

NOTICES OF PROPOSED RULEMAKING

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

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

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

[R06-484]

PREAMBLE

1. Sections Affected

R9-27-101
R9-27-202
R9-27-203
R9-27-204
R9-27-210
R9-27-301
R9-27-302
R9-27-303
R9-27-307
R9-27-310
R9-27-311
R9-27-312
Article 4
R9-27-401
R9-27-509
R9-27-702
R9-27-703
R9-27-704

Rulemaking Action

Amend
New Section
New Section
Repeal
Repeal
Amend
Amend
Amend
Amend

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

Authorizing statute: A.R.S. § 36-2903.01(F)
Implementing statute: A.R.S. § 36-2912(I)(5)

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

Notice of Rulemaking Docket Opening: 12 A.A.R. 881, March 24, 2006

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

Name: Jane McVay
Address: AHCCCS
Office of Administrative Legal Services
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034
Telephone: (602) 417-4135
Fax: (602) 253-9115
E-mail: AHCCCSRules@azahcccs.gov

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

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 proposed 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 GSA’s. However, the current rules restrict the program from offering a broader array of services than 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 proposed 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 proposed 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.

Notices of Proposed Rulemaking

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. Thus, rulemaking regarding this program is permitted but not mandatory. 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.

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.

6. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or 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:

Not applicable

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

Not applicable

8. The preliminary 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 KidsCare, 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.

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

Name: Jane McVay
Address: AHCCCS
Office of Administrative Legal Services
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034
Telephone: (602) 417-4135
Fax: (602) 253-9115
E-mail: AHCCCSRules@azahcccs.gov

Notices of Proposed Rulemaking

Proposed rule language will be available on the AHCCCS web site www.azahcccs.gov the week of December 11, 2006. Please send written comments to the above address by 5:00 p.m., January 30, 2007. E-mail comments will be accepted.

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

Date: January 30, 2007
Time: 10:00 a.m.
Location: AHCCCS
701 E. Jefferson
Phoenix, AZ 85034
Aspen Room
Nature: Public Hearing

Date: January 30, 2007
Time: 10:00 a.m.
Location: ALTCS: Arizona Long-Term Care System
110 S. Church, Ste. 1360
Tucson, AZ 85701
Nature: Public Hearing

Date: January 30, 2007
Time: 10:00 a.m.
Location: ALTCS: Arizona Long-Term Care System
3480 E. Rte. 66
Flagstaff, AZ 86004
Nature: Public Hearing

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

Not applicable

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

Not applicable

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

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

ARTICLE 1. DEFINITIONS

Section
R9-27-101. Location of Definitions

ARTICLE 2. SCOPE OF SERVICES

Section
R9-27-202. Covered Services
R9-27-203. Exclusions and Limitations
R9-27-204. ~~Out of Network Coverage~~ 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

Notices of Proposed Rulemaking

- 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 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 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"	9-27-101
"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
<u>"Employer"</u>	<u>R9-27-101</u>
<u>"Employer group"</u>	<u>R9-27-101</u>
"Enrollment"	R9-27-101
"Evidence of coverage (EOC)"	R9-27-101
"Experimental Services <u>services</u> "	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

Notices of Proposed Rulemaking

“Health care coverage”	R9-27-101
“Health care practitioner”	R9-27-101
“Hospital”	R9-27-101
“Inpatient hospital services”	R9-27-101
<u>“Late enrollee”</u>	<u>R9-27-101</u>
“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
<u>“Post-stabilization services”</u>	<u>R9-27-101</u>
“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
<u>“Subscriber”</u>	<u>R9-27-101</u>
<u>“Subscriber enrollment form”</u>	<u>R9-27-101</u>
“Substantial gainful activity”	R9-27-303
<u>“United States”</u>	<u>R9-27-101</u>
<u>“Waiting period”</u>	<u>A.R.S. § 36-2912</u>

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;

Arizona Administrative Register / Secretary of State
Notices of Proposed Rulemaking

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.

R9-27-203. Exclusions and Limitations

- ~~A. Excluded services. An HCG Plan shall not cover the following: Exclusions and limitations are as prescribed in the GSA.~~
- ~~1. Excluded services as specified in the GSA and the member handbook;~~
 - ~~2. Services not covered in the member's choice of HCG benefit options;~~
 - ~~3. Services that require prior authorization for which the member does not obtain prior authorization;~~
 - ~~4. Care for a health condition for which a state or local law requires the member to be treated in a public facility;~~
 - ~~5. Care for military service disabilities treatable through governmental facilities if the member is legally entitled to treatment and the facilities are available;~~
 - ~~6. Pregnancy termination, except when required by law to be covered;~~
 - ~~7. Treatment of gender dysphoria including gender reassignment surgeries and reversal of voluntarily induced infertility (sterilization);~~
 - ~~8. Services that HCGA, through its Medical Director, deems not to be medically necessary;~~
 - ~~9. Charges for injuries incurred as the result of:
 - ~~a. Participating in a riot,~~
 - ~~b. Committing or attempting to commit a felony or assault,~~
 - ~~c. Committing intentional acts of self-inflicted injury, or~~
 - ~~d. Attempting suicide.~~~~
 - ~~10. Infertility testing, in vitro fertilization, and all other fertilization treatments;~~
 - ~~11. Experimental services; and~~
 - ~~12. Medications not approved by the FDA.~~
- ~~B. Limitations. When providing covered services, the HCG Plan shall adhere to the coverage limitations in this Article and the following:~~
- ~~1. Inpatient hospital accommodations are covered as specified in the GSA and the member handbook.~~
 - ~~2. Alternative levels of care instead of hospitalization are covered if cost effective and medically necessary.~~
 - ~~3. Dialysis is limited to services not covered by Title XVIII, of the Social Security Act, as amended.~~

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 emergency 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~~

Arizona Administrative Register / Secretary of State
Notices of Proposed Rulemaking

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 time-frames 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

Notices of Proposed Rulemaking

- 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~~ An eligible employee selects ~~an HCG benefit plan;~~ health care coverage through HCG;
 2. ~~The An~~ 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 these rules.

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 provid-~~

Arizona Administrative Register / Secretary of State
Notices of Proposed Rulemaking

ers, 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 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

Notices of Proposed Rulemaking

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. Violating a 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; net-~~ work 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 loca-

tions.

ARTICLE 7. STANDARD 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 HCG Plans an HCG 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 which 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. 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. 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~~ 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 PROPOSED RULEMAKING

TITLE 17. TRANSPORTATION

CHAPTER 5. DEPARTMENT OF TRANSPORTATION
COMMERICAL PROGRAMS

[R06-483]

PREAMBLE

Notices of Proposed Rulemaking

1. Sections affected: R17-5-203 Rulemaking Action: Amend
2. **The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**
Authorizing statute: A.R.S. § 28-366
Implementing statute: A.R.S. § 28-5204
3. **A list of all previous notices appearing in the Register addressing the proposed rule:**
Notice of Rulemaking Docket Opening: 12 A.A.R. 4349, November 24, 2006
4. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**
Name: Janette M. Quiroz
Address: Administrative Rules Unit
Department of Transportation
1801 W. Jefferson, MD 530M
Phoenix, AZ 85007
Telephone: (602) 712-8996
Fax: (602) 712-3081
E-mail: jmquiroz@azdot@azdot.gov
Please visit the ADOT web site to track progress of this rule and any other agency rulemaking matters at www.dot.state.az.us/about/rules/index.htm.
5. **An explanation of the rule, including the agency's reasons for initiating the rulemaking:**
In conjunction with the Arizona Department of Public Safety, the Division proposes to amend R17-5-203 to require Commercial Motor Vehicles (CMVs) identified under R17-5-203(B)(3) to obtain a United States Department of Transportation number for intrastate travel within Arizona. This amendment is proposed as an effort to facilitate tracking and identification of those CMVs with a poor safety rating.
6. **A reference to any study relevant to the rules that the agency reviewed and proposes either to rely on or not to 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:**
The Division did not rely upon nor review any study relative to this rulemaking.
7. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**
Not applicable
8. **The preliminary summary of the economic, small business, and consumer impact:**
The proposed rule amendment is anticipated to promote highway safety in Arizona. It affects CMVs, state and local law enforcement agencies that inspect commercial vehicles, and motorists sharing the roads with commercial vehicles.
It will require a federal motor carrier identification number for intrastate vehicles to facilitate tracking and identification of those with a poor safety rating. No fee is charged for obtaining the federal identification number, which is available on the Internet or through the U.S. mail. The only cost to the CMV operator would be for lettering to display the federal identification number. Law enforcement will benefit by being able to focus audits and inspection activities on problem carriers and the motoring public will benefit by reducing unsafe trucks and busses on the roadway.
There is no cost to the state or the commercial vehicle industry associated with registration and the cost of displaying the identification number on the vehicle is minimal.
9. **The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:**
Interested parties may communicate with the Agency official listed in item #4 concerning the economic impact statement.
10. **The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:**
Date: January 30, 2007
Time: 1:00 p.m.
Location: 1801 W. Jefferson
Nature: Public Hearing
11. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of**

rules:

None

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

None

13. The full text of the rules follows:

TITLE 17. TRANSPORTATION

**CHAPTER 5. DEPARTMENT OF TRANSPORTATION
COMMERCIAL PROGRAMS**

ARTICLE 2. MOTOR CARRIERS

Section

R17-5-203. Motor Carrier Safety: 49 CFR 390 - Federal Motor Carrier Safety Regulations; General Applicability and Definitions; General Requirements and Information

ARTICLE 2. MOTOR CARRIERS

R17-5-203. Motor Carrier Safety: 49 CFR 390 - Federal Motor Carrier Safety Regulations; General Applicability and Definitions; General Requirements and Information

- A.** 49 CFR 390.3 General applicability is amended as follows:
1. Paragraph (a) is amended to read:
Regulations incorporated in this Section are applicable to all motor carriers operating in Arizona and any vehicle owned or operated by the state, a political subdivision, or a state public authority that is used to transport a hazardous material in an amount requiring the vehicle to be marked or placarded as prescribed in R17-5-209.
 2. Paragraph (b) is amended to read:
A motor carrier driver domiciled in Arizona who operates a commercial motor vehicle defined in A.R.S. § 28-3001 shall comply with the requirements of A.R.S. Title 28, Chapter 8 and any rule made under that Chapter.
 3. Paragraph (c) is amended to read:
A motor carrier operating in Arizona in furtherance of a commercial enterprise, shall comply with the financial responsibility requirement specified in A.R.S. Title 28, Chapter 9, Article 2, and 49 CFR 387.
 4. Paragraph (f)(6) is deleted.
- B.** 49 CFR 390.5 Definitions. The definitions listed in 49 CFR 390.5 are amended as follows:
1. If the term "Commercial Motor Vehicle" or "CMV" is used in reference to the controlled substances and alcohol use and testing requirement of 49 CFR 382, the term has the meaning prescribed in 49 CFR 382.107.
 2. If the term "Commercial Motor Vehicle" or "CMV" is used in reference to the licensing requirements prescribed under A.R.S. § 28-3223, the term has the meaning prescribed under A.R.S. § 28-3001.
 3. If the term "Commercial Motor Vehicle" or "CMV" is not used in reference to the controlled substances and alcohol use and testing requirement of 49 CFR 382 or the licensing requirement prescribed under A.R.S. § 28-3223, the term means a self-propelled, motor-driven vehicle or vehicle combination, used on a public highway in this state in furtherance of a commercial enterprise that:
 - a. Has a gross vehicle weight rating (GVWR) as a single vehicle or a gross combination weight rating (GCWR) of 18,001 pounds or more for purposes of intrastate commerce;
 - b. Transports passengers for hire and has a design capacity of seven or more persons; or
 - c. Transports a hazardous material in an amount requiring marking or placarding as prescribed in R17-5-209;
 - d. Is not an intrastate-operating tow truck that has a GVWR up to 26,000 pounds, but a tow truck operator remains subject to all other provisions prescribed under 49 CFR 391.41, 391.43, 391.45, 391.47, and 391.49; and
 - e. Operates for purposes of interstate commerce with a GVWR of greater than 10,000 pounds.
 4. "Exempt intracity zone" is deleted and has no application in R17-5-203 through R17-5-206.
 5. "For-hire motor carrier," "private motor carrier," "private motor carrier of passengers (business)," and "private motor carrier of passengers (nonbusiness)" are deleted from R17-5-203 through R17-5-206 and the term "motor carrier" is substituted.
 6. "Regional Director of Motor Carriers" means the Division Director of the Arizona Department of Transportation, Motor Vehicle Division.
 7. "Special agent" means an officer or agent of the Department of Public Safety, the Division, or a political subdivision, who is trained and certified by the Department of Public Safety to enforce Arizona's Motor Carrier Safety require-

Notices of Proposed Rulemaking

ments.

8. "State" means a state of the United States or the District of Columbia.
9. "Tow truck," as used in the definition of emergency in 49 CFR 390.5, has the meaning prescribed under A.A.C. R13-3-101.

C. 49 CFR 390.15 Assistance in investigations and special studies. Paragraph (a) is amended to read:
A motor carrier shall make all records and information pertaining to an accident available to a special agent upon request or as part of any inquiry within the time the request or inquiry specifies. A motor carrier shall give a special agent all reasonable assistance in the investigation of any accident including providing a full, true, and correct answer to any question of the inquiry.

D. ~~49 CFR 390.21 Marking of CMVs. Paragraph (a) is amended to read:
This Section applies to all motor carrier vehicles operated in Arizona. A motor carrier not subject to U.S. Department of Transportation marking requirements shall mark its vehicle with the:~~

- ~~1. Company name, or~~
- ~~2. Business trade name, and~~
- ~~3. City and state.~~

49 CFR 390.19 Motor carrier identification report.

(a) Each motor carrier that conducts operations in interstate commerce, intrastate commerce if the carrier requires a Safety Permit as per § 385.400 of this Chapter, or intrastate commerce in a CMV defined under A.A.C. R17-5-203(B)(3) must file a Motor Carrier Identification Report, Form MCS-150, or the Combined Motor Carrier Identification Report and HM Permit Application, Form MCS-150B for permitted carriers, at the following times:

E. §390.21 Marking of CMVs.

(a) General. Every self-propelled CMV as defined under A.A.C. R17-5-203(B)(3), subject to subsection B of this Chapter must be marked as specified in paragraph (b), (c), and (d) of this Section.

FF. 49 CFR 390.23 Relief from regulations.

1. Paragraph (a) is amended to read:
Regulations contained in 49 CFR 390 through 397 do not apply to a motor carrier that:
 - a. Is exempt from federal jurisdiction, and
 - b. Operates a commercial motor vehicle used or designated to provide relief during an emergency.
2. Paragraphs (a)(1), (a)(1)(i), (a)(1)(i)(A), (a)(1)(i)(B), and (a)(1)(ii) are deleted.
3. Paragraph (a)(2)(i)(A) is amended as follows:
 - a. An emergency has been declared by a federal, state, or local government official having authority to declare an emergency; or
 - b. An emergency situation exists under A.R.S. § 28-5234(B) as delineated in R17-5-210.
4. Paragraph (a)(2)(i)(B) is amended as follows:
The Arizona Department of Public Safety Commercial Vehicle Enforcement Bureau determines a local emergency exists that justifies an exemption from any or all of these Parts. If the Arizona Department of Public Safety Commercial Vehicle Enforcement Bureau determines relief from these regulations is necessary to provide vital service to the public, relief shall be granted with any restrictions the Arizona Department of Public Safety considers necessary.
5. "Interstate commerce" as used in paragraph (b) means engagement in a commercial enterprise.

FG. 49 CFR 390.25 Extension of relief from regulations - emergencies is amended as follows:

A motor carrier seeking to extend a period of relief from these regulations shall obtain approval from the Arizona Department of Public Safety Commercial Vehicle Enforcement Bureau. The motor carrier shall give full details of the additional relief requested. The Arizona Department of Public Safety shall observe time limits for emergency relief from regulations as prescribed under 49 CFR 390.23(a), but may extend a period of relief after considering:

1. Severity of the emergency,
2. Nature of relief services to be provided by the motor carrier, and
3. Other restrictions that may be necessary.

G.H. 49 CFR 390.27 Locations of motor carrier safety service centers is amended to read:

A motor carrier requesting relief from these regulations shall contact the Arizona Department of Public Safety, Commercial Vehicle Enforcement Bureau, Telephone (602) 223-2212.