, an employee or an agent of an HCG Plan, including a network provider or an out-of-network provider.

B. Written notice. For immediate termination of a member's coverage under subsection (A), HCGA shall mail a notice of termination of coverage to the member's last known address within one business day after HCGA terminates a member's coverage. The notice shall state the date and time coverage was terminated and the reason for termination.

C. Termination of a member's coverage with 30-day notice. HCGA may terminate a member's coverage 30 days from the date of the notice for any of the following reasons:
1. Repeated and unreasonable demands for unnecessary or uncovered medical services;
2. Failure to pay any copayment, coinsurance, or deductible;

3. Violation of a material provision of the member handbook;
4. Termination of employment;
5. Change in status of the member that is required for eligibility under R9-27-302; or
6. Changes to the eligibility criteria for a dependent under R9-27-303.

D. Written notice. For termination of a member's coverage with 30 days notice under subsection (C), HCGA shall mail a notice of proposed termination to the member's last known address. The notice shall state the reason for proposed termination and the date coverage will be terminated.

E. Termination of an employer group. If HCGA does not receive the full premium payment from an employer for an employer group by the premium due date specified in the GSA, HCGA shall send notice of the final due date to the employer at the employer's last known address. The notice shall advise the employer that HCGA must receive the full premium payment by the final due date contained in the notice and state the reason and date for the termination of coverage for the employer group if the full premium is not received by the final due date.

F. Exclusion of member from eligibility and enrollment. HCGA may exclude, as ineligible to enroll or re-enroll, any member whose prior health care coverage has been terminated by HCGA for any of the following reasons:
1. Clear and convincing evidence of fraud or misrepresentation regarding enrollment or criteria listed in R9-27-302 and R9-27-303 when the member applies for coverage or obtains services;
2. Committing or threatening to commit violence toward an employee or an agent of HCGA, an employee or an agent of an HCG Plan, including a network provider, or an out-of-network provider;
3. Repeated and unreasonable demands for unnecessary or uncovered medical services;
4. Failure to pay any copayment, coinsurance, or deductible;
5. Violation of a material provision of the member handbook.

G. Exclusion of an employer from eligibility and enrollment. HCGA may exclude, as ineligible to enroll or re-enroll, an employer whose prior health care coverage has been terminated by HCGA for any of the following reasons:
1. Violating a provision of the GSA;
2. Committing or threatening to commit violence toward an employee or an agent of HCGA, an employee or an agent of an HCG Plan, including a network provider, or an out-of-network provider;
3. Clear and convincing evidence of fraud or misrepresentation regarding eligibility and enrollment criteria for an employer in R9-27-301.

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

A. Except as specified in subsection (B), HCG coverage for a member shall terminate on the date specified in the notice mailed to the member as provided in R 9-27-310 (B), (D), or (E).

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

R9-27-312. Continuation Coverage

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

ARTICLE 4. ~~CONTRACTS AND GSAS~~ Repealed

R9-27-401. ~~General~~ Repealed

~~**A.** Contracts to provide services. The HCGA shall establish contracts to provide services with qualified HCG Plans under A.R.S. § 36-2912.~~

~~**B.** GSAs with employer groups. The HCGA shall establish GSAs with employer groups under A.R.S. § 36-2912.~~

~~**C.** Contracts and GSAs. Contracts and GSAs under A.R.S. § 36-2912 and on file with the HCGA are public records unless otherwise made confidential by law.~~

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-27-509. Information to ~~Enrolled Members~~ Subscribers

A. Member handbook. HCGA shall produce and distribute a printed member handbook to each ~~enrolled member~~ subscriber by the effective date of coverage or as otherwise stated in ~~contract.~~ the GSA. The member handbook shall include the following:
1. A description of all available services and an explanation of any service ~~limitation,~~ limitations, exclusions from coverage, and charges for services, when applicable;
2. An explanation of the procedure for obtaining covered services, including a notice stating that the HCG Plan is only liable for services authorized by a member's primary care provider or the HCG Plan;
3. ~~Locations, telephone numbers, and procedures for obtaining emergency medical services;~~ Procedures for obtaining emergency medical services;

4. An explanation of the procedure for obtaining emergency medical services outside the ~~HCG Plan's service area;~~ network of an HCG Plan;
5. ~~Causes for which~~ Circumstances under which a member may lose coverage;
6. A description of the grievance and request for hearing procedures;
7. Copayment, coinsurance, and deductible schedules;
8. Information on obtaining health services and on the maintenance of personal and family health; and
9. Information regarding ~~emergency and medically necessary~~ medically necessary emergency transportation offered by ~~the HCG Plan; and~~ an HCG Plan.

~~10. Other information necessary to use the program.~~

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

ARTICLE 7. ~~STANDARD~~ STANDARDS FOR PAYMENTS

R9-27-702. ~~Prohibition Against Charges to Members~~ Charges to Members

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

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

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

~~**A.** A HCG Plan is not responsible for reimbursing a provider if the member requests provision of services, other than emergency medical services, that are excluded under the GSA, have not been authorized by the HCG Plan, or are not the result of a referral to the provider by the HCG Plan or the member's primary care physician.~~

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

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

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

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

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

R9-27-704. ~~HCG Plan's Liability to Noncontracting Hospitals for the Provision of Emergency and Subsequent Care to Enrolled Members~~ Liability of an HCG Plan to a Noncontracting Hospital for the Provision of Emergency and Post-stabilization Services to Members

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

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

NOTICE OF FINAL RULEMAKING

TITLE 13. PUBLIC SAFETY

CHAPTER 8. DEPARTMENT OF PUBLIC SAFETY
LOCAL RETIREMENT BOARD

[R07-149]

PREAMBLE

1. Sections Affected **Rulemaking Action**

R13-8-101	Amend
R13-8-103	Amend
R13-8-104	Amend
R13-8-105	Amend
R13-8-106	Amend
R13-8-109	Amend
R13-8-110	Amend
R13-8-111	Amend
R13-8-112	Amend
R13-8-115	New Section

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. § 38-847(F)

Implementing statute: A.R.S. §§ 12-2292, 38-431.03, 38-844, 38-844.02, 38-844.05, 38-844.10, 38-847

3. The effective date of the rules:

June 30, 2007

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

Notice of Rulemaking Docket Opening: 11 A.A.R. 1062, March 11, 2005
Notice of Rulemaking Docket Opening: 12 A.A.R. 3905, October 20, 2006
Notice of Proposed Rulemaking: 12 A.A.R. 4609, December 15, 2006

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

Name:	Robert Ortega, Secretary to the Local Retirement Board
Address:	Department of Public Safety 2101 W. Encanto Blvd. P.O. Box 6638 Phoenix, AZ 85005-6638
Telephone:	(602) 223-2147
Fax:	(602) 223-2921
E-mail:	rortega@azdps.gov

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

The purpose of this rulemaking is to update the Board's rules to ensure their consistency with relevant statutes that have been amended or adopted since the Board's last rulemaking endeavor. The rules address administrative procedures of the Board in implementing its statutory duties.

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

None

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

Not applicable

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

The economic, small business and consumer impact of these amended rules and new rule will be minimal because the rules simply update and clarify the procedures required by state law.

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

The Board made two unsubstantial changes between the proposed rules and the rules submitted to G.R.R.C.; the changes can be described as typographical changes. In R13-8-111(A), a hyphen was inserted between the words "self" and "employment" in the sixth line of the rule as published. In R13-8-115(C), the word "reasonable" was changed to "reasonably." In addition, the Board made other minor changes at the suggestion of G.R.R.C. staff involving punctuation and involving minor word revisions in R13-8-103(E), R13-8-104(C), R13-8-105(H), R13-8-106, R13-9-109(A), R13-8-110(A), the title to R13-8-111, R13-8-111, R13-8-112 and R13-8-115(B).

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

No written or oral comments were received by the agency.

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

None

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

None

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

No

15. The full text of the rules follows:

TITLE 13. PUBLIC SAFETY

CHAPTER 8. DEPARTMENT OF PUBLIC SAFETY LOCAL RETIREMENT BOARD

ARTICLE 1. PROCEDURES

Section

ARTICLE 1. PROCEDURES

R13-8-101. Definitions and Interpretation

A. "System" means the Public Safety Personnel Retirement System, created by the provisions of A.R.S. Title 38, Chapter 5, Article 4 (A.R.S. § 38-841 et seq.).

B. "Local board" means the Department of Public Safety Local Retirement Board for the Public Safety Personnel Retirement System established pursuant to A.R.S. § 38-847.

C. "Secretary" means the secretary of the local board.

D. "DROP" means deferred retirement option plan.

~~**D.**~~**E.** Interpretation and application of the rules in this Chapter shall be consistent with the definitions set forth in A.R.S. § 38-842.

R13-8-103. New Memberships

A. Within one month of hire, the secretary shall distribute membership forms to the newly employed commissioned officers.

B. After receipt of completed membership forms, the secretary shall request each applicant's medical report from the medical advisor of the Department of Public Safety and review the medical reports. The secretary shall report to the local board when the medical ~~advisor has indicated that any applicant has a condition which required a category II medical review for compliance with the Arizona Peace Officer Standards and Training Board medical requirements.~~ report indicates a pre-existing physical or mental condition or prior injury.

C. The local board at its regularly scheduled meetings shall review the applications for new membership for eligibility in the

system and the medical reports of any applicants with a ~~medical waiver.~~ pre-existing physical or mental condition or prior injury.

D. If an applicant has a physical or mental condition or injury that existed or occurred prior to the date of membership in the system, but is otherwise eligible for membership, the local board shall approve membership, excluding accidental, catastrophic, or ordinary disability benefits relating to the ~~preexisting~~ pre-existing physical or mental condition or injury.

E. If the local board denies membership or approves membership with an exclusion based on a ~~preexisting~~ pre-existing condition or prior injury, the secretary shall so notify the applicant in writing.

F. The local board may review on its own initiative and redetermine its prior decisions on membership and exclusions. The local board shall notify any member of any meeting at which the local board will review a prior decision affecting a member's membership.

R13-8-104. Normal Retirement ~~and,~~ Deferred Retirement, Deferred Retirement Option Plan (DROP) and Reverse DROP

A. When a member applies for normal retirement ~~or,~~ deferred retirement, DROP, or reverse DROP, the member shall be provided with the appropriate forms, information on the documentation required, and assistance in applying for retirement benefits.

B. When all required forms and documentation have been fully completed and submitted to the secretary, the application for normal retirement ~~or,~~ deferred retirement, DROP, or reverse DROP shall be placed on the agenda for the next regularly scheduled meeting of the local board, provided the submission is completed ten calendar days prior to the meeting.

C. ~~Upon a member's application, the~~ A member shall be permitted to address the local board when the local board is considering the member's application.

R13-8-105. Disability Retirement

A. When a member applies for ordinary, accidental, catastrophic, or temporary disability pension, the member shall be provided with the appropriate forms, information on the documentation required, and assistance in applying for a disability pension.

B. When all required forms and documentation have been fully completed and submitted to the secretary, the secretary shall schedule the appointed Medical Board, notify the claimant of the date, time, and location of the Medical Board examination, and forward the application and all appropriate papers to the Medical Board.

C. If the claimant is applying for an ordinary disability pension, the local board shall request the Medical Board to address specifically:

1. Whether the claimant:
   a. Has a physical condition which totally and permanently prevents the claimant from performing a reasonable range of duties within the member's department, or
   b. Has a mental condition which totally and permanently prevents the claimant from engaging in any substantial gainful activity, and
2. Whether the claimant's disability is the result of a physical or mental condition or injury that existed or occurred prior to the claimant's date of membership in the system.

D. If the claimant is applying for an accidental disability pension, the local board shall request the Medical Board to address specifically:

1. Whether the claimant has a physical or mental condition which totally and permanently prevents the claimant from performing a reasonable range of duties within the member's job classification,
2. Whether the disabling condition was incurred in the performance of the member's job duties, and
3. Whether the claimant's disability is the result of a physical or mental condition or injury that existed or occurred prior to the claimant's date of membership in the system.

E. If the claimant is applying for a temporary disability pension, the local board shall request the Medical Board to address specifically:

1. Whether the claimant has a physical or mental condition which totally and temporarily prevents the claimant from performing a reasonable range of duties within the member's department, and
2. Whether the disabling condition was incurred in the performance of the member's job duties.

F. If the claimant is applying for a catastrophic disability pension, the local board shall request the Medical Board to address specifically:

1. Whether the claimant has a physical condition which totally and permanently prevents the claimant from engaging in any gainful employment,
2. Whether the disabling physical condition or injury was incurred in the performance of the claimant's employment duties, and
3. Whether the claimant's disability is the result of a physical condition or injury that existed or occurred prior to the claimant's date of membership in the system.

~~F.~~G. Upon receipt of the Medical Board's evaluation, the secretary shall forward a copy of the evaluation to the claimant, and the application for disability retirement shall be placed on the agenda for the next regularly scheduled meeting of the

local board, provided the evaluation is received ten calendar days prior to the meeting.

~~G.~~**H.** ~~Upon a member's application, the~~ A member shall be permitted to address the local board when the local board is considering the member's application.

R13-8-106. Medical Examination of and Recovery by Member with Accidental or Ordinary Disability

A. When the local board determines that a member qualifies for an ordinary or accidental disability retirement pension and the member will not reach normal retirement date within one year of the initial determination, the local board shall determine whether and when to request medical ~~examination~~ re-examination pursuant to A.R.S. § ~~38-844(D).~~ 38-844(E).

B. If the local board requests ~~the~~ a medical ~~examination,~~ re-examination, the secretary shall so calendar the requested medical examination; process and direct the relevant medical documents; notify the ~~pensioner~~ member of the date, time, and location of the medical examination; and forward appropriate documentation to the doctors or clinic performing the medical examination.

C. The local board shall request the Medical Board performing the medical ~~examination~~ re-examination to address specifically whether the ~~pensioner~~ member has sufficiently recovered to be able to engage in a reasonable range of duties within the member's ~~job classification.~~ department.

D. Upon receipt of the report of the medical ~~examination,~~ re-examination, the secretary shall forward a copy to the ~~pensioner~~ member and place the item on the agenda for the next regularly scheduled meeting of the local board, provided the report is received ten calendar days prior to the meeting.

E. The ~~pensioner~~ member shall be permitted to address the local board at any board meeting at which a determination on recovery may be made.

F. If the local board determines that the ~~pensioner~~ member has recovered sufficiently to be able to engage in a reasonable range of duties within the member's ~~job classification,~~ department, the local board shall ~~so~~ notify the ~~pensioner~~ member and the member's department. If the member's department makes an offer of employment to the member, and the member refuses an offer of employment from the member's department or from any employer in the system, the local board shall terminate benefits.

G. If the local board determines that the ~~pensioner~~ member has not recovered, the local board shall determine whether and when to request another medical ~~examination~~ re-examination pursuant to A.R.S. § ~~38-844(D).~~ 38-844(E).

H. Notwithstanding the provisions of subsections (A) and (G), the local board may request a medical ~~examination~~ re-examination pursuant to A.R.S. § ~~38-844(D)~~ 38-844(E) at any time prior to ~~a disability pensioner's~~ the normal retirement date of a member with a disability pension.

R13-8-109. Benefits Calculations

A. The local board delegates to the secretary the calculation of DROP benefits, service retirement benefits, ~~including all service retirements and surviving spouse, guardian, and eligible child benefits for deceased members who were receiving service retirements, and the calculation of~~ disability retirement benefits, and death benefits for ~~including all disability retirements,~~ surviving ~~spouse,~~ spouses of members and retired members, ~~guardian,~~ guardians, and ~~eligible child~~ eligible children. ~~benefits for deceased members who were receiving disability retirements, and surviving spouse, guardian, and eligible child benefits for non retired, deceased members.~~

~~B. Upon request by a member, the secretary shall estimate the amount of the monthly pension at the time the member applies for retirement.~~

~~C.~~**B.** Subsequent to the issuance of a member's last paycheck, the secretary shall calculate the member's service retirement benefits or the disability retirement benefits.

C. Subsequent to a member's last contribution to the System after approval of the member's participation in DROP, the secretary shall calculate the member's DROP benefit.

D. The member, surviving spouse, guardian, or eligible child shall receive notification of the calculation of benefits by receiving benefits from the system or by certified mail.

R13-8-110. Termination of Benefits

A. Upon the death of a retired member, the local board shall terminate the member's benefits effective the first day of the month following the death and shall ~~entertain~~ consider applications for survivor's benefits, if and when submitted.

B. When an eligible child is no longer eligible, the local board shall terminate the child's pension and, where appropriate, any guardian or conservator's pension.

R13-8-111. Income Reporting for ~~Substantial Gainful Employment of~~ Member with ~~Accidental or~~ Ordinary Disability Pension

~~A. For purposes of applying A.R.S. § 38-844(E), "substantial gainful employment" shall mean work, business, or activity in which the member is engaged for compensation unless the work, business, or activity is principally in or in conjunction with a recognized program of education, instruction, or training which allows a member receiving disability payments to acquire skills and knowledge necessary to seek employment in a field not covered by the system.~~

~~B. For purposes of applying A.R.S. § 38-844(E), "earned income" shall include income or other compensation received for labor performed or services rendered by a member on disability. Such income and other compensation includes wages,~~

~~salary, retainers, commissions, fees, and compensation for the member's labor or services which would otherwise be taxable as income, such as housing, automobile expenses, travel, and gifts. "Earned income" does not include income received by the member from savings accounts, stocks, bonds, proceeds from rental properties, promissory notes, and other forms of capital investments or from pensions, disability insurance, or social security.~~

~~C.~~**A.** No later than April 30 of each year, each member receiving ordinary disability payments during the period prior to the member's normal retirement date shall provide a notarized statement to the local board which identifies all ~~earned~~ income from employment, including self-employment, received by the member in the previous calendar year and describes the ~~work, business, or activities in~~ employment and self-employment from which the member ~~was engaged for compensation.~~ received income. The statement shall also include the fair market value of all benefits received by the member during the previous calendar year as compensation for such ~~work, business, or activity.~~ employment or self-employment. Copies of all income tax statements, 1099 forms, and W-2 forms reflecting the member's income for the previous calendar year shall be attached to the notarized statement.

~~D.~~**B.** Upon written request by a member, the local board may grant the member an additional 30 days to allow the member to provide the local board with the information required under subsection ~~(C).~~ (A).

~~E.~~**C.** If a member fails to report ~~earned~~ income as required by this rule, the local board shall suspend any further ordinary disability payments to the member until ~~such time as~~ the member reports ~~such earned~~ income for the previous year.

D. After the local board reviews the reported income information, the secretary shall return the copies of all income tax statements, 1099 forms, and W-2 forms to the member.

R13-8-112. Rehearing on Original Determination

A. The local board shall conduct rehearings pursuant to A.R.S. § 38-847(H) as though the rehearings were an adjudicative proceeding under A.R.S. Title 41, Chapter 6, Article 6 (A.R.S. § 41-1061 et seq.).

B. If the fund manager applies for a rehearing, the claimant whose benefit determination may be affected shall be a party to the proceeding.

C. By ten calendar days prior to the rehearing, the claimant or fund manager shall submit to the local board a list of witnesses whom the claimant or fund manager intends to call to testify at the hearing and of all exhibits which the claimant or fund manager intends to use at the hearing as well as a copy of all listed exhibits.

D. By ten calendar days prior to the rehearing, the claimant or fund manager may submit to the local board a written statement setting forth the facts of the case and a brief addressing relevant issues.

E. If the claimant, fund manager, or local board desires subpoenas pursuant to A.R.S. § 41-1062(A)(4), ~~said~~ the subpoenas shall be submitted at least ten calendar days prior to the rehearing to the secretary for issuance by the presiding hearing officer. Service of the subpoenas is the responsibility of the party requesting issuance of the subpoenas.

F. Applications for permission to take depositions pursuant to A.R.S. § 41-1062(A)(4) shall be submitted to the secretary for determination by the presiding hearing officer.

G. Unless the local board decides otherwise, the chairperson of the local board shall function as the presiding hearing officer. ~~The local board may appoint a hearing officer to preside over the rehearing and to make written findings of fact and conclusions of law and a written recommendation to the local board with respect to any issues presented at the rehearing.~~

H. The burden of proof for establishing a disability shall be with the claimant.

R13-8-115. Confidentiality of Medical Records and Data

A. Medical records and data of members held by the local board are confidential and are exempt from public copying and inspection requirements of A.R.S. § 39-121 et seq.

B. The local board shall discuss all medical records and specific medical data in executive session, including the taking of testimony that is specifically required to be maintained as confidential by state or federal law, unless the member signs a consent form to discuss the member's medical records and data in an open meeting.

C. The member, member's legal counsel, and only individuals whose presence is reasonably necessary in order for the local board to carry out its executive session responsibilities may attend an executive session pursuant to A.R.S. § 38-431.03(A)(2) to discuss the member's medical records and specific medical data.

NOTICE OF FINAL RULEMAKING

TITLE 14. PUBLIC SERVICE CORPORATIONS; CORPORATIONS AND ASSOCIATIONS; SECURITIES REGULATION

CHAPTER 4. CORPORATION COMMISSION – SECURITIES

[R07-148]

PREAMBLE

1. Sections Affected **Rulemaking Action**

R14-4-135 Amend

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

Authorizing statutes: A.R.S. §§ 44-1821 and 44-1845

Implementing statute: A.R.S. § 44-1843

Constitutional authority: Arizona Constitution, Article XV, §§ 6 and 13

3. The effective date of the rule:

June 30, 2007

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

Notice of Rulemaking Docket Opening: 12 A.A.R. 1425, April 28, 2006

Notice of Proposed Rulemaking: 12 A.A.R. 2288, June 30, 2006

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

Name: Abby Henig

Address: Arizona Corporation Commission, Securities Division
1300 W. Washington, Third Floor
Phoenix, AZ 85007-2996

Telephone: (602) 542-0187

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E-mail: ahenig@azcc.gov

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

R14-4-135 ("rule 135") provides an exemption from registration with the Arizona Corporation Commission ("Commission") for securities that qualify for federal registration with the United States Securities and Exchange Commission ("SEC") under the Multijurisdictional Disclosure System.

On July 1, 1991, the Multijurisdictional Disclosure System ("MJDS") became effective upon its implementation by the SEC and regulatory authorities in Canada. (SEC Release No. 33-6902; SEC Release No. 34-29354). The MJDS provides a mechanism for reciprocity in cross-border offerings of securities between the U.S. and Canada. The basis for this reciprocity is the principle of mutual acceptance of the home jurisdiction's disclosure requirements and securities registration review procedures. Under MJDS, a Canadian issuer that qualifies as a "substantial issuer" is able to use a registration statement prepared in accordance with Canadian requirements to offer its securities in the U.S. Such an offering may be part of a simultaneous offering in the U.S. and Canada, or it may be made only in the U.S. Except in special circumstances, the SEC will not conduct a review of the registration application in addition to the Canadian review for Canadian MJDS securities offerings. For offerings made simultaneously in both jurisdictions, the registration of the offering of securities will automatically become effective with the SEC when it is cleared by the Canadian securities regulator. Offerings made only in the U.S. will automatically obtain SEC effectiveness within a specified number of days after filing.

In order to accommodate MJDS offerings, the Commission adopted rule 135 in 1991, providing an exemption for MJDS offerings effective with the SEC, as long as a filing had been made with the Commission seven days before an offering in Arizona was made.

Since adoption of rule 135, the review period in Canada has been reduced. The Commission amended rule 135 so that offerings filed pursuant to the MJDS system become effective in Arizona upon the effective date with the SEC, provided that before the offer is made a prospectus or offering circular is filed with the Commission and the requisite fee is paid.

The impetus behind the original rulemaking was the encouragement of legitimate capital raising activities across national borders. Removal of the seven-day period underscores this original intent; predicating the exemption on the securities registration being effective with the SEC and offering materials being filed with the Commission ensures investor protection.

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

None

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

Not applicable

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

Pursuant to A.R.S. § 41-1055(D)(3), the Commission is exempt from providing an economic, small business, and consumer impact statement.

10. A description of the changes between the proposed rule, including supplemental notices, and the final rule:
None

11. A summary of the comments made regarding the rule and the agency response to them:
The Commission did not receive written comments to the rule.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:
None

13. Any material incorporated by reference and its location in the text:
None

14. Whether the rule was previously made as an emergency rule and, if so, whether the text was changed between the making as an emergency and the making of the final rule:
Not applicable

15. The full text of the rule follows:

TITLE 14. PUBLIC SERVICE CORPORATIONS; CORPORATIONS AND ASSOCIATIONS; SECURITIES REGULATION

CHAPTER 4. CORPORATION COMMISSION – SECURITIES

ARTICLE 1. IN GENERAL RELATING TO THE ARIZONA SECURITIES ACT

Section
R14-4-135. Exempt Securities – Multijurisdictional Disclosure System

ARTICLE 1. IN GENERAL RELATING TO THE ARIZONA SECURITIES ACT

R14-4-135. Exempt Securities – Multijurisdictional Disclosure System

An offering of securities within this state which has been declared effective with the U.S. Securities and Exchange Commission (the "SEC") on Form F-7, F-8, F-9, or F-10 shall be added to the class of securities exempt under A.R.S. § 44-1843, provided that before an offer is made in Arizona:

1. A prospectus or an offering circular, the standards of form or content which are prescribed by any provision of the Securities Act of 1933, or rules and regulations promulgated thereunder, and Form F-7, F-8, F-9, or F-10, whichever is applicable, shall be filed with the Commission ~~at least seven days before the offering is made~~; and
2. A nonrefundable exemption fee as provided in A.R.S. § 44-1861(G) shall be paid to the Commission.